

Mothers' expectations of midwives' care during labour in a public hospital in Gauteng

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Background: Mothers develop expectations regarding midwives' care during labour and when these are not met mothers become dissatisfied and eventually have negative experiences of their labour. It is only when mothers' voices are heard by midwives in the labour ward that efficient and quality care will be provided. To ensure mothers have a positive experience of labour, midwives should include mothers' expectations when caring for them.

Objective: The purpose of the study on which this article is based was to determine mothers' expectations of midwives' care during labour. To achieve this purpose the researcher sought to explore and describe mothers' expectations of midwives' care during labour in a specific public hospital in Gauteng.

Method: A qualitative, exploratory, descriptive and contextual study design was used. Face-to-face, in-depth individual interviews were conducted with mothers about their expectations of midwives' care during labour. Data were then analysed with an open descriptive method of coding (Tesch's eight steps) that is appropriate for qualitative research to identify categories. The data was also analysed by an independent coder. The categories were subsequently placed within a holistic health promotive nursing theory that encompasses body, mind and spirit.

Results: The findings revealed the provision of comfort and support as the two main aspects that the mothers expected from the midwives' care. The mothers expected midwives to improve their communication skills with them (mothers) as well as with fathers or partners if they were available. The mothers expected midwives to facilitate bonding between mother, father and baby, and also encouraged the midwives to improve their (midwives') knowledge, skills and morale.

Conclusion: The results of this study should assist midwives in providing holistic quality care to mothers during labour, thus providing satisfaction and positive experiences of the mothers' labour.

Introduction

Pregnant mothers wait in anticipation for nine months, with a variety of thoughts and emotions, eagerly expecting the uncomplicated births of healthy babies. However, pregnant mothers also fear that the pain of giving birth will be unbearable or that something will go wrong. All women seem to develop expectations of childbirth but the kinds of expectations vary (Lowdermilk & Perry 2006:402). The World Health Organization (WHO) estimates that worldwide, as many as 1500 women die every day due to complications related to pregnancy or childbirth. Similarly, 10 000 babies die per day within the first month of life and an equal number of babies are born dead. More than 90% of these deaths occur in developing countries, most of them in Africa (Republic of South Africa, National Department of Health 2012:6) In addition, maternal deaths cause one million children to become motherless annually (D'Ambruoso, Abbey & Hussein 2005:1)

A woman's expectations arise from her social conditioning: her education, including prenatal education programmes, her own birth experience and the influence of authority figures like her doctor. Other expectations arise from stories her friends and relatives have told her, films, television programmes, books and magazines. The information that she has received contributes to her beliefs about child-bearing and what she expects to happen when she gives birth (Highsmith 2006:141).

Women also differ in their expectations of relationships with midwives (Hunter 2006:310). For some women, knowing the midwife and establishing a bond with her is important, whereas for others, the most important aspect is feeling confident in the skills and ability of the midwife (Lowdermilk & Perry 2006:426). From the women's expectations, personal relationships appear to be valued over role-based relationships. For example, mothers feel valued when the midwives

provide them with the expected and needed care during labour. Some women view midwives as friends, with the relationship characterised by mutuality and intimacy (Nicholls & Webb 2006:415).

According to the Scottish Government Department of Health, Social Services and Public Safety (2010:22), midwives play a central role in ensuring that women have a safe and life-enhancing experience based on their expectations during their maternity care and that their babies and families have the best possible start in life. Midwives are autonomous professionals whose unique and specialist contribution affects the whole population: each of us at the time of birth, the great majority of people who become parents and the half of these who become mothers. Women and their families expect a service that provides clear communication and explanations, effective teamwork, a safe, caring environment and continuity of care. A midwife's role is to ensure that these expectations are understood and met (Scottish Government Department of Health, Social Services and Public Safety 2010:22).

There is growing awareness that a person's individual beliefs, expectations, attitudes, perceptions and thoughts not only have an influence on how mothers feel and behave but directly influence the reality they experience (Fenwick *et al.* 2005:30).

The lack of a birth plan, a communication document that is uniquely designed according to the mother's needs and expectations, may lead to unfulfilling experiences (Fraser, Cooper & Nolte 2010:451). These authors echo Maputle and Nolte's (2008:5) view that midwives' inability to give information and clear explanations to mothers during labour may lead to feelings of disappointment which may later generate negative experiences. If mothers are not given adequate information, they may not be able to communicate with their physicians and midwives or be willing or able to ask questions (Hunter 2006:320). Not allowing the fathers or partners to provide support to the mothers during labour may prevent bonding from occurring between them and the baby. According to Lowdermilk and Perry (2006:426), fathers are valuable in providing support, encouragement and reassurance to the mothers during labour.

This article explores and describes mothers' expectations of midwives' care during labour. Face-to-face, in-depth individual interviews were conducted to investigate mothers' expectations of midwives' care during labour.

Problem statement

Hunter (2006:310) states that a woman-midwife relationship should be a partnership based on equality, shared responsibility, empowerment, continuity of care giving, individual negotiation and informed choice and consent. Henderson and Macdonald (2004:433) agree with this view by stating that the relationship between the mother and the midwife is ideally a partnership ethos requiring

the involvement of the mother and her partner in decision making whereby the mother is able to voice her needs, expectations and wishes freely. They further indicate that the midwife should strive to build a relationship of mutual trust and create an environment in which expectations, wishes, fears and anxieties can be discussed, based on good communication resulting from a two-way interaction between equals.

Barker *et al.* (2005:315) reported accounts of mothers feelings of little control that were related to inadequate information provision, poor communication and lack of opportunity to influence decision making, including negative attitudes and behaviours of maternity staff that were linked to mothers' negative feelings such as fear, anger, disappointment, stress, guilt and inadequacy.

Mothers going through labour and childbirth must receive individualised holistic care to meet their unique needs and expectations because they experience stress and physical pain, hence, midwives as skilled attendants should provide an environment which allows mothers to go through childbirth with dignity by providing adequate and relevant information that allows the mother to make relevant informed decisions (WHO 2003: 35).

According to Maputle and Nolte (2008:56), once mothers seek midwifery care during childbirth, they are expected to follow set standards, midwifery protocols and procedures that do not always manifest the experiences, needs, expectations and priorities of mothers during childbirth. Furthermore, Modiba (2012:19) explains that where care is appropriately organized, and midwives hold interpersonal, clinical skills and knowledge, care is more likely to be positive. If care is fragmented, oriented to technology, protocols and standards rather than human relationship, where midwives do not have professional autonomy and the culture of care is institutionalized, even if they hold the best skills, attitudes and knowledge, the midwives will not be able to do their best in support of the mothers and their families.

From the above stated problem statement the following research question arose: what are the mothers' expectations of midwives care during labour?

Purpose and objective of the study

The purpose of the study was to determine mothers' expectations of midwives' care during labour in a public hospital in Gauteng.

To achieve this purpose, the researcher sought to explore and describe mothers' expectations of midwives' care during labour.

Significance of the study

This study may ensure that, in order to improve practice, midwives' care must be based on evidence of what mothers expect of midwives care during labour. The study may

inform midwives' care that could be rendered to the pregnant mothers during labour. Provision of care to be rendered may be individualised, based on mothers' expectations; thus enhancing the quality of care that is rendered to mothers during labour.

Paradigmatic perspective

The study focused on the promotion of health of the individual, family, group and community, using the Theory for Health Promotion in Nursing (THPN) (University of Johannesburg 2006:2). This theory is specifically applicable in the realm of midwifery practice as the mother is viewed holistically in interaction with her environment. The midwife as a sensitive, therapeutic professional facilitates the promotion of health through the mobilisation of resources. The meta-theoretical assumptions of the THPN (University of Johannesburg 2006:2) are:

- unconditional acceptance of people and respect for human rights;
- sensitivity towards cultures through empathy and caring;
- realizing and facilitating virtues such as honesty, commitment, trustworthiness, acceptance of responsibility and accountability, courage and perseverance, and promoting co-operation and empowerment by being consumer friendly and helpful through availability and accessibility.

Operational definitions

For the purpose of this study, the following concepts were used as defined below:

- Mother refers to a female parent of a child or offspring (Allen 2006:903). The mother in this study refers to a pregnant individual who was in labour at a specific hospital in the Gauteng province.
- Expectation refers to the hopeful anticipation of a desired event (Allen 2006:487). In this study expectation referred to the mothers' anticipation of midwives' care during labour.
- Midwife refers to a person who has been admitted to a midwifery educational programme, duly recognised in the country in which it is located, who has successfully completed the prescribed course of studies in midwifery, and who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery (International Confederation of Midwives' Council Meeting 2005:1).
- Care refers to those assistive, supportive, helping, facilitated, professional, moral and culturally accepted actions rendered to the individual, family or group, whilst feeling concern or interest, providing protection and showing attention to the one being cared for; through a competent and interactive therapeutic caring relationship (Msolomba 2007:207).
- Labour refers to the act of giving birth to a child. It is characterised by regular and rhythmic uterine contractions and the gradual dilatation and effacement of the cervix. The first stage lasts until there is full dilatation of the

cervical os, the second stage lasts until the baby has been delivered and the third stage implies the delivery of the placenta and membranes (Brooker 2006:136). The fourth stage refers to the period after delivery of the placenta up to one hour post-delivery (Dippenaar & Da Serra 2012:316) In this study labour occurred when the mother had reached term, that is 36–40 weeks of pregnancy, and commenced when the cervix was 3 cm dilated until 10 cm dilatation; it included the first, second and third stages up to the end of the fourth stage of labour.

Research approach and methods

The study was quantitative, explorative, descriptive and contextual in nature. A qualitative approach was used in order to gain insight into mothers' expectations of midwives care during labour through discovering meanings they attach to these expectations (Burns & Grove 2005:52). The study was also contextual since validity of the findings is claimed only in the labour ward of a specific public hospital in Gauteng where the study was conducted (Minnie, Klopper & Van der Walt 2008:52).

Setting

The study was conducted at a specific public hospital based in the Gauteng province. This is a third level academic hospital that provides specialised service to a semi-rural nearby community. It also serves as a referral hospital for other level one hospitals and clinics that are nearby.

Study population

Polit and Beck (2012:738) define a research population as an aggregate of all the individuals or objects to be studied with some common defining characteristics. In this study the population entailed all mothers' who delivered in the labour ward under the care of midwives and were then transferred to the postnatal ward of a specific public hospital in Gauteng. The mothers were recruited from the postnatal ward because for the first two hours after delivery (fourth stage of labour) they need adequate rest and time to bond with their new born babies. The mothers also need to be closely observed by midwives (to exclude complications such as postpartum bleeding). Those who agreed to participate were willing to be interviewed on day one of their postnatal period (the day following delivery). This date was convenient for the mothers because those who deliver normally without any complications are usually discharged on day one or two following their delivery day.

Sampling

Purposive sampling was used to ensure that a specific representation of the entire population was selected (Polit & Beck 2008:338). No predetermined number of participants was specified. In order to be included in the study, the mothers could be of any age and the pregnancy must have reached term; the mothers must have been observed for more than four hours in the labour ward because this would give

adequate time to experience care provided by the midwives. For ethical reasons of not inducing further trauma through the interviews, only mothers who had delivered normally and their babies were alive were included. Mothers must have given informed consent to participate in the study.

Pilot study

De Vos *et al.* (2011:237) define a pilot study as a procedure for testing and validating an instrument by administering it to a small group of participants from the intended test population. Two face-to-face, in-depth individual interviews were held with mothers who were chosen from the population, but were not included in the main study. The researcher conducted a pilot study to determine whether the central question and the instrument used elicited the information being sought. The results yielded the intended information; hence the central question was not changed. The findings from the pilot study were not included in the main findings.

Data collection

Data was collected in a suitable environment for the mother identified by the hospital management whilst babies were cared for in the nursery. Face-to-face, in-depth individual interviews were conducted in English because all the participants were able and willing to speak English and one central question was asked:

Please tell me, in detail, what are your expectations of midwives' care during labour?

A tape recorder was placed strategically to capture dialogue between researcher (moderator) and the participants. Each interview lasted for 45 min to 1 h.

The researcher conducted follow-up interviews with the mothers during their six week postnatal visit to verify whether the results were a true reflection of their verbalised expectations.

Data analysis

Data analysis was done by the researcher concurrently with data collection using Tesch's eight steps (Creswell 2009:186). Data was collected until no new data emerged and saturation was reached. The data was also analysed by an independent coder, who then met with the researcher to discuss and reach consensus on the identified categories and subcategories.

Trustworthiness

Lincoln and Guba's model (De Vos *et al.* 2007:345–347) was used to maintain trustworthiness of the study. The following criteria for trustworthiness were applied in this study: credibility, transferability, consistency, neutrality.

Credibility was enhanced by implementation of the following strategies:

- Member checking. Follow-up interviews were held with the participants for validation of the data.

- Peer examination. The study was supervised by an expert in research methods and midwifery. The data was also analysed by an independent coder experienced in qualitative research methods and midwifery.

Transferability was enhanced by giving a thick description whereby the researcher gave in-depth discussion of the research methodology and the findings.

Consistency was ensured by using a peer examination strategy, as well as by doing stepwise replication in which the researcher was under the guidance and supervision of the mentor throughout the study.

A dependability audit was ensured by the involvement of an experienced researcher (supervisor) in qualitative methods, who followed the progression of the study to analyse and evaluate decisions made, as well as to determine whether comparable conclusions could be reached given the same data and research context.

The researcher's authority was established by analysing the characteristics that enabled her to conduct the research efficiently. The researcher has a master's and doctoral degree in Midwifery and Neonatal Nursing, has developed investigative skills, literature review experience and interviewing skills as well as experience in qualitative research methods.

Neutrality entails freedom from bias in the research procedure and findings. It also refers to the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher (Babbie & Mouton 2011:278). The researcher held discussions on the collected data with the participants. In some stages of the research project, discussions were also held with the supervisor and an independent coder. The researcher made use of reflective thinking by putting aside her own speculations, feelings, problems, ideas, prejudices and impressions when analysing the data.

Ethical considerations

Permission to conduct the study was obtained from the Research Ethics Committee at the University of Johannesburg Faculty of Education and Nursing Science and the management of the hospital where the study was conducted. Informed consent was obtained from the participants before data collection commenced but first the researcher explained the purpose and objectives of the study in detail. The participants were informed that they could withdraw from the study at any time without fear of being victimised. Confidentiality was maintained throughout the study by not attaching names to the collected data but using codes. The participants were also assured that the tapes that contained the interview information would be erased after transcription of the interviews. The researcher treated the participants with respect by asking questions about their personal views sensitively and they were assured that they would not be exposed to harm or exploitation (Polit & Hungler 2001:76). The participants were informed that

they would not be remunerated for participating and that the results of the study may be published. The researcher provided the participants with her contact details should they have any questions about the study.

Findings and discussion

Discussion of the findings includes responses from the mothers in the study. Tesch's eight steps (Creswell 2009:186) were used to identify categories that were named according to the most descriptive word for that category. These categories were then positioned within the universal categories of THPN (University of Johannesburg 2009:2–13), which was used as a theoretical framework to guide this study that comprises body, mind and spirit.

Body

Regarding the participants' physical well-being, the participants indicated that they desired comfort and a pleasant environment. During admission there was a need for the midwives to give the mothers prompt attention, welcome them warmly and orientate them to the labour ward. Midwives were required to show them a bed to lie on or offer them a chair to sit on before asking them questions and examining them physically. Two of the participants said:

'Firstly, I would expect them to welcome me with a smile and ask me what I am there for and what my problems are.' (Participant 4, mother, teacher, 27 years)

'I expect basic things, like to be shown around ... especially regarding things that I would use in the ward, where to look for help; that is, the basic orientation for starters' (Participant 5, mother, dressmaker, 33 years)

Dippenaar and Da Serra (2012:334) justify the mothers' expectations by stating that the midwife should welcome the mother and give her a brief explanation of the activities which will take place to confirm whether she is in labour or not. They also point out that the mother should be seated in a comfortable chair, but if she is experiencing severe labour pains it may be necessary for her to lie on the admission couch. Privacy must be maintained all the time.

Littleton and Engebretson (2005:507) concur with the mothers' expectations by stating that the midwife should introduce herself, ask the names of the mother and those accompanying her, and accompany them to the admission room. As the midwife helps the mother undress and get into a hospital gown, she also begins to develop rapport and establish the midwifery database. In referring to the mothers' expectations, Leifer (2005:99) agrees that the mother should be made comfortable, and recommends that if she wants to rest in bed, a side-lying or semi-fowler's position rather than a supine position is most comfortable and avoids supine hypotensive syndrome.

Fraser *et al.* (2006:424) explain that the initial examination of the mother should be preceded by taking history regarding her labour, including when labour started, whether the membranes had ruptured and the frequency and

strength of contractions. Her temperature and pulse must also be monitored.

The participants expected the midwives to do a needs assessment based on the mothers' emotional status, social problems, knowledge about labour and perception of pregnancy. In reporting on the assessment of the mother during labour, Dippenaar and Da Serra (2012:218) state that monitoring the progress of labour requires more than assessment of the cervical dilatation and uterine contractions. Midwives should give weight to other skills such as abdominal palpation and knowledge of women's changing behaviour. Fraser *et al.* (2006:434) agree with the mothers' expectations by stating that the midwife has a traditional and professional role to fulfil: of clinical assessment of the progress of labour and the physical status of the mother and baby.

During the first stage, the participants expected midwives to provide them with comforting measures such as rubbing their backs and abdomens, assisting them to assume a comfortable position, giving them pain relieving medications, holding their hands, offering them something to drink and then preparing them for delivery. Two of the participants commented as follows:

'I want to say that massage does help there. I think if there is somebody there just to rub your tummy or back or even touch you that would ease off the strength of the pain.' (Participant 4, mother, teacher, 27 years)

I would expect the midwife to assist me in whatever way to endure this pain and if possible, let them give me a pain relieving injection (Participant 2, mother, cashier, 28 years).

Adams and Bianchi (2008:109) emphasise that touch conveys an attitude of caring and encourages comfort. However, a pat on the hand or shoulder may be acceptable to some but not to others. Nurses must consider the client's personal space and cultural background when determining appropriate touch during labour. Holding the mother's hand, stroking her hair or similar actions convey caring, comfort, affirmation, and reassurance at this vulnerable time. Adams and Bianchi (2008:109) also endorse the expectations of mothers in this study by stating that massage, as a form of touch, relaxes muscles and increases blood flow and enhances the release of endorphins, promoting comfort whilst decreasing pain. The Multicultural Perinatal Network (2007:1) contends that massage can be soothing and relaxing to the back, shoulders and legs. They also recommend that a body lotion may be used for massaging the mother.

Romano and Lothian (2008:100) point out that maternal positions that are consistent with the anatomic principles (such as squatting or kneeling positions to enlarge the pelvis) are generally safe and acceptable to women. This idea is supported by the Multicultural Perinatal Network (2007:1), who report that the mother may experience less pain in some positions than in others during labour. Labouring women tend to find upright positions, such as sitting, standing and walking, most comfortable. Many choose a lying down

position as labour advances. Moving about during labour is usually more comfortable than staying still and helps labour to progress as a result of gravity and the changing shape of the pelvis. The Public Health Agency of Canada (2000:7) indicates that a policy of encouraging mobility, particularly in early labour, can potentially facilitate the progress of labour and increase comfort.

Romano and Lothian (2008:98) support the mothers' expectations by stating that eating and drinking during labour provides essential nutrition and energy for the labouring woman. Labour is hard, active work that requires calories, not just hydration. In addition, labouring women preferred to eat and drink rather than fast. The Public Health Agency of Canada (2000: 15) agrees with this view by stating that although the practice of withholding food and fluid once labour has begun exists in many settings, it has become a concern. This practice is not supported in the literature partly because all labours are unique. Thus decisions must be made on an individual basis.

During the second stage of labour, the participants expected the midwives to assist them by holding their legs so as to alleviate cramps and to cut episiotomies professionally. One participant made the following comment:

'Maybe say, for instance you are cut in your private part or a stitch, I think it must be done professionally, so that I must not suffer the pain later after giving birth whilst I am at home.'
(Participant 1, mother, student, 23 years)

Henderson and Macdonald (2004:497) point out that it is not uncommon for the woman to complain of leg cramps, particularly if she is tensing her muscles during bearing down efforts and utilising the common practice of pulling her knees to her chest. This may be relieved by massage and by extending the leg and dorsiflexing the foot – that is, bending it upwards.

With regard to comfort during the third and fourth stages, the participants expressed the desire to be stitched professionally and to be given a bath and treatment for cleaning the wound. They expected the midwives to place extra pillows at their backs to facilitate good rest:

'I mean, washing me, dressing me up and giving me some hot tea or soup then putting me into a comfortable bed...'
(Participant 3, mother, housewife, 31 years)

'They must constantly check on me, in terms of my physical condition.'
(Participant 1, mother, student, 23 years)

Fraser *et al.* (2006:487) state that midwives who have had instruction and have had supervised practice in suturing the perineum and are judged to be proficient may carry out the procedure in the case of an episiotomy or second-degree tear. It is kind to the mother to complete this aspect of care without undue delay and whilst the tissues are still anaesthetised. Similarly, the Scottish Government Public Health Agency of Canada (2000:12) argues that the practice of routine episiotomy should be abandoned. Olds *et al.* (2004:1026) explain that the midwife should teach the mother how to care for the episiotomy, since this promotes healing and reduces the incidence of infection.

Johnson and Boyd-Davis (2003:615) state that after giving birth, the woman should be covered with a warm blanket, offered a warm drink if she is not nauseated from an analgesic, and assured that the occurrence is normal. This is usually enough to make the chills transient and will allow her to fall into a sound, much-needed sleep. Most women will then sleep for at least an hour.

Most mothers appreciate being able either to wash or shower at this stage, which can do much to restore comfort and increase a sense of well-being (Fraser *et al.* 2010:466). These authors also suggest that simple comfort measures such as mothers will appreciate are being able to brush their teeth and apply lip balm or cream to alleviate dry mouth and sore lips, especially if inhalational analgesia has been used during labour. There is no evidence to suggest that restriction of food or fluids is necessary, thus a meal and fluids can be offered while the midwife completes her task, and the mother and her support person enjoy a little privacy with the new family member. De Kock and Van der Walt (2004:14–10) emphasise that the first hour after birth is a potentially dangerous period because of the possibility of haemorrhage. Continuous assessment of the uterus should be made to ensure that the uterus stays firmly contracted. If the uterus is boggy (atonic), the fundus should be massaged until it is firmly contracted.

Mind

In terms of the mind, the participants expected the midwives to support them by showing increased sensitivity, that is, not being harsh with them but rather consoling them. The participants' wished for the constant presence of the midwife. They expected the midwives to show interest, concern, advocacy, sympathy and empathy, and to give them emotional and moral support:

'They should not be harsh with me.'
(Participant 5, mother, dressmaker, 33 years)

In the study, the participants confirmed what D'Ambruso *et al.* (2005:7) have emphasised, namely that women expect attending midwives to provide guidance and counselling. However, they indicated that providers expect women to know what to do at various stages during labour and delivery and that their lack of knowledge drew reprimands from some attending nurses and midwives. Some of the participants indicated that the nurses and midwives had shown a poor attitude towards them. Their behaviour had included rudeness, undeserved or inappropriate reprimands, shouting at women who were in labour, a lack of sympathy and empathy, refusal to assist, refusal to allow women in labour to touch or hold a midwife, threatening the women with poor outcomes if they did not comply with instructions, denying them service and showing a lack of moral support and encouragement.

Similarly, Maputle and Nolte (2004:83) reported in their study that some mother participants had a firm conviction that midwives lacked comforting measures and emotional support skills. The mothers indicated that midwives had no

sympathy and were unfriendly and that some scolded the mothers.

In discussing mothers' expectations, Kneisl and Trigoboff (2009:37) maintain that genuine interest and concern provide the basis for a therapeutic alliance. The nurse conveys general interest and concern by trying to understand the client's perspective, working with the client on mutually formulated goals, and persisting even when breakthroughs and improvements are subtle and slow instead of dramatic and quick.

Fraser *et al.* (2006:434) explain that emotional support is provided by exercising skill in imparting confidence, expressing caring and dependability as well as being an advocate for the childbearing woman if needed. The midwife should display a tolerant non-judgmental attitude, ensuring that the mother is accepted, whatever her reactions to labour may be. Similarly Kneisl and Trigoboff (2009:39) state that successful advocacy is a positive experience for nurses as well as for clients. Clients derive benefit, and nurses feel good about their ability to be agents of change. The mothers who participated in the study also expressed these views.

Nicholls and Webb (2006:424) support Hunter's (2002:660) standpoint that nurses' presence includes portraying a high level of nursing skill, being open, honest, and non-judgmental with the client, listening intently to her needs and concerns, understanding the privilege of being part of the client's life, and the client's perception of the meaningfulness of the relationship with the nurse. They argue that being there for the woman and having good communication skills are the most important aspects of good midwifery care (Nicholls & Webb 2006:424).

The participants emphasised the need for communication. They expected the midwives to explain their actions and findings, and to guide and encourage them on what to do, without shouting at them but reassuring them throughout labour:

'They should explain to you in simple terms because sometimes they say 'push' and you don't know what you are doing, and they shout at you meanwhile you don't understand what 'pushing' is all about. So 'pushing' should be taught and clearly explained so that nothing goes wrong during the delivery.' (Participant 1, mother, student, 23 years)

In articulating their expectations, the participants were in agreement with Lowdermilk and Perry's (2006:426) claim that the midwife can alleviate a woman's anxiety by explaining unfamiliar terms, providing information and explanations without her having to ask, and preparing her for procedures that will follow. The midwife can provide support to the mother by helping her maintain control and participate to the extent she wishes in the birth of her infant and by acknowledging the mother's efforts, as well as those of her partner, during labour and providing positive reinforcement. This idea is supported by Fraser *et al.* (2006:435), who contend that midwives must provide support by giving information that ensures the mother understands events, feels free to ask questions and is aware of how labour is progressing.

Littleton and Engebretson (2005:541) explain that it is important for support persons to help the mother cope by assuring the mother that all is going well, staying with her, and coaching, guiding, encouraging and reassuring her as required throughout the process of labour. The mother needs constant support during labour.

The mothers who participated in the study said that they wished to be congratulated on the birth of the baby. They expected the midwives to instruct them on child care and do follow-up visits in the postnatal ward. One participant said:

'I expected them to continue as we started, to congratulate me for being brave and for giving birth to a healthy child.' (Participant, mother, cashier, 28 years)

Fraser *et al.* (2006:434) assert that the support person must ensure that the mother understands every procedure and the results of every examination, that she is informed on the progress of her labour, and that she is praised for her efforts and encouraged to continue.

Parent-newborn attachment is promoted by encouraging the family to be involved with the newborn, such as holding, feeding, and changing its napkins (Leifer 2005:161). Nearly every contact the nurse has with the parents presents an opportunity for teaching that can facilitate their competence in newborn care. The midwife should demonstrate procedures such as baby bathing and cord care to the parents. The mother should be assisted to latch the baby on the breast, especially if she is a primigravida.

The participants expressed a need for the nursing profession to be transformed:

'We need an overhaul of the nursing profession. The fact that you are ... assisting someone to give birth to a child, do the job just like it's a calling, not like somebody has forced you to do that. Look well after the mother.' (Participant 5, mother, dressmaker, 33 years)

According to the Scottish Government Department of Health, Social Services and Public Safety (2010:33), midwives need to reclaim the core values of their profession and promote these with professional pride to lift the overall public perceptions of midwifery. This concurs with the views expressed by the participants in the study.

Spirit

In terms of the spirit, the participants expressed the following expectations:

'Allowing my husband to support me physically and emotionally is the best thing that could happen to me.' (Participant 4, mother, teacher, 27 years)

'They must bring my baby before I go to the other ward. I want to see it, cuddle it, and love it because I want to see my flesh and blood immediately and really feel that this is my baby.' (Participant 2, mother, cashier, 28 years)

Lowdermilk and Perry (2006:428) point out that although a man other than the father may be the woman's partner, the father of the baby is usually the support person during

labour. Often, he is able to provide the comfort measures and touch that the labouring woman needs. In addition, he is usually able to interpret the woman's needs and desires for staff members.

Basavanhappa (2006:329) agrees with this view by stating that the father's presence at the birth can be a profound experience for the new parents and make them aware of parenthood as a mutually shared effort. The father's encouragement to sustain the pushing efforts is important. The partner remains at the mother's side, speaking directly into her ear, if needed. He will coach the mother to perform pushing techniques and praise her for her efforts.

Luxner (2005:92) recommends that parents should be provided with an opportunity to see and touch the baby immediately after birth. If the baby needs resuscitation, parents should be allowed to see and touch the baby before it is transferred to the nursery.

According to Romano and Lothian (2008:100), newborns held skin-to-skin by their mothers cry less and stay warmer than newborns placed in warming cribs. Skin-to-skin contact also exposes babies to their mother's normal bacteria, not the hospital germs, which lowers their risk of acquiring infections.

The mothers expected the midwives to respect their cultural and religious beliefs. Their views echo Basavanhappa's (2006:313) standpoint that midwives should know and understand how culture mediates pain because they regularly care for mothers from a variety of cultural backgrounds. In similar vein, Kneisl and Trigoboff (2009:33) state that nurses are better able to meet their clients' socio-cultural needs when they acknowledge that culture and society influence their beliefs, values, attitudes and behaviour.

Conclusion and recommendations

In this study, the mothers' expectations were based on practical issues that are of interest in the maternity health care services. Some of the mothers' expectations in this study were not supported by findings from other studies conducted. All the literature sources used in this study were based on the mothers' expectations during labour and not on midwives' care. For example, in this study, the mothers expected the midwives to give them prompt attention, welcome them warmly, show them the bed, or offer them a chair before asking them questions and examining them physically. The participants also expressed a need for the nursing profession to be transformed. The study was aimed at determining mothers' expectations of midwives' care during labour as these expectations are central to the provision of quality holistic care by midwives.

The findings of the study have shown that the mothers' expectations of midwives' care during labour are for the provision of physical comfort, emotional support, clear communication including good interpersonal skills, and

encouragement of bonding between the mother, father and baby. The findings of this study confirm previous findings and contribute additional evidence that massage as a form of touch promotes physical comfort and that labouring women tend to find upright positions such as sitting, standing and walking most comfortable. Regarding the provision of emotional support, it was also found that being there for the mother and having good communication and interpersonal skills are the most important aspects of quality midwifery care. The findings of this study endorse previous studies and contribute evidence regarding bonding between mother, father and baby. It was also found that the father's presence at the birth can be a profound experience for the new parents and makes them aware of parenthood as a mutually shared effort and that newborns that are held skin-to-skin by their mothers cry less and stay warmer than newborns placed in warming cribs.

Based on the information provided above, the researcher recommends that midwives should attend interpersonal skills workshops to enhance their communication skills with the mother and father or partner if he is available. The father or partner should be allowed in the labour ward and encouraged to provide comfort and support to the mother. It is further recommended that midwives should attend training regarding the 'Baby Friendly Hospital Initiative' that encourages bonding between the mother and baby immediately after delivery by implementing skin-to-skin attachment and early breastfeeding.

One of the limitations of the study was the small sample size. Furthermore, the results cannot be generalised since the study was contextual in nature, only individual interviews were conducted and the study was only conducted amongst one racial group.

When the midwives' care includes the mothers' expectations, quality holistic care is facilitated and the mothers' wait in anticipation for nine months is rewarded by positive experiences of her labour.

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Competing interests

The author declares that she has no financial or personal relationships which may have inappropriately influenced her in writing this article.

Author's contributions

M.S. (University of Limpopo) conducted the research, and drafted and revised the manuscript.

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