Chapter 17
Tranquil Birth: Revising Risk to Sustain Spontaneous Vaginal Birth

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Elma’s second labor was very different from her first, an unnecessary “emergency” cesarean section (CS) in an expensive private clinic in Cape Town in 2013. Elma was not unusual in having an unnecessary cesarean (CMS 2020). In 2015 in South Africa, private hospitals had CS rates of almost 70% and public hospitals had rates of around 30%, much higher than the WHO’s (2015) suggested national rate of 10–15%. Elma was unusual in perceiving that hospital birth was too risky, in terms of its likelihood of resulting in subsequent cesareans with their risks of, for instance, placenta accreta, placenta percreta, and ill effects on her psychological well-being. She was also unusual finding a midwifery practice experienced in vaginal births after cesareans long before she conceived again, and so had plenty of time to let go of her fears about birth before her vaginal birth at home in 2015.

For her second labor in 2015, Elma chose an independent midwife whose hospital transfer rate was only 9%, and who was very experienced with vaginal births after cesareans (VBACs) and twin births (both considered extremely high risk in hospitals). Elma’s second delivery took place under tranquil conditions at home, accompanied only by her husband, doula, and midwife. Her labor took roughly 40 h, most of which were peaceful, quiet, and almost uneventful. While in early labor, Elma cleaned her home and slept; later she used the warm water of a shower to ease the pain of her contractions. A midwife checked Elma’s blood pressure and the fetal heart rate regularly with unobtrusive hand-held devices and found no reasons for concern. After 38 h, when she was dilated to 6 cm and tiring, the midwife, with Elma’s permission, briefly manually stretched her cervix. Elma had prepared for the birth by exercising, researching, and attending intensive antenatal classes.

1 Names and identifying details of people described in this chapter have been changed to protect their privacy.

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Elma had decided to give birth at home mainly to avoid the culture of fear that was so pervasive in institutional health settings across South Africa.

The attitude and ideology of providers can have a profound influence on the outcome of a birth (Hodnett et al. 2013; Byrom and Downes 2015). This chapter describes “tranquil birth”—a term I use to describe what my interlocutors would term a “peaceful,” “positive” or “compassionate” or even “traditional African” birth. Since COVID-19 emerged, societies worldwide have become ever more highly medicalized, and South Africa is no exception. In this context, where people are fearful of infection, it is possible that birth will be further institutionalized and, in the early days of the first South African lockdown in March 2020, non-hospital midwives and doulas were excluded from institutional births and further delegitimized as non-medical workers (even if for their own safety). However, along with reducing pressure on hospitals, tranquil birth methods may enable birthing mothers to avoid hospitals, as which are epicenters of infection.

My ethnographic fieldwork in Cape Town from 2014 to 2017 focused on observing one midwifery practice that was very effective in producing extraordinarily low cesarean and transfer rates. Fieldwork included interviewing parents and attending about 150 prenatal appointments and classes, where some parents invited me to attend their births. I also interviewed health professionals and prominent clinicians, attended professional meetings for obstetricians, and visited birthing facilities across Cape Town, including public and private hospitals. Independent midwives were, for the most part, registered nurses who were regulated by the South African nursing association, while others were traditional healers regulated by the Traditional Health Practitioners Council in South Africa. Some few independent midwives were direct-entry midwives (midwives who do not pass through nursing training first) who had taken international courses and then interned with midwives in South Africa. As such, these direct-entry midwives had less hospital time than registered nurses, although they were also allowed to register with the nursing association, even if it took years to complete this registration. I also spent time with a traditional midwife who ran a practice from her shack home in a very poor neighborhood. As was typical of traditional midwives, she did not charge a fee, though she would accept gifts. She had a day job as a housekeeper, with an employer who was understanding about her needing to leave sometimes for births.

South Africa’s maternity care system can be characterized as providing care that is both “too much too soon” (TMTS) and “too little too late” (TLTL) (Miller et al. 2016). Neither poorly resourced public hospitals nor well-resourced private hospitals consistently offer tranquil birthing. Despite great concern for maternal and infant mortality rates, public health policy tends toward centralized TMTS over-medicalization that cannot be consistently implemented in public hospitals, where TLTL care prevails as Freedman (2016) notes. This situation strips midwives of decision-making authority in both public and private sectors. Given the vast divide between South African haves and have-nots—in 2015 the widest gap in the world (according to the GINI coefficient)—public and private health sectors are usually considered as having nothing in common, and there are very few studies of private South African healthcare. My study is unusual for including higher income families
and for considering birthing practices across income. The women in my study differed greatly in terms of their financial resources, yet were drawn together by their desire to avoid (1) cesareans and (2) birth humiliation.

17.1 Fearfulness and Institutional Apartheid

The midwives, families, and doulas I interviewed reiterated that caregivers and parents need to let go of their fears about a woman’s physical capacity to give birth without instrumental or pharmaceutical assistance. Yet what I observed in Cape Town was more than letting go of fears about pain or rupture. To support tranquil birth, South African midwives, families, and doulas also needed to let go of their beliefs about apartheid social divisions and birth as an imminent emergency. Effectively, they needed to let go of their belief in the modernist order that apartheid doctrine had enforced.

“Emergency talk” has long been a dominant feature of South African sociality. Afrikaner Nationalist stalwarts motivated their apartheid policies by convincing a White electorate that they were constantly under threat from their Black compatriots (Lorne McDougall 2013). While it could be argued that there is considerable urgency to reduce the national maternal death rate, framing this effort as a social-clinical emergency pushes a lot of buttons locally. A predilection to crisis thinking is a feature of our times, and not limited to South Africa (Roitman 2013), and the conflation of social and clinical emergency is at the heart of many humanitarian health interventions. According to Peter Redfield (2013), the focus on short-term geopolitical clinical emergencies allows for evading the political inequities that make such emergencies chronic.

In South Africa, there was nearly a decade of political emergency before the end of Apartheid. White South Africans were taught in state schools to fear violent Black uprisings, though the anti-apartheid movements eschewed non-strategic (civilian) targets and worked actively for 40 years to find peaceful resolution (Lorne McDougall 2013). Considering forms of birth, and even birth itself, as an emergency in this historical context of political fearfulness brings into play all kinds of residual fears. As a doctor told me about ordering an emergency cesarean in a public hospital in the middle of the night: “I am the one to marshal the troops.” The metaphors of war and conflict pervade maternity care discourse and practices in ways that are unhealthy and traumatic for families and birth practitioners.

Apartheid doctrine enforced and insisted upon obedience to false racial distinctions as well as different standards of education, housing, and healthcare (Coovadia et al. 2009) for different racial groups as well as totalitarian control and other forms of violence to uphold those distinctions. To help tranquil births emerge, the caregivers I met traveled across racialized boundaries in the city and accepted learning from traditional African midwives who were mistakenly viewed in mainstream medicine as medically “less evolved.” Well-off families left what they had considered the safety of plush hospitals to visit shabby midwives’ offices in edgy neigh-
borhoods, and registered for births at public hospitals they had previously characterized as chaotic, because CS rates in private hospitals stand at around 70% while those in public hospitals stand at around 26% (Gonzalez and Grant 2019). Less well-off families believed that they deserved better care than that provided at public hospitals and mobilized financial resources for their daughters to birth in less rushed settings such as homes and private birth centers. The resulting antenatal care and births could require many hours of labor support, but far fewer resources in terms of technology and post-birth interventions. According to my interlocutors, when mothers felt empowered during birth, they were able to heal psychologically from previous humiliations experienced during birth.

Elma persevered through a long labor in order to birth vaginally because she was convinced that this would be safer than a repeat cesarean. For her first birth, as soon as labor started, Elma and her husband had called an ambulance to rush her to the private hospital, a very uncomfortable (and expensive) ride. Although neither Elma nor her infant were in any distress, the obstetrician on call advised a cesarean since Elma’s cervix was dilating at a rate of less than 1 cm per hour. When Elma resisted this suggestion, he said with some annoyance that he was in danger of missing the start of his rugby match. The second time he advised a cesarean, Elma relented but then changed her mind. She was physically restrained while receiving an epidural and screaming at the anesthetist to stop, to no avail. Unsurprisingly, Elma suffered severe post-natal depression, and decided she could not endure another cesarean. I found that many women, like Elma, experienced some degree of coercion during their labor or delivery at either private or state hospitals. Coercion took the form of rushing consent, specifically through not advising about reasonable alternatives, not advising of the risks incurred with physician-preferred treatment, by threatening to withdraw emergency care or threatening to exclude preferred birth partners.

Most of the women who chose this midwifery practice had experienced births in both private and public hospitals. Only 17% of South African women could afford private medical care in 2015 (CMS 2016). Private hospital care emerged in the last years of apartheid, as a way of replacing Whites-only public hospitals, but now cater to all upper income earners. However, low income and impoverished South Africans tend overwhelmingly to be people of color, so public healthcare is effectively racially distinct. In South Africa, once having had one cesarean, subsequent vaginal birth (whether in a private or public hospital) is unlikely. Support for vaginal birth after cesarean (VBAC) has been declining dramatically over the last 5 years, and what works (as in Elma’s birth) is so far contrary to hospital protocols as to make VBACS almost impossible to achieve in hospital settings.

Studies have shown that birthing in South Africa’s predominantly Black public hospitals can be a humiliating experience (Honikman et al. 2015). However, I found that women who birthed in predominantly White private hospitals also routinely found their birth experiences to be humiliating, albeit sometimes in different ways. Women in both public and private hospitals were regularly subjected to invasive protocols they found unnecessary—in the name of “reducing risks” of maternal and newborn death. This unfortunate situation suggests a broader problem than the actions of individual providers and extends to a fearful institutional obstetric culture.
in both public and private sectors. For South African women whose families were subjected to apartheid-era humiliations, the continuation of institution-based humiliation during birth is devastating. The consequences of humiliation during birth extended far beyond the mother’s psychology to include long-term negative health impacts for mothers and families. It appears that the experience of humiliation may lengthen labor in subsequent deliveries, leading to a higher likelihood of surgeries overall (Hodnett et al. 2013).

17.2 Risky Definitions of Risk

The families and health professionals I spoke with felt that pervasive risk-thinking led to unnecessary surgeries and trauma. Alternative providers and their clients judged it less risky to: (1) allow labor to start spontaneously; (2) avoid epidurals; and (3) promote deliveries without vacuum suction or cesareans. Elma and many others like her chose to move away from a TMTS obsession with risk, intervention, and duration of labor in order to reduce the likelihood of creating a situation that requires further interventions.

In addition to the medical risks associated with repeat cesareans, increasing cesarean rates are unsustainable for lower income countries whose maternity care systems are already stressed with poor outcomes and provider shortages. There are ongoing national efforts in China, Brazil, and other countries to reduce the numbers of cesareans in order to create more sustainable healthcare and improve outcomes for mothers and newborns (Van Lerberghe et al. 2014). Inefficient medical interventions do not only waste money and time, but are also likely to result in more extreme medical interventions, which further contradict sustainability (Renfrew et al. 2014, 1134).

The reason for high cesarean rates even among homebirth midwives is what midwives termed a “culture of fear.” Midwives told me repeatedly that doctors supporting homebirth or birthing center vaginal deliveries were haunted by a very few cases with adverse outcomes. Doctors spoke of the fear of malpractice suits that could end their careers. If homebirth midwives wanted the support of clinicians, they needed to adhere to the stringent protocols the clinicians set, including cutting labor short. Toward the end of my fieldwork, hospital groups asked midwives to sign liability documents that forced them to follow protocols the doctors alone had set and over which the midwives had no influence. For doctors, childbirth risk could be controlled through risk stratification, strict labor protocols, and the always available cesarean.

High cesarean rates in South African public and private hospitals were produced by extending the category of “high risk” women, as well as by obscuring the risks of repeat cesareans. Women over 35 years of age, pregnant with multiples or breech babies, are automatically classified as high risk, as are prior cesareans. In the private sector, when pregnancies are classified as high risk, cesareans are routinely scheduled for one week prior to the due date. In addition, most private sector pregnancies
seem mysteriously to become high risk in weeks 38–40. During my three years of fieldwork, women would repeat the same refrain about why they had cesareans: “The doctor said the baby was too big for my hips.” Many private sector cesareans were scheduled following diagnoses of cephalopelvic disproportion (CPD), insufficient amniotic fluid, and placenta calcification. These diagnoses can be highly subjective prior to delivery and many are not confirmed after delivery.

No woman I spoke with was ever informed by her doctor about the risks of repeat cesareans, nor the risks associated with babies not carried to term. If “high-risk” women insisted on a trial of labor by not scheduling a cesarean before their due date, they were allowed a maximum of ten hours of labor before cesareans were advised. The possibility that labor can proceed safely far beyond ten hours in these cases was not considered (Simpson 2014, Littlejohn 2011), and women were not advised that they could continue to labor beyond ten hours. Doctors and many independent midwives did not acknowledge that latent labor (up to 6 cm dilation) may take days in a woman’s first pregnancy. Women who had not had prior cesareans routinely received synthetic prostaglandins to speed up or induce labor, which is known to be a factor related to higher cesarean rates. The same women who might need longer labor times due to the use of prostaglandins would then receive cesareans if they were not fully dilated within ten hours of hospital admission.

In both Cape Town’s public and private sectors, unless a woman and her family were very, very determined, and had support from a select handful of experienced birth practitioners, a first cesarean led inexorably to subsequent ones, and with each subsequent cesarean the possibility of vaginal birth became ever more remote. High private sector cesarean rates as well as the racially structured division of wealth in Cape Town meant that cesareans came to be associated with privilege, and many poor women longed for the special attention of an obstetrician during surgery. While cesareans in private hospitals were relatively safe in the short-term and mostly performed under optimal conditions, public sector cesareans incurred far greater risk (Gebhardt et al. 2015). Further, women who had a first cesarean with medical insurance at a private facility were destined for public sector cesareans if they lost their jobs and/or their medical insurance.

Sustaining spontaneous vaginal birth has considerable health and economic benefits (Simpson 2014, Renfrew et al. 2014). In the first place, pharmaceutical, instrumental, and surgical interventions require expensive infrastructure that is limited in most South African public hospitals. In South African hospitals, a cesarean typically means three nights in a facility, during which time breastfeeding and maternal bonding can easily be undermined. Physical recovery from cesareans is costly to individuals, families, and society, in terms of the extended recovery time during which a woman might lose her job or be unable to perform necessary tasks at work or home. As previously noted, even in well-resourced private hospital settings, repeat cesareans pose considerable risks to future pregnancies due to the increased likelihood of placenta previa, placenta accreta and percreta, as well as uterine rupture after cesarean (Spong et al. 2012). Further, increased bleeding in labor and instrumental delivery lead to higher rates of HIV transmission to the infant. Roughly 30%
of mothers were HIV-positive in South Africa in 2012 and some four million women lived with HIV in 2017.

There is growing concern that pre-labor cesareans (typical in South Africa for high-risk pregnancies) deprive infants of beneficial developmental effects of labor stress and the microbiome of the vaginal canal (Odent 2015). Other significant health benefits to infants and mothers from spontaneous vaginal birth include: less chance of childhood diabetes, allergies and obesity; increased likelihood of successful breastfeeding and its benefits (neonatal immunity and nutrition), and breast cancer reduction benefits for mothers (Childbirth Connection 2012). In a country with very high rates of diabetes, extreme food insecurity for many households and high child mortality due to malnutrition, successful breastfeeding can literally save lives, as well as help reduce the cost of public health care.

While childbirth risk is managed through cesareans in the private sector, this form of risk management is too expensive for the public sector. Yet the two arenas of birth are connected, as ideas about how to define and manage childbirth risks circulate between private and public sectors. All South African medical staff complete training in state hospitals before they move to the private sector. In efforts to meet UN Millennium and Sustainable Development Goals, public sector maternity care has seen increased standardization of labor management and increased medicalization of childbirth.

About ten years ago, state facilities started programs to reduce mother to child HIV transmission, including HIV tests during pregnancy and administering ARVs in antenatal care; such programs increased medicalization at public facilities. Now, although public maternity facilities are severely under-staffed and under-equipped, and although public transport is unreliable and/or requires expensive travel through dangerous areas (Ferreira 2016), women are increasingly encouraged to birth at hospitals. Public sector midwives told me that one consequence of a more standardized regulation in public sector settings is a rise in transfers from midwife-run obstetric units, and a rise in cesarean rates. As I noted above, cesareans are more risky in public hospital settings than in private ones, especially in rural areas where there may not be enough staff to check for hemorrhages during the night, or where surgeons or operating theaters may be poorly equipped (Moodley 2010). Although money does not move between private and public sectors, staff and ideas do, including the idea that childbirth is an emergency that needs to be controlled with interventions such as cesareans.

17.3 Sustainable Birth

In the context of historical anxiety around birth, decisions to trust in the natural physiology of labor and delivery are radical innovations. As a counterpoint to the fearful imaginary of emergencies, both clinical and political, a midwife’s birthing space in an informal settlement can be viewed as a sanctuary from overly medicalized maternity care in both private and public facilities. “Informal settlements” are
low-status neighborhoods, precarious in standing with the Cape Town City Council, characterized by shack dwellings and inadequate infrastructure such as a lack of plumbing. Patience was a midwife whose home in an informal settlement was sometimes a birthing center. Patience’s clients were typically treated more harshly in public maternity care because of their African immigrant status, religious beliefs, and language. In some cases they knew of women experiencing harsh treatment in hospital and aimed to avoid hospitals if at all possible. Patience’s clients were very poor, and, as was typical of traditional midwives, she did not ask any fee, though she accepted gifts. Her home was small and dark, without windows, yet the effect was not at all claustrophobic, but rather cozy, like a ship’s cabin. Patience’s space was clean and efficiently organized, and, while noises from the street and neighboring shacks could be heard clearly, it felt more private than the hospital laboring rooms I visited, because no one went in and out. For a time, the shack was a bounded space, a sanctuary within which it is easier to birth (Stenglin and Foureur 2013). Women coming here typically delivered without pharmaceutical or instrumental intervention within a few hours of arrival, and the last labor had lasted only an hour. I learned that short labor times were typical of second and subsequent spontaneous vaginal births. In her ten-year practice, Patience said she had never needed to transfer a client for a cesarean.

One of the midwives I met told her clients, “All you need to birth is the space between your legs.” Margaret could always get a laugh with that slightly risqué comment, but her main aim was to reassure them that they merely needed the relaxation to allow their bodies to take over and to stop the production of adrenaline that would slow labor. Michel Odent (2004), among others, has argued that the clinical management of labor and delivery causes stress, cortisol, and adrenaline to rise, while blocking oxytocin and other hormones that promote physiologic labor, maternal well-being, and maternal-infant bonding. In conditions where a clinical risk model is easily triggered, it is difficult for women to fully relax and labor to proceed as easily in a tranquil, bounded space that the female body needs. A tranquil labor requires physical privacy, with the support of trusted birth companions who know how to step back and let natural labor proceed without excessive restrictions, interventions, or humiliations, all of which can bring labor (and cervical dilation) to an abrupt halt (Littlejohn 2011; Hodnett et al. 2013; Erhardt 2011; Scamell and Stewart 2013). Sometimes home is the most tranquil setting, but if the home setting is too crowded or busy with relatives, then Margaret would offer her home as a setting, reserving her bedroom and ensuite bathroom for birthing clients. She also had a room with emergency equipment, should the mother or newborn need assistance.

Tranquil birth providers have experienced how a calm setting reduces clinical risk. Rachel, a registered traditional healer, told me of a case of shoulder dystocia—a dangerous situation in which the baby’s shoulder is stuck behind the mother’s pelvis. Rachel used the McRoberts technique for manipulating the mother’s body and was able to free the shoulder within a short time. When I asked her what caused the dystocia, I expected an answer I had heard from hospital-based providers, who describe shoulder dystocia as resulting from cephalopelvic disproportion, which would generally be an indication for an emergency cesarean. Rachel surprised me
by stating that the cause was a lack of privacy that prevented the mother’s pelvic muscles from opening up as wide as they should have, given how many people attended this birth. She blamed herself for failing to make the birthing environment more private by asking some family members to leave.

Midwives like Rachel, Patience, and Margaret actively create a tranquil birth space in order to reduce and manage perinatal risk. Keeping the lights low, using massage and warm water to relax the laboring woman, keeping vaginal exams to a minimum, and monitoring the mother’s contractions and fetal heart rate unobtrusively and intermittently using a hand-held fetoscope all facilitate a woman to move into an optimal laboring state. Midwives try to help women connect with their bodies, rather than overthinking, which actually slows or halts their labor progress (Odent 2004). For a mother to labor comfortably, she needs to lose her own sense of time, which the midwife protects as sacred from outside interventions. Above all, the providers tried to maintain their own emotional awareness and calm, which allowed them to access their deepest intuition (Davis-Floyd and Davis 2018).

There is more to tranquil birth than what happens during labor. Tranquil birth providers work hard at establishing trust by preparing families for labor. Antenatal consultations I attended with Margaret and a doula were at least an hour in length, and most of the time was spent chatting with clients about labor and birth. These sessions could be intense when mothers revealed previous traumatic experiences, but such sessions were also quite raucous as Margaret made jokes that encouraged her clients to overcome bodily taboos. The sessions created invaluable trust and bonds between the midwife/doula duo and their clients. Margaret believed that the baby becomes familiar with her voice and her touch as she palpates the uterus and that this familiarity contributes to birth tranquility and easier labor. Margaret also spends a lot of time during antenatal sessions informing clients about how to prepare for birth physically, by encouraging them to exercise and control their diets. She began offering antenatal classes in which she and her doula team taught their clients and families about physiologic labor and worked through potential psychological stumbling blocks such as past physical or sexual trauma that could prevent a mother from fully opening up and letting go during the various phases of labor.

Lastly, the midwives and doulas I interviewed built confidence in their methods by keeping themselves informed about techniques, ideas, and clinical experience, and by building a community. Margaret and her team of doulas/midwives draw on their own experiences as well as on the international literature they read in support of natural birth, and they travel within Africa and internationally at times to learn about traditional methods and midwifery practices that have withstood the test of time. Keeping in touch with other midwives who practice tranquil birth methods—even by WhatsApp during labor—and sharing their empirical experiences and birthing skills with each other helps them build a knowledge community to empower midwives to make births safer and more tranquil.
17.4 Conclusion

The tranquil birth attendants I studied sustain the skills necessary for spontaneous vaginal birth by creating a peaceful and safe space in which labor and delivery are not emergencies waiting to happen. There have been significant innovations in scaling up this effort across facilities in Cape Town. For instance, one public sector midwifery unit has partnered with an NGO to provide a doula for local clients when possible. The doulas donate their time to complete their training and clients receive the much-needed birth support that helps advance their labor and ward off some interventions. Two midwives from Margaret’s practice formed a partnership with a public maternity care training branch in Cape Town, where midwives learn the midwifery model of care, or what I call “tranquil birth” methods.

Neither South African public nor private maternity care is sustainable in terms of improving birth outcomes for mothers or newborns: the cesarean rate in private hospitals is far too high to be necessary or affordable (as recently pointed out in a Medical Schemes Council Report), and consistent claims of coercion are worrying. Public hospitals are currently simply too over-crowded and under-staffed to be consistently safe places to birth, despite the best intentions. In Cape Town as elsewhere in South Africa, travel to and from public institutions is often unaffordable and also unsafe for low income or impoverished women, so safely localizing birthing at home or non-medical birth centers would help poorer families to have better access to midwifery care and make birth in South Africa more sustainable and lower cost. The tranquil birth model outlined in this chapter is flexible and builds on traditional bodies of knowledge. Its de-centered approach that shifts births away from private and public hospitals makes better use of existing human and financial resources. If widely implemented, this approach would reduce the fears and risks so prevalent in hospital birth and generate a much more sustainable future for birth in all of South Africa.

South Africa is on the verge of a (slow) public health revolution, as proposed in the 2015 draft National Health Insurance Bill, intended to even out resources between the public and private sectors. The COVID-19 State of Disaster Regulations may kick-start health resource sharing—time will tell. Certainly, everyday life has become dramatically more medicalized since COVID-19 was defined as a public threat in South Africa in March 2020; it is not yet clear whether birth will be further medicalized—especially since avoiding medical institutions for birth makes even more sense now. However, I have heard of obstetricians suggesting early cesareans in order to avoid pressuring hospitals later, when more coronavirus patients are expected, and, since the advent of COVID-19, even more severe restrictions have been placed on birth companions in South African private and public institutions, just as they have been in many other countries. Hospitals and clinics have come to be considered epicenters of contagion, and so birth partners are considered both to be at risk and to carry risk. For midwives and doulas working in institutions and already feeling delegitimized, and for clients hoping for birth support, the new regulations provoke anxiety. Midwives and doulas express concern at the trauma for
birthing mothers of unassisted and highly medicalized births in South African private and public hospitals under COVID-19 conditions. Given the higher chance of in-hospital infections, and the pressure on such institutions to prioritize virus patients, it seems clearer than ever that tranquil and sustainable birthing must rely on homes and non-medical birthing centers to decentralize care.

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