Supporting women's reproductive capabilities in the context of childbirth: Empirical validation of a midwifery theory synthesis

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Objective: To conduct an empirical validation of the theoretical model of midwifery care suggested by Peters et al. (2020).
Design: A qualitative deductive methodology was used to validate the theoretical model of aims and objectives of midwifery care. The existing model was validated for midwifery care before, during and after childbirth by interviewing women who had reported high satisfaction with childbirth and low fear of childbirth postpartum.
Setting: Data were collected via interviews with women who had given birth from January to March 2018 at a middle-sized hospital in south-east Sweden.
Participants: Swedish-speaking women aged ≥ 18 years, were invited by midwives to participate at a postpartum maternal healthcare ward, and they received oral and written information. They filled in a demographic questionnaire, a grading of their birth experience on a 0–10 numeric rating scale (NRS) and the Wijma Delivery Experience Questionnaire Version B (W-DEQ B). We used ≥ 7 as the cut-off for high satisfaction with childbirth (NRS), and a sum score ≤ 60 for low fear of childbirth (W-DEQ B). Of 172 women, 28 were eligible, of whom 20 were interviewed 8–13 months postpartum. The interviews were analysed using qualitative content analysis with a directed approach.
Findings: All of the model’s levels and their aspects were found in the interviews. All women had experienced a trusting relationship, including individual and woman-centred care, communication, choice and continuity, prompt attention and an empathic attitude. A majority described midwifery in terms of promoting security, and almost all had experienced aspects of personal control. The objective of midwifery care, described as the facilitation of women’s reproductive capabilities, was described as being met by half of the women. The importance of pep talks and coaching was emphasized, and partner support could be added to the model.

Key conclusions and implications for practice: Our findings indicate that the theoretical model proposed by Peters et al. (2020) is mainly applicable to midwifery care of women reporting high satisfaction with their birth experience and low postpartum fear of childbirth. Our findings suggest that this model may serve as a clarification of the unique objective of midwifery care, and could be used by midwives in daily clinical work and in midwifery education programs.

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Introduction

Worldwide, four women give birth each second of every day. By the time you finish reading this sentence, eight children will have been born (The World Counts, 2020). Childbirth is among the most common, constant and natural of all human experiences. The wellbeing and health of pregnant women, the birthing experience, the medical outcome and the health of babies are reliant on the presence of midwives or skilled attendants, and the relationship

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Abbreviations: FOC, fear of childbirth; NRS, numeric rating scale; W-DEQ B, Wijma delivery experience questionnaire version B.

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between midwives and birthing women (Ten Hoope-Bender et al., 2014; De Labrusse et al., 2016). The specific care and relationship between the woman and the midwife during the childbearing period are conceptualized as woman-centred care (Fontein-Kuiipers et al., 2018), which can also be used as an indicator for high quality midwifery care (De Labrusse et al., 2016). Midwifery care has a significant impact on childbearing women worldwide, their babies, and their families (Ten Hoope-Bender et al., 2014). Therefore, midwifery is important at an individual level, but also provides an opportunity to strengthen health systems, to contribute to better public health and to reinforce the economic sustainability of communities and countries (Ten Hoope-Bender et al., 2014; Van Lerberge et al., 2014).

During the past century, childbirth has moved from the home to health facilities in most areas of the world, which has had both positive and negative consequences. While the increasing number of births supported by skilled attendants in healthcare settings has contributed to reducing mortality among women and babies significantly, it has also led to the medicalization of childbirth (Klaus et al., 2002). Following this progress, midwifery as a profession has gone through changes throughout history, influenced by a significant increase in the medicalization of childbirth (Mathias et al., 2020).

Midwifery is a salutogenic field, focusing on the promotion of women’s reproductive and sexual health and rights including the normal physiological processes of childbearing (International Confederation of Midwives, 2005). While midwives have been working practically and “hands-on” with childbearing women for centuries, midwifery science is young as a scientific and academic field: the development of midwifery research was initiated in the late 1980s (Vermeulen et al., 2019). Theoretical midwifery models based on systematic and scientific development are still scarce. The existing models are mainly focused on the birthing process rather than support from early pregnancy for the new role as mother (Eri et al., 2020).

To strengthen the scientific development of midwifery further, Peters et al. (2020) performed a theory synthesis following recommendations by Walker and Avant (2011), in which existing midwifery theories were combined with literature based on women’s preferences. Their aim was to identify a model representing the objective of midwifery care, including work with pregnant women, postpartum care and gynaecological care. The model is unique in that it includes more aspects of midwifery care than solely childbirth. It describes midwifery care as a hierarchical process of three levels, with the objective being to support the reproductive capabilities of women at the highest level (Fig. 1). This objective is based on operational aims at the two levels below. On the basic level, a trusting relationship should be established. Five aspects related to the skills and practices of the midwife could help to shape this relationship: individual and woman-centered care, interpersonal communication, choice and continuity, prompt attention and empathetic attitude. Based on a trusting relationship, the midwife may reach the targets at the second level: promoting women’s security, personal control and orientation. These three operational aims on the second level, together with the trusting relationship, are described as the conditions on which the objective of midwifery – support of reproductive capabilities – is built. The theory is based on sources from Western, industrialized countries which is important to remember when applying the model in a clinical context (Peters et al., 2020).

An important step in the development of a theory is empirical validation of the new model (Peters et al., 2020; Reed, 2019). An empirical validation examines to what extent the theory is applicable in the clinical context, in this case midwifery practice. If the theory is based too much on a theoretical and academic foundation, it may have limited clinical implications (Reed, 2019). Therefore, the aim of the present study is to conduct an empirical validation of the theory of midwifery care suggested by Peters et al. (2020).

**Method**

**Design**

A qualitative deductive methodology was used to validate the theory of aims and objectives of midwifery care. We tested the theory in relation to midwifery care before, during and after childbirth by interviewing women. As this was, as far as we know, the first empirical and qualitative validation, we wanted to test the theory on a group of women who were likely to have experienced all aspects of care represented in the theory. Therefore, we included women who reported high satisfaction with childbirth and low fear of childbirth (FOC) postpartum.

**Participants and procedure**

In Sweden, care before and during childbirth is organized so that midwives are the primary and independent caregivers for uncomplicated cases. During the antenatal period, midwives have responsibility for pregnant women within a certain geographic area. During and after birth, the midwives are accompanied by assistant nurses. From the birthing women’s perspectives, it is not always clear or relevant to distinguish between midwives and assistant nurses. Therefore, in this study, we included women’s experiences of care provided by both midwives and assistant nurses, while experiences with physicians were excluded.

In some regions in Sweden, caseload midwifery is being introduced, meaning that women receive their ante-, intra- and post-natal care from a known midwife or her/his colleague(s) (Sandall et al., 2016). However, caseload care was not implemented in the hospital participating in this study, where the women generally encountered midwives at the delivery ward, who were previously unknown to them.

Women who had given birth from January to March 2018 at a middle-sized hospital in south-east Sweden were consecutively invited to participate in the study. They were invited by midwives at the postpartum ward and they received oral and written information about the study. Of 300 women, 172 (57.3%) gave written informed consent to participate in the study by filling in a study-specific questionnaire. The questionnaire consisted of demographic questions, a grading of their birth experience on a 0–10 numeric rating scale (NRS) and the Wijma Delivery Experience Questionnaire Version B (W-DEQ B). The W-DEQ B is a validated questionnaire consisting of 33 items which gauges women’s experience of different aspects of the childbirth on a six-point scale (0–5). The total sum score range is 0–165, and it is used to identify the level of FOC postpartum. We used a W-DEQ B cut-off sum score ≤60 for low FOC (Korukcu et al., 2016; Wijma et al., 1998) and NRS ≥7 for high satisfaction with childbirth (Stephansson et al., 2018).

Inclusion criteria were age ≥18 years, Swedish-speaking, NRS ≥7 and W-DEQ B ≤ 60. Women who had been diagnosed as bipolar, with psychosis disease, or were suicidal were excluded.

Of the 172 women, 28 were eligible. The women were contacted by the first author. Twenty women agreed to participate, five declined participation and the other three did not answer when phoned. Before the interview, all women were informed about the study and their right to withdraw their participation or stop the interview at any time. In total, 20 women were interviewed at eight to 13 months (median nine) postpartum.

The study was approved by the Regional Ethical Review Board of Linköping (Rec.no 2017/498–31; amendment Rec.no 2018/505–32).
Data collection

An interview guide was made by the research group and tested in a pilot interview. The first author conducted telephone interviews starting with an open-ended question: “Would you please tell me about your birthing experience?” Thereafter, questions about experiences of ante- and post-natal care were asked following the natural flow of the conversation. Subsequent questions and probes were used to enhance the understanding of the women’s narratives. The interviews ranged from 18 to 53 min (median 26) and were taped digitally and transcribed verbatim.

Data analysis

Qualitative content analysis with a directed approach was performed. In directed content analysis the data are tested on an existing theory or model with a previously formulated matrix, often theoretically derived (Hsieh and Shannon, 2005). We used the hierarchical model of midwifery care (Peters et al., 2020) to test if the operational aims and objective could be identified in the women’s accounts of midwifery care.

The analysis was performed by the first and fourth authors. In the first step, the verbatim transcripts were read through and statements that comprised experiences of midwifery care were identified and marked. In step two, the statements were examined and marked with six different colors according to the aims and objective of the theory. Those statements that did not match the aims or objective of midwifery were categorized as an additional cluster “miscellaneous” and were analyzed later in the process. In the third step, the content of each aim was further analyzed and some statements were removed. In step four, all statements regarding the same operational aim or the objective (i.e., marked with the same color) were clustered in digital files. The content of each file was defined using numbers for the subheadings (for example 1 for respect and dignity, 2 for participation). The content of each subheading was described, and relevant statements were selected. To ensure trustworthiness, the first three steps were performed by both researchers separately, with the material divided between them. Before step four, all highlighted statements were compared and discussed, until agreement was reached.

The statements from the “miscellaneous” cluster represented aspects that did not apply to the previously given theory. Therefore, they were analyzed using an inductive approach and conventional content analysis (Hsieh and Shannon, 2005). First, the statements were reread. Then, a description of the statements was made. The cluster was identified as “supporting the partner” and constituted a separate cluster. This inductive analysis was made by the first and fourth authors.

Trustworthiness was further strengthened as the final clustering was read and approved by all authors. The authors represent the fields of midwifery, psychology and obstetrics and all have experience and skills in qualitative research methodology.

Findings

Table 1 presents the demographic characteristics of the included women. They were 18–37 years of age (mean 29) at the time of birthing. Half of the women had their first child. They were all born in Sweden and all had a vaginal birth. From the women’s stories, it was evident that midwives were represented in the vast majority of experiences with healthcare staff, as women referred to these staff as midwives.

All of the models’ three levels and their aspects were found in the interviews (Table 2). All women reported that midwives established a trusting relationship (level one). Most of them talked about experiences of being provided with individual and woman-centred care, communication in an interpersonal way and with an empathic attitude. All but one woman described midwifery in

Fig. 1. The hierarchical model of the means and targets of midwifery according to Peters et al. (2020).
terms of promoting women’s security (level two), and the majority described both physical and mental health promotion. Almost all the women mentioned aspects of personal control, and more than half of them described situations where both aspects (respect/dignity and participation) were promoted. Likewise, almost all the women talked about being strengthened in their orientation before, during and after childbirth by practical help and information from midwives. Level three, with the objective of supporting the reproductive capabilities of women, was described by half of the women. An additional cluster, “Supporting the partner” was found in our analysis and is also presented in Table 2. Quotes with fictional names are used to illustrate the findings.

Trusting relationship

Individual and woman-centred care

Most women described experiences of individual and woman-centred care, and said that midwives treated them with the attitude of “being here for them”, and conveyed a genuine interest in helping and supporting them, from early pregnancy to postpartum consultations. They appreciated that the midwives made an effort to give individualized support. Some described the midwives’ understanding of their individual needs as a “sixth sense”. For example, Anna mentioned how the midwife saw her feeling lost and overwhelmed by the intense contractions, and therefore took an active role in guiding her through the birth. Tanya, pointed out the importance of individualized and woman-centred care:

They were there for us. And I mean that for another couple, they had to be there for them too. But in their way. – Tanya

Midwives’ ability to understand women’s needs in different situations and to adapt support accordingly was valued. Some women described how the midwives, in their ambition to customize the support, even deviated from clinical routines or guidelines. For example, Selma was offered a single room at the postpartum ward, although it was reserved for those who had undergone a complicated childbirth.

Another appreciated aspect of woman-centred care was that the midwives stepped back after the birth, when the parents met their new-born baby for the first time. The midwives were still present, and took care of problems such as ruptures, but without disturbing the family.

Table 1
Demographic characteristics of women included in the study.

<table>
<thead>
<tr>
<th>Parity, n (%)</th>
<th>29 ± 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>First child</td>
<td>10 (50)</td>
</tr>
<tr>
<td>Second child</td>
<td>8 (40)</td>
</tr>
<tr>
<td>Third child</td>
<td>2 (10)</td>
</tr>
<tr>
<td>Cohabiting with the other parent, n (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18 (90)</td>
</tr>
<tr>
<td>No</td>
<td>2 (10)</td>
</tr>
<tr>
<td>Employment prior to childbirth, n (%)</td>
<td></td>
</tr>
<tr>
<td>Working full-time</td>
<td>11 (55)</td>
</tr>
<tr>
<td>Working part-time</td>
<td>6 (30)</td>
</tr>
<tr>
<td>Student</td>
<td>2 (10)</td>
</tr>
<tr>
<td>Parental leave/sick leave/other</td>
<td>1 (5)</td>
</tr>
</tbody>
</table>
Interpersonal communication

The communication with midwives was mentioned by all women when asked about their experiences of midwifery support. They described good communication as dialogue characterized by openness and non-judgement. Some women wanted the midwives to ask open-ended questions, while others preferred more directed questions. Follow-up questions were important, as they confirmed that the midwives were really listening. Moreover, responsiveness was valued, as was the midwives’ ability to pick up subtle signals from the women. For example, Miranda was grateful to the midwife who during her pregnancy could verbalize her worries even though she had not fully conceptualized them herself. Midwives who were a little older and had longer experience were often described as particularly skilled communicators. During pregnancy, women also valued discussing other things in life that were not related to them becoming a mother, such as their work situation, or public matters.

Many women emphasized the importance of interpersonal communication during birth, where midwives helped them through the process by coaching and pep talks. The midwives’ pep talks gave women guidance about when to push and how to breathe, but also made them feel strong and able to rely on their body and on their ability to give birth.

This was one of the first things they mentioned when asked about experiences of support during childbirth. Selma raised this issue:

She [the midwife] encouraged us that we can manage this and that we are strong, gave us loads of encouragement, and then when it was time to push, then, well she was also so full of energy, we were like a team in there. – Selma

Choice and continuity

None of the women said anything about having the opportunity to choose a midwife during childbirth or postpartum. However, some women had asked for the same antenatal midwife to support them in several pregnancies. They described a sense of security from seeing a midwife with whom they had already built a trusting relationship. The women appreciated that the midwife remembered them and brought up details from the previous pregnancy.

Even though my husband was not there as he was working and found it hard to get away, she remembered what his job was and that made me feel like she was focusing on me while I was there and that she knew who she had in front of her. – Maria

During their time at the hospital, most women met several midwifery teams since they often stayed for a few days. They emphasised the importance of being informed about changing personnel, and of the new team properly introducing themselves. Most women experienced continuity of care, as no one but the midwife and nurse assistant in charge of their birth entered the room.

Another aspect of continuity was the dialogue between different wards. For example, Sarah explained that the midwife at the delivery ward knew important things that had occurred during her pregnancy, and the midwife at the postpartum ward was aware of decisions made at the delivery ward.

Prompt attention

Women’s experiences of prompt attention were mostly related to the context of childbirth. Most women expressed a wish for midwives to be present during specific periods of the childbirth, while others expressed a need for a continuously present midwife all the time. For Anna, the midwife’s constant presence made her feel secure and confident. On the contrary, Sarah wanted the midwife to enter the room quickly if called on:

Well, I guess I felt safe in the knowledge that if I pressed the button someone would come quickly or that someone was in the room when Adam went outside or something. That felt really important. – Sarah

Another aspect of being given prompt attention was described as the midwives’ ability to invite women to engage in a longer conversation. They felt they were seen and heard when the midwife sat down on a chair or squatted by the bed to talk with them. The opposite was described when the midwives stayed close to the door halfway in the corridor.

The few women who experienced lack of attention described the midwives as stressed. Mona, for example, heard emergency alerts from the other birthing rooms, which gave her the impression that the personnel did not have enough time for her.

Empathic attitude

Most women commented on the importance of an empathic attitude from the midwife. They described most midwives as friendly and calm, and this made them feel safe, and enabled them to embrace the pregnancy and birthing process. Linda, for example, described the midwife as friendly, calm and empathic, which made her trust the midwife. The trusting relationship with the midwife made Linda feel safer and more confident in the unpredictable situation of giving birth for the first time.

The women felt more relaxed when the midwife could make a few jokes to relieve the atmosphere. The empathic attitude was described as a fine balance between being friendly and humble, but still being clear, focused and ready to take the lead if needed. For example, some women found it helpful when the midwife confirmed their pain during birth, but also reminded them that the pain was leading them toward meeting their baby. Sometimes, physical contact was experienced as a sign of an empathic attitude:

She [the midwife] explained everything that was happening, but there were also these little gestures such as when the midwife walked past me she would stroke my arm like this. Or ... the student midwife who held me when I had to push, the student midwife stroked my leg as if she ... well, she wanted to give me some extra strength that way. Like little things like that. – Lisa

Security

Physical health promotion

Most women were satisfied with the physical care before, during and after childbirth. They mentioned how the midwife continually and in different ways made sure that their bodies and babies were following the expected course of pregnancy and childbirth. The women expressed their trust in the organizational routines for monitoring their own and the child’s health. The structured way of promoting physical health made women feel that the midwife knew exactly what to do and why in different situations.

Most women found the number of check-ups during pregnancy to be adequate, but Caroline would have preferred an additional check-up during the early second trimester as it was too early to feel the foetal movements.

Another aspect of the experience of physical health promotion was related to the midwives’ ability to have a back-up plan if something did not work out as planned. Having different “tools in the toolbox” reinforced women’s feelings of physical security. One example is from Frida’s birth experience:
When the epidural did not work they came with a heated cushion and massaged the small of my back for six hours (laughs). So there was some poor person doing a very hard job. // That's what made the whole birthing feel like it was under control. - Frida

Mental health promotion

Several women emphasized the importance of feeling secure in respect to the mental and emotional aspects of becoming a mother. Mental health promotion was mainly referred to in the context of pregnancy check-ups and care at the postpartum ward. In both instances, women appreciated the midwife asking questions about their mental wellbeing so that they did not have to bring it up themselves. The women felt a pressure from society and social media to feel perfectly happy during pregnancy or after childbirth, and some felt ashamed when their mood was affected by worries or fear. Therefore, it was a relief to be asked how they felt, as the question itself presumed that it was okay to feel down or worried.

I felt that I could open up to her about pretty much anything, even if there were things that were a bit embarrassing or some difficult things. She would, like, ask me if I felt down and things like that. She asked those questions so I did not need to bring up anything myself but instead just answered questions about how I was feeling. – Maria

Beside being open about feelings and worries, mental health promotion could concern practical tasks, such as making appointments to discuss induction of birth, and booking appointments to see a counselor. While most women experienced that the midwives cared for their mental health, there were exceptions. Mona expressed her desire for a deeper relationship where she would have felt more comfortable opening up.

Personal control

Respect and dignity

Almost all women mentioned issues related to respect and dignity. No grand gestures were needed to feel respected; the women felt respected when the midwives presented themselves and the team, smiled and made them welcome. Personal control was reinforced when the midwife remembered things about the women's previous pregnancy and childbirth, or from previous consultations. They also felt in control when the midwife confirmed that she had read the medical file and was familiar with the current situation, mental wellbeing so that they were familiar the midwife and the team. Diana described feeling respect and dignity, and a sense of not being just one in the crowd:

Yes, that I did not just feel like one of all those who came in to give birth, well this is the next woman to give birth, but instead she devoted all her attention to me and gave me what I needed right at that moment. She did not make me feel like I was just a part of her job. – Diana

An important aspect of respect and dignity concerned vaginal examinations. The sense of control was reinforced if the midwife explained what she was going to do, asked if she could start the examination, and did so in a gentle way, with a continuous calming chat and eye contact. Mathilda gave a similar example of feeling respected when receiving breastfeeding support:

I remember that she asked before, like, 'May I help you? May I touch your breast and put the baby in the right position?' And I'm just like 'Yes, thanks for asking'. – Mathilda

A few women also gave examples of not feeling in control or respected, such as being left in the room for a long time without any information, or not being taken seriously when seeking care for difficulties during pregnancy like hyperemesis. Although these may have been isolated situations, they were remembered and carefully described by the women. Sometimes these occasions contributed to a negative experience of midwifery support, and some of the women had felt neglected and hurt.

Participation

Experiences of participation and personal control were described by several women. For example, it could be that the midwife asked for women's preferences regarding pain relief and birthing positions during childbirth. These women wanted shared decision-making based on their individual preferences and the professional recommendation. The dialogue gave them a sense that a team was being created, where the women, their partners and the midwife were a unit that were striving to achieve the same goal. Other women reported that they could be involved in decisions about practical things, such as the time spent in the postpartum ward. When the midwives confirmed and followed the wishes expressed in Viktoria's birth plan, it strengthened her sense of participation:

I got to test different positions because I had written that in the letter. I thought that they listened very carefully and read through the letter very thoroughly and made sure that things were the way I had written, and things like that. – Viktoria

Some women felt loss of control and lack of participation. These experiences were often related to lack of information about the plan or the next step of the birthing process.

Orientation

Practical help

The women had many different experiences of practical help during childbirth and postpartum, but no one mentioned any practical help during pregnancy. During childbirth, many women appreciated being encouraged, for example, to use a walking trolley and a Pilates ball to make the contractions more effective. They also appreciated when the midwives helped them to relax by massaging their back or cooled them off by using cold towels on the forehead.

The women expressed thankfulness to midwives who were engaged and whom the women reported did “that bit extra”. For example, during Philippa's birthing, the midwife insisted on doing an amniotomy to progress the birth:

It was very comforting that the midwife dared to trust her own knowledge and as I said, finally told the doctor that 'no, we actually have to sweep the membranes'. Because the doctor did not want to help but instead she said that 'no, this, it has to run its course'. – Philippa

While most women were satisfied with the practical help during childbirth, they had diverging experiences of the postpartum ward. Those who had given birth to their first child were in need of more help with practical care for the baby, such as how to safely lift and hold the baby, change nappies and clean the baby. Some women felt embarrassed when asking for help, and had the feeling that the midwife trivialized their insecurity.

Most women also wanted practical help with breastfeeding, including those who had breastfed before. Although most women were satisfied with the breastfeeding support, some women wanted more genuine support in the transition toward becoming
a breastfeeding woman. Some found the breastfeeding support instrumental and with too much focus on how often and for how long the baby was breastfed.

**Information**

The need for information was met for most women during pregnancy and childbirth. Hormonal and bodily changes were the areas where most women wanted information during pregnancy. Being continually informed made the women feel secure and safe before and during childbirth.

I remember that I went there to have the membrane swept. I remember that I was a bit scared before it was done because I did not really know what it entailed, if it was dangerous, but she [the midwife] explained everything very carefully and clearly so it felt good when the time came, and she explained what would happen afterwards, that I may bleed and that it was nothing unusual. – Viktoria

However, some women experienced a lack of information during the birth, for example Mona, who did not understand why she was forbidden to eat during the birth, and why she could not continue having the nitrous oxide during the pushing contractions.

During their stay at the postpartum ward, the women were provided with a lot of information that was mainly focused on breastfeeding and practical care for the baby. Some women expressed wanting more information on their physical recovery.

**Reproductive capabilities**

Reproductive capability was described in terms of the women’s confidence in their ability to bear, nourish, birth and feed their child, and their sense that their bodies were capable of fulfilling their reproductive purpose. Some women stated that it was their physical and mental preparation before childbirth that reinforced their capability to give birth. For others, who had given birth before, the previous birth experience made them feel relaxed and secure as they knew what to expect. Those whose childbirth preparation entailed listening to the body expressed a new feeling of trust in the ability of their bodies, which could be interpreted as a reinforcement of their reproductive capability.

It feels good when you know you can trust your own body and listen to it. So I know that now, and I know how my body works in other situations as well. – Vera

**Supporting the partner**

As shown above, all aspects of the model proposed by Peters et al. (2020) were identified through deductive analysis. However, an additional theme was also identified that is not covered in the model. This theme relates to support from the woman’s partner.

Women mentioned the importance of midwives confirming and engaging their partner during pregnancy consultations and childbirth. When midwives talked to the partner, they increased the women’s sense of shared responsibility for the child. They also felt safe when they knew that the partner was taken care of.

She [the midwife] also spoke with my husband, he was involved in the whole thing, and that meant I felt safe because he was my support and she did not exclude him, but instead she involved him in the whole thing too. – Maria

**Discussion**

Our findings indicate that the theoretical model proposed by Peters et al. (2020) is, for the most part, applicable to midwifery care of women reporting high satisfaction with their birth experience and low postpartum FOC. Unlike most other midwifery theories, Peters et al. include aspects of midwifery care before, during and after childbirth. We were able to identify experiences from all three levels and all the different aspects of the model in a sample of 20 interviews. Additionally, we found partner support to be an aspect that is not presented in the original theory.

The first level – a trusting relationship – had the richest content. Due to the pyramidal structure, the relationship is described as a solid basis for reaching the higher aims. The relationship as the foundation for midwifery care is empirically validated by this study. Several other midwifery models also present the relationship between woman and midwife as a component of midwifery care, but the degree of its importance varies (Maputle and Donavon, 2013; Berg et al., 2012; Halldorsdottir and Karlsdottir, 2011; Berg, 2005; Kennedy, 2000). Historically, midwives and skilled attendants often had a personal relationship with the women they were supporting, while maternity care nowadays is more fragmented. Women typically receive care from a variety of different providers throughout their childbearing time (Mathias et al., 2020). The short meetings put high demands on the social and communicative skills of the midwife.

Some issues were frequently highlighted in our data, despite receiving limited attention in the theoretical model. For example, in the model, the importance of pep talking and coaching was commonly brought up by our participants but these are only briefly mentioned in the model. To many women, coaching and pep talking were the most important tasks of the midwife during childbirth.

On the other hand, one aspect that is described in the model was not found in our material: no woman mentioned the opportunity of choosing the midwife to support her during childbirth. Some had requested the same antenatal midwife for several pregnancies, but no one mentioned making specific requests regarding who would support them during or after childbirth. This may be related to the organizational structure of the delivery ward where the participants gave birth. Possibly, the women did not consider this possibility, as it was never presented as an option. This study was performed in an organization which did not offer continuity of care during antenatal, intrapartum and postpartum care. Midwifery continuity models such as caseload midwifery are expanding in many countries, and several studies show that women are satisfied with having access to a known midwife when giving birth (Hildingsson et al., 2020; Sandall et al., 2016; Dahlberg and Aune, 2013).

Some overlapping aspects were found in the analysis. For example, there was no clear division between Respect and dignity (level 2, Personal control), and Woman-centred care and Empathic attitude (level 1, Trusting relationship), as the experiences and descriptions sometimes overlapped. This overlap may be related to the definition of woman-centred care, in which respect and empathy are both important components (Fontein-Kuijpers et al., 2018).

Furthermore, the role of the partner and the relationship between the midwife and the partner are not visualized in the original model, where the partner is just mentioned briefly (Peters et al., 2020). In contrast, we found the support of the partner to be an important aspect of women’s experiences of support – they felt supported when the midwife confirmed the role of the partner. In Sweden, the woman’s partner is often present during pregnancy consultations and childbirth, but of course this may not always be the case in other cultural norms, traditions and countries. The important role of a supportive partner for women’s mental wellbeing and maternal transition to parenthood has been highlighted in other studies (Werner-Bierwisch et al., 2018; Kainz et al., 2010; Persson and Dykes, 2009).
Every medical discipline has its unique objectives, which evaluate the performance of the work. For example, as a physician, the objective is to cure the patient, and for a nurse, the objective is achieved when the patient is cared for (Vogd, 2011). In the theory of Peters et al. (2020), woman-centred care is part of a trusting relationship, which in turn forms the foundation of the objective of midwifery care to facilitate a woman’s reproductive capabilities. Peters et al. (2020) hope that their model can specify the work of midwives and that it may be applied in quality improvement of care and teaching. The model also provides a wider approach to the aim of midwifery care, as it involves a number of aspects in addition to woman-centred care (Peters et al., 2020). This empirical validation mainly, but not entirely, supports the model of Peters et al. to serve those purposes.

Methodological considerations

All the participants were born in Sweden and the context of Peters et al. (2020) theory is European, which limits the transferability to a solely European perspective. Furthermore, the included women all had a positive birth experience and postpartum FOC, as we intended to test the theory on this specific group. However, this means that this empirical validation was limited to a specific group of childbearing women, and the next step in the validation process could be to test the theory on a more heterogeneous sample, including women who have undergone caesarean section. In addition, there is always a risk of recall bias in a retrospective study. Although there were questions about antenatal and postpartum care, there was more focus on care during birth in the interviews. More information on ante- and post-natal care could have enriched the analysis.

A strength of this empirical validation is that our research group was not familiar with the research group who developed the theory, which increases the independence of the validation process and thus decreases the level of bias. The researchers of the present validation study have different professional backgrounds (midwives, obstetrician and psychologist), although all are researching the area of childbirth. These different backgrounds have added different perspectives to the analysis, providing a researcher triangulation which enhances trustworthiness. This is a strength of the study.

Conclusion

The theoretical model of the aims and objectives of midwifery practice, as presented by Peters et al. (2020) was empirically validated by this study, and may serve as a clarification of the unique objective of midwifery care in a European context. The model could be used by midwives in clinical daily work and in midwifery education programs, but some aspects need to be taken into consideration when it comes to the clinical applications of the model. This empirical validation was based on a selected group of women with high birth satisfaction and low postpartum FOC, meaning that the model may not apply to all childbearing women. Additionally, pep talks and coaching were more emphasized by the participants compared to the original model. Partner support is not included in the model, but was highlighted as important by the participants. These aspects could be taken into account when further developing the model.

Ethical approval

The study was approved by the Swedish Ethical Review Authority 2018-10-18 (Reg. no. 2017/498-31, amendment 2018/505-32).

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Declaration of Competing Interest

None declared.

Credit authorship contribution statement

Hanna Grundström: Conceptualization, Data curation, Formal analysis, Writing – original draft. Anna Malmquist: Conceptualization, Writing – review & editing. Katri Nieminen: Conceptualization, Writing – review & editing. Siw Allehagen: Conceptualization, Formal analysis, Writing – original draft.

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