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Women's experience of early labour in a free-standing birth centre: Midwifing embodied labour

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ABSTRACT

Issue: Women who present at hospital labour wards in early labour must often meet measurable diagnostic criteria before admission.
Background: Early labour is a phase of neurohormonal, emotional, and physical changes that are often not measurable. When admission to birthplace is based on results of diagnostic procedures, women's embodied knowledge may be disregarded.
Aim: To describe the early labour experience of women with spontaneous onset of labour in a free-standing birth centre, as well as midwifery care when women arrived in labour.
Methodology: An ethnographic study was conducted in 2015 in a free-standing birth centre after receiving ethics approval. The findings for this article were drawn from a secondary analysis of the data, which included interview data with women and detailed field notes of midwives' activities related to early labour.
Findings: The women in this study were instrumental in the decision-making process to stay at the birth centre. Observational data showed that vaginal exams were rarely conducted when women arrived at the birth centre and were not a deciding factor in admission.
Discussion: The women and midwives co-constructed early labour based on the lived experience of women and the meaning that this experience held for both.
Conclusion: Given the growing concern about the need for respectful maternity care, this study provides examples of good practice in listening to women, as well as an illustration of the consequences of not doing so.

Summary of Relevance

Issue

Onset of labour is often described using biological markers, including changes to the cervix and strength of uterine contractions. However, labour onset is a complex process that includes neurohormonal and emotional changes.

What is already known

Midwives must often follow institutional guidelines when they admit women to a hospital labour ward. Studies of women's early labour experiences and midwifery care in early labour have shown that there is often a discrepancy between women's embodied experience of labour and clinical care in hospital settings.

What this paper adds

This paper describes spontaneous onset of labour and early labour of women registered to give birth at a free-standing birth centre. In addition to this, it describes the interactions between the midwives and the women at the birth centre when they arrive. This study demonstrates that early labour is an integral component of the way in which symbolic meaning is made by women and midwives together concerning the labour process.

Introduction

For childbearing women who believe that labour has begun, one of

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the most challenging decisions is when to leave for their chosen birthplace [1,2]. The decision-making process is complicated by fears of getting there too soon or too late [2,3]. In addition to this, there is an added layer of uncertainty that has been identified in studies concerning early labour, as there is no clear definition of labour onset, and, therefore, no definitive point at which care should be given [4–6]. Because the dynamic of labour is difficult to predict, women often seek professional advice and reassurance, especially if they cannot foresee how much longer they will be able to cope when they are in pain, as was shown in Cheyne et al.'s and Cappelletti et al.'s studies [7,8]. In Dixon et al.'s studies, for women who knew their birth midwife and were able to contact them in early labour, they felt comfortable staying at home after being reassured on the phone [9,10]. Women have also been shown to decide when to leave for the hospital in early labour based on their beliefs about birth. In Carlsson et al.'s study, women who experienced birth as natural felt safe at home in early labour, while women who perceived birth as a medical event preferred to present at the hospital in early labour. [11]. The anxiety generated by the uncertainty of gaining entry to the labour ward may be recognized by labour ward or FSBC staff, however their main concern may be to make sure that women are not admitted earlier than necessary, since women are often "bound by the clock" as soon as they are admitted [12,13].

Studies have shown that the transition between experiencing early labour at home and gaining access to a hospital labour ward is perceived as a gatekeeping space by both women and midwives [1, 3, 14]. These studies show that women and their birth partners are often anxious about knowing when they should seek permission to cross the threshold of the hospital labour ward [1,3]. Getting this judgement wrong and either being sent back home 'not in labour' or arriving too late for support and pain relief is a concern for many women [6,8]. For some of the midwives in these studies, exercising their gatekeeping role was essential, both to control the workload on the ward, but also because of evidence that women who experience early labour at home are less likely to need technical and/or pharmacological interventions once their labour is established [15–17]. In terms of making the final decision, Cheyne et al. (2006) examined hospital midwives' perception of onset of labour, and found that midwives fell into two categories: those who used the cues from women to make a diagnosis and those who used institutional factors to guide their decision to admit a woman to the labour ward [18].

Gross et al. found in their 2003 study of women's descriptions of labour onset that "a woman's own recognition of the onset of labor may well be as solid as any surrogate measure that has been proposed thus far" [5]. Olza et al.'s meta-synthesis assessed the psychological features of labour progress based on women's narrative accounts of labour, demonstrating that women have an emotional journey through labour, as Dixon et al. has shown [9,10]. Early labour is a complex process that encompasses physical changes, along with neurohormonal and psychological changes [19]. Hanley et al., found that the definition of onset of labour in research literature was most frequently described as a change in the cervix, as well as the frequency and strength of uterine contractions [20].

Most studies of early labour to date have been undertaken in hospital labour ward settings. When compared to birth centres and home births, hospital labour wards are more likely to be associated with standardised use of procedures [18], potentially influencing the spontaneous behaviours of both women and midwives. In order to assess the spontaneous nature of, and interplay between women's accounts of early labour and those of midwives, this paper examines the accounts of women entering a free-standing birth centre (FSBC) in spontaneous labour, and the practices of midwives in that setting.

Aim

The aim of this article is to understand the experience of early labour of women registered to give birth in a FSBC, and how FSBC midwives care for women when they arrive in labour.

Ethics

Ethics approval was given by STEMH at the University of Central Lancashire, unique reference number STEMH 212 on April, 24, 2014.

To comply with ethics and data protection regulations, information and descriptions that could reveal the identity of the participants or the research site have not been used in this article. All participants mentioned in this article have been given pseudonyms.

Methodology

The data that underpin this paper were part of a doctoral study conducted in 2015, with a focus on perceptions of risk and safety in German FSBC care. This was an ethnographic study which included one-to-one interviews with women registered to give birth at the birth centre, one-to-one interviews with midwives at the research site, as well as participant observation and conversational interviews throughout the observation periods. The findings for this article were drawn from a secondary analysis of the data, focusing on women's stories describing their experiences of early labour at home and in the FSBC. Descriptions of midwives' activities related to early labour were drawn from detailed and extensive field notes. Having two data sources, women's narratives and ethnographic data, enhances the credibility and validity of a study, referred to as data triangulation [21].

Methods and Symbolic interactionism (SI)

Symbolic interactionism (SI) was chosen as the most appropriate theoretical perspective for this study. SI is a social constructionist theoretical perspective developed by Herbert Blumer and is concerned with revealing social processes that underly human interactions, as well as the meanings that things have for human beings [22,23]. Lived experience in all contexts is a process of interpretation, meaning making, and response that is context specific and made visible through interactions.

In line with SI, several different data collection methods were utilized. These included semi-structured interviews, conversational interviews, and participant observation. Blumer believed that interviews with research participants were significant in that they could reveal the meanings that participants ascribed to the research phenomenon. In addition to this, Blumer also considered observation of interactions as essential to aid the researcher in opening up to novel ideas, using observation to promote reflexivity [23].

Data collection and analysis

The interviews were recorded on a handheld recording device. All except one were undertaken in German. They were transcribed verbatim and analysed in the original language by NIS. NIS translated excerpts for supervisory meetings with SD, the second author, and two further doctoral supervisors, Fiona Clare Dykes and Barbara Katz Rothman, as well as for publication. While NIS independently engaged in coding, these findings were discussed regularly with the study participants and the doctoral supervisors.

After transcription, NIS read through the interviews and put aside data that was not related to the research focus, as Boyatzis recommends [24]. For example, NIS found that a good way to establish rapport with the midwives was to ask where they had completed their training. Establishing rapport with interview partners is important in order to build a trusting relationship [25]. The answers to this question were not relevant to the focus of the study and were thus set aside and not coded. After this, interview data were analysed inductively using thematic analysis according to Braune & Clarke (line-by-line coding) [26]. While conducting data analysis of the interviews, NIS was continuing data

collection during participant observation sessions at the birth centre.

The ethnographic field notes were analysed using methods described by Spradley, which included discovering cultural domains and creating taxonomies [27]. Domain and taxonomic analyses aid the researcher to interpret observations and to re-enter the field and focus observations on issues that hold meaning for the researcher, as well as the research participants. As in thematic analysis, Spradley writes about searching for the discovery of cultural patterns in data. To accomplish this, the researcher moves from observing, experiencing, and observing or participating in social situations, to using analysis of the gathered data to learn how the parts of the social situation are organized, thereby revealing taken-for-granted patterns.

As the themes were being developed through this iterative process of data collection, analysis, and subsequent data collection, NIS shared these findings with the midwives at team meetings, as well as with the midwives in the kitchen (the break room) when the situation allowed. Moreover, NIS saw most of the women who had been interviewed on several occasions at the birth centre, and, at the latest, at their postpartum interview, where she shared discoveries with them and listened to their feedback.

Research participants

This ethnographic study was conducted in a FSBC in Germany with > 150 births per year. The research participants included women registered to give birth at the birth centre (n = 30), as well as 17 midwives. The staff collectively decided to participate in the study, however each midwife in the team was given the choice to opt out of interviews and observations. The team of midwives at the end of the study was comprised of 19 midwives who all worked in different capacities at the birth centre, including birth assistance, antenatal care, ante- and postnatal classes, operations, billing, and quality management, with 0–25 years' experience at the FSBC. Two of the midwives chose not to be interviewed, however none refused to be observed. During the data collection period, two new midwives joined the team. Only one of these was interviewed, as the second new midwife joined the team at the end of the data collection period and chose not to be interviewed. Table 1 shows the midwives who were interviewed and their years of experience in free-standing birth centres. (See Table 1).

The inclusion criteria for the midwife participants were that they worked in some capacity at the birth centre and gave their consent to participating in the study, which included being observed and possibly having a semi-structured interview. Midwives were given study information and asked to sign a consent form if they agreed. All together 17 midwives were interviewed. The interview topics were as follows:

- Where did you do your training?;
- Tell me about your decision to work at the birth centre;
- (If the midwife had worked in a hospital before commencing work at the birth centre): Tell me about births at the hospital that had an effect on your decision to work at the birth centre;
- What are your hopes and wishes for women who start their birth at the birth centre;
- Tell me inspiring birth stories;
- Tell me stories about challenging births.

Table 1
FSBC Experience of Midwife Participants.

Midwives	Experience at the time of the interview
Mathilde	3 years
Rebecca	12 years
Beatrice	8 years
Tanja	> 15 years
Karla	> 15 years
Paula	10 years
Janina	3 years
Katarina	2 years
Miriam	3 years
Claire	9 years
Daniela	> 15 years
Antonia	9 years
Vera	> 15 years
Renate	6 months
Elizabeth	5 years
Silke	2 months

The inclusion criteria for women in the doctoral study were that they were registered to give birth at the FSBC, were over 18 years old, and were > 34 weeks of pregnancy. NIS continued to recruit women for the study until she had observed enough births to reach data saturation (n = 7). In the doctoral study, a total of 30 women participated in the study. Twenty-nine women participated in antenatal interviews, and 28 women were available for an interview between six to eight weeks postpartum. These interviews lasted between 45 and 90 min. Conversations about early labour formed approximately the first 10–15 min of the interviews. The questions used to prompt the women at the postnatal interviews were: Tell me about your birth? How did it start? For this secondary analysis, data were only used from women whose labour onset was spontaneous (n = 23). Women who met the study inclusion criteria were approached by the midwives when they arrived at the FSBC for an appointment and asked if they would be interested in participating in the study. (Full recruitment information can be found at [28].).

Nature of the research site

FSBCs in Germany are independent institutions that offer antenatal and intrapartum care for pregnant and birthing women. At the study FSBC, there were two rooms for births, as well as rooms for antenatal appointments and parent education classes. The layout of the birth centre made it possible to hear births in every other part of the birth centre, including the kitchen/midwives' break room and the antenatal care rooms. The midwifery team gave NIS access to all of the rooms at the birth centre, subject to consent from the people involved.

Reflexivity

NIS: After having worked for nine years on a busy labour ward and having caught over 1000 babies, I began working at a FSBC. At the beginning of this study, I had been working at the FSBC for three years as the primary midwife at births (called 'first' midwife), as well as providing antenatal care to women registered at the birth centre and offering antenatal classes. I believed that birth in FSBCs is safe, however I was unable to explain the mechanisms to the skeptical colleagues I had worked with in the labour ward. Although I wasn't a naïve participant observer, I was able to enter the field with curiosity and openness. My field notes included reflections of my observations. I regularly met with SD and other members of my doctoral supervisory team to discuss and reflect on the data, as well as my positioning.

SD: I am a midwife with 20 years' experience on a busy labour ward, followed by 20 years as a midwifery academic. At the beginning of this study, I believed that midwives who work in birth centres and women who choose to birth there are orientated towards physiological labour and birth where this is safe and personalised, and this is in tune with my personal and academic focus. I also believed, based on professional experience and previous studies I have been involved in that women are often uncertain about how to decide if they are in established labour; that this can lead to anxiety and, consequently, increased pain for some; and that midwives sometimes judge early labour on the basis of textbook definitions, rather than listening to and observing the labouring woman.

During the analysis, both authors checked for disconfirming data against these pre-suppositions.

Findings

The findings are divided into two sections: results from the interviews with women, and results from the ethnographic observations.

Interviews with women

Of the 30 women included in the main study, 23 had spontaneous onset of labour and were included in this secondary analysis. Table 2 (below) shows the birthplace and parity of the respondents, as well as any hospital procedures used.

Cultivating early labour

The overarching theme arising from the women's accounts is characterised as *Cultivating early labour*. This is underpinned by 3 subthemes: *Noticing small changes*; *Coping in early labour at home*; and *Deciding to go to the birth centre*.

Noticing small changes

Many of the women noticed small changes in their behaviour, longings, and sensations just before onset of their labour. One of the participants, Yvonne, didn't want to have physical contact with her husband the evening before labour began, and rejected a hug. This was uncommon for her, and she decided that it was a sign that she would go into labour. She said:

> In the night from the 14th to the 15th, my partner came home late from work, and he wanted just to hug me, and I told him no and then I knew that something was unusual because, normally, that wouldn't bother me. And, yeah, at 2 am I got the first light contractions. Yvonne, 1g1p

Table 2
Place of birth and hospital procedures.

Name	Gravida/ Para	Place of birth	Procedure at hospital, where applicable
Henny	2g2p	Birth centre	
Ingrid	2g2p	Birth centre	
Yvonne	1g1p	Birth centre	
Lilly	1g1p	Birth centre	
Frida	1g1p	Birth centre	
Jessika	2g2p	Birth centre	
Marie	2g2p	Birth centre	
Monique	4g3p	Birth centre	
Annika	2g2p	Birth centre	
Tamara	1g1p	Birth centre	
Iris	1g1p	Birth centre	
Regina	2g2p	Birth centre	
Frauke	1g1p	Unplanned home birth	
Vanessa	3g3p	Unplanned home birth	
Nadia	1g1p	Birth centre Transfer postpartum	Manual removal of the placenta
Magda	1g1p	Birth centre Transfer postpartum	Suture of complex tear
Dora	1g1p	Birth centre Transfer postpartum	Suture of sphincter tear
Louisa	1g1p	Hospital	Epidural, oxytocin drip, vaginal birth
Simone	3g3p	Hospital	Artificial rupture of membranes, vaginal birth
Rachel	1g1p	Hospital	Vaginal birth
Saskia	1g1p	Hospital	Epidural, oxytocin drip, vacuum extraction
Jeannette	1g1p	Hospital	Epidural, oxytocin drip, C-section
Eva	1g1p	Hospital	C-section

Nadia, a pregnant healthcare professional, was in her first pregnancy and noticed that she was having more non-painful, practice contractions than usual. She noticed the change and hoped to jump start her labour with sex. She explained:

> We had sex that night, and I hoped that would get labour started. And then, at 1 am, I got some stronger contractions…. They were painful, but I had the feeling that it wasn't really it. Nadia, 1g1p

Nadia's contractions came and went during the day; she went into labour that evening. Marie had been having contractions for a few days but hadn't yet informed the FSBC. After receiving acupuncture at an antenatal appointment, she felt somehow different.

> I got acupuncture and got the needle in my pinky toe for the first time. The day after that, I felt somehow soft, soft and open, and in the evening, I thought, here we go. We took the last picture of my belly, and it started after that. I felt so ready after the acupuncture. Marie, 2g2p

The women registered to give birth at the birth centre had all had healthy pregnancies and were in general well prepared for birth and encouraged to contact the birth centre when they were feeling uncertain, at every stage during pregnancy and labour.

Coping during early labour at home

The women had different ways to cope with early labour, depending on the intensity of the contractions. After they were certain that the contractions were increasing in strength and frequency, they involved their partner. One of the women, Lilly, who had already presented at the birth centre once, came home after that visit and tried to manage on her own. She said:

> We went home, and I went into the tub. I had contractions every 5 min. … After the bath, I was lying on the sofa for a half hour and then I lay down next to (my husband) in bed, but I woke up as if I were shocked every few minutes, and he was getting shocked by this as well. Lilly 1g1p

When the contractions didn't go away, she and her husband panicked a bit, so they called the midwife again and left for the FSBC.

Most of the women did not panic when they felt the first contractions. Like Frauke explained in the quote below, they tended to approach their first signs of labour with curiosity, searching for a position that helped them manage pain.

> Well, it was between Monday and Tuesday, during the night, that I seemed to be having contractions. I though, hmm, I couldn't really figure it out. … I managed best standing up, lying down was the worst. …I wasn't sure if they were dilating the cervix. I had imagined that it had to be more painful. Frauke, 1g1p

One of the ways that women coped was to call the midwife when the contractions became quite painful. They were all offered the choice to come to the FSBC when they called, however the midwives often asked the question: Are you still able to manage on your own? If the answer was yes, then the midwife encouraged the woman to try to stay home for another hour. Dora called the midwife 3 times before she left for the FSBC. She explained:

> My membranes ruptured at 4 am; then I called the midwife and told her this. She asked if I had contractions, and I said no. But 5 min later, they started. Then I called her at 5 am again and asked when I should come. She said that if I can still manage at home, to stay home. She said that I should call her again when I wasn't able to cope anymore. Then at 6 am, that was the case. Dora, 1g1p

None of the women complained in their stories about waiting to go to the FSBC when the midwives asked them to try to stay home longer.

Deciding to go to the birth centre

The women's stories indicated that the midwives wanted them to stay home as long as possible. They made the decision to go to the birth centre for several reasons. One of these was when they could no longer cope with the pain at home. Magda, whose labour had become painful quite suddenly explained:

> I called the midwife and then she said, yes, relax some more at home, lie down again, and at 11:00, you have an appointment here. Come then… and, if it gets worse, call again. We managed for another 45 min and by then I felt as if I were filling up the building with my screams. So, I called again, and the midwife said- okay, come right away. Magda, 1g1p

Some of the women, however, left for the FSBC because their partner was uncomfortable remaining at home. Yvonne, who had laboured alone on the sofa all night, was discovered by her partner early in the morning. She said:

> My partner got up at 6:30 and asked me why I'm lying on the sofa. So I told him. The contractions were still coming every seven minutes. …And somehow a half hour later, they were every four minutes. I was here the whole time until he got nervous and asked me, somewhat unsettled, are you really, really, really sure? And then he wanted to at least call the FSBC. So, I did, for him, and then we left home shortly after. Yvonne, 1g1p

Ingrid, who was pregnant with her second child and still breastfeeding her first child, had felt her membranes rupture early in the morning. While she was breastfeeding her first child, contractions began. She called the birth centre several hours later. She didn't yet want to leave home, even though her husband was nervous. When her contractions were quite frequent, she decided it was time. This is an excerpt from her story:

> I noticed at 7 am that my waters had broken … and at 9 am I called the birth centre. I told the midwife: I think the baby is coming today. She said, see how you are. … Then I took a bath and made myself comfortable and had my husband sitting next to me who kept saying: Shouldn't we be going? … But I was completely relaxed. At some point I realized: now it's getting so that I'd like to go. I got out of the tub and said, now we should go. Ingrid, 2g2p

Some of the women wanted to arrive at the FSBC while they were still able to comfortably travel there. Henny, who was having her second child, didn't want to wait until the last minute to go to the birth centre. She said:

> I didn't want to wait until it was super strong, so we called the birth centre and said we were coming. We got there at around 11 pm. And on the way I thought, the first minutes in the car there was nothing! Oh no, now were driving there and the contractions are gone. … They came again right away after we got settled in there. Henny, 2g2p

The final reason for wanting to go to the birth centre was curiosity. Nadia, although she was a medical practitioner and had conducted her own vaginal exam, was perplexed by the results. She explained:

> I told her (the midwife): the contractions are back… I told her that it didn't yet feel like the real thing. I told her that I had done a vaginal exam, that the amniotic sac is bulging, cervix is effaced, but if it was 3 cm—I wasn't certain …I suggested: How would it be if I come by and you check me, and we see what's happened already? Nadia, 1g1p

Women's reasons for leaving for the birth centre were diverse. Some were unable to cope at home, while others called out of respect for their partner's feelings. Others were curious and wanted to know where they were at in their labour, which they assumed a vaginal exam could answer.

Triangulating observational and interview data

NIS had a total of 64 periods of observation at the FSBC totaling 520 h. During field work sessions, women often arrived in early labour. NIS stayed in the kitchen at the birth centre, which also doubled as the break room and work room for the midwives. She had no personal contact with the women unless they had invited her to their birth, however, from the kitchen, she could usually hear the women who were labouring in the birthing rooms. It was also possible to hear the vocalizations of the labouring women (which included moaning, chant-like toning of a vowel, and sometimes screams during contractions) not just in the birth centre, but also from the courtyard outside.

The field note data generated one overarching theme, *Assessing early labour,* and two subthemes: *Midwifing early labour* and *Guided and misguided by vaginal exams*. As this ethnographic study was conducted from the theoretical standpoint of symbolic interactionism, the field note data serves to triangulate the women's accounts, while also contributing to meanings constructed through the interactions of midwives amongst themselves, with the labouring women, and with the researcher.

Assessing early labour

Midwifing early labour

None of the women who arrived at the FSBC during NIS observations had a vaginal exam right after arrival. In the interviews with the research participants, most reported not having a vaginal exam within the first two hours of being at the birth centre; and several did not have any vaginal exams before they gave birth. When NIS asked Marie, one of the women who gave birth at the birth centre, when the midwife conducted a vaginal exam after she had arrived at the birth centre in apparent labour, she explained:

> She asked long after I arrived (at the birth centre), at some point in the later phase, if I would like (a vaginal exam)…She had an idea how far along I was and then I said, yes, go ahead. … She checked (the cervix) once when I was in the bathtub. I was 8 cm. Marie, 1g1p

When the woman and her partner arrived, the midwife greeted them at the door of the birth centre and accompanied them to the prepared birthing room. The midwife usually stayed in the room for the first 10–20 min to make a primary assessment. The midwives all engaged the women in conversation, if there were long pauses between the contractions, in part to witness the change in demeanor when the contraction began. However, the midwives did not ask leading questions about where pain was experienced if the women hadn't offered this information. If the woman had only had 1–2 contractions in that time, they left the room and came back into the kitchen, saying that they wanted to give the woman time to arrive and get adjusted. At this point, NIS often asked the midwives questions, as in the following field note:

> At around 2 am, Annika came with her husband. Daniela went into the small birthing room with Annika and her husband. After about 20 min, Daniela came into the kitchen to get me. She told me that she was okay with me coming into the room. (She said that) Annika had hardly any contractions and could talk through all of them. I went back to the kitchen before the CTG (fetal heart monitoring) was finished.
>
> After the CTG, Daniela came back into the kitchen. I asked her what she would do. Would she send Annika home? Absolutely not, she told me. The reason she gave was: Annika said that she was in labour and

would give birth. Daniela explained that she is sure that she will "find her way into labour"—develop a dynamic, and that the contractions will increase. When I asked her if she had conducted a vaginal exam, she told me: There's no reason for doing one yet. She said she and her baby are ready for the birth and doing well. Field notes 17

The decision to stay at the birth centre when women did not present with strong contractions, like in the field notes excerpt above, was woman-led. The midwives were never observed to send a woman home who expressed that she would go into labour, even though her contractions told a different story. NIS observed on several occasions that, when women arrived at the birth centre, they had long pauses between their contractions and reported that their labour had slowed down on the way to the birth centre. According to the midwives, when women settled in at the birth centre, their labour dynamic often picked up, and their contractions increased. The midwives gave the women time to acclimatize and only conducted a vaginal exam if they had been there for several hours with no change in labour dynamic. While there are various methods to assess labour phase, including but not limited to abdominal palpation and frequency of contractions, these midwives predominantly used women's vocalizations and women's personal descriptions to assess labour.

While midwives did not perform abdominal palpation to assess early labour, they did palpate the abdomen to assess the woman's connection to her baby and sense for themselves the vitality of the baby. In an interview with the midwife Rebecca, who had been working at the FSBC for 12 years, she explained how she connected to labouring women at the birth centre, especially those women whom she hadn't met during pregnancy.

For me, contact is crucial. I use my hands to make contact, to feel the belly. At my most recent birth, I didn't know the woman. I didn't have a connection to her or to her baby, and I always find this to be difficult. So, I asked the woman: is your baby cooperating? Is your baby kicking? She said: No. I don't feel anything. (Laughs unpleasantly) Then I had to listen to the heartbeat for the first time, you know, connect this way, because her belly was so tense, and I couldn't sense anything. And then at some point, the pauses between the contractions were longer, and we could both see the baby moving. We came to the conclusion that it was active, and that was good. Midwife interview, Rebecca

Lastly, the midwives did not do vaginal exams as a means to convince the woman to go home and come back later. This was echoed in all of the postpartum interviews. If women felt that their contractions were strong, the midwives did not oppose them by seeking a measure to convince them otherwise.

Guided and misguided by vaginal exams

I discovered that I could learn a great deal about the midwives' work with labouring women while sitting in the kitchen, since I was party to the midwives' conversations with each other and could hear the women quite well from the kitchen. This was a conversation that took place between Janina, who was working with a woman whom she felt was in the latent phase of labour, and several colleagues who were in the kitchen. Janina, who had been working at the birth centre for three years, hadn't yet called the second midwife.

The midwife Janina came into the kitchen and started talking about Nora, a woman who is at the birth centre in one of the birthing rooms. She said that she has been there since early morning and has had contractions for days. She hasn't done a vaginal exam yet because she doesn't think that it would give her any information that she needs. She could hear that the woman wasn't yet in labour. Field notes 8

While the midwives respected the women's subjective experiences and let them stay at the birth centre in early labour, they occasionally conducted vaginal exams for organizational purposes, even though they could hear that the woman was in early labour. This was the case when Renate, a midwife who was still in her first six months working at the birth centre, needed guidance from her team-mentor, who was also on-call as the second midwife that day. The second midwife, Miriam, who had five years' experience at hospital births where she had mentored student midwives, had been working at the birth centre for three and a half years. She wanted to go home and rest, however the first midwife, Renate, was uncertain how far along in labour the woman was for whom she was caring. When midwives at the birth centre were uncertain about care, especially in their first year at the birth centre, the second midwife was present even in early phases of labour. Otherwise, the second midwife was usually called shortly before the birth.

Renate and Miriam (two midwives) are in the kitchen where I'm sitting and discuss the woman who is here to give birth. Miriam is giving her advice, telling her what to do, asking her what she thinks and how she sees things. Renate started working at the birth centre in the last year and still needs guidance. They discuss the vaginal exam… Miriam wants to have a clear answer about going home or staying…

Renate doesn't want to check the cervix, since she thinks that it will disturb the woman… Miriam says: "It would be better not to check, but I want to know if I can go home." Miriam is the second midwife and only has to stay if the woman is in active labour. Renate goes to do a vaginal exam. Miriam complains that that is one thing about the birth centre that is not different than the hospital. She says: "Sometimes, there is an unnecessary vaginal exam in order to get clarity that has nothing to do with the actual birth at all, but with organizational concerns." Field notes 3

Renate, in her first year at the FSBC, wasn't yet able to assess labour phase and progress well enough without conducting a vaginal exam to know if her second midwife should stay at the birth centre. At the birth centre, the midwife's needs, as opposed to institutional needs, directed the midwives' conduct.

One case at the FSBC stood out as a contradiction to all the other experiences that NIS had during participant observation. Having been called to the birth centre for Monique's birth, who had extended an invitation to her birth, NIS witnessed the negative effect that an early vaginal exam can have on a midwife's perceptions of a woman's vocalizations and enactment of labour.

The midwife called me at 17:34 … told me that Monique was at the birth center, she came with 1–2 cm, (first vaginal exam was at 16:12: Cervix 1–2 cm dilation, head at the pelvic inlet). … She said that she didn't really have a lot of contractions and that I could come later. … I arrived at around 6 pm. (The birth was 40 min later.) …She told me that Monique's membranes had just ruptured. I wanted to go back to her right away. The midwife thought that she would still need a long time to birth, since her second birth, which was also at the birth centre, had lasted 18 h… (In the room with the birthing tub) the midwife sat next to the door that was between the bathroom and the birthing room…She pushed (Monique's) file towards me. You should read this, she said to me. (I felt) it wasn't relevant for me to read that she came with 1 cm cervical dilation so I closed the file and pushed it back to the midwife and told her that I would read it later. Suddenly, Monique said that she felt she had to push. She started to scream …. (The midwife) seemed to be calm. Her voice was steady and she was speaking calmly to Monique. She got a glove and told her that she would do a vaginal exam to see if she had really progressed. …The midwife asked Monique to lean back and sit on her bottom. She tried to do a vaginal exam. …When the next contraction came, Monique … was screaming and panicking, shouting that her (bottom) was falling out. … Monique was straight out screaming–not breathing, not toning, but screaming. She was also pushing. … At this point, the

> midwife told me that she thought that the birth was going to take five more hours. … (When the next) contraction came, Monique said: it's burning, the head is coming out, I have to push… The head was almost at the perineum. Field notes 18

The midwife at this birth, although she had over 3 years' experience at the FSBC, was fixated on the results of the initial vaginal exam. Her interaction with Monique was filtered through that vaginal exam, preventing her from witnessing Monique's rapid path through labour.

Discussion

In this study, women looked to the midwives to guide them through the unfamiliar territory of labour [1, 11, 29]. The women and midwives co-constructed early labour based on the lived experience of women and the meaning that this experience held for both. In doing this, cervical dilation lost its authority to determine care decisions most of the time. A woman who believed that her labour had begun, and who asked for care, received it because she believed she needed it. Downe et al. discovered in their metasynthesis of expert intrapartum care that one aspect of expert midwifery care, according to James et al., 2003, was that the midwives "were able to 'let the woman own the labour'" [30]. Berg et al. discovered in their interviews with women postpartum that they wanted to be "seen as an individual" and "supported and guided on their own terms" [31]. When a midwife's care is individualized, the midwife can "meet the woman where she is" [32].

In this study, midwives rarely sought information through examinations in order to disconfirm women's personal accounts of labour in favour of making a medicalized diagnosis of labour onset. This may be different in hospital settings, as Cheyne et al. wrote in their study about midwives' diagnosis and management of labour [18]. They wrote: "the institutionalized setting of birth in many countries requires a clear-cut distinction between a woman being in labour, and therefore being admitted to the hospital, or not being in labour and staying at home." Because of the way that the midwives were organized at the research site, this distinction was not of primary importance. They generally only needed a more accurate assessment of labour phase in the expulsion phase, in order to make a timely call to the second midwife. In addition to this, the midwives at the research site did not discuss amongst themselves other subtle ways of labour assessment, even though they might have been doing this. Burvill found in her grounded theory study of midwifery diagnosis of labour onset several themes including "importance of women's reports and responses to their experience" and "intuitive and gut feelings" [33]. These two themes are echoed in this paper.

For care to be respectful, the women's cues and spoken and unspoken needs must be addressed [34,35]. When women are made to feel silly when they contact the midwife and are not taken seriously, this casts a shadow on women's self-confidence [1]. The three main premises of symbolic interactionism as defined by Herbert Blumer underpin this analysis:

> [1].human beings act toward things on the basis of the meanings that the things have for them; [2].the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows; [3].these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters [23].

When the cervix or other standardized measure is used as a proxy to demarcate the moment that labour begins or the moment that care should begin, the woman's experience is appropriated, and her authority as the expert of her body is jeopardized [36,37]. As was seen in the example of Monique above, whose cervix was dilated one centrimetre shortly before her labour progressed rapidly, the cervical measurement could not predict the labour dynamic and the course of labour. Liz Smythe, in her study about safe care, wrote: "Responsive doing ensures an alert connectedness with the moment of 'now'" [38].

However, even in this setting there were times when a few midwives were observed to default to using vaginal examinations, either for practical reasons (to make decisions about going off shift) or, in one case, because they could not read the clear signs that the labour was progressing rapidly to the bearing down phase. It was not possible to interpret the underlying rationale for these observations that went against the general run of the data. However, they may relate to the deeply embedded normative use of vaginal examinations in clinical practice, meaning that it becomes the default tool when midwives feel they are not able to rely on other signs and symptoms.

Implications for practice

Caretakers need to amend the weight that examinations in early labour carry in present and future decision making. When women are supported in their subjective experience of pregnancy, labour and birth, their narratives show empowerment [39]; if not, then trauma can result [40,41]. Relationships with caregivers are at the core of this experience, as was shown by Dixon et al. in the confidence that women showed in early labour within the context of continuity of care [10,42]. Furthermore, in the analysis of the women's interviews in this study, they often had a good sense for what they considered to be the beginning of their labour, a discovery in Gross et al.'s study about women's recognition of labour onset [5]. While vaginal examinations can be a useful, and even essential tool in certain circumstances, the findings of this study suggest that, where there is time and space to build relationships of trust between women and midwives, the behaviours and responses of labouring women are critical indicators of progress. Finding ways to build trust and promote these observations in mainstream practice could improve both the sensitivity and specificity of support for physiological labour and birth, as well as early recognition of when labouring women might need or want extra help.

Conclusions

Early labour is often seen by maternity care providers as a minor part of the process of labour and birth. In contrast, this study demonstrates that early labour is an integral component of the way in which symbolic meaning is made by women about the labour process, and that getting support for women right at this stage can be critical in their experience of the later stages of labour and of birth. Paying attention to what each individual woman says and tailoring advice and support to meet their needs and the sense they make of what is happening to them is likely to increase their capacity to cope in later labour and to enhance trust in caregivers. However, the study also shows that some midwives still prioritise standard measures of labour progress that have different symbolic and, therefore, practical implications, over the embodied and evident behaviors and responses of women and their labouring bodies. Given the growing concern about the need for respectful maternity care, this study provides examples of good practice in listening to women, as well as an illustration of the consequences of not doing so.

Limitations and strengths

Several limitations of this study have been identified. Notably, NIS collected data at one FSBC in Germany. Therefore, the findings and insights captured in this study are not necessarily transferable to all birth centres in Germany, nor to FSBCs in other countries, or to other birth settings. A limitation of secondary analysis is that the data may no longer be relevant [43]. However, while this study was conducted in 2015, NIS is currently conducting research in FSBCs throughout Germany and has observed that the descriptions of care in this article are consistent with present-day observations. A key strength of the study is the rich level of description obtained, and the in-depth and triangulated data that view the phenomena of interest from the perspective of both

the labouring woman and the staff attending her. Attention to reflexivity and to a conscious search for disconfirming data strengthen the dependability of the findings.

In addition to this, a secondary analysis of data means that the researchers are not able to return to their participants to ask specific questions [43]. In the case of this article, this means that NIS could not ask the midwife-participants for descriptions specific to their assessment of labour onset. However, during participant-observation at the birth centre, NIS was able to observe midwives with labouring women, as well as listen to and participate in conversations about women in early labour. This information that midwives shared amongst each other is a good indication of their assessment practices.

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Ethical statement

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CRediT authorship contribution statement

Nancy Stone: Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. **Soo Downe:** Conceptualization, Supervision, Writing – original draft, Writing – review & editing.

Conflict of interest

None declared.

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