Good birth narratives: Diverse South African women's perspectives

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Abstract

Background

There is currently a substantial international research focus on issues relating to childbirth distress, traumatic birth and negative birth experiences. Less research attention has been paid to women's narratives or accounts of positive or affirming birth experiences, particularly in the South African context. The aim of this article is to explore the ingredients of a 'good birth' experience from the perspectives of South African women's birth narratives.

Methods

An exploratory, qualitative research design using unstructured interviewing and a narrative methodological framework was used to explore women's perspectives about the ingredients of a 'good birth' experience. Sixty-one participants were obtained via convenience sampling. The sample including 35 low-income black women and 26 middle-class, predominantly white women, aged 18–45 years who had recently given birth to an infant. Thirty-three women gave birth in the public healthcare system, with 25 of these women having vaginal deliveries and eight reporting a caesarean section. Two women had unassisted vaginal births while in transit to public healthcare facilities. Twenty-six women gave birth in the private healthcare system; 15 participants had a planned homebirth with a private midwife, nine had an elective caesarean section, one woman had an emergency caesarean section and another participant gave birth vaginally (with epidural) in a private hospital.

Findings

Less than half of the women ($n = 26$) narrated positive birth experiences. Almost half of the women ($n = 30$) narrated distressing birth experiences while five women reported neutral birth experiences. This paper focuses only on women's 'good birth' narratives ($n = 26$). Good and affirming birth narratives were characterized by the following three themes, namely: (1) a sense of presence, (2) physical and ontological safety and (3) respectful care.

Conclusion

The bodily and corporeal aspects of the birth experience were found to be central to women's 'good birth' narratives. A key conclusion is that maternal healthcare provision needs to be reimagined in ways which acknowledge, centre and respect the unique and vulnerable corporeality of birthing women, regardless of type of birth.

Keywords: Childbirth; Good birth; Embodiment; Childbirth narratives; South Africa; Qualitative

Introduction

All is not well with childbirth in South Africa. The maternal healthcare system is bifurcated and unequal, with the public (state-funded) sector characterized by poor infrastructure, lack of resources and increasing reports of poor quality of care and obstetric violence (Jewkes et al., 1998; Kruger and Schoombee, 2010; Human Rights Watch, 2011; Silal et al., 2011; Author). The private healthcare system, while well-resourced, is highly interventionist and has an extremely high caesarean section rate, with estimates ranging between 40 and 82 percent (Rothberg and Macleod, 2005; Tshibangu et al., 2002; Naidoo and Moodley, 2009). Maternal mortality rates (MMR) differ dramatically across public and private sectors; the MMR in the private sector is estimated as 40 deaths per 100,000 births (Bateman, 2014) while in the public health system the estimated figure is 134 deaths per 100,000 births (Moodley, Fawcus and Pattinson, 2018). The split between public and private healthcare sectors is also still highly racialized, with 83 percent of patients in the public sector being black and poor (South African Demographic and Health Survey, 2007). Furthermore, while approximately 84 percent of white South African women have access to private, highly resourced healthcare, only 32% of black African women have access to private healthcare (StatsSA, 2013). The kinds of births that South African women experience thus differ dramatically according to class/race positions.

Most qualitative research on childbirth in South Africa has focused on the experiences of poor women in the public healthcare system, where there are increasing reports of women being abused, mistreated and subject to inhumane care during labour/birth (Kruger and Schoombee, 2010; Human Rights Watch, 2011; Author). This study departs from this predominant focus on distressing and negative birth experiences and explores the ways in which South African women (across socioeconomic, public/private and racial differences) narrate 'good birth' experiences. Understanding what makes births good from women's perspectives is crucial in efforts to envision, design and implement changes in maternal healthcare that will improve how women feel about their birth experiences. Research has shown that childbirth is a central event in women's emotional lives and that feelings associated with birth can continue to impact on women's sense of self, mental health and relationships for many decades (Simkin, 1992). It is also important that we understand what good births mean to women from a range of socioeconomic and racial positions. To date, most research looking at birth satisfaction has been conducted with middle-class, white women in various settings in the global North (Fowles, 1998; VandeVusse, 1999; Gibbins and Thomson, 2001; Green and Baston, 2003; Davis-Floyd, 2003). This study aims to explore a range of South African women's good birth narratives in order to explore commonalities and differences across race/class positions.

There is currently a substantial international research focus on issues relating to childbirth distress, traumatic birth and negative birth experiences (Creedy et al., 2000; Baker et al., 2005; Elmir et al., 2010; Nilsson et al., 2010; Thomson and Downe, 2010; Schroll et al., 2013; Author). Less research attention has however been paid to women's narratives or accounts of positive or affirming birth experiences. When researchers have explored good or affirming births they have often equated good or positive births with a particular type of birth (i.e.

'normal' or 'natural'). Good births have thus at times been examined only via the experiences of women who have had so-called 'normal' or 'unmedicated' births (i.e. Parratt, 2002; Hardin and Buckner, 2004; Nilsson et al., 2013; Aune et al., 2015). Problematically, this entrenches the idea that a medicalized birth experience cannot be positive, good or empowering. Such assumptions have been challenged by studies that have found that some women regard medical intervention as positive aspects of their births (Lavender et al, 1999; Thomson and Downe, 2010) and that women can potentially find healing in medical procedures such as caesarean sections after traumatic vaginal deliveries (see Thomson and Downe, 2010).

The aim of this paper is to explore women's 'good birth' narratives across different types of birth (homebirth, elective caesarean section, vaginal deliveries in hospital, emergency caesareans) obstetric and maternal healthcare settings (public and private) and race/class positions. A narrative methodological framework is used to allow women's perspectives of what makes birth good, empowering and affirming, to be foregrounded. There is currently a lack of research about women's positive birth stories in the South African literature on childbirth. Moreover, there has been scant attention in the broader international social science literature on childbirth to the dynamics and characteristics of good births across different modes of birth and in relation to race-class differences (but as an exception, see Davis-Floyd, Barclay, Daviss and Tritten, 2009).

Methods

This study used a narrative approach (see Riessman, 2008) interested in eliciting and exploring modes of birth storytelling to explore the birth experiences of 61 cis-gendered women, aged between 18-45 years, who had recently given birth in the Cape Town area of South Africa. The data was collected via two separate research projects (see Table 1); in the first study interviews were conducted with 26 middle-class, predominantly white (n=24) women. Fifteen of these women gave birth at home with a private midwife. Nine participants chose to have an elective caesarean section, one woman had an emergency caesarean section and another gave birth vaginally (with epidural) in private hospital settings. In the first study, both pre- and post-birth interviews were conducted but this paper reports only on the post-birth interviews (which occurred four to six weeks postpartum). In the second study, 35 low-income black women who had recently given birth in the public healthcare system were interviewed. Ethical approval was obtained from the University of Cape Town's Health Sciences Faculty Human Research Ethics Committee.

In the first study, participants were recruited with the help of eight private midwives in Cape Town. An advert calling for research participants was also placed in several local community newspapers as well as one national South African pregnancy magazine. A request for participants was also made through antenatal classes at four local private hospitals. Interested potential participants then contacted the author and an interview time and place was agreed on. All of the interviews with middle-class pregnant women took place in their homes, except for one that was conducted at the participant's place of work. Informed consent was obtained from all participants and the principles of anonymity and confidentiality were guaranteed. Interviews lasted between one and three hours and were all conducted, audio-recorded and transcribed by the author. Fifteen of the women had successful homebirths with private midwives, nine women had elective caesarean sections in private hospitals, one woman had an emergency caesarean and another had a vaginal delivery with epidural in the private healthcare sector.

Table 1. Sample characteristics.

	Study 1	**Study 2**
Participants	*n* = 26	*n* = 35
Race	White = 24	Black = 35
	Black = 2	
Mode of birth	Homebirth = 15	Vaginal Birth = 27
	Elective Caesarean = 9	Emergency Caesarean = 8
	Emergency Caesarean = 1	
	Vaginal Birth with Epidural = 1	
Place of birth	Home = 15	Maternal Obstetric Unit = 16
	Private hospital = 11	Public hospital = 17
		Birth in transit to facility = 2

In the second study, participants were recruited with the help of a local non-governmental organization that offers primary prevention services, counseling and support to parents and caregivers. This organization also runs a home-visiting programme in peri-urban and impoverished areas of the Cape Town area in which new mothers are supported via home visits by trained community workers. Community workers told women participating in this programme (who had given birth in the last four weeks) about the research project. They then liaised with interested women and the researcher to set up suitable times for the interviews. Before interviews were conducted, the project was again explained to potential participants and informed consent was obtained. Women were assured of confidentiality and the protection of their identities. A consent form (provided in English, Afrikaans and translated into isiXhosa) was read to each woman and her signature was obtained if she consented to participate in the research. Women could choose to be interviewed in either English or Afrikaans. Following consent, unstructured interviews were conducted which began with the broad question, 'Can you tell me what happened with your birth experience?' In line with a narrative methodological approach, interviews are structured around one central open-ended question which serves as a 'narrative invitation' (Riessman, 2008) indicating to participants that they are being asked to share their experiences in narrative form. On the basis of the stories and experiences shared by participants, the interviewer then asked follow-up questions in a naturalistic and conversational style. This kind of approach is well suited to a narrative methodological framework given that narratives are more likely to be elicited by an open-ended and unstructured interviewing style (Riessman, 2008). Interviews were thus co-constructions between interviewer and interviewee and did not proceed via a rigid, predetermined interviewing script or schedule. Interviews were conducted, digitally recorded, transcribed, and if necessary translated, by the author. Most of the interviews took place in women's homes (n=32). All of the women lived in peri-urban, informal settlements marked by overcrowding, high rates of violence, gangsterism and poverty. The majority of women were Afrikaans-speaking and of mixed racial descent (n=27). Eight African women were interviewed. Most of the births were vaginal deliveries (n=27) with eight women reporting a caesarean section. Sixteen of the births took place in low-resourced community obstetric clinics (operated by nurse-midwives), seventeen births took place in public hospitals and two births happened while in transit to healthcare facilities.

A thematic approach to narrative analysis (Riessman, 2008) was utilized to analyze the data from both projects. Thematic narrative analysis is suited to the analysis of common themes across a number of narratives and is concerned with the content of what is told rather than with the structure or function of narratives (Riessman, 2008). Transcripts were read repeatedly and inductively coded in order to synthesize the data. Codes were refined into narrative themes and categorized into different narrative types on the basis of their central themes, for example: narratives of distress, good birth narratives and minimalistic or neutral narratives. This paper focuses only on good birth narratives. A detailed analysis of childbirth distress narratives has been reported elsewhere (Author).

Findings

Nearly half of the participants (n=30) narrated distressing birth experiences. Five women told neutral stories about their births and 26 women narrated good births. Distress narratives were characterized by poor quality of intrapartum care, relational abuse and lack of respect (by caregivers) for the emotional and subjective experience of birth and becoming a mother. Middle-class women who gave birth at home with a private midwife were in general the most

satisfied with their birth experiences, with fourteen out of fifteen reporting 'good births'. Women birthing in the public sector predominantly (n=18) used 'narratives of distress' to articulate their experiences (Author). Eleven women birthing in public healthcare settings narrated good births and one woman who gave birth via elective caesarean in the private sector narrated a good birth. Most of the women who had caesarean sections in the private sector (n=10) narrated distressing experiences (n=6). This paper focuses only on good birth narratives as told by 11 low-income women who gave birth in the public sector, 14 women who birthed at home with a private midwife and one woman who had an elective caesarean in the private sector. A thematic narrative analysis highlighted three central themes in good birth narratives, namely: (1) a sense of presence, (2) physical and ontological safety and (3) respectful care. The analysis shows that acknowledging, respecting, supporting and validating the deeply vulnerable, and intensely corporeal, aspects of the birth experience, makes women feel good about their births.

A Sense of Presence

Women narrated a sense of presence as a key element of good birth narratives. This narrative theme had two meanings in women's stories and related to (1) the embodied presence of supportive others and (2) a feeling of being self-present, an embodied agent and an active participant during labor/birth. Good birth narratives with suffused with the presence of concrete and supportive others who went along with them for the journey of labor/birth. As a result, in these narratives there was no sense of feeling isolated, lonely or alone (which was a key characteristic of childbirth distress narratives). Participants repeatedly spoke about the importance of knowing that someone was there – *with them* – during the challenging, painful and often stressful experience of labour. Being 'with women' meant more than simply being in the room as a spectator, passive bystander or as medical personnel engaged in routine medical checks. As Cynthia, a low-income woman who gave birth in the public sector, said:

> They [nurses] hel(ped) me, they *talked* with me – every time when I got the pain because the child's head was already there (R: ok) they talked with me, the one nurse talked with me, she said 'push ha(rd)', the time that I couldn't push, then I was TIRED then she said to me I must push and then I ***pushed***...

As she reiterates no less than three times in this short speech extract, caregivers 'talked *with me*' (emphasis added), describing an interpersonal dynamic in which those around her were fully present *with* the corporeal birthing process she was experiencing. Similarly, Sarayda, who also gave birth in the public sector, spoke about the special treatment she received from her caregivers during labor/birth:

> The nurses were very attentive um (*) they were there all the time <u>for me</u>, not leaving me alone, it was a good birth for me, they were good with me, they gave me **excellent** treatment. <u>I felt good</u>. When I gave birth to her, and then I just asked the nurses to pray with me for her, and the nurses were standing there, they were so like um, they were really part of everything there with me.

Like Cynthia, Sarayda emphasizes the importance of caregivers being there for her and with her throughout the laboring and birthing process. In good birth narratives women also spoke

about being the centre of a hub of supportive interpersonal care and attention (i.e. there to be comforted, conversed with and looked after) rather than the object of a medicalized spectacle (i.e. there to be measured and observed). For example, Liezel, a middle-class woman who gave birth at home with a private midwife, narrated her birth as a collective endeavor in which she was supportively and viscerally entangled with her caregivers and birth companions, to the point where actual boundaries between bodies became blurred.

> You see it was also going with support, I mean if you imagine the scene with X [partner] behind me, and I'm standing, and my sister's on, at my left leg and the midwife's at my right leg, and my foot was actually <u>on</u> them, on their laps or legs or something, I dunno, but my feet wasn't on the ground (…) and then there's, then there's another midwife who's there next to the other midwife, like say in the middle, and I'm standing and then I would, then I would feel the contraction come and then I would go <u>down</u> and I would say 'Okay it's coming' and then you would just have everybody's energy and everybody's attention like on you and it would be '*aahuuuh*' and everybody's '*aahuuh-ing*' with me (…) and they're all like right <u>there</u>, it's not just, kind of me sitting pushing like somewhere, everybody's making *a noise* as well so I didn't feel like <u>I</u> was grunting or anything, like everyone was kind of grunting with me and talking.

Rather than being a passive patient, Liezel narrates being the centre of a supportive and strongly embodied (holding, breathing, grunting) hub of intermeshed bodies. Her account graphically describes the embodied presence of supportive others during labour as a process in which entire corporeal and affective energies are focused on the birth giver and birth process. Any easy sense of separation between the birthing woman, medical caregivers, partner, and family members is challenged in her story. Instead, she describes her 'good birth' as an event characterized by body-to-body care, in which whole bodies become visceral mediums of support, affirming presence and sources of tactile comfort. Women's stories suggest that the affective energies of those around them (i.e. present, detached, supportive, hostile) are central forces shaping the ways in which they *feel* about their birth experiences.

For many women who told positive stories about their births, there was a clear sense of satisfaction that pervaded their talk. Several women thus repeatedly described their births as 'good' or as 'nice' or as 'fantastic'. For example, according to Sarayda, "it was a good birth for me" and "<u>I felt good</u>". The supportive presence of others often seemed to allow women the space to achieve births in which they felt personally and subjectively empowered and affirmed. For example, Jane, a middle-class woman who gave birth at home with her partner and a private midwife, told a good birth narrative in which birth was told as empowering, enlarging and *viscerally* satisfying. A sense of fleshy satisfaction permeated her birth narrative, in which birth was repeatedly described as 'good'. For example:

> It was lovely, I felt very supported, and it was good (**). And then things really, really, really got sore (laughs) I was able to tell myself 'it's just pain' and (chuckles) it's going to pass and it will get better (…) it was, it was a fantastic birth, it was really thrilling, it's the best thing I've ever done in my life! There was a lot of pain, but it was so, it wasn't traumatizing at all, yes it was really good, in fact I really want, want to have another one now to see if I can do it all again! Yes, it was, it was a good birth.

In Jane's story, there is both a sense of being supported by the presence of supportive others

and a strong feeling of her own *self-presence* in which she is able to meet the pain and challenges of the labour process. In many ways, women's stories suggest that the ability to be self-present and enact a sense of positive embodied agency during labor/birth is dependent on having the presence of supportive and affirming others. Lyerly (2006: 103) defines 'agency' during childbirth as, "the power and the presence to preside over one's own experience of giving birth". This definition suggests that 'agency' is a process of individual, self-contained 'control over' the process of birth. In contrast to this definition, women's good birth narratives invoked agency instead as a relational and embodied capacity or phenomena. Furthermore, a sense of embodied engagement or 'agency' during labor/birth did not always translate into an experience of being in control of pain or the bodily birthing process. Women's good birth narratives suggested instead that it is a sense of presence (of supportive others and linked to this a feeling of self-presence) that is centrally important in making them feel good about their birth experiences. This was a common feature of birth narratives across different settings and modes of birth. For example, Lola, a middle-class woman who had an elective caesarean section in a private hospital, told a 'good birth' story that highlighted the importance of having both the supportive and engaged presence of caregivers and (enabled by this) being self-present – even during surgical modes of birth.

> It was a very positive experience, the moment that they lifted her up, it was like everyone was sort of keeping their breath in, it's a fantastic moment, I think I could experience it better because I wasn't in pain, I was totally satisfied and fulfilled with what I went through, it was a fantastic moment, and um, all the doctors and the nurses and everything, they actually, they give you that moment, it's not as if there's rushing around (…) it's not as if they're just there to do their job, so it is, that makes it very special I think, the anaesthetist was actually talking to me, telling me what they were doing, what was going on and saying 'Ooh they're pulling him out, the head's coming out' and 'ooh there's a baby!'. The tears were like rolling down my face, it was an *incredible* (*) um moment, it's really <u>amazing</u>.

Even in the case of caesarean section (and perhaps more importantly) caregivers need to act as supportive others who are present with women and engaged in making them feel part of the process of birth (even if it is a surgical event). Having staff focused on the moment of birth (everyone is described as collectively holding their breath) and on the birthing woman/couple, talking with and describing what is going on at all times, enabled Lola to feel a strong sense of presence and involvement in her caesarean birth. As a result, it was a good birth for her that made her feel positive and affirmed.

The idea of 'presence', involving the presence of supportive others and self-presence, was thus an important ingredient of good or positive birth narratives. Across different settings and modes of birth, women spoke of the importance of having the full presence of engaged and supportive others that often enabled them to enact forms of positive self-involvement and self-presence during labor/birth.

Physical and Ontological Safety

The second theme associated with good birth narratives was a sense of physical and ontological safety. Physical safety referred simply to feeling safe and looked after. This often related to receiving proper and prompt medical attention and treatment. The importance of physical safety

as an ingredient of a good birth has been missing from discussions of 'good births' that have centred on the experiences of middle-class women in well-resourced settings. Given that privileged women generally enjoy full access to life-saving technology, equipment and interventions if needed, basic physical safety during labor/birth is often taken-for-granted in these settings. For low-income South African women giving birth in the public sector – a context in which MMR's are still relatively high – a sense of feeling physically safe was an important aspect of a positive birth experience. In addition to physical safety, women also narrated the importance of ontological safety in relation to a positive birth experience; by 'ontological safety', I mean a sense of being free to enact embodied agency without fear of threats to self in the form of hostile treatment, punishment or judgement.

For low-income women, physical safety was an extremely important aspect of a good birth experience. Many of these women described the presence of medical machinery, monitoring and technology as reassuring, comforting and as adding to feelings of safety. For example:

> **Tracy-Lee**: There was somebody and they were monitoring the baby, because I was very concerned over the baby, I was constantly checked up on, everybody in the ward, they do rounds like every two hours (…) and if you press the emergency button they respond in a, just five seconds and they're there.
>
> **Interviewer**: So the nurses – the treatment was good at the hospital?
> **Vanessa**: Very good yes, because the room where I lay, they, the sisters that were on duty, they come in the morning, the evening and uuh give you *pills* and everyone that needs pills, asks for pills and so on, injections.
>
> **Esme**: They [nurses], they look after the people quite well, they examine you alright.

Being examined, monitored and given pills, painkillers and injections made these women feel that they were being taken care of and that the labor/birth process was being adequately managed and in safe hands. However, it should be noted that the feelings of safety and security generated by the presence of machines and medical interventions were contingent on positive enactments of technology. By 'positive enactments' I mean simply that monitoring, interventions and machinery were applied in sensitive and affirming ways. Obstetric technology is not inherently either positive or negative (see Lyerly, 2006) but materializes as affirming or alienating in relation to the ways in which it is applied by caregivers and technicians. Childbirth distress narratives were thus filled with stories of women (across race/class differences) being upset by technology and interventions (i.e. electronic foetal monitors, cervical checks, injections, intravenous drips) that were applied in hostile, dismissive or nullifying ways (Author).

Along with the importance of feelings of physical safety and security in relation to 'good births', women also narrated a different sense of existential safety in their positive birth stories that I term 'ontological safety'. This refers to women's ability to feel safe enough to act – verbally, bodily and performatively – in ways counter to everyday norms of feminine containment, propriety and control. Childbirth is an intensely fleshy experience in which the body potentially becomes 'loud' (Shabot, 2016) and uncontainable and in which birthing women grunt, scream, squat, sweat and bleed in ways which threaten everyday presentations of (controlled, contained, disembodied) selfhood. This means that childbirth is a time of vulnerability in which women's sense of self can be threatened and subject to shaming or ridicule by the responses of those around them to their labouring/birthing bodies. As a result,

women need to feel ontologically safe – that is, they need to feel secure that they will not be punished, shamed or insulted – in order to enact embodied forms of agency during birth. Women birthing at home with private midwives were most assured of this kind of ontological safety given that labour/birth happened on their own terrain and they were surrounded by their own material objects, comforts and as many supportive others as they wanted. For example:

> **Erin**: The, the pleasantness of the environment made a big difference, just like being able to dance around in my bedroom, and then *afterwards* (*) getting back into my bath and having a bath and then being tucked up in my bed, I mean you're in your own comfortable bed and not a hard, hospital bed, it's just, it just felt nice (*) it was very nice, and everytime a contraction would come I sort of grabbed him [partner] I would kind of lean on him (…) it's a very *physical* experience (*) and its work, you know. I feel very proud of myself (giggles)

> **Jane**: And my husband was **there**, by then I was grunting and groaning, I wasn't quite anymore, but it was quite good also, it helped to be able to give a good groan if I needed to.

> **Sam**: I was making jokes and singing along with music, even through contractions I was, my sister organized some nice mixed tapes and I would sing along to the music, and then even on the pushing out stage, we played music, I was just trying to sing with it, cause then you're relaxed, I remember the people laughing at me because I was singing too loud (laughs) I was very strong you know.

For Sam, Jane and Erin, being at home meant that they felt intrinsically safe and free to enact whatever forms of embodied agency were comfortable, comforting and enabling to them, whether this meant dancing, singing or grunting. Feeling ontologically safe also meant feeling okay with the mess and non-threatened by the corporeal substances (i.e. blood, water, faeces and amniotic fluid) that are part of the labor/birth process. For example:

> **Yolande**: It's not very dignified (*) I just kept thinking I'm going to have to clean this floor, I kept laughing and saying, 'This is not dignified girls; this is not dignified'. I'm messing all over. But with the sheets and everything you're not actually messing the floor itself (…) when you're at home and you're squatting and (*) it's, it's not very dignified, it's messy and there's water and there's (*), and there's blood everywhere, and it's not dignified, but um, it definitely helped to be able to move around, your body tells you exactly where it needs to be.

In this extract, the laboring/birthing body is constructed as a uniquely vulnerable corporeality in which bodily boundaries and 'control' become fluid and unstable. This is a body that leaks fluids in uncontrollable ways and that often demands/needs to move and act in transgressive and exuberant ways. Yolande is able to make this into a laughing matter (at home) and accept the messiness of birth because she feels safe enough to do so. Many women who narrated birthing distress narratives spoke about the ways in which their laboring/birthing bodies were shamed by caregivers who shouted at them for 'messing' or who told them to clean up their mess even while they were in the painful throes of labour (Author).

Safety was a key ingredient of a good birth experience as narrated by women across maternity care contexts. However, for low-income women, physical safety was particularly

important, with medical interventions and technologies often experienced as reassuring (when applied sensitively). Ontological safety was also a key issue for women and speaks to the importance of recognizing the particular corporeal vulnerabilities of labor/birth and designing care in which women are empowered to experience and accept these bodily challenges without fear of censure, punishment or shaming.

Respectful Care

The third theme associated with good birth narratives was 'respectful care'. Respectful care had three sub-dimensions, namely: (1) that birthing women were treated as full human persons, (2) that the process of birth itself was treated with respect and (3) women's corporeal vulnerability during birth was recognized and met with hands-on and body-to-body care.

Having their humanity respected was a core element of positive birth narratives and meant that women were not just treated as medical objects to be monitored and managed but that they were regarded and acknowledged *as persons* and thus worthy of a kind word, conversation, information and consideration. The importance of caregivers engaging in conversations was a common aspect of good birth narratives. For example, according to Bronwyn, a low-income woman who have birth in a public sector hospital:

> It's very nice there, I felt like I was in a hotel – *being served* (laughs), it's nice there, they treat you very well, in the morning they come in and greet you with a smile on their face and it's nice, and they always talk to you, like make conversation, and so you're never lonely there or feel like you're ***out***, you don't fit in, they're so nice and friendly (…) *It was*, it was a nice *experience* when she was born. Oooh, it was the best time of my life! (laughs)

Here we can see the importance of basic human respect for birthing women. Small interpersonal considerations such as being greeted with a smile or being engaged in conversation had positive affective consequences and were an important part of good birth narratives. In the South African context, childbirth has become intensively medicalized (with most women birthing in obstetric facilities); along with this has come a tendency to treat labouring/birthing women as body-objects there to be managed and controlled (Author). Birthing women however do not want to be dehumanized or objectified but repeatedly stressed the centrality of respectful care which acknowledged and treated them as full human persons.

A second component of 'respectful care' involved caregivers' attitude towards the birth process itself. Good birth narratives were suffused with descriptions of healthcare providers respecting the birth process and treating it as a reverent or special event. For example, according to Cynthia who gave birth in the public sector:

> They [nurses] were very nice, they weren't ru(de), they didn't say *you* or *IT*, they were very nice, they *talked* almost like you are now (*) you are important. It's *important* to them.

In this short extract, the importance of respectful care is highlighted – Cynthia describes both being respected as a whole subject or person ("they didn't say you or IT") and the ways in which the birth process itself was treated as important or significant. A key critique of the medicalization of birth is that the psycho-emotional significance of the birth event

for women is often unacknowledged and disrespected (Author). This study suggests that respect for the life-giving process of birth is an important aspect of what makes women feel good about their birth experiences. For women who gave birth at home, the respect shown by midwives towards the birth process was often a most cherished and moving aspect of their remembered experiences. For example:

> **Lizette**: They helped me out of the bath and I became aware that these two midwives were drying me with these towels, and they were both like kind of drying my legs, so it was as though they were kind of *kneeling* almost in a way, and I was so, it was such an amazing experience, I mean I really felt that these women – who were taking *care* of women with humility and with respect, aagh – it was just, I mean it was so powerful.

Lizette describes a moving scene in which she is lovingly tended and respected (as a birth giver) by her caregivers. They kneel before her and dry her legs, acting with reverence towards her and enacting an attitude in which birth is regarded as an important life event. This kind of descriptive scene contrasts dramatically with the ways in which women narrated the attitudes of caregivers in 'distress narratives' – in which healthcare providers (and maternal health institutions) were often described as disrespectful towards women and birth more broadly (Author).

The third aspect of 'respectful care' involved being the recipient of tactile, hands-on 'body to body' care. Women across class/race positions spoke about the importance of supportive touch during labour/birth as a key component of what made births 'good'. For example:

> **Angela**: Through every contraction they breathed with me and held me, that made such a difference for the pain, I dunno why but every time one of them would go away, I'd feel the difference in pain [Home-birth with private midwife].

> **Sarayda**: I felt like a celebrity there, the treatment they gave, it was very, it was very nice treatment they gave me, checked every time is my pillow okay – 'how are you feeling?' – checking my pulse and damping my head from the sweat and all that [Public sector birth]

> **Yolande**: Somebody was holding my hand, somebody was talking to me, somebody was rubbing my back, somebody was massaging my lower back, it was just the fact that there were people around who, who cared, and that touch, you know, I was in the middle of a contraction and X [midwife] just put her hand across my back and just pushed gently, and you focus on the white warmth of the massage as opposed to the white pain of the contraction, it just makes, it makes it so much easier [Home-birth with private midwife].

These extracts collectively highlight the importance of 'body-to-body' care during labour/birth. During birth, women enter into a state of corporeal vulnerability in which pain, fear, loss of control and multiple insecurities (i.e. Will the baby be okay? Will I be okay? Can I do this?), result in a need for comforting reassurance that is best provided by embodied others who care with their bodies, hands, arms, smiles, gestures and gaze.

Discussion

This article explored the central ingredients of good birth experiences from the perspectives of diverse South African women's birth narratives. Focusing on the good birth narratives of 26 women across race-class divides, who gave birth in both the public and private healthcare sectors in South Africa, the paper highlights women's perspectives of what made them feel good about their births. Good birth narratives were found to be characterized by three key themes, namely: (1) a sense of presence, (2) physical and ontological safety and (3) respectful care.

It was found that recognition, support and respect for the uniquely embodied and psycho-emotional aspects of labor/birth made women feel positive about their experiences. While previous studies have focused on the 'factors' (i.e. support, control, decision-making) associated with childbirth satisfaction (Fowles, 1998; VandeVusse, 1999; Gibbins and Thomson, 2001; Green and Baston, 2003), these factors have often been treated as disembodied phenomena with little acknowledgement or exploration of the embodied aspects of women's positive birth experiences (but see Nilsson et al., 2013 as exception). In this study, it was found that most of the ingredients associated with good birth narratives were related to the treatment, recognition and respectful care of the vulnerable corporeality of labor/birth. It is thus imperative that efforts to improve maternity care acknowledge the centrality of the embodied aspects of childbirth and implement protocols and strategies that will enable women to feel nurtured, affirmed and empowered to engage with all of the psychofleshy challenges of labor/birth. As argued by feminist writers, childbirth is a unique corporeal event that is ontologically and emotionally challenging to women; it disrupts boundaries between self/other, implodes and challenges self-control and is overwhelmingly visceral (Adams, 1994; Young, 1990; Raphael-Leff, 1991, 1993; Lupton and Schmied, 2013). In this study, I provide insights into the ways in which caregivers' responses to these embodied aspects of birth are fundamentally interwoven with good quality of care and birth satisfaction. The study also supports the finding/s made in the literature on negative, traumatic and distressing births that the relational and affective dynamics of labor/birth are integral in shaping the ways in which women cope and engage with pain, labor, bodily challenges and medical interventions during birth (El-Nemer, et al., 2006; Swahnberg et al., 2007; Thomson and Downe, 2008; Nilsson et al., 2010).

In this article, I showed that women collectively desired fully engaged, present and supportive others who went along *with them* on the journey of birth giving. Having the full presence of supportive others who were focused on them and the process of birth, enabled women to construct forms of embodied agency and self-presence (i.e. feeling personally engaged). Finding ways of coping with the embodied challenges of labor/birth were thus found to be intimately intertwined with the presence of supportive others. Having a full sense of presence, involvement and embodied agency were thus achieved with the help of caregivers and companions. In contrast to other discussions and investigations of 'positive births', in this study I found that safety was a central aspect of good birth narratives. The lack of attention to the importance of physical safety as an aspect of birth satisfaction is likely explained by the fact that most research to date has been dominated by the perspectives of middle-class women in settings of the global North (VandeVusse, 1999; Gibbins and Thomson, 2001; Green and Baston, 2003). Low-income women in this study underlined the ways in which medical interventions and drugs could make them feel safe, reassured and positive (as long as they were applied sensitively). This suggests that any reduction of positive or good births to a certain type of birth (usually non-interventionist or 'natural' modes of birth) is not reflective of what matters to women in relation to birth. As argued by Lyerly (2006), it is not mode of birth, technology

or place of birth that makes a birth good, violent or distressing. Instead it is the ways in which birthing women are treated and in which their embodied and emotional realities are either dismissed or affirmed that are at the crux of how women come to feel about their birth experiences. Feeling safe, both physically safe, and ontologically safe enough to embrace or engage with the embodied challenges of birth, were integral to such affirmations. Childbirth is fundamentally a time of vulnerability (regardless of type of birth) in which women's sense of self can be shamed, reduced, affirmed or enlarged. Feeling safe, surrounded by supportive others and treated with respect during labor/birth were found to be core features of feeling good about self and about experiences of birth.

Respect was found to be a further key ingredient of good births. As human rights birth activists have argued (Tritten, 2009; Rattner, 2008) it is vital that women are treated as fully human subjects during birth and that they enjoy all of the rights associated with this (i.e. confidentiality, choice, informed consent). Women's birth narratives suggest however that while broad principles are important, it is in the everyday relational encounters between birthing women and caregivers that human selfhood is either recognized and respected or denied. For women across race/class differences, small interpersonal considerations (such as a friendly smile or conversation) made all the difference between feelings of objectification and dehumanization and feelings of positive affirmation. Women's good birth narratives also suggest that wider sociocultural respect for the process of labor/birth is an overlooked aspect of positive births. Women thus appreciated it when the personal and emotional significance of birth was recognized, valued and respected by healthcare professionals and those around them. This was the case regardless of type of birth.

There are a number of limitations to this research. First, this study is based on participants from a relatively narrow geographical region of South Africa. Further research is needed which explores positive birth experiences across a wider geographical range, including rural areas of South Africa. Second, the research included only a small number of African women (n=8) and findings would have been strengthened by the inclusion of more African women's birth narratives. Language barriers however made this difficult to realize. The study was also based on convenience sampling and certain sub-groups of the sample are small – i.e. very few women birthing in private hospital settings were interviewed. Future research is needed which explores a larger corpus of women's birth experiences (both positive and distressing) in the private hospital context in South Africa.

By focusing on a diverse range of women's narratives about birth, this study has highlighted the ingredients of positive birth experiences. A qualitative narrative approach and unstructured interviewing allowed women's perspectives and stories to be foregrounded. The ingredients of good birth experiences were inextricably linked to the treatment of women's vulnerable corporeality during labor/birth. Caregivers' sensitive responses and affirmations of the intensely embodied and psycho-emotionally challenging aspects of birth via supportive presence, affirmations of safety, body-to-body care and respectful care, were fundamental to women's good birth narratives. The findings of this study have implications for the development of interventions and strategies to improve women's satisfaction with their birth experiences. It is vital that efforts to improve maternity care do not overlook the critical importance of the embodied, corporeal and psychofleshy aspects of birth and their centrality in shaping women's positive and affirming birth experiences.

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