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HOME SWEET HOME BIRTH :

A QUALITATIVE STUDY ON THE

PERCEPTIONS AND EXPERIENCES OF HOME BIRTH

A thesis presented in partial fulfilment
of the requirements for the degree of
Master of Arts in Psychology
at Massey University.

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1994

ABSTRACT

The management of pregnancy and childbirth, and the home as a location of birth, are all topics subject to considerable debate. Such debate often relies on emotive appeal rather than reference to relevant research.

A series of three interviews were conducted with seven women planning home births. The most important reasons why women decided to have a home birth were the desire to have an established relationship with their midwife, wanting continuity of care from their midwife, wanting family involvement in the birth and wishing to retain control and avoid interventions.

Postnatally, in most instances, high levels of satisfaction were expressed by women about the quantity and quality of information they received, the care they received from health professionals, their satisfaction with the birth experience and with their relationships with health professionals. Most women did not experience feelings of loss of control at the birth and the majority of women did not experience feelings of depression postnatally.

Women's perceptions of pregnancy and childbirth were in accordance with the midwifery model of childbirth and it is proposed that women seeking home births hold a deeper and more encompassing belief in the tenets of the midwifery model in comparison to women who have hospital births. Findings are also in accordance with other research, both national and international.

ACKNOWLEDGEMENTS

I would like to thank a number of people who made a significant contribution towards the completion of this thesis. Firstly, special thanks are due to the women who gave up their time and shared their feelings and experiences about such an intimate and important event in their lives. It was a privilege to hear their stories.

Secondly, my supervisor Cheryl Woolley. I would particularly like to thank her for her acceptance of and tolerance towards the presence of my daughter (who seems to have an aversion to childcare) during supervisory sessions.

I would also like to express my gratitude to the Palmerston North domiciliary midwives who handed out Information Sheets to their clients. And in particular to Priscilla Baken and Fiona Barnett, for also reading and commenting on parts of my thesis.

Thanks are also due to my partner Andrew Boyle for his belief in me, encouragement, lateral thinking and computer skills. And, last but not least, to my children who must remain the original impetus for my fascination with pregnancy and childbirth.

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GLOSSARY

Apgar score One minute and five minutes after birth all babies are assessed using this scoring system. The Apgar score provides a rapid assessment of the baby's condition and is based on a baby's heart rate, respiratory effort, muscle tone, grimace (reflex irritability) and colour. The range goes from zero to ten. Ten is the maximum score, although rarely achieved. A score of five or below means the infant is depressed and at the five minute assessment can be associated with residual neurologic damage or even neonatal death.

Domiciliary midwife Strictly speaking this term applies to any midwife who provides antenatal, intrapartum, or post-partum care to a woman in their own home. For the purposes of this thesis, however, it will be used exclusively for midwives practicing as home birth midwives. Hence, in this thesis the terms domiciliary and home birth midwife/midwives are synonymous.

Independent midwife A term applying to any self-employed midwife. In this thesis it applies to midwives who provide antenatal and postnatal care in the home and who also provide women with intrapartum care in the hospital.

Epidural Lumbar epidural injection of local anaesthetic. Narcotics which numb the lower half of the body are given by continuous infusion in the epidural space. Commonly used for pain control in obstetric practice.

PNMR	Perinatal mortality rate
MMR	Maternal mortality rate
MHBA	Manawatu Home Birth Association
ARM	Artificial rupture of the membranes
GA	General anaesthetic
Oxytocin	A drug to stimulate uterine contractions
Episiotomy	Incision into the perineum in the second stage of labour
GPU	General practitioner unit
Margaret	Pseudonym used for all midwives
Richard	Pseudonym used for all doctors

[...] Indicates words have been left out of a sentence

[....] Indicates a sentence missing between sentences

[] With a word inside the brackets means that word has been added to a quote to aid comprehension

Chapter 1:
INTRODUCTION

"Birth [...] is an experience with the importance of marriage or death"
(Barrington, 1985, p. 134).

Every year in New Zealand a small minority of women have a planned home birth. There have also always been a few women who give birth at home unplanned or in transit. However, this thesis is solely concerned with women who have planned for a home delivery and who have made the appropriate preparations for such a birth. Note that the terms 'woman or women planning to have a home birth' are used for convenience and ease of reading, although generally a woman and her partner would plan a home birth together.

Over the last decade the number of home births has slowly been increasing, from a total of 253 in 1981, to 900 in 1989, to 1200 in 1992 (McLouchlin, 1993). This increase is reflected in Manawatu figures, with home births increasing from 24 in 1986, to 51 in 1989, to 121 in 1992 (Staff, 1993, February).

It was during the 1970s and 1980s that regional Home Birth Associations began to form (Donley, 1992). These were small consumer groups that aimed to give information and support to women wishing to have a home birth. Usually a domiciliary midwife (or midwives) was associated with a group, although some groups existed without midwives as well as groups existing in areas where no doctors would attend home births. Legally all births had to be supervised by a doctor and by refusing to attend home births doctors effectively removed the option of birth at home for women. It was not until 1990 that midwives regained the right to provide all maternity services without the supervision of a medical practitioner.

Due to historical issues it was the norm that domiciliary midwives worked through local Home Birth Associations. While this has changed, in the Manawatu the midwives who advertise as domiciliary midwives are still all involved with the local Association to some extent. This ensures a degree of accountability. For example, the Manawatu Home Birth Association (MHBA) reviews midwives practices through the Domiciliary Midwives Standards Review Committee. Perhaps what has changed in recent years is the fact that now only a minority of women who have a home birth belong to the Association. Since home birth midwives advertise

their services independently of the Home Birth Association, women can choose to have a home birth and not belong to the Association. However, it would still be correct to say that the majority of women having a planned home birth in the Manawatu would use one of the midwives associated with the MHBA.

HOW HOME BIRTH WORKS IN THE MANAWATU

Currently in the Manawatu there are seven domiciliary midwives connected to the MHBA, six working from Palmerston North and one from Dannevirke. Over the time of this thesis this number has remained stable, although there has been a change in personnel with one midwife temporarily retiring from working as a midwife and another moving into working as a domiciliary midwife. Occasionally some of these midwives also do domino births, where the baby is born in hospital but the midwife is contracted to provide care antenatally, during the labour, and postnatally. (McFarland (1990) defines domino as an English term meaning (DOM-IN-O) DOMiciliary midwife IN and Out.)

The MHBA has a membership of around 100 individuals, couples or both. Women wishing to have a home birth can join the Association (cost being \$25pa) and this gives them access to equipment which the Association loans or hires out (e.g. birth pool, birthing stool, homeopathic kit, siblings kit, baby massage kit, antenatal classes, pram), the library of books, videos and general information, and monthly newsletters. The monthly meetings of the Association give women the opportunity to meet midwives and discuss their philosophy and way of practising before making a decision on which midwife would best suit their needs. Due to high demand, though, choices are often made on availability rather than philosophy. Meetings also provide a source of information about a variety of topics as meetings generally have a theme such as water birth, breastfeeding, or homeopathy. As stated earlier, however, the majority of women having a home birth in the Manawatu do not become members of the Association.

Having decided to have a home birth women have various options about which health professionals will provide care for them. They can choose to have the majority of their antenatal care by their own general practitioner (GP), with some visits from their chosen midwife. In this situation the midwife will be their main carer for the labour, calling the GP when delivery is imminent. The midwife also provides the majority of postnatal care.

If a woman's GP does not do home births she may choose to go to a GP who does home deliveries, or she may choose midwife only care. In such a case the primary midwife would do all the antenatal care, with a second midwife doing a minority of visits. Nearing the time of delivery the second midwife would be called, as happens with GPs. A woman could also choose to have the majority of her antenatal care provided by her midwife, with her GP taking a secondary role, or have equally shared care between her midwife and GP.

Regardless of the specifics of care given however, it is always the case that two health professionals are present at home births in the Manawatu. It would also be fair to say that there has generally been a tolerant and positive relationship between midwives and home birth doctors (a minority of GPs in Palmerston North), with little of the ill-feeling and professional aggressiveness that has occurred in some areas.

The relationship between domiciliary midwives and the local hospital has been somewhat more difficult, although far more amiable than in some areas of New Zealand (Donley, 1992). For example, in some areas domiciliary midwives cannot accompany their clients into hospital due to hospital policies and access agreements. In the Manawatu there has been an unwritten agreement that domiciliary midwives could stay with their clients. This was mainly due to the fact that home birth midwives had worked, or were working, at the hospital and so were well known and accepted by hospital staff. More recently the situation has become less clear but midwives report there is more emphasis on hospital procedure and protocols. What actually occurs, though, seems to also depend on who is on duty at the hospital more than anything else (E.R. Salmons, personal communication, November 3, 1994).

Although the majority of births do take place in the home, the transfer rate is about 10%, with many women who transfer returning home within a few hours of giving birth (Staff, 1994, March).

HAVING A HOME BIRTH

Generally a woman in labour will telephone her midwife in the early stages. The midwife may or may not visit at this point but will remain in contact thereafter. At some point she and her client will decide that it is in the woman's interests that she stay. Clearly this will vary between women

and their labours but it can be many hours before the midwife believes the baby will actually be born.

After the birth (of the baby and the placenta) the midwife will stay for at least two hours, ensuring that both mother and baby are safe, adjusting well, and adequately cared for. All midwives carry telepagers and women are always told to contact them if they have a concern.

Postnatally Manawatu midwives generally visit twice a day for two to three days, then once a day until the fifth to seventh day, after which further visits are negotiated with women. Midwives are paid to visit 12 times in the first six weeks, with no particular schedule being set down by legislation. In reality visiting practices can vary considerably due to the needs of a particular woman, her baby, or both. It is not uncommon for more visits to occur than are paid for. GPs and second midwives also visit although the frequency tends to depend on individual circumstances.

The MHBA sends each woman an evaluation questionnaire about the care she received from her midwife and these are analysed by the Domiciliary Midwives Standards Review Committee. Each midwife appears before the Domiciliary Midwives Standards Review Committee annually. Complaints can also be laid with and investigated by the New Zealand College of Midwives.

Chapter 2

HISTORICAL OVERVIEW

"The demands of giving birth are exceptional and they bring out exceptional characteristics in those who go through it" (Niven, 1992, p. 52).

INTRODUCTION

In this chapter I will briefly consider the history of maternity services in New Zealand. I will not try to outline the customs of Maori culture pertaining to childbirth but focus on the development of services that arose from the European tradition. Although such services have, in recent years at least, become more sensitive toward the tangata whenua and people from other cultures, I believe that the culture that surrounds childbirth in New Zealand is still dominated by the culture of medicine, this being derived from Europe, and more latterly the developed world in general.

This chapter will be divided into four sections. The first will examine the role of midwives and the rise of medicine in centuries past. The following three will look only at the New Zealand situation. The development of services from the time of colonisation until the 1970s will be considered first. Then the period from the 1970s until the Nurses Amendment Act of 1990 will be reviewed. Finally, the situation since the Act was passed will be discussed.

LAY MIDWIFERY AND THE RISE OF MEDICAL SCIENCE

While prostitution is often cited as being the world's oldest profession it is more likely that midwifery is. As Edwards and Waldorf (1984) note, women have always attended other women at birth. In fact the word midwife derives from midwoman, a thirteenth century word which denotes a woman who is with the mother at birth.

However, while midwifery can be viewed as an ancient and highly skilled profession it has also been a political one. Ehrenreich and English (1978) state that the conflict between female lay healing and the medical profession goes back to the witch hunts of the late fifteenth and early sixteenth centuries when thousands of executions occurred. Undoubtedly those murdered were not solely midwives, or females even, but among the "crimes" people were executed for are services which midwives and wise women provided, such as contraceptive measures, abortion,

drugs to avert miscarriage, and drugs to ease labour pains (Ehrenreich and English, 1978; Kitzinger, 1991).

Traditionally health care and knowledge of childbirth were regarded as an important part of a woman's role, with the majority of 'healing and caring' work being performed in the home by women (Kitzinger, 1991; Oakley and Houd, 1990). Childbirth was simply viewed as a life event through which the majority of women passed (Roberts, 1981). As such women attended other women in childbirth and the skills of midwifery were handed down through the generations.

Oakley and Houd (1990) believe that two transition periods lie between childbirth being an event controlled and attended by women and the current situation. The first is the emergence of professional medicine and the exclusion of women from it. The second is the colonisation of midwifery by the (then) new speciality of obstetrics.

Jakobsen (1991) states that in the seventeenth and eighteenth centuries pregnancy and birth were viewed by medicine as a 'natural' state. It was over this period, though, that medical knowledge developed rapidly and became more of a public concern (Kitzinger, 1991; Roberts, 1981). The first hospitals were built, but the majority of births still took place within the home, with hospitals providing a place of birth for some poor and destitute women only.

Medicine came to be increasingly viewed as an elite profession, but not a fit profession for women (Ehrenreich and English, 1978), and in fact with the professionalisation of healing, women were actively excluded from institutions that taught medicine (Kitzinger, 1991). The use of instruments to assist in problem births was, similarly, not seen to be the province of midwives.

Livingston (1987) states that midwives continued to be the principal attendants at normal births, but as medicine became more organised and male practitioners gained greater acceptance, this situation was to change. Midwives were to become increasingly marginalised, even in normal birth.

Leavitt (1986) in her book "Brought to Bed. Childbearing in America, 1750 - 1950" states that there is considerable evidence that women feared dying or being permanently injured during childbirth - a not unreasonable fear since this was relatively common. For example, using available statistics she estimates that deaths from maternity-related causes were sixty-five times

greater at the turn of the century than they were in the 1980s. That is, there was one maternal death for every 154 live births, compared to 1 to 10,000 in 1980. Given the high fertility rate she estimates that a woman who had five children would have had a 1 in 30 chance of dying.

Alternatively Loudon (1992) believes that deaths in childbirth accounted for a relatively small proportion of deaths amongst women of childbearing age. He calculates that maternal deaths for women aged between 15-44 years in 1890 were 8.8% of total deaths for women in England in that age category. By 1930 it was very similar, at 8.3% of total deaths. Consequently the high rate of dying in childbirth at that time needs to be kept in the context of the high rate of general mortality.

Even so, with figures such as these it is not surprising that women actively worked to reduce childbirth risks. Leavitt's (1986) belief is that these very real fears of the dangers of childbirth meant women were prepared to try new procedures in the attempt to reduce mortality and morbidity. And, this meant that traditional childbirth practices, such as childbirth being a women only event, were more easily transformed. Certainly this quest for safer childbirth can help explain the speed at which birthing procedures and practices changed and why women so readily accepted them.

MIDWIFERY IN NEW ZEALAND

In New Zealand the Pakeha settlers initially relied on trained or lay midwives for support and care both for the labour and delivery and postnatal care and household assistance (Donley, 1986).

The Midwives Registration Act in 1904 led to the development of training and registration of midwives and the establishment of St Helens maternity hospitals where midwives were trained. Hence, lay midwifery was gradually phased out, although initially untrained midwives could be registered under certain circumstances (such as having been practising for at least three years and having been certified by a doctor, or on passing an examination).

Donley (1986) believes that in the years preceding the First World War most births still took place within the home and were attended by midwives. Doctors generally attended emergencies and the wealthy only.

Mein Smith (1986) states that between the two World Wars in New Zealand and overseas there was a shift to institutionalised medicine. Hence, by 1920, 35% of births took place in hospitals, the figure rising to 58% in 1926 . This rise happened despite the fact that Health Department monitoring of maternal mortality trends in the 1920s pointed to the fact that a midwife's attendance was less dangerous for a woman than that of a doctor (Mein Smith, 1986).

This was a period of high maternal deaths due to puerperal sepsis (blood poisoning), which resulted from infections unwittingly transmitted by medical professionals. New Zealand's high maternal mortality rates provoked heated debate among doctors and obstetricians who initially refused to accept that they could be the cause of the infection (Mein Smith 1986). In spite of this denial the Health Department was successful in gradually reforming the practices and organisation of New Zealand hospitals and maternal mortality rates reduced, with the St Helens hospitals leading the way in safe standards of care.

While the perception that childbirth was safest in hospital was a significant factor in the shift toward institutionalised birth, so too was the use of sedation, an option not available with domiciliary births. Throughout the 1920s and 1930s this gained greater acceptance in New Zealand in spite of the associated increase in forceps delivery and increased rates of maternal infection (Donley, 1986).

Mein Smith (1986) states that the social reforms, such as free hospital and antenatal care that occurred in the 1920s, gave general practitioners and the newly established but vocal Obstetric and Gynaecological Society the opportunity to place themselves in a position of considerable strength by the 1930s. Consequently, by 1938, 81.75% of births took place in hospitals with both a doctor and midwife present 75% of the time (Maternity Services Committee, 1976).

The Labour government's social reforms in the 1930s consolidated the trend towards both the use of GPs as primary caregivers and hospitalisation. This was encouraged by the payment of a universal maternity benefit. This egalitarianism meant that all women had similar access to medical care. With upper and middle class women leading the way, the use of physicians rather than midwives, and birth in hospital rather than home, meant the control of childbirth by obstetrics and the trend towards institutionalised childbirth and the medicalisation of birth was further advanced.

Leavitt (1986) believes the rapid change from home to hospital was the most significant transition in childbirth history, more so than men being involved in birth or the use of interventions. She states that "The location of childbirth uncompromisingly and directly altered women's birth experiences, replacing the traditional female-centred domestic childbirth with a physician-directed medical and surgical event" (p. 195).

As Donley (1986) notes, "The midwife as an independent practitioner was fast disappearing by the 1940s" (p. 49), with her role becoming that of an obstetric nurse. This situation was compounded by the dramatic increase in medical technology used in childbirth.

RECENT DECADES

From the mid-1900s women began to question aspects of hospital care. Leavitt (1986) believes that with childbirth no longer holding the dangers to life and health that it had for previous generations, women began to focus on improving the psychological dimensions of the hospital experience.

She proposes two images of birthing women. One, a woman in her own home, surrounded by women she had chosen to be present, but feeling vulnerable to death and debility despite that. The second, a woman in an impersonal hospital, alone among strangers, but feeling vulnerable in the institutional routine despite her belief of safety. As Leavitt (1986) notes, neither woman had the confidence of a healthy outcome plus the freedom to make choices on how to conduct the event.

In New Zealand, though, women theoretically had this choice until the Nurses Act 1971. Prior to this midwives still had the autonomy to provide antenatal and postnatal care and deliver babies in the home "on their own responsibility" (Hammonds, 1993). With almost all births being hospital based in the preceding decades it is likely that the majority of women, and perhaps midwives even, would have been ignorant of this. With the passing of the Nurses Act this option disappeared however, and midwives were required to work under medical supervision (Hammonds, 1993).

Ironically it was also in the 1970s that New Zealand women began to question the right and might of the dominant medical ethics surrounding childbirth. This questioning was partly as a result of the resurgence of feminism that occurred around this time but was also linked to the rise of

interest in 'natural' childbirth which occurred both here and overseas from the 1940s on. It represented both a rejection of patriarchal institutions and a challenge to the medical model of childbirth (Pratt, 1990).

Associated with this challenge was the small number of women who decided to give birth at home. They were attended by a domiciliary midwife and sympathetic GP, as legally a midwife could not deliver a baby without a doctor's supervision. Donley (1986) notes that domiciliary midwives, by working outside the hierarchical structure of the hospital system, were "beyond the direct control of obstetricians and gynaecologists" (p. 49).

Not surprisingly obstetricians tried to thwart this trend, partly by the issuing of 'risk lists'. For example, in 1982 the Maternity Services Committee published a report which "set 55 all-encompassing and quite arbitrary risk factors requiring a pregnant woman's referral to an obstetrician" (Donley, 1986). It also recommended that the Obstetrics Standards Review Committee oversee the contracts of domiciliary midwives and contained recommendations to control GPs who attended home births also.

Naturally this was opposed by the Domiciliary Midwives Society and the consumer established Home Birth Associations. They also contended that the report contained "unscientific, contradictory and irrelevant statements based on false premises" (Donley, 1986).

Despite the attempts of obstetricians to stop home births and bring domiciliary midwives under their control the number of home births continued to slowly increase, with 176 in 1977, 253 in 1981, 387 in 1985 and 900 in 1989 (McLoughlin, 1993). These births were attended by the approximately 50 domiciliary midwives throughout New Zealand who had gained permission to practice as a home birth midwife from the Minister of Health and a doctor (McLoughlin, 1993). Legally a GP was also required to take overall responsibility for the birth, although in reality this did not always occur.

However, this was soon to change, as the Labour government passed the Nurses Amendment Act in 1990.

THE NURSES AMENDMENT ACT 1990

This Act allowed midwives to take full responsibility for women before, during, and after birth, either at home or in a hospital. It greatly increased women's options, as they now could choose between GP and rostered hospital midwife, rostered hospital team, sole midwife care, or shared care (GP and midwife). More significantly, doctors were no longer the gatekeepers of home births. However, it has also been the case that the number of home births has continued to rise only slowly. From 1037 in 1990, to 1148 in 1991, to 1200 in 1992, and to 1204 (preliminary data) in 1994 (McLoughlin, 1993; Staff, 1994, March).

McLoughlin (1993) notes that the Nurses Amendment Act led to a dramatic increase in the numbers of independent midwives, from the 50 (out of 1600) prior to the Act being passed, to 350 in 1993 (and growing). However, the clients of independent midwives are largely made up of women who intend giving birth in hospital but who wish to have one-to-one support for their birth, to already know their midwife before they go into labour and who seek continuity of care. The numbers of babies born at home have not risen along with the numbers of independent midwives. In fact, most such midwives would not be experienced enough, have the necessary equipment nor the desire or philosophy necessary to undertake home births.

Donley (1991) believes that this situation perpetuates the obstetric control of childbirth as the independent midwife still has no actual control due to the very nature of the institution. Clearly the politics of childbirth have not been put to bed by either side of the divide, with the College of Obstetricians and Gynaecologists continuing to try to put restraints on independent midwives and GPs with proposed guidelines of when women should be referred to obstetricians (McLoughlin, 1993).

For domiciliary midwives there are big differences between the situation prior to the Act and since it. In essence these are two-fold. Firstly, there is the amount which they can claim for their services. In September 1988 they received a 50% increase in fees which raised the amount they received to \$250 for supervising a labour and delivery for a 6 hour period. Additional time was paid at \$37.50 an hour and up to six prenatal and/or postnatal visits were paid at a rate of \$16 per visit (Pay increase, 1988, October).

Now they are able to claim the same fees as doctors. Hence, for the same six hour labour and delivery a midwife now could claim \$722.10. Pre and postnatal visits are paid at \$22.70 per visit.

The second significant difference is that midwives can now practice autonomously as professionals without having to be supervised by a GP. They are, however, still subject to investigation in case of a complaint as well as possible disciplinary action. This gives midwives the same status as doctors, reinstates their autonomy and also allows women to choose midwife only care should they want it.

CONCLUSION

Midwifery is an ancient and skilled profession which stretches back over the centuries. Traditionally only women were responsible for childbirth and such skills were passed down from generation to generation and considered an intrinsic part of a woman's role. Childbirth was regarded as a normal event, although marking a transition in a woman's life.

The rise of medicine gradually resulted in there being a conflict between medicine and midwifery, and midwifery came into disrepute and midwives were viewed as poor alternatives to man-midwives and doctors. Fuelling the disrepute of midwifery was the opposition to women as healers and the exclusion of women from universities and places of learning. While there is debate over the extent to which childbearing impacted on female mortality, there is no doubt that maternal mortality and morbidity was a real threat to women. The consequence was that women were prepared to try new approaches to childbirth and so traditional childbirth practices were overthrown more easily.

In New Zealand, Pakeha women initially relied on both lay and trained midwives, with the early 1900's bringing the establishment of St Helens maternity hospitals and midwifery training. This gradually spelled the end of lay midwifery. The first three decades of the twentieth century saw dramatic changes to birth, the location of the majority of births changed from the home to hospital, and new medical techniques, such as sedation, were introduced. Unfortunately, maternal mortality rates were still high, and in fact were higher for hospital than home birth, due to puerperal fever.

Government policy had the effect of increasing the use of both hospitals and GPs, and midwives increasingly practised in hospitals under medical control. Theoretically, however, midwives did have the authority to practice independently until 1971, after which time legal requirements were such that all births had to be supervised by a medical practitioner.

The 1970s also saw the beginnings of an interest in 'natural' birth and home birth, with women expressing concern about the medicalisation of birth, the routine use of some procedures and high intervention rates. Small numbers of women gave birth at home, and despite opposition from obstetricians and most GPs the numbers of babies born at home slowly increased.

In 1990 the Nurses Amendment Act heralded big changes for midwives and greatly increased the options available to women. Midwives regained their autonomy and large numbers of women took up the opportunity to have continuity of care and personal support from independent midwives for their pregnancies and deliveries. The majority of these births still took place in hospitals, however, and it has been suggested such a situation actually perpetuates institutional and obstetric control rather than challenging it. This situation has also caused some feelings of betrayal for home birth lobbyists who fought hard for the legislative change and who feel the most benefit has been to independent midwives who do not challenge the medical model of childbirth and who are content to practice within the hospital system.

For domiciliary midwives, though, the new Act brought significant changes. Their status was restored, they were paid at the same rate as GPs and they could practice autonomously. For women having a home birth the Act now allows them to choose midwife only care if they desire it, or have their midwife as their primary health professional. As birth is now under both midwifery and medical control it has also meant that it is easier for women to have a home birth should they wish to.

Chapter 3

SAFETY AND INTERVENTION

"I believe that childbirth is mostly safe and always sacred"

(Barrington, 1985, p. 7).

INTRODUCTION

In this chapter two issues are considered, safety and intervention. The relative safety of home and hospital birth and the problems which arise when trying to compile meaningful statistics is discussed first. For example statistics of previous decades are not necessarily relevant today due to changes in medical techniques and procedures and because of social changes.

Other pitfalls to be aware of when comparing home and hospital birth are also outlined, such as high risk women, planned and unplanned home births, and transfers from home to hospital.

Two possible reasons for falling mortality rates are then outlined. Firstly, that hospital birth is safer than home birth, and, secondly, that social changes have resulted in reducing mortality. Tables are presented that show mortality rates for home and hospital birth, taking into account various risk factors, and it is suggested that such statistics illustrate that childbirth practices have largely been formed from an ideological perspective rather than a scientific one.

The second issue, that of intervention is one of considerable concern to women choosing home birth. While it is acknowledged that there can be a link between safety and intervention, in the majority of births that is not the case and the incidence of intervention then becomes of interest.

Several studies which compare home and hospital birth outcomes are discussed, along with studies that show there has been an increase in assisted deliveries over recent decades. New Zealand figures for assisted deliveries are also provided and, following that, the cascading nature of intervention is considered.

SAFETY

Possibly the most contentious issue about home birth is the question of the physical safety of mother and baby. Once this issue is addressed the different facets of home and hospital birth can then be considered on their own merits rather than remaining over-shadowed by the notion that home birth is always a risky undertaking.

In fact it could be argued that women have always faced increased risk of death and debility in hospitals. For example, in 1925 in Washington DC in the United States, three times as many women died in childbirth in hospitals compared to those who gave birth in their homes (Edwards and Waldorf, 1984). Similarly in the United States in the 1930s the maternal mortality rate (MMR) of hospitals was 5.3 per 1000 live births and 2.3 per 1000 for home births (Barrington, 1985).

However, while such statistics serve to reinforce the problems of infection that occurred in hospitals at that time, they are irrelevant in terms of the argument about the relative safety of home or hospital now. Medical techniques such as blood transfusion and the use of antibiotics were not available when such figures were compiled, let alone the range of options available today. Consequently, it is necessary to look to very recent decades to gain data that is useful for meaningful comparison of home and hospital.

Such an undertaking is still fraught with difficulty. For example issues such as age, parity, socioeconomic status, health and the spacing of children represent just a few of the variables that affect the birth of a given child. Of particular concern is the fact that figures for women of high risk are likely to be almost exclusively included in hospital figures and so skew the results, with the consequence being that hospital figures still cannot be meaningfully compared to home birth figures.

Alternatively, for home birth figures to be useful they should only include planned home births. As Ford, Iliffe and Franklin (1991) note, of the approximately twenty home deliveries per day in Britain, only half are intentional. Unplanned home births tend to highly inflate figures. For both home and hospital birth statistics to be accurate it is also important that women booked for home birth, but who transfer to hospital during labour or post-partum, are still placed within the home

birth figures. All New Zealand Home Birth Association statistics note transfers and reasons for transfers. All are also planned home births.

Tew (1978) notes that the argument advanced, and accepted as true, in support of hospital birth is that of enhanced safety for mother and baby. The acceptance of this argument was not difficult given that statistics illustrated falls in both the Perinatal Mortality Rate (PNMR) and MMR as science advanced, hospitalisation became the norm and specialists were increasingly used. More recently researchers have pointed out that this merely shows a correlation between increased hospitalisation and falling mortality rates and that this correlational relationship has tended to be advanced as if it were a causal relationship (Huntingford, 1978; Tew, 1978).

Another strong correlational relationship to falling mortality rates are social changes. These would include changes such as fewer very young or very old women giving birth, improved standards of living, improved nutrition, increased stature of women, fewer very large families, greater spacing between children and a general improvement in health care services available to women and children (Smulders and Limberg, 1991).

The New Zealand MMR for the years 1989 to 1991 was 9.6 per 100,000 total births. While the figure looks low it does not compare well with the Australian rate, of 4.4 per 100,000 births, or the British rate at 6.2 per 100,000 births. It is also higher than the previous three year period (1986-1988) when the rate was 6.7 per 100,000 total births (Maternal deaths, 1993).

In fact, Umbers (1994) states that the New Zealand MMR between 1980 and 1992 was 13 per 100,000 live births, with New Zealand women being four times more likely to die from childbirth than Australian women. Further, this rate places New Zealand fourth worst in the industrialised world, includes a disproportionately high number of Maori and Pacific Island women and is more than 50% higher than the MMRs of the United Kingdom and United States. Clearly figures such as these show that maternal mortality is still of concern, even though in comparison to previous eras there has been a dramatic fall in maternal deaths.

In fact the MMR of the Western world is now so low that it is not useful for meaningful analysis on the relative safety of home versus hospital birth (Chamberlain, 1988; Tew, 1991). Consequently attention is now more usually focused on PNMRs, and increasingly as PNMRs drop, on morbidity rates.

Tew (1987), using British data, notes that high infant mortality rates are most often associated with high rates of hospital births, and in both high and low risk groups the still-birth rate of hospital is much higher than that of home birth.

Using the data of the British 1970 survey which included information of every still and live birth in one single week throughout the entire United Kingdom, Tew (1990) found that the analysis showed "consistently and unmistakably an excess of mortality among births in hospital" (p. 29), as illustrated in Table 1.

Table 1. Percentage of births and perinatal mortality rate (PNMR) by labour prediction score (LPS) and place of birth.

LPS ⁽¹⁾	Level of Risk	Percentage of Births		PNMR/1000 Births	
		Hospital ⁽²⁾	GPU/Home ⁽³⁾	Hospital ⁽²⁾	GPU/Home ⁽³⁾
0-1	Very Low	39.4	59.4	8.0	3.6
2	Low	23.0	22.3	17.9	4.8
3	Moderate	15.6	10.6	32.2	2.0
4-6	High	18.2	7.5	53.2	14.2
7-8	Very High	2.9	0.2	149.1	111.1
0-12	All	(n=11141)	(n=4660)	27.8	4.9

- (1) The labour prediction score (LPS) is a risk score constructed by the British Births 1970 survey researchers. It includes the antenatal prediction score (APS), which considers age, parity, social class, obstetric history (stillbirth, neonatal death, abortion, caesarean section) and co-existing disease (diabetes, hypertension). In addition the LPS includes risks from complications which have an important influence on labour (for example antepartum haemorrhage, duration of pregnancy, foetal distress and breech presentation).
- (2) Excludes general practitioner beds.
- (3) General practitioner units and home are seen as equivalent.

Source: Tew (1990), data from the British Births 1970 survey.

As can be seen, the increased mortality of hospital holds across all risk levels, with the high risk births in general practitioner units (GPUs)/home being lower in mortality, at 14.2 than that of the low risk hospital group, at 17.9. In fact, British GPUs and New Zealand secondary maternity hospitals are very similar. (In making GPUs and home equivalent, home birth figures would tend to be inflated and GPUs deflated.) Tew (1990), a medical research statistician, did analysis on the

different risk categories of women and concluded that less than one eighth of the discrepancy between hospital and home PNMRs could be explained by the greater proportion of higher risk hospital births. See appendix 1 for further analysis by Tew (1990).

Similarly Jowitt (1993) gives a Dutch PNMR of 18 per 1000 births in consultant hospitals in the presence of a doctor and 1 per 1000 for home births in the presence of a midwife. She also notes that the United Kingdom Winterton Report (1992, cited Jowitt, 1993) states that, "There is no convincing and compelling evidence that hospitals give a better guarantee of the safety of the majority of mothers and babies. It is possible, but not proven, that the contrary might be the case" (p. 191).

Such research throws considerable doubt on the widespread belief that hospital is invariably safer than birth at home. While Barrington (1985) is correct in stating that, "No-one would denigrate the contribution of modern medicine to the improved safety of the high risk mother and child" (p. 20), it would also appear to be true that, "Perhaps the most persistent and striking feature of the debate about where to be born, however, is the way policy has been formed with very little reference to the evidence" (Editorial, 1987, p. 108).

INTERVENTION

As has been noted, in contrast to earlier eras when women faced a very real threat of death or debility in childbearing, the issue of safety is often not the central concern of women giving birth these days. As mortality rates dropped and the fear of women of possible death faded, other issues gained prominence. One issue that is usually of considerable concern for women choosing birth at home is that of intervention (Abel and Kearns, 1991; Ford et al, 1991; Jakobsen, 1991; Pratt, 1990).

Obviously there is a link between intervention and safety. Intervention can ensure the survival of mother, baby, or both, and the necessity for intervention in some cases cannot be denied or underestimated. Since the majority of births are without complications, however, what will be considered in this section is the incidence of intervention, particularly in relation to the home versus hospital debate.

One study that is widely quoted in the home versus hospital safety controversy is a United States study by Mehl, Leavitt, Peterson and Creevy (1976, cited, Mehl, 1978). Mehl et al. matched women giving birth in hospital or at home case by case for maternal age, risk factors, gestational length, parity, education and socioeconomic status.

Results showed that the hospital group were given three times as much oxytocin, there were twenty-two times more forceps deliveries and four times more caesareans, a nine times greater incidence of episiotomies, and two hundred and sixty-seven times more use of analgesia and anaesthesia. There was also significantly more intra-uterine foetal distress, elevated blood pressure during labour, post-partum haemorrhages and meconium staining. Meconium is a baby's first bowel motion. Its presence in the amniotic fluid suggests the baby has undergone stress. Shoulder dystocia (difficulty birthing the shoulder) also presented more frequently with hospital births.

The home group had significantly more second stage labour dystocia (lack of progress in the second stage), bleeding during labour and occiput posterior deliveries. (The baby has not rotated, so their backbone is against the mothers backbone. The ideal position being baby's backbone towards the front of the uterus).

In terms of neonatal complications, the hospital born babies suffered more birth injuries, had more infections, needed more oxygen at birth, had a greater incidence of respiratory distress lasting 12 hours or more, needed more resuscitation, had more total non-congenital complications, and lower 1 minute and 5 minute Apgar scores. The Apgar score gives a rapid assessment of the baby's condition. It consists of the baby's heart rate, respiratory effort, muscle tone, grimace (reflex irritability) and colour. The range goes from zero to ten, with ten being the maximum score, although rarely achieved. A score of five or below indicates the infant is depressed and at the 5 minute assessment can be associated with neurologic damage and even neonatal death. (Berkow and Fletcher, 1992).

No significant differences between the two groups were found in the intra-partum (during birth), or neonatal deaths, or neurologically abnormal infants.

A United States study of lay midwives from the well known "Farm" midwifery service in rural Tennessee compared the outcomes of 1707 planned lay midwife attended births with physician

attended hospital births (Durand, 1992). No significant differences were found for foetal or neonatal death, labour related complications or low 5 minute Apgar scores. However, the assisted delivery rate for the Farm midwives was 2.11% compared to 26.6% for physicians and the caesarean section rate was 1.46% compared to 16.46% respectively. Hence, safety was comparable but far fewer women had assisted deliveries with the lay midwives.

Affonso (1981) notes that in the United States caesarean births have increased from 3% in 1948 to 6% in 1969 to 14.7% in 1978. She notes that in 1979 69.9% of all deliveries had no complications, but in 1980 this figure had dropped to 54.4%. Affonso further notes that caesarean birth has approximately four times the risk of maternal mortality as vaginal birth, most frequently from infection. Postpartum infection rates are 3-7% for vaginal deliveries but five to ten times higher for caesarean births. Furthermore the PNMR is 11.1 per 1000 births for vaginal deliveries but 15.5 per 1000 births for caesarean births, after adjustments for differences in birth weight. A Finish study noted that as small maternity hospitals closed, caesarean rates increased. In 1964 there were 132 maternity hospitals and a caesarean rate of 4%, but in 1980 there were only 50 hospitals but the caesarean rate was 14% (Valvanne, 1991).

Closer to home Boland (1989) examined a matched sample of 51 home births and 509 hospital births in Sydney Australia using 1984 data from the Maternal/Perinatal Statistics Collection. She concluded that there were significantly fewer complications for first time mothers giving birth at home compared to hospital, the figures being 46.1% and 68.3%-74.5% respectively. And, secondly, that complication rates for women of the same low risk status giving birth for the first time varied considerably between hospitals. Namely from 37.3% to 84.6%.

A 1989 New Zealand study by Tilyard (1989, cited Jakobsen, 1991) of 1032 low risk women showed that both intervention in labour and the rate of foetal distress was much higher among private specialists and hospital clinics than rural doctors. Since virtually all home births in New Zealand would be classified as low risk Jakobsen (1991) compared Tilyard's study with home birth statistics to arrive at the following:

Table 2. Foetal distress and intervention rates in New Zealand.

Foetal Distress:	%
Home birth	1.5
Rural GPs	3.6
Private specialists	9.5
Hospital clinics	23.1
Intervention Rates:	
Home Birth	53.5 ⁽¹⁾
Hospitals	83.0

- (1) The home birth intervention figure may seem high given the non-interventionist approach and environment associated with home birth. However homeopathy is included as an intervention in statistics, with approximately one-third of women receiving treatment.

Source: Jakobsen (1991)

In terms of the broader picture, it would seem unfortunately, that New Zealand has a higher than acceptable level of intervention. Wagner (1990), the Director of Perinatal Health Care Services' European region for the World Health Organisation, commenting on the caesarean section rate in New Zealand (see Table 3) states that, "This would be considered the high borderline that would be permissible in any developed country" (p. 14).

He then notes that the operative vaginal births rate (forceps or vacuum extraction) varies between 10-20% also, and this he believes is the single most important problem in New Zealand's perinatal epidemiology (see Table 3). This problem is two pronged though, the first being that the rate is, "At least double what it should be" (p. 14), the second being that most operative deliveries are by forceps not vacuum extraction. Vacuum extraction is viewed as preferable and results in less trauma and pain for women.

In conclusion he notes that the overall operative rate of births in New Zealand at 25-30% means that, "Over one quarter of all New Zealand women have their baby either cut out or pulled out" (p. 15). These rates are at least double those of most European countries, although Jowitt (1993) states that in 1985 in England and Wales the forceps rate was 10% (with a staggering 50% rate for the United States).

The national rate from the Home Birth Associations for 1992 works out at 2.0% each for caesareans and forceps deliveries (Staff, August 1993). This is in line with the Dutch rate of 1.5% for caesarean births, with approximately half of all births in Holland occurring in the home with midwives (Hibbard, 1981). Dutch researchers Smulders and Limberg (1991) note that there is a correlation between a safe and a pleasant delivery, as the use of forceps or vacuum extraction always carries risks.

Table 3. New Zealand Operative Births in percent (1989). Unofficial figures obtained from hospital records

	C-Section	Operative Vaginal	Total
Home Birth	3.7	1.4	5.1
Wellington Women's	15.5	14.5	30.0
Middlemore	8.8	5.4	14.2
National Women's	15.7	12.1	27.8
St Helens	13.8	12.3	26.1
Waikato	14.9	11.0	25.9
Taranaki Area	13.5	9.0	22.5
Hastings	8.4	23.0	31.4
Napier	11.6	20.0	31.6
Palmerston North	19.0	8.3	27.3
Nelson	11.3	18.0	29.3
Christchurch Women's	22.0	15.0	37.0
Queen Mary Dunedin	16.3	14.3	30.6
Dannevirke	7.0	12.0	19.0

Source: Wagner (1990) (modified)

In fact Rothman (1982) notes that hospitals have never been proved to be the safest place to give birth. They can present dangers to women and their babies due to overuse of medication, higher risks of infection and obstetrical interference in the physiological process of birth.

As many researchers note, one of the problems of intervention is that of the cascading nature of interventions, one intervention often produces a need for another, which produces a need for yet another. It is also the case that if health professionals and institutions have set policies, interventions may also be given at times when they are not actually necessary, rather than each case being treated on its own merits. For example in the Netherlands in 1979 one out of three women sent to hospital for expected medical complications ended up having an uncomplicated

birth (Smulders and Limberg, 1991). If medical staff are too quick to intervene such women would end up having interventions before it became apparent that they did not actually require them.

CONCLUSION

In this chapter the questions of safety and intervention have been discussed. While the importance of safety is, naturally, of prime concern statistics appear to refute the widespread belief that hospital is the safest place in which to give birth. For women giving birth it is probably true to say that while the issue of safety is considered, especially by those planning a home birth, it is not necessarily the central issue. This is because in the vast majority of cases a normal pregnancy will end in a healthy birth without complications.

Often of more concern to women considering home birth is intervention, and again, statistics suggest that no intervention in birth is more common for births at home. Along with other factors, such as access to health care and poor standards of living, the high overall rate of operative births in New Zealand could be connected to the higher rate of maternal deaths. If so, New Zealand health professionals involved in the childbirth area need to reconsider their practices and look to countries with lower rates as one way of reducing these disturbing figures.

However, what always needs to be borne in mind when considering safety and intervention in birth, is that there is no such thing as absolute safety in birth, a small number of babies will die. Also, intervention in birth always carries its own risk (Page, 1991; Smulders and Limberg, 1991). Hence, birth is always a case of balancing the risks of doing nothing and doing something (Rothman, 1982).

Chapter 4

CURRENT ISSUES IN HOME BIRTH RESEARCH

"A maternity service which loses touch with the feelings and expectations of its clients will not meet their needs" (Chalmers, 1978, p. 52).

INTRODUCTION

This literature review is divided into six sections. Section one is concerned with the importance of information. Areas covered include lack of knowledge of home birth as an option, the critical nature of information to decision making, women's desire for information and how this is frequently not met. Also, provision of information generally appears to have positive consequences by reducing stress, increasing adaptation, and increasing feelings of control and satisfaction.

The second section examines why women decide to have a home birth. Reasons discussed include issues of control, the increasing medicalisation of birth, the wish for a 'natural' or 'normal' birth, continuity of care and having an established relationship with a midwife, having control over who attends the birth and their degree of involvement, the environment of home, separation from partners and other children, bonding and breastfeeding. Because of their importance some are discussed in greater detail in other sections of this chapter.

The third section discusses the issue of control. Reference is made to the fact that control is frequently not adequately defined, although there appears to be a distinction between internal and external control. Debate surrounds the desirability of internal control, while feelings of external control appear to be linked to the provision of information and to participation in decision making. Women's views on decision making and feelings of control during birth are discussed, along with the influence of client-staff relationships on feelings of control. It is noted that good relationships can mean women retain feelings of control even in emergency situations. Section three also considers the importance of control for home birth women, and home birth and decision making. Feelings of control, both at home and in hospital, are associated with feelings of satisfaction and other positive psychological outcomes.

Section four examines social support and continuity of care. Firstly lay social support is discussed. Research in health psychology generally finds that social support has beneficial effects and that home birth provides the potential for increased social support. Also, social support is especially important for birth at home due to fewer pain relief options. The influence of social support on labour, delivery and outcomes for babies are outlined, along with the desire of women for support. The impact of social support on psychological outcomes for mothers is also examined. Secondly, continuity of care and midwifery support is discussed. The difficulty of establishing a supportive relationship within the current hospital maternity system is considered, although it is noted that midwives typically provide considerable support for women during labour and post-partum. Other issues discussed include the desirability of midwives providing psychological care along with physical care, both to women and to women's support networks, and the effect of supportive care on labour and maternal and infant outcomes. Again, it is suggested that a key factor is the relationship that exists or develops between women and midwives. Women's desire for continuity of care in childbirth is examined and findings indicate that this is a prominent concern of women having a home birth.

Section five looks at disadvantages of home birth, such as the domestic and childcare responsibilities associated with the home, lack of rest, the possibility of having to transfer to hospital, the lack of pain relief options at home, relationship problems between women and midwives, risk factors for women or their babies, and negative reactions of others to women planning a home birth.

The last section is concerned with satisfaction with childbirth. It is noted that there are difficulties in defining and measuring satisfaction and some of these are outlined. Satisfaction is then discussed in relation to issues such as the provision of information, feelings of control and participation in decision making, satisfaction with staff and other support people. It appears that there is an inverse relationship between satisfaction and chemical pain relief, and that both minor and major interventions decrease satisfaction. Also considered is satisfaction and birth location and whether women would choose the same birth location if having another baby.

INFORMATION

This section is concerned with the importance of information during women's pregnancies, labours and postnatally. Information is viewed as central to the understanding of available

choices and to decision making. Information is also shown to affect women's experience of childbirth and their satisfaction with their experience.

Lack of knowledge of home birth as a birth option is highly possible in countries where it is not typically offered as an alternative. This would include New Zealand. In a United States study Sacks and Donnenfeld (1984) interviewed three different groups. These included hospital couples, maternity centre couples and home birth couples. Of the hospital group 28% of the mothers and 47% of the fathers were not aware maternity centres were a birthing option, and 16% of the mothers and 37% of the fathers indicated no knowledge of home birth as an option. In contrast, except for one in each group, all maternity centre and home birth couples indicated knowledge of all three birth alternatives.

It is also the case that women may have knowledge about the option of home birth, but lack sufficient information to make an informed choice. McSherry (1986) studied 48 women in the Manawatu area and found strong opposition to home birth. The main reason women gave was that home birth was unsafe, yet half the women gave birth in hospitals which, "held no more emergency facilities than those carried by domicillary (sic) midwives" (McSherry, 1986, p. 64).

That women seek information is well documented in studies. Green, Coupland and Kitzinger (1988) asked women if they could discuss the things they wanted to with professionals. Thirty-three percent said that they always could, 51% said they could most of the time, 12% said only occasionally, 3% hardly ever could, with 1% never being able to. A 1984 study of 4,000 women by the Danish Institute of Epidemiology found that during pregnancy women preferred to get advice from a midwife as they felt they could discuss more issues with a midwife than their doctor. Women also stated that at least 25 minutes were necessary for each antenatal visit (Houd, 1991).

There are also class differences as to the amount of information received and satisfaction with it. Green et al. (1988) found that lower class women tended to be more dissatisfied with the amount of information they received, and Pratt (1990) states that the lower the social class of woman the greater the likelihood of wanting more information. This is backed up by other research which found that women of higher social classes were given more information, but lower class women knew less and understood less than higher class women (Niven, 1992). Consequently, their need

for information was greater, which no doubt would contribute to feelings of dissatisfaction at the amount of information received.

Shapiro (1983, cited Pratt, 1990) found that despite many antenatal visits, for the majority of women their desire for information was not met and their health professionals' perception of the extent of their wish for information was highly underestimated. Kirkham (1989, cited Niven, 1992) also found this in a study which looked at three groups of women, a consultant hospital group, a General Practitioner Unit group, and a home birth group. Information, both good and bad, was what all groups said they wanted most from their midwives. As Pratt goes on to note, studies suggest that women must actively seek information as it is unlikely their health professionals will meet their needs in this area.

McSherry (1986) also found that the women she interviewed wanted greater information than they received. The ability to "promote the exchange of information" was rated by women as the most desirable characteristic of a doctor (p. 63). Conversely the worst characteristic was seen to be unapproachability.

McSherry (1986) also noted that many women felt unable to gain further information by questioning their doctor due to feeling intimidated by his/her manner. Alternatively, Boreham and Gibson (1978, cited Pratt, 1990) suggest that the reason women do not pursue information is because to do so would imply a lack of confidence in the doctor's judgement. Pratt points out that, "This infers that the power imbalance was being reaffirmed by doctor dominance and patient passivity in the interaction process and that patients continued to abdicate responsibility against their own best interests" (p. 17).

In terms of home birth women, Pratt (1990) believes they want as much information as possible, and McClain (1987, cited Pratt) found that home birth women knew significantly more details about friends' pregnancies and birth experiences compared to women having hospital births. Schiff and La Ferla (1985, cited Pratt) found that all their home birth sample had discussed birth experiences with their midwives but only half of the hospital group had discussed their preferences with obstetricians. Similarly, McSherry (1986) found that two-thirds of her sample had not discussed the coming labour and delivery with their doctor.

In fact, research strongly suggests that women's desire for information is positive in that the attempt to understand and make sense of what is happening, or could happen, helps prepare women for actual events. For example Mason (1987) states that women who actively sought information in pregnancy about labour and birth were more likely to adapt well to labour, delivery and early motherhood compared to those who did not so prepare.

Norton (1983) goes further and suggests that effective childbirth preparation would produce truly educated consumers which would do more to lower the PNMR and improve obstetric care than any other force. The study by Middlemiss, Dawson, Gough, Jones and Coles (1989) would suggest that this is one way obstetric care could easily be improved. Middlemiss et al. studied the anxiety of women experiencing high-risk pregnancies. The experimental group had home based care which included the encouragement of women to participate in discussions about the management of their pregnancy. The control group had standard hospital based care. Groups were matched for maternal age, parity, gestational age, marital status, socio-economic grouping and reason for referral.

Psychological assessments were conducted using the State Trait Anxiety Inventory STAI and the Zung self-evaluation questionnaire at weekly intervals up to delivery. Results showed no significant differences between the groups for the Zung Depression scale or trait anxiety levels. The State anxiety scores showed that women in the experimental group had considerably lower State anxiety levels (with a mean of 34.05, SD 9.24, compared to control group levels of 41.90, SD 9.93, at $P < 0.01$). It was concluded that women in the experimental group did have lower anxiety levels than those in the control group.

It is not only antenatally that information is important however. Niven (1992) believes that one way to minimize anxiety and stress during birth is for staff to provide sufficient information to counteract unnecessary worries and reassure women their experience is normal. Information is not always forthcoming however. An Italian study by Ramito and Zalateo (1992) found women had only a "scanty knowledge" of what had been done to them during delivery (p. 234). They state that studies from a variety of countries, "Have confirmed that physicians and nursing staff tend to give incomplete information about what they intend to do or what they are doing, and that the women often emerge from encounters with health personnel (and thus also from giving birth) without understanding what has been done to them, why it has been done, and what the possible alternatives might have been" (p. 234).

Annandale (1987) notes that information is an essential ingredient of patient control, a statement which Green et al. (1988) would confirm, as they found that the amount and quality of information that women received was strongly related to whether they felt in control of what staff were doing to them. Not feeling in control was associated with wanting to know more or having been given misleading or confusing information.

Green et al. (1988) also found a significant relationship between satisfaction postnatally and the amount of information women received, wishing they had more information prior to the birth and feeling they had been given misleading information. Similarly, they also found associations between women's feelings about the information they received and two additional measures: emotional well-being and positive descriptions of baby.

WHY WOMEN CHOOSE HOME BIRTH

Pratt (1990) in her New Zealand study states that 60% of her home birth respondents ranked the ability to be in control as the most important factor in their choice of birth location. Control was also of concern for the (New Zealand) women Abel and Kearns (1991) interviewed. The women in the study believed that their power to control what happened to them was reduced in the hospital system and that this increased the risk of medical intervention. Conversely, they felt that being at home enabled them to feel in control. (The word 'control' is being used in relation to decision making, i.e. what happens to the woman, rather than control of oneself.) Due to the importance of control for women it will be discussed in greater detail later in this chapter.

Overseas literature also states that control is an important issue (Cunningham, 1993; Homebirth Australia, 1993; Morse and Park, 1988). Sacks and Donnenfeld (1984) note that feeling in control was important for 68% of the women surveyed who gave birth at home. Linked with the desire to maintain control is the belief that losing control over what happens to you in hospital results in an increased likelihood of medical interventions occurring, an increased likelihood of the use of medication, or both.

The increasing medicalisation of birth has been the source of considerable disquiet. Objections to routine hospital practices, combined with previous hospital experience, can influence women in deciding on home birth (Jakobsen, 1991; Kitzinger, 1978; Klee, 1986; O'Connor, 1993). Ford et

al (1991) state that they believe aversion to technological intervention is a powerful motivation in some women seeking home birth, and Morse and Park (1988) note women frequently seek to avoid the iatrogenic risks associated with hospital.

Associated with this is a distrust of conventional medical practice (Hannah and Davies, 1990; Hazell, 1975, cited Abel and Kearns, 1991; and Pratt, 1990) and a belief that the ready access to technology brings with it the temptation to use it (Jowitt, 1993). Women seeking home birth, and perhaps the majority of all expectant women, generally wish to have a 'natural' or 'normal' birth or both, and often an 'active' one also. The term 'active' is associated with the notion of control over decision making (Cunningham, 1993), but is also concerned with the ability to physically move about. Clearly this is impossible if women are being continuously monitored, have an intravenous infusion or an epidural anaesthetic. Avoidance of interventions is also associated with the term 'natural' or 'normal' and is a powerful motivator for women wanting their babies to be born at home (Homebirth Australia, 1993; Kitzinger, 1978; Morse and Park, 1988; O'Connor, 1993; Pratt, 1990; Zander, Lee-Jones and Fisher, 1978).

Another factor that is frequently cited by women as a reason for deciding to have their babies at home is that of continuity of care. In the majority of hospitals in New Zealand women do not meet the staff who will care for them in labour before their admittance. Once there they may have changes in midwives depending on shift change-overs, plus they will have different midwives post-partum.

Continuity of care and the establishment of a relationship and rapport with their midwife is seen by home birth women as crucial. It could be argued that vast numbers of New Zealand women would agree if the numbers who have chosen independent midwifery care since legislative changes in 1990 are anything to go by. For example, there were 50 independent midwives handling 1,000 births in 1990 and 350 handling 11,000 births in 1993. However, only 1,100-1,200 of the 11,000 births would be home births (McLoughlin, 1993). Some hospitals have obviously recognised women's wishes for such care and have improved services to women by instigating "know-your-midwife" schemes (for example in Nelson and Wanganui).

The New Zealand studies of Abel and Kearns (1991), Jakobsen (1991), Pratt (1990) and Strid (1991) all found that continuity of care was important for the women they surveyed, and overseas

literature supports this finding (Kitzinger, 1978; Houd, 1991; Zander, 1984). Due to its importance continuity of care will also be discussed in greater detail later in this chapter.

Linked with the desire to have a personal relationship with their midwife is the wish to maintain control over who attends the birth and to fully involve those chosen to attend (Cunningham, 1993; Hasslacher, 1988; Kitzinger, 1978; Sacks and Donnenfeld, 1984; Strid, 1991; Zander, 1984). Generally women wish to involve their partners as fully as possible and the presence of trusted family and friends is seen to increase the relaxation engendered by the home environment. By selecting only those people whom she trusts a woman ensures that her privacy, at such a personal time, is safeguarded.

Both privacy and giving birth in a familiar, relaxed and peaceful environment are also important as reasons why women choose home birth. Hasslacher (1988) notes that there is no outside disturbance to the flow of labour, while Zander (1984) believes home gives a sense of relaxation and security by virtue of the familiar surroundings and the presence of family and friends. Other authors note that women believe that not having to leave the home means labour is not disrupted by the move to hospital (Abel and Kearns, 1991; Hannah and Davies, 1990).

Not being separated from the new baby, from other children and from their partner are other reasons why women may choose home birth (Hannah and Davies, 1990; Homebirth Australia, 1993; Kitzinger, 1978). In fact Sacks and Donnenfeld (1984) note that 68% of their sample mentioned that avoiding being separated from their baby was one reason why they decided to have a home birth. This desire of women not to be separated from their new baby may be linked to the belief that bonding and the establishment of breastfeeding are better achieved at home (Abel and Kearns, 1991; Cunningham, 1993; Hasslacher, 1988; Kitzinger, 1978; Klee, 1986).

Other reasons which women may consider important include the lesser disruption that occurs to family life, and the quality family time that occurs immediately post-partum (Hannah and Davies, 1990), being able to have their total care provided by a midwife (Homebirth Australia, 1993), the woman always being the centre of attention (Hasslacher, 1988; Strid, 1991). The possibility of women being subject to conflicting advice is also eliminated (Hasslacher, 1988).

Finally, Klee (1986) notes that the decision to have a home birth may mean that women choosing home birth simply have a different ideology or explanation of birth. Given the divergent views of

the medical and midwifery model of childbirth (see Chapter 5 for a more detailed description of these models) this must remain a possibility and may, in fact, be the underlying reason why women decide to have their babies at home.

CONTROL

As stated earlier the desire to maintain control is for many women one of the major reasons why they choose home birth. However, there are differing interpretations on the definition of control. Annandale (1987) when discussing health care in general, sees control over decision making about the process of health care as the key. Clearly control then relies on the quality and quantity of information and on the relationship between the health professional providing the information and the client receiving it. As Annandale notes, not only must the health professional be willing to give (or share) control with the patient, the patient must be willing to accept control. Annandale also notes that control can also be viewed in terms of a person being responsible, or in control of their own health maintenance, and states that this form of control can deflect attention away from control over the decision making process.

Control is also difficult to define when discussing maternity care. Jakobsen (1991) believes that there is a crucial relationship between self-control and social control. She suggests that women must gain control over their environment so that they are relaxed and unrestrained enough to lose control, so they "go with the flow of labour" (p. 55). That is, women must overcome socialisation/social control and feel secure and relaxed so that they work with, rather than against, the labour process. To take this further, women entering an institution cannot gain control over their environment and cannot properly relax. They therefore remain restrained by their socialisation, and so tend to unconsciously fight against the labour process.

Green et al. (1988) also state that the definition of control is problematic. They note that the desirability of internal control is debated, with some theories suggesting that it is desirable that women maintain control over their own behaviour, while others advocate women relinquish internal control. For example they note that two influential childbirth theories are founded on different beliefs. Dick Read (1933, cited Green et al.) advocated "natural childbirth" using progressive relaxation techniques. As Green et al. state, the focus is on "flowing with one's body rather than trying to assert control over the childbirth event or distance oneself from it" (p. 1.17).

Alternatively the psychoprophylactic or Lamaze method advocates women develop and maintain control over their behaviour (Kitzinger, 1989). For home birth women it would seem that there is a belief that (internal) control is better maintained in the home due to environmental factors, such as the reduction in stress and the familiar and comfortable surroundings (Kitzinger, 1978; Kleiverda, Steen, Andersen, Treffers and Everaerd, 1990).

In fact, though, it seems that it would be beneficial to differentiate between internal control (as discussed) and external control. Green et al. (1988) believe external control is linked to the right to choose, and is the sense of control most likely to be lost when entering an institution. They further note that there is a problem in distinguishing between perceived control and actual control and that perceived control may be very different from actual control.

Green et al. (1988) suggest that external control may be partly achieved through participation in decision making, information and choice being a necessary prerequisite for this. It is this external definition of control that appears to be the most prominent in the literature, although the way in which 'control' is being defined is frequently not elaborated.

Annandale (1987) proposes two essential ingredients for patient control. Firstly, having all the available information to make an informed decision. Secondly, having the jurisdiction to make the decision without experiencing negative consequences if the client goes against the health professional's preference (p. 1247).

Access to information has been discussed in an earlier section but it is worth reiterating its importance to the concept of control. Annandale (1987) found that receiving information about what was and what was not beneficial to a good pregnancy was central to women's sense of control. This is backed up by Green et al. (1988) where lack of control during labour and delivery was associated with women wanting more information or having been given misleading or confusing information.

When Green et al. (1988) asked women who should make most of the decisions about their labours (assuming no complications), nearly three-quarters of their sample wanted to participate in decision making and not just be "kept informed". Fifty-five percent of the respondents expected issues to either be discussed with them or to make decisions themselves. Similarly, they found that only approximately 2% of respondents preferred not to be in control of what doctors

and midwives did to them during labour. Even in an emergency situation 6% of Green et al. (1988) sample still wanted to be in control of decisions. And, although 72% saw decisions in such situations as staff responsibility, 65% of that group still wished to be kept informed in an emergency situation.

In terms of outcomes, Green et al. (1988) found that approximately half their sample felt in control "all or most of the time" in non-emergency situations, and noted that these women were less likely to have experienced obstetric procedures. It is interesting to note though that the study found that women who were "not sure" whether they had experienced a procedure were the least likely to have felt in control. Obviously, if a woman is unsure whether a procedure occurred or not it is likely that discussion did not take place and Green et al. suggest that the way in which intervention occurs influences women's feelings of control. That is, while it is obviously more difficult to maintain control when a birth has complications, intervention does not necessarily mean a loss of control.

This is a point also noted by other research (Bassett-Smith, 1988; Jakobsen, 1991; Oakley and Houd, 1990; Salmon and Drew, 1992), with Salmon and Drew stating that, "Mothers' feelings of participation in the intervention or in the decision to use it may be more important determinants of their experience than the use of the procedures per se" (p. 325). Such findings also introduce a cautionary note to the use of technology. For, as Kitzinger (1991) notes, information necessary to making decisions is embedded in the technology itself, which staff control. Consequently in high technology births a hierarchical system of power and decision making can easily be applied, as opposed to low technology births where decisions can more easily be made by everyone involved.

It is also interesting to consider the long-term effects of control. Simkin (1991) conducted a survey of 20 women in order to find out whether their first birth experience affected them, and if so, in what way. All of the births had taken place 15-20 years previously. Simkin (1991) found that control over what happened to women and decisions about the care they received were important factors in long-term satisfaction and in women's subsequent self-image.

Clearly women's participation in decision making is reliant upon them having a reasonable relationship with staff, and it would appear that the relationship between women and staff also affects women's feelings of control (Green et al., 1988; Jakobsen, 1991; Oakley and Houd, 1990). Oakley and Houd compared two groups, a "know-your-midwife" group (who could be assumed

to have developed a relationship with their midwife antenatally) and a control group. Following labour and delivery 42% of the know-your-midwife group felt "very much in control", compared to 24% of the controls. Conversely, 22% of the know-your-midwife groups did not feel in control "much or at all" as opposed to 33% of the control group.

Given that feelings of control are possible in emergency situations it follows that women will not necessarily experience loss of control if they have a hospital birth, or that they will necessarily experience feelings of control if they have a home birth. What several studies do suggest though is that control is more easily maintained at home than hospital (Annandale, 1987; Donley, 1991; Rothman, 1982). For as Rothman points out, in hospital a patient is outnumbered and overpowered and therefore is in no position to be an equal participant.

This is an issue with which Donley (1991) would agree regarding birth in New Zealand. She notes that even when a domino midwife is used, (domino midwives do antenatal care, deliver the baby in hospital, then care for the woman in her home - some women only stay in hospital a few hours, most less than 12,) the birth is still under medical (institutional) control, rather than the control of the woman or her midwife.

Jakobsen (1991) found that four of the seven (New Zealand) women she interviewed actively sought control of their birth and believed home birth gave them greater control over the sort of birth they would have. Strid (1991), a New Zealand home birth consumer, believes that home birth puts the woman in control and means that she cannot be so easily intimidated or taken advantage of in her own home.

Such beliefs might well hold true. For example Dawson-Black (1985) found her home birth respondents perceived themselves as having more control than either the medicated hospital or the unmedicated hospital respondents. And, in a British study by Kirkham (1989, cited Niven, 1992) which compared women giving birth in a consultant unit, General Practitioner Units or at home, it was found that home birth women did have greater control over decisions. Kirkham (cited Niven) states that home birth midwives treated women more like colleagues and provided information and support which enabled women to make informed decisions about clinical matters. The consequence was that women were, "Able to make decisions in their own home that were impossible for most midwives to make in consultant units" (p. 42).

Given the desire for and importance of control for women it is not surprising that it is associated with women's feelings of satisfaction. In fact Green et al. (1988) note that the act of exercising choice gives satisfaction regardless of the adequacy or inadequacy of the options. That aside, several studies support the notion that control is associated with satisfaction, (Hodnett and Osborn, 1989; Humenick, 1981, cited Green et al.; Niven, 1992; Romito, 1986) according to Green et al. in a linear way. It is also linked to satisfaction with staff, with Niven (1992) stating that for the client it appears personal and staff control are interwoven and mutually supportive. That is, if women feel they have personal control as well as a sense of control over staff decisions and actions, this leads to an enhanced sense of satisfaction and well-being.

Green et al. (1988) found that both internal and external control were associated with a number of factors that contributed to their measures of psychological outcomes, including increased satisfaction, fulfilment, and emotional well-being scores. Their research suggests, though, that attitudes of staff towards the women in their care is of greater importance to outcomes such as emotional well-being and satisfaction, than women having detailed choice over what is done. That is, how rather than what is done is the most important factor.

Green et al. (1988) note that lack of control was associated with minor interventions (such as episiotomy, enema, electronic monitoring), as well as obstetric emergencies and psycho-social factors, including lack of staff continuity, unsupportive staff and insufficient information. As would be expected they also found that, not only were control and satisfaction associated in a linear fashion, but there was also a direct link between the level of control women felt they had over what staff were doing to them and satisfaction.

This critical issue of staff-client relationships is reinforced by Green et als. (1988) finding that women who were kept informed, had decisions discussed with them, or felt in control of decision making felt equally fulfilled (81%). Women who felt that staff "just got on with it" and who were not informed about issues or decisions were significantly less likely to feel the experience had been fulfilling (70%).

(Satisfaction, as a psychological outcome, will be discussed as a topic in a later section of this chapter.)

SOCIAL SUPPORT AND CONTINUITY OF CARE.

Two other important reasons why women may choose to have their babies at home are, firstly, that should they wish to, it enables them to surround themselves with family or friends with whom they wish to share this very special time and with whom they have a close relationship. Secondly, by so doing they have ample opportunity to establish a trusting and supportive relationship with a midwife of their choice who will attend them antenatally, during labour and delivery, and postnatally.

Lay Social Support

Support from close family and friends is beneficial, with research in health psychology suggesting that support networks have a buffering effect for people. For example Wideman and Singer (1984) note that research indicates that social support may be related to immunology and that social contacts affect both psychological and physiological breakdown from a wide variety of non-infectious disorders.

Nuckolls, Cassel and Kaplan (1972, cited Wideman and Singer, 1984) found that women whose life change scores were high both before and during pregnancy and who had few favourable psychosocial assets had three times as many complications as women with high life change scores but many favourable psychosocial assets. Niven (1992) also quotes similar research and notes that social support is helpful for pregnant women, especially if they are experiencing a stressful pregnancy. She further notes that the best social support comes from partners, sisters, mothers or close friends. While health professionals can provide a degree of support, to provide optimal care for women they should ensure that they support the woman's supporters who are better able to provide constant support to the woman.

Peterson, Mehl and Leiderman (1979) note that home birth gives greater potential for the involvement of the father in pregnancy, birth and the care of the newborn. It emphasises the responsibility of the couple for actions and delivery decisions compared to institutional responsibility inherent in hospital birth.

In fact, for home birth, social support is especially important as generally pain relief is based around non-pharmaceutical interventions (such as homeopathy, hot and cold compresses,

massage, etc.) and psychological support. McClain (1987, cited Pratt, 1990) found that the home birth women in her/his sample claimed more support from their social networks, and Cohen (1982, cited Pratt) found that partners of home birth mothers were seen as supportive and very positive, while those of hospital birth mothers were seen as under-involved in the process. Certainly, as Pratt comments, the home environment can provide both physical and emotional advantages.

Social support also has positive effects for women in labour (Bassett-Smith, 1988; Crothers and Allen, 1985; Hodnett and Osborn, 1989; Livingston, 1987; Niven, 1992; Oakley and Houd, 1990; Wideman and Singer, 1984), with Valvanne (1991) stating that a modern Finish midwife's saying is, "The child's father is the best pain relief for its mother" (p. 225). And there are also positive consequences in relation to length of labour and complications. Guatemala studies of intrapartum social support found lay companions (previously unknown to women) decreased the length of labour and reduced the incidence of perinatal complications, with fewer babies needing neonatal intensive care (Klaus, Kennell, Robertson and Sosa, 1986; Sosa, Kennell, Klaus, Robertson and Urrutia, 1980, cited Hodnett and Osborn; Niven).

While there are obviously important differences between Guatemala and western countries, the impact of social support appears to hold. A United States study (Kennel, Klaus and McGrath, et al., 1988, cited by Niven, 1992) had three groups, firstly a "doula" group. Doula is a Greek word meaning 'woman's servant' and in this context refers to a woman who gives constant emotional and physical support to women throughout active labour and delivery. Secondly a 'silent' group, where a woman was present throughout the labour, monitored women's charts and logged their progress, but gave no obvious support to women. And, lastly, a control group. The control group had a higher rate of caesarean birth and forceps delivery, the doula group had the lowest rate of epidurals, forceps and caesarean births, while the silent group fell between the two.

Similarly Oakley and Houd (1990) presented the following Table to illustrate that social support does affect outcomes, with 59% of women experiencing a perinatal problem when they lacked support compared to 27% experiencing them when they had social support.

Some research finds otherwise however. For example Bennett, Hewson, Booker and Holliday (1985) found no relationship between support measures and labour interventions, although there were positive correlations between support and pain relief, and between support and satisfaction.

Table 4. Percentage of women having perinatal problems during labour with and without social support.

	% No Social Support (N=249)	% With Social Support (N=168)
Caesarean section	17	7
Meconium staining	18	3
Asphyxia	3	2
Oxytocin	13	2
Analgesia	4	1
Forceps	3	1
Other	1	1
No problems	41	73
Total	100	100

Source: Klaus, M. et al, 1986, cited Oakley and Houd, 1990.

Certainly the vast majority of women desire support during labour. Green et al. (1988) found that 94% of their sample wanted a birth companion with them at all times during labour, and 90% actually experienced this. They found that many women commented positively about their partners support and the few women whose partners were not with them said that that was the worst thing.

New Zealand research by Crothers and Allen (1985) found that only 7% of women had only hospital staff with them during labour, with 25% having only hospital staff for the actual delivery. The majority (87%) said they found the presence of a support person at the time of delivery as "very valuable", and while 5% were "not worried either way" (i.e. whether someone other than hospital staff were present or not), no woman said that she wished she had been alone or that they found the presence of their support person distracting or unhelpful (p. 33).

Ratima, Ratima, Durie and Potaka (1994) noted that of the Maori women they interviewed (all of whom had given birth in the Palmerston North region,) those who reported more positive birth experiences also commented on the, "tremendous support from whanau" (p. 17).

Jakobsen (1991) in her New Zealand home birth study, notes that all the women she interviewed found their support people were supportive, although some expressed irritation at occasional

ineptness of supporters. Regarding caesarean birth Affonso (1981) found all women said they had wanted more verbal and physical contact with another person, as well as their husband's support. When partners were present at the birth women expressed less fear and also had fewer difficulties postnatally.

It would seem that supportive contact has an impact on a variety of psychological variables, with Green et al. (1988) finding that it was linked to emotional well-being, satisfaction, fulfilment and mother's descriptions of their babies. The women who gave more negative descriptions of babies and were the least fulfilled and satisfied were those whose birth companions could not stay with them the whole of the time.

Others also believe that support affects things such as mother-baby interaction (Hales, 1991; Wideman and Singer, 1984) and that a father's involvement will affect his feelings towards his baby and the birth in general (including caesarean birth) (Affonso, 1981; Hales, 1991; Kitzinger, 1978; Niven, 1992; Peterson et al., 1979).

It is interesting to note that Peterson et al. (1979) found that fathers' experience of birth and their behaviour towards their partner and baby during delivery were more important than prenatal attitudes in determining their involvement postnatally. They therefore concluded that the birth experience can be a powerful catalyst for nurturing behaviour, and as Kitzinger (1978) points out, home birth tends to enhance bonding between father and baby (although it could be argued that early discharge would also serve this purpose).

Continuity of care and midwifery support.

One important source of social support is the support women derive from the midwives who attend them. The New Zealand system of maternity care for uncomplicated cases typically comprises antenatal care being provided by the family GP. When in labour the main caregivers are hospital employed midwives, with the family GP or a hospital doctor actually supervising and delivering the baby. Postnatally the bulk of the care is again provided by hospital midwives, with daily visits from hospital doctors or GPs.

In New Zealand women often have not met their midwife prior to entering the hospital when in labour, and in fact the structure of the hospital system means midwives either work in the

antenatal, or labour and delivery, or postnatal area. Consequently a woman has little or no chance of knowing the midwife they will encounter when entering in labour, and they will rarely have the opportunity to check their perceptions of the labour and birth with the midwife or midwives that cared for them. While that does not preclude the possibility of the establishment of good relationships between women and midwives it does make it more difficult, and it has also been suggested that the hospital system can make it difficult for midwives to build "positive, cooperative relationships" with women (Kitzinger, 1991, p. 11).

As stated elsewhere there are other options should a woman decide it is important for her to have a prior relationship with her midwife. Besides home birth, women can have the services of an independent midwife (at no extra cost), and some hospitals have implemented "know-your-midwife" schemes whereby women are attended by the same hospital midwife throughout their pregnancy, labour, delivery and postnatally.

Background details aside, just what does research say on the importance and effectiveness of social support from midwives, and women's experience when attended by the same midwife throughout. McCrea and Crute (1991) believe that midwives have a professional responsibility to care for their client's emotional and psychological well-being as well as meet their physical needs, while Gardner (1985, cited Bassett-Smith, 1988) believes that midwives physical and psychological presence has three dimensions.

Firstly, there is a cognitive dimension through which a midwife communicates empathy and understanding of what the woman in labour is experiencing, particularly regarding the physical nature of labour and the pain associated with it. Secondly, an affective dimension which hinges on the midwife's ability to communicate her regard for and interest in her client. For example, this includes the way in which a midwife makes suggestions and gives feedback, her behaviour and whether she acts with or without consultation with the woman. And, thirdly, the last dimension is the physical presence of the midwife, and includes such things as the use of touch and massage, hot and cold cloths and ensuring women take sufficient fluids and foods to sustain them.

Niven (1992) tends to cast the net wider and suggests that good health care (from all the professionals involved) involves the psychological care of, not only the mother, but also the father and baby. She suggests that good care involves respect, compassion, reassurance, the provision of

information and choice, acknowledgment of concerns and the sharing of joys and sorrows. Niven also suggests the theme of psychological care should consist of, "Health professionals caring for one another, Health professionals caring for families, families caring for one another, and, at the end of the chain of caring, the baby, who cares for no one and demands care of exceptional quantity and quality" (p. 5). For Niven then the midwife's role is to maximize care for the woman, and one of the most effective ways of doing this is to ensure that the woman's supporters are well cared for also.

McSherry (1986) found that, "A major theme of women's comments about relationships with staff during labour centres around the need for a calm, supportive environment" (p. 104). She also found that the physical environment, physical difficulty of labour, and level of medical intervention during the labour and birth was of less importance than the quality of the relationship between women and their caregivers.

Some research suggests that supportive care by midwives, and medical staff in general, can affect the labour process and improve outcomes (Barrington, 1985; Hodnett and Osborn, 1989; Jakobsen, 1991; McFarland, 1990; Niven, 1992; Oakley and Houd, 1990; Pratt, 1990), and one of the key factors in such a relationship appears to be the development of women's trust and confidence in their midwife (Barrington; Green et al., 1988; Jakobsen, 1991; Lobban, 1988; McCrea and Crute, 1991). It has been suggested that this is easier to achieve if the woman and midwife have already established a relationship prior to the commencement of labour, and is one of the arguments advanced in favour of continuity of care (Abel and Kearns, 1991; Staff, 1994, March; Hannah and Davies, 1990; Hasslacher, 1988; Kitzinger, 1978; Pelvin, 1990; Pratt, 1990).

The study of know-your-midwife schemes in Britain (in which women do experience a form of continuity of care) would suggest that the care given is better received by women than standard care. For example Flint, Poulengeris and Grant (1989) in evaluating such a scheme at St George's Hospital, London, found that, compared to the control group, the know-your-midwife group found their care more acceptable in almost every aspect studied. Antenatally they experienced fewer delays, easier discussion of anxieties and greater satisfaction. Following delivery they were more likely to feel they had been well prepared for labour and gave better ratings to staff. Six weeks post-partum there were, "Striking differences in the women's recollection of labour, about their preparedness for child care, and the ease with which they could discuss problems during the puerperium" (p. 13).

Women also experienced less intervention (e.g. in augmentation, epidural, intramuscular analgesia and episiotomy), although they did have more vaginal tears and had longer labours. Neonatal outcome was similar in both groups but in the know-your-midwife group neonatal resuscitation was used less frequently.

Green et al. (1988) British study found that there was considerable support for continuity of care, with 62% of women saying they hoped to have met the midwife who would attend them in labour prior to their being admitted, and 87% stated that they would like the same midwife with them throughout labour.

Following birth Green et al. (1988) found that only 24% had previously met their midwife and that when this was the case often women commented favourably on it. They also found that 66% actually experienced some degree of continuity and those who did said they felt more relaxed, cared for and secure, while women who did not expressed disappointment about that aspect of the birth. What is interesting to note, however, is that satisfaction was found to be related to having at least one midwife for the whole of labour, but not to having met the midwife before.

In New Zealand, literature on home birth would support the notion that the relationship between a woman and her midwife is of crucial importance (Abel and Kearns, 1991; Hasslacher, 1988; Jakobsen, 1991; Pelvin, 1990; Pratt, 1990), with Jakobsen and Pratt both finding more value was placed on the relationship with midwives than doctors.

Pelvin (1990) believes that the Nurses Act heralded a new age for New Zealand midwifery, the central feature of which was the provision of continuity of care. This, she believes, means that the trust developed antenatally will result in women feeling safe as they enter labour in the knowledge that their midwife is familiar with their needs and desires. And Hasslacher (1988), another New Zealand domiciliary midwife, adds the point that it is easier to work with a woman with whom a midwife already has established a relationship. There is also a belief this enables midwives to be more effective in their practice. By monitoring the mother and baby over the antenatal period they have the "whole picture", rather than fragments of a picture, when it comes to the labour and birth (P.J. Baken, personal communication, November 4, 1994).

It is also thought that home care allows a partner's desire to participate to be more easily realised, particularly given that the midwife and partner are most likely to have met at least once previously (Abel and Kearns, 1991; Hales, 1991; Hasslacher, 1988; Kitzinger, 1978; Kleiverda et al., 1990; Morse and Park, 1988; Sacks and Donnenfeld, 1984). Continuity of care also means women are not subjected to conflicting advice (Hasslacher; Kitzinger; Mason, 1987; Strid, 1991; Zander et al., 1978), with Niven (1992) stating the home birth places couples in a position of power, in that they are in a situation whereby they can reject advice if they so wish without the negative effects that such rejection might bring in an institutional setting.

Finally, Simkin's (1991) study on the long-term effects of giving birth (all of which took place in United States hospitals 15-20 years previously,) found that all women interviewed remembered the way staff behaved and the things they said. She concluded that it was important caregivers realised that there was the potential for psychological benefits or damage to occur at all births and that the intense memory which women held about the event would be an important element in how she perceived and valued herself in the future.

DISADVANTAGES OF HOME BIRTH

Because the above discussion focuses on the reasons why women wish to have a home birth, it could be considered a one-sided view. However, from the literature it is clear that women having home births do see it in overwhelmingly positive terms.

It could also be argued that there are some disadvantages to having a baby at home (Abel and Kearns, 1991; Campanella, Korbin & Acheson, 1993; Chamberlain, 1988; Staff, 1994, March; Kitzinger, 1978; Kleiverda et al., 1990). The most obvious disadvantage is that the home is the site of domestic activities and responsibilities, still predominantly women's domain (Abel and Kearns; Campanella et al.; Zander et al., 1978). Related to the possibility women may continue to have to take care of other children and domestic activities is the notion of lack of rest.

Lack of rest is considered to be another disadvantage to home birth, although this is in no way straightforward. In her Manawatu study McSherry (1986) found that approximately one-third of her hospital sample experienced tiredness while in hospital. She noted that, "Tiredness/lack of sleep were the commonest physical complaints experienced by mothers. No mother said her baby was responsible for her tiredness" (p. 125). Rather the most common causes were being disturbed

due to lights, noise or other people. Kitzinger (1978) found that, although one out of the sixty-five women in her home birth sample did feel they lacked rest, the women generally felt that they received more rest at home than they would have in hospital.

One big disadvantage of home birth revolves around the possibility there may be problems in a labour and women may have to transfer to hospital. Hasslacher (1988) notes that there is no difference between transferring a woman (in New Zealand) from a secondary maternity unit or from home as domiciliary midwives carry the same resuscitation equipment. Clearly there is a difference for the women concerned in terms of their expectations and, possibly, in the attitudes which they encounter once in hospital.

In terms of the likelihood of transfer, Staff (1994, March) estimated that there is approximately a 10% chance of transfer. This estimation is supported by the national home birth statistics for 1993 (preliminary analysis) which gives a transfer rate of exactly 10% (Staff, 1994, November). Statistics show, however, that the majority of transfers are due to failure to progress rather than emergency situations. When unexpected complications do arise, though, research suggests there may be higher mortality and morbidity rates (Chamberlain, 1988).

One of the reasons for the rate of transfer, and to some women a serious disadvantage of home birth, is that fewer pain relief options are available for women giving birth at home. Generally domiciliary midwives rely on 'natural' methods of pain relief, such as acupuncture or homeopathy, the use of hot and cold water and compresses, massage, touch and psychological support (Staff, 1994, March).

Another possible disadvantage to home birth, or in fact in any one-on-one situation, is that a woman may have a poor relationship with her midwife (Kitzinger, 1978). Having access to another midwife or midwives should this happen, would be desirable. While poor midwife-client relationships could occur in some areas of New Zealand where only one domiciliary midwife is practising, this situation should be balanced against the likelihood that the same could also occur in hospital. The advantage in the hospital setting would be that the disliked midwife would not be the sole carer for the woman.

Kitzinger (1978) also notes that difficulties can arise if a woman's midwife has already been called away to another birth when the woman rings, and another midwife replaces her. While this

is true, again the situation needs to be compared with the hospital system whereby women do not generally know their midwife anyway.

For some women there may be potentially serious disadvantages to home birth for themselves, their babies or both. The problem is in identifying who falls into this group and various risk scoring systems have been used in an attempt to do this. Moore (1978) outlines some of the factors that he believes need to be considered. For example primigravidae over 30 years of age, multigravidae over 35 years of age, women with medical disorders, previous operations on the uterus, previous low-birthweight babies, and so forth. Moore views such factors as guidelines rather than hard and fast rules and states that they should be interpreted in conjunction with all the information about the mother and her environment. In New Zealand Bonham (1982) included all women expecting their first baby and all women over 30 years as high risk and believed that their care should be provided by specialists rather than GPs (midwives are not mentioned).

Chamberlain (1988) considers the debate over home and hospital birth in broader terms and points out that those who argue against home birth do so due to their concern about, "Unpredictable hazards that may arise, even in the best screened populations" (p. 772). A study by Dixon (1982, cited Chamberlain) found that 5% of the women who delivered in hospital but who were eligible for a home birth would have endangered themselves. Another 4.3% had babies that needed immediate attention. Therefore, Chamberlain felt these figures represented the degree of hazard which low risk women and their babies faced in having a home birth.

However, it was also noted that the most common problems were post-partum haemorrhage for mothers and resuscitation of the baby. Given that New Zealand domiciliary midwives carry drugs in case of haemorrhage and oxygen for resuscitation, the usefulness of these British figures is debatable. For example, Chamberlain (1988) notes that a nation-wide survey found that in only 28% of cases intravenous sets and fluid was carried as part of the equipment for a home birth. Palmerston North domiciliary midwives state that they always have such equipment and that the New Zealand College of Midwives recommends that all domiciliary midwives carry such equipment. The policy of always having two health professionals at a home birth is also to ensure that if problems arise both mother and baby will have the care of a health professional (P.J. Baken, personal communication, November 18, 1994). However, this practice is not necessarily followed in all areas of New Zealand, in some areas two health professionals are not always in attendance at a birth (P.J. Baken, personal communication, November 18, 1994).

One other possible disadvantage which is not stated in the literature concerns the negative comments and attitudes that women can encounter when they tell others they are planning to have a home birth. These can be from acquaintances, friends, relations or medical personnel who believe home birth endangers the life or well-being of the baby. Unless a woman is socially isolated from positive comments, or has not thoroughly considered all the issues involved, she is unlikely to change her mind in the face of negative remarks, although if the comments are from someone close to her she may well be upset. Negative remarks from medical personnel may be harder to counter, but as Zander (1984) notes, it is, "Presumptuous and inappropriate for medical personnel to suggest they are more concerned about the outcome of the pregnancy, the health and well-being of the mother and baby, than she is herself" (p. 129).

Zander et al. (1978) cite the following advantages and disadvantages for home and hospital birth:

HOME

Familiar setting.

Baby unlikely to be separated from mother.

Mother and baby surrounded by family

Physical rest may be restricted by household demands, especially if other children are at home.

No opportunity for comparison with other mothers and babies.

Mother under the care of those she has established a relationship with.

Mother can do what she likes when she likes.

HOSPITAL

Unfamiliar setting.

Baby likely to be separated from mother.

Mother and baby separated from family

Mother can rest well having no responsibilities but rest may be disturbed by ward routine and the presence of other babies.

Mother may feel influenced by comparing the performance of herself and her baby (e.g. sleeping, eating patterns).

Mother under the care of professionals she has previously had little contact with.

Mother tends to have to conform to ward routine.

No inherent conflict between mother and midwife, who will tend to be orientated to the mother's needs, whom she tends to regard as an individual rather than one of a group. Mother less likely to be viewed as a patient.

Advice usually given by one or few, hence is less likely to be conflicting.

Medical advisers (eg G.P.) see this as the start of their continuing care.

Potential conflict between nursing staff and mother: 1) over "who knows best" for mother and baby 2) as post-natal ward does not fit the usual model of the hospital in that patients are not sick.

Advice often given by several advisers, hence is frequently conflicting.

Medical advisers see this as the end of the process, following which they'll have no continuing care.

A recent article on New Zealand childbirth choices in the magazine "Consumer" (Staff, 1994, March) outlines the different advantages and disadvantages of the various care options. It is stated that, "One of the main advantages of home birth is that you get to build up a good relationship with your midwife; this in itself can make labour easier. Being at home can also help you feel more relaxed" (p. 7). The main disadvantage is seen to be reduced pain relief options and it is noted that approximately 10% of women will have to transfer to hospital.

Having a hospital birth with care from an independent midwife also gives the advantage of continuity of care and it is suggested that many women may feel more secure in the hospital environment. Suggested disadvantages are that hospital lacks the "home comforts" of a home birth and that if complications occur at a small community hospital women will be transferred to a larger one.

Shared care between a doctor and independent midwife is noted as being a popular choice. The main advantage of this being that women receive continuity of care from their midwives while still maintaining their relationship with their family GP. It is pointed out that a potential disadvantage is if a midwife and doctor disagree and cannot work cooperatively together.

The "Consumer" (Staff, 1994, March) article states that the most common choice is the traditional arrangement of care from the family doctor with hospital midwives providing care during labour, delivery and post-partum, under the supervision of the GP. The advantage is that women already

have an established relationship with their doctor. The disadvantage, that women are likely to be looked after by several different midwives none of whom they are likely to know.

Private specialist care is seen to provide the advantage of having an established relationship if complications arise, the disadvantage being cost. It is pointed out that free specialist care is provided in emergency situations however, and that the majority of women do not need to see an obstetrician during pregnancy.

SATISFACTION

It could be argued that a satisfying birth is one which ends with a healthy mother and baby. However, since that is the norm it is also important to consider what constitutes a more or less satisfying experience and how women's birth experiences can be enhanced.

Chamberlain (1988) comments that women's satisfaction with childbirth is "terribly" important, while Rothman (1985, cited Livingston 1987) notes that, "A birth that leaves wives angry at husbands and husbands feeling they have failed their wives is *not* the same as a birth experience that draws the two closer together" (original emphasis) (p. 258). It could also be argued that a birth that leaves a woman feeling frustrated, incompetent, powerless and unsupported by whoever attended her, can never be viewed as satisfactory, however grateful and satisfied she might be concerning her baby's well-being. Such a situation can also affect maternal-infant interactions (Green et al., 1988; Mercer and Marut 1981; Niven, 1992).

It is also the case that there are problems in defining and measuring satisfaction. In fact often studies do not define satisfaction at all, which means that it must be interpreted somewhat differently by different women and different groups within a culture, (let alone between cultures).

While this situation is obviously not entirely satisfactory, it can also be assumed that different individuals within a culture do hold at least some components of a concept in common, in which case it would be foolish to disregard studies that use the word in a common sense sort of way.

Green et al. (1988) suggest four difficulties in measuring satisfaction. Firstly, women generally feel relieved, grateful and positive after the safe delivery of a healthy baby and they tend to be "loyal" to their own birth. Secondly, people have a need to rationalise adverse experiences which makes dissatisfaction more difficult to detect. Thirdly, as assessment often takes place when

women are in hospital they may link the researcher to the hospital and tend not to be critical. Lastly, research questions are generally closed rather than open-ended in nature.

The difficulties of gaining an accurate picture of satisfaction are highlighted by one finding of McSherry's (1986). She found that five women who said that they "couldn't get home quick enough" after the birth also said that they "wouldn't change anything" about their hospital care (p. 78). McSherry suggests that these contradictory statements might be due to either a reluctance to criticise services or a low expectation of services.

As has been noted in the section on the importance of information, women's feelings of satisfaction are related to whether they feel they have received enough information and information that is not confusing or misleading. This was particularly so for the working class women in Green et al. (1988) study, for whom a major source of dissatisfaction was the lack of information received from staff.

Another important variable associated with satisfaction is perceived control. Green et al. (1988) found a strong linear relationship, while other researchers state that it is a key component of satisfaction (Hodnett and Osborn, 1989; Romito, 1986). As was stated in the section on control, women's perception of having participated in decision making and having control over what staff did to them form critical components of control, and hence of their degree of satisfaction or dissatisfaction (Bassett-Smith, 1988; Green et al.) As Green et al. note, this reflects how care is provided rather than what is actually done.

The consequence of that is that satisfaction with staff is crucial to women's feelings of satisfaction with childbirth. If women feel they lack information, input into decision making and control over what happens to them, clearly they will feel dissatisfied. McSherry (1986) noted that satisfaction was more influenced by the quality of emotional support which women received and by their active participation in the labour process than by the difficulty of the labour or level of intervention they experienced. Similarly Green et al. (1988) found that women who saw staff in positive terms were more satisfied, and this seems to be particularly the case when women have the same midwife in continuous attendance throughout the labour and delivery (Bassett-Smith, 1988; Jakobsen, 1991; Kitzinger, 1978).

Satisfaction is also linked to the presence of partners, including their presence during caesarean birth, and for the presence of chosen support people in general (Affonso, 1981; Bennett et al., 1985; Cunningham, 1993; Green et al., 1988; Niven, 1992). Similarly, partners satisfaction is also greater when they are present at their baby's birth (Affonso; Peterson et al., 1979).

Since chemical pain relief is not available to women planning home birth it is interesting to note that effective pain relief is not associated with satisfaction as may be expected. Rather, there tends to be an inverse relationship between satisfaction and the use of chemical pain relief (Green et al., 1988; McSherry, 1986; Morgan, Bulpitt, Clifton and Lewis, 1982), with Morgan et al. finding that epidural analgesia was the most effective form of pain relief but 16% of women receiving it expressed dissatisfaction compared to 8% of women who received no analgesia at all. Similarly Green et al. found that the most satisfied group of women were those that used no drugs, followed by women who used only gas and air.

Regarding intervention, it is hardly surprising to find that research shows dissatisfaction to be associated with it (Bassett-Smith, 1988; Green et al., 1988; Jacoby, 1987; Morgan et al., 1982). Green et al. found that both minor and major interventions were significantly related to satisfaction with birth, and that the number of interventions was also associated, the more interventions the less satisfied women were likely to be.

It would also appear that the timing of interventions affected satisfaction. For example women whose membranes ruptured spontaneously were more satisfied than women whose membranes were broken artificially, but when artificial rupture of the membranes (ARM) was performed women were more satisfied when it occurred later in labour (7 or more cm dilatation of the cervix) than earlier in labour. In addition when women took part in discussion with staff about ARM and reached a mutually acceptable decision they tended to be more satisfied. This links with Jacoby's (1987) findings that women are more likely to be dissatisfied if they experience a procedure they did not want.

It is interesting to note, though, that Green et al. (1988) found that, in general, fewer women questioned the need for major interventions compared to minor. They believe this could be due to two reasons. Firstly, because women were more likely to be given a plausible reason for major interventions. And secondly, that cognitive dissonance theory would predict the more major the intervention the more women would feel the need to believe it had been necessary.

That aside, those experiencing major interventions did tend to express less satisfaction. For caesarean birth, an elective procedure was associated with greater satisfaction compared to women experiencing emergency caesarean. And for emergency births both the length of time women had to prepare themselves for the caesarean and the use of epidural rather than general anaesthetic (GA) were important. Having little time to prepare oneself and having a GA were associated with greater dissatisfaction.

Regarding satisfaction and home birth Cunningham (1993) found that satisfaction with midwives was higher for the home birth mothers than either the Alternative Birth Centre or hospital mothers, and that satisfaction with midwife and support people could be predicted by the proportion of time they were present. In New Zealand satisfaction expressed by women giving birth at home appears to be high (Abel and Kearns, 1991; Bassett-Smith, 1988; Hannah and Davis, 1990; Jakobsen, 1991; Pratt, 1990), with the New Zealand Nurses Association (1988) stating that, "Consumer satisfaction with home births is incredible" (p. 23). In a survey by Hannah and Davies of 27 Dunedin women who had given birth at home the following results were found, "On a satisfaction scale of 1:5, with '5' indicating 'most satisfied', 19 women circled '5', four '4', two '3', one each of '2' and '1'" (p. 17).

That is not to say, however, that only women giving birth at home are satisfied. New Zealand research by Crothers and Allan (1985) found that nearly 70% of women were "very happy" with the help, care and attention of the delivery suite staff, with 89% of primiparas finding hospital a good experience. Women were less happy with their postnatal care though. Some reasons given being that nursing staff made them feel intimidated and inadequate and did not provide adequate information.

For Maori women satisfaction appears to be reduced however. Ratima et al. (1994) found that only 57% of the Maori women they surveyed gave hospital staff a rating of "good" or "very good". They also noted that 12 women (40%) had an "unacceptable experience when in hospital" (p. 16). Some of these were medical (such as having a caesarean or ARM,) but the majority related to staff attitudes and behaviour. For example, the manner of some staff and the lack of courtesy to the Maori way of doing things. They state that, "Existing mainstream services should offer maternity services which are culturally appropriate and culturally safe", (p. 22) and note that presently services at times fail in this regard.

If women are satisfied it is to be assumed that they would choose the same birth location again if they were to have another child. Homebirth Australia (1993) found that almost all their sample would choose home birth again, while MacFarlane, Smith and Garrow (1978) (Great Britain) found that 80% of their sample who had experienced both home and hospital birth preferred birth at home. New Zealand studies support these high figures, with all the women Abel and Kearns (1991) interviewed saying they would choose home birth again, and Pratt (1990) found that more women having a home birth would choose that location again compared to women giving birth in hospital.

CONCLUSION

A review of the literature suggests that information is central to informed decision making. Health professionals generally do not meet women's desire for information even though information has positive effects in terms of women's adaptation to labour, birth and motherhood. It also reduces anxiety and increases control and satisfaction.

While the reasons women decide to have a home birth are varied, the literature suggests some are held in common by the majority of women. Issues such as the desire to remain in control, to avoid interventions, to have continuity of care, to promote family bonding and breastfeeding, and for birth to take place in a familiar and relaxed environment amongst selected family and friends are generally the dominant concerns. (They may also be viewed as prominent advantages to birth at home.)

As a reason for choosing home birth, control is especially important, particularly external control. Again, information is central to informed decision making, and hence control. Women wanting to birth at home often believe control is more easily maintained in the home, but what research illustrates is that the attitudes and style of care which women receive from health professionals are critical to whether they can retain feelings of control. Being at home does enable women to actively select who will be present and to discuss issues of concern, and so in that way home can be a place whereby control is better maintained. Feelings of control are also associated with more positive psychological outcomes.

Having an established relationship with a midwife and receiving continuity of care are also prime reasons why women choose home birth. These enhance women's feelings of support and satisfaction and form key components of effective care for New Zealand women having home births. The presence of social support is associated with better outcomes and greater satisfaction for mothers, along with shorter labours, less interventions and better outcomes for babies. Such beneficial outcomes are found with social support from both partners and other lay support people, and from midwives and other health professionals.

Disadvantages^{to} home birth are seldom mentioned by women. However, disadvantages would include negative comments by others about home birth, the possibility of transfer when in labour and fewer pain relief options. Some health professionals would also argue that risk factors may constitute a serious disadvantage for some women having a home birth. Post-partum, the major disadvantage remains women's domestic and childcare responsibilities.

Lastly, satisfaction is of concern, not because women generally express the desire for it, but because it is important that services are satisfactory and that such a significant event is not marred by dissatisfaction. Satisfaction is linked to both the provision of information and to women's feelings of control. It is also influenced by the support women receive from both their partner (or other companion/s) and health professionals. Again, the style of care from health professionals is critical. Intervention tends to reduce satisfaction, as does using drugs for pain relief. Women giving birth at home generally express high levels of satisfaction and the majority would use the same birth location again if having another baby.

Chapter 5 Methodology

"Our intention is to share, not prove, our observations."

(Belenky et al., 1986, cited Stiles, 1990)

INTRODUCTION

For many decades psychological research relied upon the empirical method of investigation derived from other forms of science. Stiles (1990) notes that the empirical tradition has not always been appropriate to the research which psychologists undertake and that, at times, psychological research using such methodology has not been as successful as anticipated. Such concerns have led to increasing objections from within psychology, a situation which has occurred in other disciplines also.

Similarly, Gergen (1991) states that there is a "sea change" occurring in psychology with empiricist assumptions being "under severe, if not lethal, attack" (p. 14). Gergen then notes there are "significant competitors to replace empiricism" (p. 16) and goes on to discuss some of these alternative traditions.

While qualitative research is a fairly recent, and to some extent still controversial, method of research in psychology, it does have a longer tradition within some other disciplines. For example, the ethnographic and field study traditions of anthropology have relied on qualitative methods (Patton, 1980). It should also be noted, however, that qualitative and quantitative methodologies are not mutually exclusive or incompatible and it has been suggested that they are, in fact, complementary (Beck, 1990; Stiles, 1990).

Beck (1990) describes qualitative research as, "A systematic, subjective approach which is used to describe life experiences and give meaning to them" (p. 194), and similarly, Ramos (1989) says the value of qualitative research is that it can, "Ascertain personal meaning and other non-quantifiable subjective realities" (p. 58). Stiles (1990) notes that in trying to quantify human experience the experiential quality of it is lost. To avoid this he suggests that experience should be reported and interpreted contextually, a point of view shared with many researchers (Beasley, 1993; Gergen, 1991; Karlsson, 1992; Unger and Crawford, 1992; Wilkinson, 1986).

In Karlsson's (1992) view mainstream academic psychology has put subjective, meaningful experiences of the world in second place to natural-scientific descriptions of the world, and he proposes that the reverse should be the case. Along with others (such as Roberts, H., 1981; Stiles, 1991; and Tseelon, 1991) he also notes that all research has a cultural context, and subjective aspects, while Gergen (1991) believes that psychologists should take an "active role in exploring successors to empiricism" and encourage self-reflexive analyses (p. 13).

RELIABILITY AND VALIDITY

Marshall (1986) believes there are three criteria for assessing the validity of qualitative research. Firstly, how the research is conducted. This includes issues such as researchers' awareness of their own perspectives and the influence of their perspectives on their research, their awareness of the processes they used, and how they conducted themselves. Secondly, researchers' relationship to the data, such as whether their levels of theorising are appropriate or complex enough, and whether they have explored alternatives. Thirdly, there is contextual validity. This considers the relationship of research to other work, whether the research is viewed in context, whether it is useful, and whether it is recognisable by those that were studied.

Stiles (1990) states that reliability in qualitative research can be considered in three ways. Firstly, by examining whether participants say the same thing. Secondly, whether participants give consistent answers to questions which are worded differently, and thirdly, whether they "tell the same story on different occasions" (p. 27).

Stiles (1990) then gives seven forms of validity:

1. Testimonial validity - to find out if an interpretation is valid, the researcher should ask the people whose experience it purports to represent.
2. Triangulation - this involves seeking information from multiple sources, with multiple methods and multiple prior theories or interpretations, and then assessing convergence.
3. Coherence - or the apparent quality of the interpretation. This includes: a) internal consistency, b) the comprehensiveness of the elements to be interpreted and the relations between elements, and, c) the interpretations' usefulness in encompassing new elements that arise.

4. Self-evidence; Uncovering - this concerns the question of whether what was uncovered during the research answered the question(s) asked, or provided an answer or solution to the problem that initiated the research. Also, does the research "make sense"? Does it "feel right"?
5. Consensus among researchers - the ability of the research to convince other researchers of different perspectives. Stiles (1990) notes that this can be problematic.
6. Reflexive validity - is concerned with how much the theory is changed by the data. That is, whether it evolves with new information.
7. Catalytic validity - this is the degree to which the research process re-orient, focuses and energises participants. That is, if a theory is valid it will impact on the people whose experience it describes. As such it can be an empowering force.

THE CURRENT STUDY

Bassett-Smith (1988) states that the experience of childbirth is supremely important to most women, "Not merely as an event in their life, but as a cultural experience that has far-reaching ramifications for a woman's feelings about herself and for her transition to motherhood" (p. 1). Certainly it is an event which can stir-up powerful emotions, and the impact of these can have long-term consequences.

This being the case it seemed possible that the topic and experience of home birth could also be emotive and also that the range of beliefs that women held would not be easily captured through anything other than fairly open questioning. Having already accepted that human experience cannot be truly captured by predetermined categories and knowing that qualitative research provided a means by which it could more accurately be portrayed, it seemed obvious that this research would, of necessity, be qualitative in nature.

It was also decided that the research must be easily accessible to the women interviewed, even if at times this violated the academic conventions of psychological writing. Consequently, personal pronouns will be used throughout the thesis. Such an approach would appear to have a greater acceptance now than in the past, partly due to the different approach taken by feminist researchers. Some psychologists also believe the time has come for a debate into current conventions. To quote Gergen (1991) at length,

What, for example, are the rhetorical advantages (or disadvantages) of the standard use of the passive voice, the omission of the first person singular pronoun, the absence of emotive language and the use of statistics and citations? In what sense is it legitimate to speak of the aesthetics of a psychological writing? At a time in which psychological research, as a genre of writing, no longer seems capable of compelling an audience larger than the self-interested, attention to matters of rhetoric seems essential (p. 23).

The decision to use qualitative methodology was further advanced by the belief that the relationship between myself and the women I would study would be crucial to the depth of material gathered and that the development of good relationships was dependent on an openness and trust by the women, and by the establishment of a reciprocal relationship between us. Ramos (1989) notes that qualitative research generally means relationships are not distant and the fact that interviews usually take place in the respondent's home means that the knowledge and power balance changes, with the respondent retaining considerable power and autonomy within the relationship. And, further, that this encourages openness while preserving individual realities.

Given the depth of material which could be obtained it was also important to bear in mind my responsibility to protect respondent's welfare, as Ramos (1989) comments, the "goals of research can conflict with the goal of preserving privacy" (p. 60). Given the small number of women interviewed and the small number of women giving birth at home in the Manawatu this was particularly important. As a consequence all people identified in the report have been assigned pseudonyms. To protect midwives and doctors identities the same pseudonym has been used for all midwives (Margaret) and another for all doctors (Richard). (A total of five midwives and four doctors were involved in the care of women for their pregnancies, births or both. All the doctors were male.) The domiciliary midwife who is also a respondent has two pseudonyms, the midwife pseudonym and one for her role as an interviewee. That she could easily be identified (in her role as a respondent) by people (including fellow health professionals) due to details of her family and because she was the only domiciliary midwife to have a baby herself in 1994, was discussed between us. Her decision was still to participate in the research.

It should also be noted that the nature of the research and the qualitative method has resulted in a large volume of material being gathered. A decision was made that in order to preserve the fullness and richness of what women said, they would be quoted liberally. While this has resulted

in a lengthy thesis, it is hoped that length is countered by the greater meaning which the liberal use of quotes has resulted in.

MODELS OF CHILDBEARING

One issue that is at the heart of the choice to have a home birth, but which is not often referred to explicitly by those choosing home birth, is the way in which childbearing is viewed. In the literature this is represented by two differing models of childbirth, the midwifery model and the medical model (also called the biomedical model and sometimes the science or technocratic model) (Bassett-Smith, 1988; Beasley, 1993; Cunningham, 1993; Kitzinger, 1991; Kloosterman, 1978; Livingston, 1987; McSherry, 1986; Myers-Ciecko, 1991; Oakley and Houd, 1990; O'Connor, 1993; Page, 1991; Roberts, 1981; Rothman, 1982; Tew, 1990). It was thought that the women being interviewed for the current study would most likely subscribe to the midwifery model.

These two models illustrate the differing philosophies surrounding birth. Hence, they will be outlined in order to come to some sort of understanding of the philosophy which underlies the home birth movement, both here and overseas. The medical model continues to be the dominant one, which is reflected in the increasing medicalisation of people's lives. In the case of pregnancy and birth this means that what can be perceived as a physiologically normal and healthy process is viewed as a medical event. It should also be noted, however, that not all doctors and obstetricians would agree with all the aspects of the medical model, just as not all midwives would necessarily share the philosophy of the midwifery model.

The medical model

The medical model essentially sees pregnancy and birth as a time of intrinsic danger, and consequently, the process is a medical one. As such it requires medical services, medical expertise and medical technology. Professional surveillance and management is promoted in the interests of the safety of both the mother and baby (O'Connor, 1993). This means that the traditional doctor-patient relationship exists, with the woman becoming a passive, but cooperative, patient (McSherry, 1986). Responsibility and decision making lie with the doctor, as for any other illness (the underlying assumption being that the childbearing is an illness) (Rothman, 1982).

The view of the relationship between mother and baby is akin to that of parasite and host, or alternatively, the mother is viewed as a "vessel" in which the baby grows (Rothman, 1982). Hence, the relationship between foetus and mother is seen to be at odds, with the mother and baby having differing needs and the baby requiring an advocate other than its mother (Oakley and Houd, 1990). The process of pregnancy and birth is viewed as a particular, isolated medical event and the woman is viewed in terms of her specific medical condition (i.e. pregnancy) rather than as a holistic being (Roberts, 1981). Or, as Macintyre (1977, cited McSherry, 1986) states, "Pregnancy and childbirth are [...] relatively divorced from social and psychological context" (p. 6).

At the core of the medical model, though, is the notion of risk. Certain factors are seen as increasing the danger to both mother and child. These factors are generally personal rather than situational, such as age and parity (Oakley and Houd, 1990). As Oakley and Houd (1990) note, many different risk scoring systems have been used but there have always been problems with the accuracy of them and there is also a problem with the expanding definition of high risk. For example, Smulders and Limberg (1991) note that between 1971 and 1979, at a time when public health improved in the Netherlands, the percentage of women with medical indications in pregnancy rose from 26% to 46%.

This concern with pathology extends to the labour and birth, with a birth being judged normal only in retrospect. In effect the medical model suggests that doctors and obstetricians must be ever alert to the abnormal, as the unexpected might well happen. Consequently hospital is seen to be the location best able to provide optimal care (McSherry, 1986). Clinical intervention may also be viewed as the best way to maintain a degree of control over labour and as a form of 'treatment' for labour.

In keeping with this viewpoint is the medical model's use of fairly rigid sequences and timeframes. Labour and delivery is organised into three stages, (the first being the dilation and effacement of the cervix, the second the passage of the baby through the vagina and its birth, the last being the delivery of the placenta,) with each stage having an ideal sequence of events and timeframe. These are based on norms developed over the years and departures from these are viewed as complications and as threatening the well-being of the baby. As such they may require intervention/s (O'Connor, 1993). The problem with these timeframes is that women who take

longer than the norm are deemed to have an abnormal labour, which ignores the fact that both longer and shorter labours were used to arrive at the norm in the first place.

As the physical experience of childbirth tends to be viewed negatively, reducing or removing such experiences from consciousness is perceived positively (Macintyre, 1977, cited McSherry, 1986), hence the widespread use of chemical pain relief.

The midwifery model

The midwifery model proposes that pregnancy and birth are normal events and natural states and that the majority of births are inherently safe (McSherry, 1986; O'Connor, 1993; Roberts, 1981). Along with the belief that birth is a normal event is the acknowledgment that it is also an event of considerable significance in the life of the family. As such birth is a social, family and biological event rather than a medical one, and it brings with it important emotional changes for the people involved (Flint, 1991; Oakley, 1984). As Kitzinger (1991) notes, the midwife is concerned with the physical aspects of birth, emotional changes, the social context of birth, women's experiences of the event and with medical events.

The concept of risk is still applied within the midwifery model, but it tends to be applied somewhat differently, with greater emphasis on antenatal care factors such as diet, exercise, personal knowledge, attitude and lifestyle. Consequently the responsibility for antenatal care and for preparation for the birth lies with the mother, and pregnancy and birth are viewed in a holistic manner rather than as an isolated medical event (McSherry, 1986; O'Connor, 1993). Mother and baby are also viewed as an "organic whole", so that if the needs of one are met so are the needs of the other (Rothman, 1982).

The midwifery model also divides the labour and delivery into the same three stages, but allows greater flexibility within these stages. The belief is that every labour is unique in its specific timing, the details of progress and its character (O'Connor, 1993). Consequently what is seen as 'normal' is wider. In particular the midwifery model advocates the importance of not setting time limits, but rather of patience and vigilance (Barrington, 1985).

Another significant difference between these two models is the importance which the midwifery model places on continuity of care, from the early stages of pregnancy until two (or more if

needed) weeks post-partum (Barrington, 1985; Oakley and Houd, 1990). This continuity is believed to allow for a trusting, compassionate relationship to develop, which results in midwives being sensitive to the mother's needs, giving effective emotional support when needed and being able to respond to the specific and changing needs of a client such as ethnic, spiritual or religious needs (Oakley and Houd, 1990). The relationship between mother and midwife is also one of equality or partnership, with women being encouraged to make decisions (McSherry, 1986).

The giving of information and the acceptance of subjective as well as objective knowledge as reliable and valid are also components of the midwifery model (Oakley and Houd, 1990; O'Connor, 1993). The midwifery model also proposes that the natural course of labour should be interfered with as little as possible and interventions avoided as much as possible (Barrington, 1985; O'Connor, 1993). Emphasis during labour is on supporting the mother who is encouraged to be an active participant in the process and to adopt positions which are most comfortable for her.

Finally, the process of childbearing is seen to be a positive and fulfilling experience, particularly when women are fully involved and active during all stages of it (McSherry, 1986).

WOMEN'S ATTITUDES IN RELATION TO BIRTH LOCATION

The belief that the women I interviewed would hold views in accordance with the midwifery model was supported by other studies that examined women's attitudes towards childbearing and birth location.

Klee's (1986) United States study looked at differences in attitude between women choosing to give birth in Alternative Birth Centres attached to hospitals and those having a home birth. She concluded that the two groups had different beliefs about childbirth. The Alternative Birth Centre women did not fundamentally question or reject current (dominant) notions of birth and believed in the authority of modern obstetrics and the expertise of doctors. That is, they essentially choose a less technical hospital birth. Alternatively, the home birth women were more critical and sceptical of the medical model of childbirth and had a distrust of hospitals. They did not expect anything to go wrong, but believed that if it did they were as close to medical aid as was necessary.

Similarly Pratt (1990) notes that, "Home birth advocates have rejected the definition of pregnancy and birth as an illness. They have not considered birth to be a pathological process filled with risk and danger needing active management by medical professionals" (p. 5). Pratt's New Zealand study found significant differences in the attitudes of home and hospital groups in regard to perceptions of risk attached to childbirth, the acceptability of interventions, anxiety about the birth, and feelings of confidence in ability to care for the newborn. However, risk was found to be the most powerful factor and the only predictive one. Pratt found that perceptions of risk could be used to classify women into the home or hospital group with a 94% level of success.

Pratt (1990) and Cunningham (1993) both suggest that women giving birth at home include in their concept of risk physical safety and psychosocial aspects of the birthplace. Alternatively, women giving birth in hospital define risk more narrowly. That is, their definition of risk is focussed on physical safety and does not include psychosocial factors.

RECRUITMENT OF PARTICIPANTS

There were three ways in which participants were recruited for the study. The first was the placement of an advertisement in Whanautanga, the MHBAs newsletter, for the December 1993 and February 1994 issues (see appendix 2). I also attended MHBA meetings and spoke briefly about the research and asked any interested women to either speak to me or take an Information Sheet (as in appendix 3) and ring me if they wished to participate. The third method, and the most successful, was through domiciliary midwives. I attended a fortnightly midwives meeting, where home birth midwives discuss issues of concern to them, and talked to them about the research and answered any questions. The midwives were given Information Sheets and asked to give them to clients with suitable dates (i.e. women who were not over 32 weeks pregnant already). Midwives were also requested to make it quite clear to their clients that the care which they received from their midwife would not be affected by whether they participated in the research or not.

Typically women rang and said they were interested and a mutually suitable time to meet was arranged. If participants did not already have an Information Sheet they were given one at the first interview and any questions were answered. Two Consent Forms were also signed, one of which they kept and one of which I kept (see appendix 4).

Two pilot interviews were conducted prior to the commencement of data collection. Firstly with a woman who had had her fourth child at home about six months previously. Following her interview the questions were radically revised and a second pilot interview was conducted. This was with a woman who had had both her children at home, one being aged four and the other two.

As interviewing progressed I revised the third interview questions so that I replicated other relevant aspects of other studies, (mainly British,) in an attempt to elicit some cross-cultural data. (See appendix 5.)

THE INTERVIEWING PROCEDURE

Interviews were taped and then transcribed as soon as possible after being conducted. Although significant portions of interviews were fully transcribed, other parts were condensed and summarised. Interviews were then studied but not analysed in detail. This was to ensure that I was satisfied with the depth and breadth of material gathered. In the third interview additional questions were added to gain more information in particular areas.

Following the completion of a series of interviews (e.g. all first, second or third interviews) they were examined as a whole. Comparisons were made between the responses of women to the interview questions. That is, all women's responses to a given question were examined together. In addition the responses of individual women were looked at in a holistic way. This gave the opportunity to examine consistency and coherence in responses. When appropriate the responses of a woman to one question might be analysed and compared with the responses of another woman to a different question.

Comparison was also made between women's expectations (as expressed in the first interview) and experiences (as expressed in the second interview). Consistency of response between second and third interviews was also considered. This thematic analysis allowed the similarities and differences in the women's beliefs, perceptions, and experiences to become apparent. In addition, comparison was made with other relevant research.

Once all interviews had been written up and were in a near-final form women were given the opportunity to read and comment on the analysis. Due to the fact that she could (possibly) be identified the draft was initially given to the respondent who was also a domiciliary midwife.

This was to ensure that she was comfortable with what was written prior to the other respondents reading it. Similarly, this woman was also given the chance to read the entire thesis prior to publication to further give her the opportunity to change any part she felt uncomfortable with. She felt, however, that this was not necessary.

Pseudonyms were used in this draft form so women could easily identify whether a given comment arose from them or someone else. This process allowed women to discuss any issues that they believed were interpreted differently from what they intended. No changes were made for this reason. However, a fourth interview was conducted with one woman as her feelings about the labour and birth of her baby had completely changed in the months following the third interview.

Giving the draft interviews to women to read also gave them the opportunity to ensure that nothing was printed with which they were uncomfortable. Minor changes were made at the request of two women, with changes generally being made to increase anonymity. Some factual corrections were also made at this time. In general women said that they enjoyed reading the analysis of interviews and no concerns were expressed about the way in which interviews had been interpreted. Following this the majority of names (pseudonyms) were removed from the interview analysis (Chapters 6, 7 and 8). This was to provide greater anonymity.

RELIABILITY AND VALIDITY

Some forms of reliability and validity for qualitative research have been discussed earlier in this chapter. These will now be examined in relation to this study.

Throughout the process of the study I have been aware of my own beliefs and perspectives and how these might impact on the research. I have also been aware that since I have had home births my respondents might hold certain beliefs about my views on the subject. This would be particularly likely in the case of women I knew prior to the commencement of interviewing.

Throughout interviewing I have attempted not to put my views forward but, rather, to affirm respondent's views whether or not I agreed with them. At times I was asked for factual information by women and I responded to the best of my ability. Due to the nature of the topic, setting of interviews and intimacy which this type of interviewing can evoke, it was inevitable that

there was an exchange of experiences regarding pregnancy and childbirth between myself and women. As Swanson-Kauffman (1986) states, "While with informants, we shun the researcher-subject distinction and recognise the fruitfulness of our intersubjective copresence. It is later when home alone with the data that we strive for objectivity" (p. 69).

The results of the study indicate that it is supported by other relevant studies. The women interviewed also believed that it was true to their experiences and to what they had said. Some also stated that they believed it is important that the experiences of women giving birth at home are studied and that the interview chapters and quotes from women could be powerful and empowering for other women reading them.

While all women had slightly different perspectives there was a degree of agreement between them. Women were also consistent in their answers to questions, both within an interview and over interviews. In one case a woman had changed her perspective and this is outlined in Interview Three.

PARTICIPANT PROFILES

The participants are presented in the order in which the babies were born.

ROBYN

Robyn and her husband Ben were Pakeha New Zealanders. She was 30 years old at the time of the first interview, her husband being a year older. She had no history of stillbirths or miscarriages. Robyn and Ben were expecting their fourth child, with all the births having been planned home births. The eldest child had been born in hospital, however, and Robyn had briefly gone into hospital to have membranes removed after the birth of her third child. Their fourth child was born at home.

MARIA

Both Maria and Brent were Pakeha New Zealanders, Maria being aged 26 at the time of the first interview and Brent being 31. She had no history of stillbirths or miscarriages. Maria and Brent were expecting their third child, their first home birth. Their baby was born in hospital by emergency caesarean.

ANN

Ann and her husband Hans were expecting their fourth child. Hans was 34 at the time of first interview, Ann being one year younger. Ann was a Pakeha New Zealander. Hans was born in New Zealand and was of Dutch origin. Ann had no history of stillbirths or miscarriages. She was expecting their fourth child. The previous three births had all been home births, as was the birth of their fourth child.

KAREN

Karen was 27 years and her husband, Ken, 30 at the time of the first interview. Both were Pakeha New Zealanders, although Ken spent the first five years of his life overseas. Karen had no history of stillbirths or miscarriages. They were expecting their second child. Their first child had been a planned home birth but Karen had transferred to hospital in labour. Their second child was born at home.

PAM

Pam was 22 and Bruce 26 at the time of the first interview. Both were Pakeha New Zealanders, although Pam spent the first five years of her life overseas. Pam and Bruce were expecting their first child, and Pam had no history of stillbirths or miscarriages. They were receiving midwife only care as their doctor did not attend home births, although he had provided some care antenatally. Their child was born at home.

PAULINE

Pauline and her husband, Anthony, were both Pakeha New Zealanders, Pauline being 35 years old and Anthony being 33 at the time of the first interview. Pauline had no history of miscarriages or stillbirths. They were expecting their second child. Their first had been born at home, but had been transferred to hospital on day 5 due to jaundice. Pauline was having midwife only care for this birth. The baby was also born at home.

MIRIAM

Miriam was 37 and James 38 years at the time of the first interview. Both were Pakeha New Zealanders. Miriam had no history of stillbirths or miscarriages. Miriam and James were expecting their fourth child. All their children had been born at home, although their second child had been transferred to hospital after birth as he had inhaled meconium. Their fourth child was also born at home.

Chapter 6
INTERVIEW ONE - ANTENATAL DATA

"There is no one way of giving birth that is suitable for all women"
(Bassett-Smith, 1988, p. 4).

INTRODUCTION

This chapter is based on the material gathered in the first interviews and an examination of that material. (See appendix 6 for interview questions.) It is divided into eight sections, followed by a conclusion.

In the first section background details of the interviews are noted, such as length of time and where they took place. It includes demographic data on women and their partners. Also included is the type of antenatal care being provided in the current pregnancy, the presence or absence of antenatal preparation, and venues for the current births and any complications associated with the births.

The second section covers reasons the women decided on a home birth. These include the desire to retain control, the wish to avoid interventions, wanting continuity of care, so the birth would be a family event and that home was a familiar and relaxing environment.

Section three considers differences that the women believe exist between birth at home and in hospital. Many differences were concerned with the relationship between women and health professionals. Others include differing environments, differing amounts of responsibility, differences in stability of care and the special nature of birth being retained in the home.

Fourthly, the influence of other people on why women decided to have a home birth is considered. (The influence of partners is not discussed as it was assumed that the decision was a joint one. I believe this assumption to be correct as women did not talk of their partners except in terms of discussing issues together.)

The fifth section focuses on women's expectations of the coming labour and birth and comprises four parts. These are expectations of husbands, expectations of midwives, expectations of general practitioners or second midwives, and expectations of other support people.

Section six considers whether women had specific requests of those attending the birth and whether they had a written birth plan. Only one woman had a written plan but women usually did have specific requests of their midwives.

The seventh section discusses postnatal expectations and covers expectations of husbands, midwives and other health professionals, as well as other family and friends.

Lastly, any additional comments made by women are outlined. These include comments about previous hospital birth experiences, previous home birth experiences, ways of adjusting after the birth of a baby and the need to have a holistic perspective of birth.

BACKGROUND DETAILS

The first interviews took place between November 1993 and June 1994. They ranged from 25 minutes to 2 hours in length, with an average time of 52 minutes. All except one took place during the day, with women often arranging a time when other children would be at kindergarten or asleep. All also took place in the woman's home, bar one which took place at my house.

Initially the research was briefly outlined and each woman was provided with an Information Sheet (see appendix 3). Participants were asked whether they had any questions, and these were answered. The woman interviewee and I signed two Consent Forms (see appendix 4), one of which was kept by participants and one which remained with myself.

The first interview began with demographic data, such as age and occupation. Marital status was not requested but all couples appeared to be married, and all women used the word "husband" when referring to their partners. Women's ages ranged from 22-37 years at the time of the first interview, and partner's ages ranged from 26-38 years.

All the women were Pakeha New Zealanders, with one having spent the first few years of her life overseas. Their husbands were all New Zealanders, although one had spent the first five years of

his life in the United Kingdom and the United States. All were also caucasian, with one being of Dutch origin.

Women's occupations included a full-time mother, a vet, a social worker, two kindergarten teachers, a domiciliary midwife and one operator of a small home-based business. The partners' occupations included a technician, a coachbuilder, an assistant manager, a resource oncology nurse, a supervisor at a cleaning company, a fitter, and a manufacturer/exporter and part-time lecturer.

All couples except one had other children, with the ages of other children ranging from 2 to 7 years. Women ranged from 29 to 31 (complete) weeks pregnant. None had any history of stillbirths or miscarriages.

Three women were expecting their fourth child, one her third, two their second, and one her first child. The majority of those children had been born at home. Only two had been planned hospital births, although four had been born in hospital. Two babies had been transferred to hospital following birth, one almost immediately, one after 5 days.

So, of the 13 planned home birth babies 11 had been born at home and two had been born in hospital. Of the 11 born at home 2 had transferred to hospital following birth, and one woman briefly entered hospital following a birth to have membranes removed. These figures mean that a total of 5 home birth mothers or babies had used hospital services at the time of or shortly following a birth, although often the contact was of a short duration.

For the current pregnancy six women had the traditional arrangement of care shared between their family GP and their midwife. However, in two situations the midwife was the principal caregiver and in another case the GP provided only antenatal care, with two midwives being present at the actual birth. One woman received midwife only care.

The women had undertaken a variety of antenatal preparations. Some women had done nothing specifically, apart from talking with their midwife, as they were expecting third or fourth children. Three women mentioned reading and attending MHBA meetings, with two also either doing stretching, walking or swimming. One woman hosted Parent Centre classes for expectant parents. Pam, who was expecting her first child, mentioned Parent Centre classes, reading,

swimming and exercise classes. Two women also mentioned preparing their other children for the birth and new baby, but it is possible all women did this.

Of the study's babies, six were born at home, with none being transferred to hospital following birth. One woman (Maria) was transferred during labour due to foetal distress and had an emergency caesarean birth. Following discharge she was readmitted due to an infection in the wound, but she was the only woman to receive care from hospital sources.

WHY WOMEN DECIDED TO HAVE A HOME BIRTH

What is worth noting before beginning this section is that in response to the question on why they decided to have a home birth women often gave one or two prime reasons. However, the variety of reasons and the complexity of the whole subject was not obvious from this question alone. It is only by considering the whole interview that the complexities surrounding the reasons why women choose home birth is able to be considered. For example, often the perceived differences between home and hospital birth illustrated the women's beliefs about birth and its importance in their lives. Clearly, perceived differences were important in women's considerations of where the birth should take place, although they were often not mentioned as reasons why home birth was chosen. This is, I believe, because women tended to focus on a few main reasons for their decision. Their conceptual beliefs about labour and birth, and the holistic nature of those beliefs, were not drawn out by the question on its own. Consequently when discussing why respondents choose home birth I will consider interviews in their entirety.

Control Issues

As was noted in Chapter 4 control is frequently mentioned as one of the main reasons why women decide to have a home birth. Two women did not mention any issues of control. A further two mentioned it in terms of control over the atmosphere you could create and control over the environment. That is, control was used in a different sense to control over decision making.

For the other three women there were concerns about control over decisions. One noted that home meant that one did not have to "fight for what you want", but that you could "actually tie things down at home relatively well as to what you want". Miriam, who had a practice as a domiciliary midwife, chose home birth, "Firstly because I believed that it was the only way that I

was really going to be able to do what I wanted to do when I was birthing." She wished to retain the sense of being in control and to be significantly involved in decision making. She noted that when she first worked as a hospital midwife she believed that she would be able to get what she wanted from the hospital system (as a patient) because she was a midwife. After about five years of working in the system, however, she decided that the structure of the hospital system imposed a particular way of working which constrained women's choices and limited their control. Or as she said,

"It was the system, and people's attitudes within the system, that forced them to work in the way that they did."

It was as a consequence of such realisations that she became more interested in and committed to home birth, with it being the natural option when she was expecting her first child.

For Maria, the issue of control was extremely important. Her two older children had both been planned hospital births but had been three and four weeks early. In the hospital environment she had felt that she had no control and because her due dates were still a few weeks off she had also found that staff doubted her word that she was in labour. Consequently, for Maria the issues of having a degree of control over what happened to her, of being able to make some of the decisions and of being believed were all important.

The idea of retaining some control even if she could not achieve a home birth had been considered also, as she said, "Even if [...] I have to end up having it in hospital it means at least I'll have Margaret there." In this way she hoped to ensure that she would be believed regardless of place of birth and that she would not have to argue with staff about practices she felt were unnecessary, as occurred with her previous births. For Maria then control was the prime motivator for having a home birth, a desire sparked by unfortunate experiences within the hospital system when her two daughters were born.

This concern with control over the birth and decision making has been found in other New Zealand research on home birth. For example Abel and Kearns (1991) and Pratt (1990) found that the majority of women wished to retain control and saw home birth as being a means to achieve this. And, while only three of the women in this study discussed control in relation to decision making, it should be pointed out that by discussing issues with their midwife in the antenatal

period all women were in a position to outline their beliefs and wishes, and so have a degree of control over events.

Also, the desire to have some control over decisions was implicit in statements made by women. For example one woman believed that the home environment gave more freedom of choice, and another felt that in hospital there are set ways of doing things, while at home there was "give and take" and the ability to try different ways of doing things.

Such statements suggest that it is preferable to have choice and to try different ways, and that home allows you this opportunity (i.e. gives you a degree of control to do so). It could also be argued that for this to happen a reciprocal relationship between women and health professionals must exist. Consequently it may be that the relationship and the trust that existed between women and midwives was such that women did not feel an overt need for control, rather control was implied through the decision to have a home birth itself. Interviews 2 and 3 tend to support this conjecture.

All but one of the women interviewed had older children and all but one of these women had planned home births when having their other children (and all but two of those children were born at home). It is possible that none of these women experienced a loss or lack of control during previous births. This is probable given that feelings of control appear to be closely associated with good client-staff relationships and these are likely due to the established relationship between women and their midwives in a home birth situation. Hence, control over decision making and feelings of control may be viewed as 'givens' in the home environment, both due to the environment and due to the trust and knowledge of each other which develops between women and midwives.

This would also explain why the two women with the most experience of hospital birth (Maria and Miriam) both strongly expressed their wish for control: one having experienced losses of control and the other having seen women experience loss of control in the hospital system. For both the issues of control became more prominent, and therefore, stated more explicitly as a primary reason for giving birth at home.

Avoidance of Intervention Issues

Associated with concerns about control are concerns about intervention and the cascading nature of interventions. The wish to avoid interventions was noted by four women to some degree. One stated that she, "Didn't like obstetricians interfering". Another felt that the hospital system had a particular way of handling things that was not necessarily suitable for all women. The tendency of one intervention to lead to another and a wish to be in a situation where intervention could not occur was a theme which a number of women endorsed, as illustrated below.

"Its so easy for things to start snowballing and then people say - you don't know, because you've got no experience and they have [...] and then you begin to doubt yourself. So I wanted to be as far away from any possibility of things going that way as humanly possible".

Such statements suggest that Ford et als. (1991) findings that the desire to avoid intervention can hold significant weight for women planning home birth are true for some of the women in this study also. Some women did express a distrust of standard maternity care, a desire to use obstetric technology only as a last resort, and a belief that one intervention may result in the need for further ones.

Continuity of Care

Continuity of care and having an established relationship with a midwife is another key area as to why women choose to birth at home and it was a concern of all the women in this study. Four women mentioned continuity of care or the importance of knowing and having an understanding with their midwife. For two others knowing both their midwife and GP was important, and as both were expecting their fourth babies both had also built up relationships with their caregivers. As one commented,

"I can't comprehend in a sense what it must be like to not know your midwife when you go into a hospital."

Miriam also mentioned continuity of care, or rather the lack of it, due to her choosing a close friend from out of town as her midwife. She felt she missed out on postnatal care as her friend

generally returned home shortly after the birth. The reason she chose her friend as her midwife, however, was because of the depth of the relationship between them.

Overseas research gives the desire for continuity of care and having an established relationship with their midwife as prime reasons why women seek a home birth, and the New Zealand home birth research of Abel and Kearns (1991), Jakobsen (1991), Pratt (1990) and Strid (1991) also found that it was an important factor for the women they surveyed. As noted the present study confirms this, with all women commenting positively on it, either directly or indirectly.

The Involvement of Family and Friends

The involvement of husbands and children was another issue of concern to all women. All women expressed a desire for the birth to be a family event (rather than a medical one). Women pointed out home birth meant the family was not separated, this being of particular concern given that all women except Pam had other children. Home birth research suggests that not being separated as a family is a prominent concern, along with beliefs about the home being more compatible to the development of bonding and the establishment of breastfeeding. While the latter point was not mentioned by the majority of women, concerns about separation from partners, other children or babies was confirmed by this study. Several also remarked that their children would see birth as a natural event (as opposed to a medical procedure) and that it helped children to adjust to having a new sibling.

All women had also carefully selected those they wished to be present at the birth, again, a finding which is in accordance with home birth research in general. The involvement of other people was particularly important, however, for three of the women. For Pam, expecting her first baby, the "encouraged involvement" of the people she had chosen to be present was her prime reason for selecting home birth. Another said that for her,

"Its quite significant in who I choose to be present [at the birth]. [...] I think that everyone who's present can have an impact on the birth."

Women generally selected family and friends with whom they had a close relationship and whom they felt appreciated the importance and significance of the birth. The care of other children was

also influential in who was present and women often made remarks that a particular person was chosen, at least partially, because of their relationship with older children.

The Relaxed Atmosphere of Home

Being in the familiar, relaxed environment of home was commented on positively by some women, with several saying that home just seemed "more natural" or home birth was just "the natural thing to do". Robyn, a vet, noted that the move from home to hospital can disturb the momentum of labour and drew an analogy from her observations of animals, saying,

"As a vet I do some things differently from other vets and patients often leave here earlier than they would otherwise and then come back for daily checks. [...] I feel that the animal certainly does better being at home too."

It was also noted that the home was a more comfortable and less stressful environment.

Safety Issues

The issue of safety was only mentioned by three women. Given the controversy that has at times surfaced in New Zealand over the safety of home birth it seems unlikely that women had not considered this aspect of birth at home, (certainly Miriam must have in her professional capacity).

One woman pointed out that transferring from home was the same as transferring from a small (secondary) maternity hospital to a larger one, and that her house was closer to Palmerston North hospital than many small rural hospitals to larger hospitals, hence, that home birth could be safer than birth in some secondary maternity hospitals if a problem arose.

Additional Issues

Other issues women mentioned as factors in why they decided to have a home birth included the quality of care, that breastfeeding is better established in the home, wishing to avoid postnatal depression (believed to have occurred due to experiences in the birth of an older child in hospital), that hospitals are for people who are sick and that by staying at home you can avoid hospital "bugs", of being terrified of hospitals due to having spent a lot of time in them in childhood, and that her husband was fearful of hospitals.

DIFFERENCES BETWEEN HOME AND HOSPITAL BIRTH

As stated earlier the reasons why women choose home birth and the differences they perceive between home and hospital birth were closely related. The differences which women perceived between home and hospital birth were in some instances those that both the present and previous research have identified as reasons why women choose to have a home birth.

For Robyn the main difference was the fact that you had to physically move from home to hospital, and that the hospital environment was not particularly suitable for older siblings. The New Zealand research of Abel and Kearns (1991) and Hannah and Davies (1990) also found that one reason why women decided to have a home birth was because they believed labour could be disturbed by the move to hospital. The majority of women in this study commented that home birth was family focused and better for other children. Two women also noted that people entering the home do so as visitors, while another believed that the hospital is the domain of those that work there and that their needs can take precedence over women's needs.

One difference which the majority of women mentioned was the contrasting environment of home and hospital. Home was viewed as comfortable, friendly, and giving women freedom of movement and freedom to set their own routine, while hospital was seen as clinical, foreign, as imposing routine and as being the domain of the staff. For example, it was pointed out that at home women had their own bed, access to their kitchen and to food that they liked which they could eat when they liked. They could watch television or take a walk in the garden, and they did not have to wait to use the shower or toilet.

All but one woman who had experience of hospital childbirth services had also had problems or disagreements with (some) staff and expressed dissatisfaction with the service. Women spoke of a struggle between themselves and some staff over the care of the newborn and the negative emotions that arose from such encounters. Such a situation cannot be viewed as desirable as it would be likely to lead to feelings of helplessness and resentment while in hospital. It could also result in women feeling they were incompetent and unable to adequately care for their baby once they returned home, especially if it was their first child.

For example, Maria had the most experience of hospital services and due to both her daughters being premature there had been particular concerns over their well-being. She commented that,

"They felt like they weren't my babies and that I couldn't just go and pick them up and cuddle them."

She also had disagreements with staff. For example staff had wanted to tube feed one of her daughters and she had to argue for her to be test weighed before and after feeds to ensure she was receiving enough milk. Maria believed that due to such experiences she had suffered postnatal depression for about 18 months. The wish to avoid that happening again was one factor in her decision to have a home birth. As she said, "Looking back on it it just seems like a nightmare. So I really wanted it to be completely different this time."

A number of the other women had also had unpleasant experiences with hospital services and one made the point that at home the baby is your responsibility from the start, while another remarked that trust exists at home but not in the hospital system. Such experiences and beliefs link in with the view expressed by some women that health professionals entering the home do so as visitors, and so a different relationship exists between them and their clients. It is also true that at home there is no doubt that the baby is the responsibility of the parents. Because women are not under the direct supervision of health professionals for the majority of the time it means that there is less chance of differences of opinion on care of the child being a problem. (The relationship which has been built up between women and their midwives also means that any differences may have already been worked through.) In any event, as Niven (1992) notes, at home women can choose to ignore advice and to care for their babies in their own way and time.

In fact many of the perceived differences between home and hospital birth revolved around relationships between staff and women. They include those already outlined, such as disagreements with staff, the different relationship between women and staff at home and at hospital, and who is ultimately responsible for the baby in hospital. Other perceived differences which show a concern with the relationship between women and health professionals include having one set of people caring for you in the home, as opposed to different staff working different hospital shifts. And, following on from this, the home being an environment where you receive only one set of advice, compared to different people giving conflicting advice in hospital. It was also thought that women received individual care at home and that the people who gave

that care generally had continuing relationships with the woman. The home environment and the established relationship between women and midwives was also seen to give the flexibility and relaxation necessary to enable women to feel they could make specific arrangements or requests.

In addition to these common concerns one participant believed that birth was a very special and holy time and that this was lost in the hospital environment, as any given birth was only one of a number of things happening. However, she also wondered whether, if things were going well, being in hospital might be irrelevant. That is, whether what was "going on inside the woman" might be as important as location. The perception that due to different beliefs and needs some women may feel comfortable and secure only with hospital birth while others would only be comfortable with home birth, was a point specifically brought up by Karen, although often acknowledged in passing by other respondents.

The other difference that was often either discussed explicitly or alluded to, was that birth at home enabled women to create a particular atmosphere. For example,

"Being able to be really significantly involved in the decisions about the birth, of feeling like I'm creating the story and people are coming to help me achieve that, rather than the other way round."

"At home I can create an atmosphere that is relaxing for me. That is, a place where the people that are there know me and love me and will support me."

"Just to have that family feeling, and that it's a natural part of life, and to have everyone involved. And the atmosphere, it helps you, it helps the newborn - I'm sure it does - and it definitely helps the siblings."

THE INFLUENCE OF OTHER PEOPLE ON WHY WOMEN CHOSE HOME BIRTH

All but one woman were, to some extent, influenced by other people, often at a fairly casual level such as through discussing home birth with friends who had had one of their children at home. Hence, the influence of other people tended to be confined to friends and to differ in intensity.

One woman and her husband heard about home birth from Dr and his wife, the two families being acquaintances. The 's four children had all been born at home and it was through contact with them that the respondent and her partner got information on home birth, both by discussing it and by borrowing books on the subject.

Two women had also been influenced by friends who had had home births and had very positive experiences. One also mentioned that some people "told me I was mad". She felt that she had considered issues and come to the decision largely by herself. The other woman had contact with a family who had a home birth and talked to families in her church who had children born at home. She had also done some assignments on home birth while doing her Early Childhood training.

Karen, who worked as a kindergarten teacher, was exposed to home birth through her work. One of the parents of a child she taught was a domiciliary midwife and other parents at the kindergarten had children born at home. She noticed that babies born at home seemed to fit into the family routine with ease and older children discussed and accepted the new baby well. In discussing one particular case she said that,

"She came along with this baby and it wasn't as though this baby was secluded from the whole community. It was part of the community, it was part of the family. And that was what it was supposed to be."

Karen compared that situation with another when a baby had been born in hospital and was not brought along to kindergarten initially, and was kept apart when it was brought. She was also encouraged to consider home birth by her GP.

One woman was heavily influenced by a friend's home birth. The two couples were sharing a house and she was present at the birth and saw the midwife "in action" and the attitudes of the health professionals involved in the birth. As she said,

"I think for me it was that I had actually been present at a home birth and it just seemed so right. Even though the birth actually ended up being in hospital, I could still see that the whole process was how it should be for me. [...] To see

the sorts of equipment and what the midwives brought and the involvement of the doctors and the decision making."

For Miriam the situation was obviously different. Her mother, a maternity worker, had a very strong belief in the view that birth was normal, a belief she passed on to her daughter. When Miriam did her midwifery training, she was particularly interested in domiciliary midwives' accounts of their work. Following training her closest friend worked as a domiciliary midwife, although that also proved to have a cautionary aspect. Her friend had a baby die during a home birth and came to Palmerston North to grieve that death with Miriam. Miriam believes that a consequence of her friend's experience and her sharing of that experience was that she became more conservative regarding her practice as a domiciliary midwife. However, such an experience did not put her off home birth, as another influence on her beliefs about home birth were perceived problems with the hospital system and the people who worked within it, along with the history and politics of childbirth.

WOMEN'S EXPECTATIONS ABOUT THE LABOUR AND BIRTH

Due to the timing of the first interview (between 28 and 32 weeks) women often had not discussed all their preferences with their health professionals in depth, or finally decided who would be present at the birth. However, they all had a few things which they specifically wanted done (or not done). Only one intended to formally complete a birth plan based on the one she wrote for her other child's birth.

Expectations of partners.

The partners of all women were going to be present at their baby's birth and all women who had other children intended for them to be present also. Six of the women said that they expected support from their partners although one only mentioned emotional support, while another only referred to physical support. In fact, this respondent stated that her husband was not a good support person, and while sharing her philosophy about home birth, still felt hesitant about it. She felt that hospital birth was preferable for him in that he could have a break when he needed one more easily. Another respondent, although not specifically referring to her husband as a support person, stated that she wanted him more involved than he had been with her previous two births.

Massage and general encouragement from husbands were mentioned as examples of support by some women but the mere presence of husbands and the fact that they were "just there for me" seemed to be the key to the notion of support. One said that,

"I just hand everything over to him, I suppose that's the other thing I need him there for. Like, if for some reason he was unable to be there I think what I'd miss would be that just being able to totally concentrate on giving birth."

One woman felt she wanted her husband and mother to share the task of support, massage, coaxing, staying close and getting food or drink. More practically oriented roles, such as taking photographs and providing food and drink were also mentioned, but generally partner's prime role for the coming birth (except in one case,) was one of emotional support and physical support or strength.

Expectations of midwives.

Perhaps not surprisingly expectations of midwives tended to be greater and more specific than expectations of husbands. Support, both physical and emotional, was mentioned by the women. A number of women mentioned specific things, such as massage from midwives, but I believe that the fact that others did not mention specifics does not mean that they do not necessarily expect such things. Rather, the assumption underlying expectations of care seemed to be that health professionals and support people in general would provide whatever was asked of them.

Apart from massage one woman only mentioned that she liked her midwife to place hot pads on her perineum. Another respondent also discussed physical contact and massage, but in addition she wanted her midwife to encourage the involvement of her husband, listen to her and take what she said seriously. She also said,

"I want her to guide me a bit. She knows what I want and just to sort of keep telling me - this is what you want."

One woman felt that initially she could meet her own needs but later she needed her midwife's presence for reassurance, to give feedback, to give her directions in the second stage and to take

care of the medical side of things, such as the placenta. She felt that as this was her fourth baby with the same birth attendants they all knew what their roles were pretty well.

Another wanted her midwife to support her, verbally encourage her, to consider her and the baby's safety at all times and to monitor her and the baby and act "efficiently and quickly" if anything was wrong. In the event of transfer to hospital she wanted her midwife to, "Take more of a front role [than last time]", thereby providing greater support.

Two other women had similar expectations of their midwives. One wanted feedback and for her midwives to talk about what was happening, to coax and encourage her and encourage her husband's involvement. Also that they "do what needs to be done". The other's expectations were both physical and emotional support and encouragement.

Miriam, being a midwife herself, had different expectations of her midwife. She had got the room ready and set up her equipment for her other births and planned to do so again. She felt she did not need coaxing as she knew the process of birth. That said though, she did want her midwife to monitor her and the baby, to give her feedback and to encourage her. She also had some quite specific requests of her midwife, requests for things that she could not do for herself, such as covering her anus in second stage, strategically placing a mirror so she could see the baby descending (this was for a number of reasons, for example it would enable her to know when not to push so she would not tear,) and covering the baby's bottom as it was born so she would be the first person to see what sex it was.

Expectations of second health professionals.

Expectations of second health professionals were considerably less than those of primary midwives, reflecting the usual practice of home birth whereby second health professionals act more as a back-up than anything else.

One respondent expected her GP to help her pant as the baby was being delivered (to avoid tearing) and to massage her if she requested it. In contrast one mentioned no expectations of her GP and another only mentioned that he would place the intravenous line in if she needed it (this is more likely with greater parity). This was also mentioned by another respondent, her expectation

of her doctor was that he took emergency responsibility if it was necessary, and if it was not, that he be part of the extended family. (The families were friends and neighbours.)

One woman had fairly similar expectations of her doctor and midwife. She wanted physical and verbal encouragement and particularly wanted him to provide emotional support to her husband who was not completely at ease with birth. She also expected her GP to monitor her and the baby, to consider their safety and be prepared to act if necessary. In a similar vein, two women expected the same care from the second health professional as from the first, although in both these cases the second health professional was another midwife.

Expectations of other support people.

Aside from partners, other children and two health professionals all women expected to have other friends or relatives at the birth. One respondent had invited two friends, one whose primary role was to help her husband by giving him a break should he need it and to assist the midwife if needed. The other friend was to care for other children and to video the birth. Another respondent was unsure whether she would have one or two people present, as one could not get away for the birth if she was at work. If she was present she had no specific role but would provide general help if needed, while the other friend was expected to care for the children, provide food and drink as needed and help the midwife if necessary. Another woman had invited three people to be present, a couple and her sister. The couple were going to care for the children (including their own), generally help out and take photographs, while her sister was to provide support and assist with childcare.

Childcare was a concern of one of the other women also, although at the time of the first interview she was undecided whether her mother or a friend would be asked to help her husband with this. She had invited a close friend to be her main support person (rather than her husband,) so expected more of her, such as massage, verbal encouragement and support for her husband. The friend, Shona, was also a midwife so she thought a degree of communication between her and her primary midwife (Margaret) would take place. However the situation was complicated by the fact that Shona was 8 months pregnant, having had her previous baby die shortly after birth. Consequently, there was uncertainty about how she would react emotionally to the birth as it would bring back memories of her baby's birth and death. She had agreed to be a support person partly so that she could "work through some issues" surrounding birth on a less personal level

than when her own baby was born. The upshot was that the respondent thought it likely that the situation could be quite emotional at times. Both her midwife and doctor were aware of Shona's circumstances and the idea was that they, the respondent and her husband, would support Shona if she needed it. Hence, the issue of support in this case was intertwined, with those who were present having a dual focus to some extent.

In fact this case gives an interesting insight into the dynamics of home birth, as it was expected that all of those present at the birth would provide a network of support to those that needed it. To the respondent as she laboured and gave birth, to Shona as the birth (possibly) evoked memories of her own baby's birth and death, and to the respondent's partner as he struggled to cope with the demands of the situation. While such a case is obviously unique the expectation that support would be provided by whoever was there for whoever needed it is advocated by some researchers, such as Hales (1991) and Niven (1992). And it could be argued that by inviting people to be present at the birth home birth women in general view birth as an emotional event to be shared with people close to them - naturally it would be hoped that the emotions would be joy and elation, but it would also be acknowledged that that is not always the case.

As mentioned earlier one woman expected her husband and mother to share the role of main supporter. She also expected her father to be present but was unsure of his role. Another respondent had arranged for three people to be present, although there was a possibility one, her sister, might not be able to be. She had a friend for support and to take photographs and her mother-in-law was providing childcare.

Lastly, one woman was also unsure exactly who would be present. If her midwife friend from out of town had to return home prior to the birth she had a local midwife (Margaret) to take over. If she had not yet returned to home and was present Margaret's role would be to take photographs and help with the eldest child. If Margaret had to take the midwife role another friend (also her doctor's wife) would take the photographs and provide childcare. She had invited her mother, who was to provide care for the youngest daughter. She was unsure as to whether she would invite Dr and Mrs 's daughters (aged 15 and 17). If so they would have no specific role, rather she said,

"Its more because I want them to learn about what it means to be a woman and to give birth, and that that's a special gift to them."

This quote also illustrates how the midwifery model views birth and knowledge about birth as a developmental process, rather than just a medical event. By inviting other women to be present knowledge of birth is passed on. It is interesting to note that this is what would have occurred many generations ago but seldom occurs these days.

SPECIFIC REQUESTS OR BIRTH PLANS

Only one woman had actually written a birth plan but all women had discussed the birth with their midwife and so had the opportunity to voice any concerns or requests that they might have.

The birth plan that had been written was based on the one the respondent had written for her first child's birth and included the following concerns. That the birth would occur at home, that the midwife would do all she could to avoid a tear, and would not use a Doppler (which is a type of ultrasound) but rather a foetal stethoscope to monitor the baby's heartbeat. Also that she could have favourite music playing, be able to "go with things as they happened", to have freedom of movement, and no intervention unless absolutely necessary. After the delivery the cord was to be cut by her husband after it had stopped pulsating, she wished to breastfeed the baby "naturally" and the midwife was not to pull on the cord (to assist the expulsion of the placenta) at all.

Generally, then, the birth plan was based around general principles and it could be argued that some of it merely stated the obvious, that the birth would occur at home (unless in an emergency) and that she could breastfeed the baby naturally are expectations which it is likely all the women would hold, although they would probably not find it necessary to express them. That is, in having a home birth they would assume that the midwife knew they actually wanted to have the baby at home and that if they had told their midwife that they were going to breastfeed that they would do just that. On the other hand by writing down specific requests women can ensure that there is no conflict as to what was actually said about different issues.

In contrast two women, both expecting their fourth babies, had few specific requests but had the expectation that things would follow along similar lines to previous births. As one said,

"This is the fourth birth and we will have been together for four, there's a lot of it doesn't need to be spoken. There's a lot of assuming [...] it's more if things don't go like they have in the past."

One of these women particularly wanted hot towels in second stage and thought that the cord would probably be cut by her husband or children. The other was particularly keen to receive feedback and information from her midwife, but like another respondent, had not yet got down to specifics. So far that respondent had decided on general principles only, that she wanted the birth to be as natural as possible and without chemical pain relief if possible, and for her husband to cut the cord.

One woman did have some specific requests, largely resulting from her hospital experiences. She wanted to be believed, to make or help make decisions, and to be able to hold and breastfeed the baby immediately following its birth. She hoped her eldest daughter could cut the cord and wished to avoid the syntometrine injection (to expel the placenta) if possible. Miriam had few specific requests and believed that things she wanted she could mostly achieve for herself. Those she could not she had talked about with her midwives, such as monitoring, covering her anus, moving an anterior lip and so forth.

Finally, one respondent had made some specific requests, such as her daughter being involved as much as possible, that the baby received the Vitamin K injection rather than the oral form of Vitamin K, that she did not have gas if she had to transfer to hospital, and that midwife and GP keep a close watch on her asthma. Although she had such requests she also believed that it was counterproductive to make too many arrangements and said,

"There are things that I think will probably happen, as opposed to specifying them. I just found that a lot of my friends made so many arrangements, 'you must do this, you must not do that', that when these things didn't happen they were so disappointed, without using their common sense."

Overall it appeared women were more concerned with the general process of birth than with specific procedures or tasks. The fact that most women did not deem it necessary to do other than informally discuss concerns suggests two things. Firstly, that a considerable degree of trust must

exist between women and their midwives. Secondly, that women must feel that their general philosophy of birth is shared to a significant degree by their midwife.

EXPECTATIONS OF THE POST-PARTUM PERIOD

All but one woman expected considerable help with domestic duties for at least the first week following their baby's birth. One respondent thought her husband would have a few days off work, but of the postnatal period she said, "[my husband] will support me certainly in it, but I don't envisage anyone having to take over, unless there's a problem." She had had offers of help from friends and thought her mother would come to stay after about six weeks but preferred to continue on with her usual responsibilities saying,

"With all of them I've just got up and got back into life almost immediately."

While such a situation would probably not suit many people it obviously did suit her and her children slipped into the family routine with ease. However, it should also be noted that she did allow for the extra demands of a new baby. She was aware that she needed to be careful that she had the time in her life to cope with such demands, and she did this by reducing commitments and expectations of her in the months leading up to the birth.

One respondent was expecting her partner to have about two weeks off work and take responsibility for childcare and household tasks in the first week following the baby's birth, with her gradually assuming more of the work in the second week. Her expectations of her midwife were that she would check both her and the baby immediately after the birth and continue to monitor them in following days. This was very similar to what another woman expected. She thought her partner would take at least two weeks off and thought that the postnatal time was very important for bonding as a family. She also expected her midwife to check her and the baby and thought that the visits were important, saying,

"There's always things that are a bit different each time. Or that you've forgotten."

One woman's expectations of her midwife and doctor were very similar, to support and monitor her and the baby. Her husband was taking about a week off work and was going to take over

childcare and all domestic tasks, and she thought her mother would stay when he went back to work. She also had supportive neighbours and friends but had decided she was going to be assertive and ask relatives who visited to help out, such as getting washing in or doing dishes. She had found that she had ended up caring for some visitors last time, rather than being cared for and had decided that was not going to happen again. She also thought that she would "pull the plug" on the phone, and noted that hospital made it easier to restrict visits and interruptions.

For one woman there was uncertainty about whether her husband would have any time off work as he could not change the date of his holiday, although it was due when the baby was. However, since he worked part-time he would at least have some time at home. She was expecting to be totally cared for by her husband, mother and father for at least the first week and to have continuing support from them thereafter. She was also involved in a church group which provided support in the form of meals. From the visits by her midwife she expected information and suggestions and said that she felt a "thirst for knowledge", to ask questions and get suggestions on different ways of doing things.

Another respondent also expected her midwife to visit and monitor her and the baby. She was putting some meals in the freezer, had arranged to have a nappy service for the first two weeks, and her partner was taking two to three weeks off work and would take over childcare and basic domestic tasks. As she noted, his just being there was important. In addition she hoped her sister could take a week off work also and provide companionship and help with domestic tasks and childcare.

Miriam was unsure exactly what would happen postnatally, again because she was unsure how long (or even if,) her friend and midwife would be in Palmerston North. If she was she would help with the running of the household and childcare and provide postnatal care. If she had to leave immediately after the birth Miriam's local midwife would undertake postnatal visits, for although she could monitor and care for herself and the baby quite adequately, she liked to be treated "as any other new mum": to be encouraged about breastfeeding, to get different ideas on things and be checked by her midwife. Generally, though, domestic and childcare responsibilities would largely fall on her husband, mother, friends and relations as she said she tried to "go to bed for a week" as otherwise she found that work tended to be left for her to do.

Finally, it should be stated that while some women did not state any specific expectations of their health professionals it can be assumed that all expected their midwife to visit, monitor them and the baby and discuss any concerns. Several women commented that they could ring (or page) their midwife any time, before or after the birth, and such statements illustrate that women expect ongoing contact, advice and ideas from their midwives.

ADDITIONAL COMMENTS

To the final question of Interview 1 (Is there anything else that you want to say or anything that you think I've missed) two women said "no" and one just said that she hoped the birth went well and was a positive experience.

One woman commented how she and her partner had found that their children had "fitted into" their lives. She said,

"I'm just careful, I suppose throughout the pregnancy but particularly towards the end, that the load that I carry is something I'll be able to continue to carry and that I don't take on things that are too much. You decide where your priorities are and where you want to spend your time. I find that there's so much to do anyhow that that's something I'm conscious of, you know, prioritising my time, where I'm going to spend it. Then when the baby arrives that's okay, it's not suddenly going to have to change everything."

Two of the women made comments that referred back to their motivation for having a home birth. The question allowed one to return to and elaborate on her hospital experiences. She discussed how having chemical pain relief had resulted in her daughter having breathing problems, and the disagreements she had with staff over care of the children. She also said that due to such experiences she had suffered postnatal depression which lasted "a good 18 months", following the birth of her second child. Having a home birth would, she hoped, ensure that she retained control and did not get depressed, for as she said,

"Looking back on it it just seems like a nightmare. So I really wanted it to be completely different this time."

Given her feelings, that she should be attempting to create an experience far removed from her other two birth experiences seemed hardly surprising.

The other respondent's original motivation for having a home birth stemmed from the positive experience of being involved in a friend's home birth. The respondent discussed witnessing her friend's birth (which was before she had children) and commented that,

"So many women go into birthing never having been present at a birth and I don't know that videos are the same. I don't think that seeing it on video is the same as actually being present. [...] The whole emotional [pause] oh, just the colours and things, the whole momentum of a birth really. And, like what happens before and after. So much of that can be quite new."

She also remarked that she felt very lucky that she had been able to have the same attendants at all four of her births. Clearly her first experience with home birth had had a significant influence on her decision to have her first baby at home and her own birth experiences had consolidated her feelings and beliefs on the home as a birth environment.

Lastly, one woman talked about how she and her partner had followed their daughter's "pattern" after her birth, rather than trying to impose one on her. Also that,

"Birth is a part of life and it's a holistic thing and you've got to think of every aspect - emotional, spiritual, physical or whatever."

CONCLUSION

For these women it initially appeared that the desire to remain in control was of less importance than for home birth women in comparable studies, both national (Abel and Kearns, 1991; Jakobsen, 1991; Pratt, 1990) and international (Cunningham, 1993; Homebirth Australia, 1991; Morse and Park, 1988; Sacks and Donnenfeld, 1984). However, the majority of women made remarks which contradict this conclusion and it would seem that deeper probing around the question of control would have revealed that retaining control over the birth was important for women. It may also be that home birth in New Zealand is such that active participation and

control is accepted as part of the process of birth at home. Therefore, by choosing home birth New Zealand women implicitly illustrate a desire for control.

This is supported by statements of women in which the flexibility and choice of home birth is commented on, the underlying assumption being that they were free to exercise that choice, and therefore, to have a degree of control. Also, those women who had previously experienced loss of control, or seen other women experience it, appeared more aware that home birth could ensure that control was maintained, or at least stated their awareness more explicitly. It is also supported by statements made in the following two interviews.

If this proposal is correct, though, it presupposes that a mutually trusting relationship exists between women and their midwives. The establishment and development of such a relationship is an important factor in why women seek home birth. Research also suggests that such a situation is beneficial for women giving birth and results in greater job satisfaction for midwives. All the respondents in this study felt that having an established relationship with their midwife or receiving continuity of care was very important. While the majority of the women had had the same midwife for more than one birth, what struck me was that almost all women talked of their midwife as a friend (as well as their midwife).

The relationship of friendship between women and midwives and the ease with which it appeared to develop must rest upon a foundation of mutual trust and dependence, along with other factors such as the intimacy of home which encourages disclosure and gives ample time for discussion, the personalised care women receive, the fact that midwives enter the home as guests and, possibly, because the marginal nature of home birth in New Zealand means the relationship is built upon a shared understanding or philosophy of pregnancy and birth, an understanding which is to some extent at variance with the dominant one. That several women did express a degree of distrust of hospital policies and practices illustrates that conventional obstetric care was questioned.

Women also had a desire for the birth to be a family event. Again this goes against conventional thought that sees the actual birth as a medical event, with it being more of a family event on the mother and baby's return to their home. The women in this study wished to avoid any separation from their babies and between family members as a whole, and home birth was seen as a way to achieve this and to promote family bonding.

Those invited to provide help and support at the birth tended to be close friends or family. This reinforces the event as a significant one in the couples' lives and in their relationships. It suggests that the women chose to give birth in an environment in which they would receive maximum care and support, which was tailored to their individual needs and largely given by people with whom they would have continuing relationships.

The familiarity and relaxation which the home engendered was seen to contrast strongly with the hospital environment. This was viewed as clinical, foreign and as having set procedures and ways of doing things. Some women also clearly felt that in hospital they did not, or would not, receive personal care, that they would have to argue for their baby to be cared for the way they wished it to be, that they would have routines imposed on them, and that they would receive conflicting advice from different staff members.

Perhaps their viewpoint could be summed up by saying that they tended to see hospital as the domain of those that worked there, rather than a partnership between them and health professionals as they believed occurred in the home environment. This notion of a partnership, as opposed to 'experts' having all the answers, also forms part of the midwifery model of childbearing.

In fact, though, the majority of concerns and beliefs that women raised were also aspects of the midwifery model of childbirth. The desire to retain control and have a say in decision making, to have a partnership relationship with midwives based on shared information and philosophy, for the birth to be a family event and to take place in the relaxed environment of the home and a holistic view of pregnancy and birth, all form important components of the midwifery model.

Expectations for the current birth

All women had made arrangements to ensure that they had considerable support available at the labour and birth, provided by people close to them or with whom they felt very comfortable. Typically husbands formed an important part of this network, along with midwives. The second health professional and others present usually had a secondary role. They would provide support to the woman if called upon to but generally were to assist the midwife and husband and provide childcare.

The majority of women looked to partners and midwives to provide their psychological and physical support, both so important for birth without chemical pain relief. Obviously health professionals were also expected to give optimal health care to both mother and baby, and also to give feedback and different suggestions as to how best cope with the different stages of labour and birth.

While women did not usually have a lot of specific requests the underlying assumption appeared to be that midwives would use their experience to monitor the labour as it progressed and give a range of ideas for women to try. It was also expected that all those present would provide continuous constant care as the woman needed or requested it, and also to others if they needed it.

Hence, a network of care was generally available, with the woman as its central focus but encompassing all within it. Again, this illustrates the trust that exists between those involved in a birth, as well as mutual confidence. Confidence from the midwife towards the woman in her ability to give birth without (chemical) pain relief, and from the woman towards the midwife for her professional skills, and towards all those present for their caring abilities.

Following the birth it is customary for midwives to visit and so it can be assumed that all women would expect this. Such visits would include the monitoring of the women and babies and the provision of the opportunity to discuss any issues. That women felt that they had ready access to their midwife was apparent by their comments that they could phone them at any point if they had a concern.

All except one woman expected to be relieved of household and childcare tasks for at least a week following the birth and the majority of women seemed to have had, or to expect to have, little difficulty in gaining adequate rest and time to enjoy their new baby.

Chapter 7

INTERVIEW TWO - THE LABOUR AND BIRTH

"In a woman's home a birth is, whatever else it may be, a unique life event"

(Rothman, 1982, p. 274).

INTRODUCTION

This chapter is based on material from the second interviews. (See appendix 6 for interview questions.) It is divided into 7 sections, followed by a conclusion.

The first section gives background details of the interviews, such as length of interviews, ages of babies at the time of interviews and where babies had been born.

Section two covers women's experiences of labour and birth. It includes background information on women's labours and considers women's experiences in relation to their expectations of midwives, second health professionals, partners and other support people.

Section three discusses a range of more general information, such as whether women's experiences were similar to what they had expected and who women thought made decisions during their labour and birth.

The fourth section covers the post-partum period and includes information on care from midwives and second health professionals. It also considers care and assistance from partners, family and friends in relation to domestic tasks.

Section five examines women's feelings about the care they and their babies received.

Section six discusses whether women believed they would have another home birth if they were to have another child.

Finally, the seventh section examines any additional comments made by women.

BACKGROUND DETAILS

The second interviews with women took place between January and August 1994. They averaged 58 minutes in length, with the range being from 45 minutes to 1 hour 15 minutes. All took place at the women's homes and all but one occurred during the day, the exception taking place in early evening.

The ages of the babies ranged from 2 days to 3 weeks 1 day. Six babies had been born at home and none of these mothers or babies experienced problems which resulted in hospital care being needed. Only one woman required sutures due to a tear. The seventh woman, Maria, had transferred to hospital as the foetal heart beat indicated problems and the baby was subsequently born by an emergency caesarean under GA. The baby had Apgar scores of 9 and 10 and once born posed no further worries. Mother and baby came home on day 4 but were readmitted the following day for three more days due to Maria having an infection in the wound.

THE EXPERIENCE OF LABOUR AND BIRTH

All women had a period of time when they experienced contractions but were unsure whether they were in labour. For example Maria had woken at 1 a.m. with contractions but as this had happened on other nights she was not sure whether they signalled labour was actually starting. Similarly Miriam had had "fairly strong" contractions throughout the day but had "ignored them because they didn't feel a lot different" from the Braxton-Hicks she had been having for a week.

If it was night women just tried to get comfortable and go back to sleep. During the day they tended to continue with their daily activities. As one said,

"To me, if you can keep functioning you can't be in labour!"

Some phoned their midwives, however, and let them know they might need them later. (Midwives generally encourage this as it allows them to organise their time and commitments with this in mind.) For some women it was only a couple of hours that they remained uncertain as to whether they were entering labour, but for others many hours passed before they decided that contractions were such that they were definitely in labour.

The length of time midwives were with the women prior to the actual birth varied considerably and reflected differences in the length of labours. The times ranged from 1 hour 15 minutes to 11 hours. Although not all women provided the actual time when midwives finally left their homes, of those who did 2 hours after the birth was the shortest amount of time that elapsed between a birth and the midwife's departure.

In coping with the birth all six women who had their babies at home used physical contact with others at some point. For example massage, holding (and squeezing) others hands, leaning or resting on partners or other support people were mentioned by all. All these women also mentioned health professionals used hot towels on the perineum, abdomen or back in an attempt to alleviate pain. Some also used cold towels. In addition one woman laboured in the birth pool and another had showers and a bath.

Other strategies included a special chair the midwife brought to the birth, rocking in a circular motion, use of a birth stool, pressure on acupressure points and cooling women with cold cloths or by fanning them. Two women mentioned the use of homeopathic remedies but it is likely that they were used more frequently than that. Three talked of a mirror being used so they could see the descent of the baby.

Some women who gave birth at home also made positive comments about the psychological support and feedback they received from health professionals. This was particularly so in one case when a respondent temporarily lost control. Her doctor talked about things other than the labour with her, but both her doctor and midwife also tried to get her to re-focus on what was happening and suggested various things that she could do to help. This did have a positive effect and helped her regain control.

In Maria's case she needed a lot of support from her midwife, as did her husband. She found the information and reassurance she gained from her midwife very important and felt that she would not have coped as well as she did with the birth if she had not had that one-on-one care.

Probably because of the fact that it was her first child, Pam had the longest labour and used the greatest number of coping strategies. However, all women expressed satisfaction with their health professionals for their attempts to relieve discomfort and pain.

Second midwives/GPs arrived at a later stage of the labour, four within the hour prior to the birth and two within one hour thirty minutes of the birth, and all of them left before the primary midwife did. In the case of Maria her midwife accompanied her to the hospital and stayed with her husband while Maria was under GA. Her doctor also came to the hospital.

Expectations of midwives.

Psychological support and feedback from midwives played a greater role in some births than in others. Lesser feedback and support was generally because of two factors. Firstly, some women had considerable experience of labour. Because labour progressed in a predictable and orderly way they had their previous experience to reassure them all was going smoothly, and so needed less psychological support from midwives. Secondly, some labours were quite rapid and being managed through the labour and birth was the prominent need. For example, one birth had gone so smoothly the respondent noted,

"There was very little for Margaret [...] to do basically."

Two women had short labours and one said that because it was so quick,

"You just had to be managed through with it. [...] And I couldn't fault that."

In contrast one woman went through a time when she "completely lost it" and was screaming, yelling and abusive. "And I was fair screaming and bellowing [...] telling Margaret, 'don't do that, I don't want you to touch me, leave it alone'." The situation improved, however, due to two factors. Margaret did not leave her alone and did remove a painful anterior lip. She and the GP then,

"Explained how I could actually help and what I could actually do. And once they got that and I was able to concentrate on what to do, I was able to cope with it a bit better."

Due to the situation she found herself in, Maria also had a need for considerable support and reassurance from her midwife. As she said,

"It all happened so fast. I just cried and cried - I thought the baby was going to die. Everyone was sort of panicking. But Margaret was really good and it was really good having her. [...] She was just sort of explaining, 'now you know what's happening? Do you understand why this is happening and you're going to have a GA, a general anaesthetic, and we haven't got time for an epidural'. And just making sure that she went over and over it with me."

(The lack of time Maria refers to is because administering an epidural takes longer than a GA and due to foetal distress the quickest possible method was used.)

Specific requests which women had made to midwives appeared to have been met. For example one woman requested and received hot towels on her perineum and another believed that her birth plan was followed. Miriam also felt that her requests had largely been met, although she would have liked more hot packs on her perineum. She also had a lot of discomfort and pain in her back and noted, "Most people massage very lightly. As a midwife I've always massaged hard, strong pressure. And I feel if someone had come up and given me strong pressure that would have been really useful."

Maria had requested guidance and for greater involvement of her partner Brent. Obviously with the transfer to hospital circumstances were changed, but Margaret stayed with Brent which Maria said was "really good" as it provided a degree of support for him. She also 'intercepted' the baby as he was taken from the theatre to the nursery so Brent could hold him. Consequently, under very changed circumstances, Maria believed that her midwife had fulfilled her expectations as far as she was able.

In fact, although Maria had had to transfer to the hospital she did not regret attempting to have a home birth. She described the period of time she had been in labour at home as "really good". She also believed that had she been having a hospital birth, she would not have been so closely monitored, and in fact might not have even left home for the hospital at the stage when Margaret became concerned about the baby's welfare. She also said, "I did have a feeling it wasn't quite right. I think Margaret did too because she said she normally wouldn't monitor right through contractions like that. But she had a feeling something wasn't quite right."

Maria accepted Margaret's assessment of the situation saying,

"I trusted her, I trusted her judgement, and if she was worried, fair enough."

On that basis she transferred to hospital where a foetal heart monitor was attached to the baby's scalp. The caesarean followed shortly after, although the anaesthetic was not fully effective and Maria was aware of quite a lot of the things said and done in the theatre.

For example she felt being cut (and the pain of being cut) and was conscious enough at one point in theatre to ask, "Is my baby alright?" and to hear the reply of, "Yes, you've had a little boy." She did not mention whether this had had an adverse emotional impact but said she found the whole experience "really scary". She was very relieved on waking to be reassured that the baby was healthy and well. To quote her,

"I was really relieved that my baby was okay and really thankful to everybody - that was probably the morphine as well! But I was just so pleased I had a healthy baby. It was just such a big shock, I was still feeling in shock, like I've had a caesarean! God! [...] I still feel a bit like it now [3 weeks 1 day later], I still find it hard to believe that it all really happened. It was just the furthest thing from my mind. I mean right up until we went into theatre I still sort of thought, maybe this isn't going to happen after all."

That women do feel gratitude to staff has been noted by Green et al. (1988) and the shock and psychological impact of having an unplanned caesarean is also well documented (Affonso and Stichler, 1981; Lieberman, 1987; Mercer and Marut, 1981; Travis, 1988). Affonso and Stichler note that all women come to a birth experience with a particular set of expectations and the actual experience will either confirm or negate their expectations. Further, that discrepancies between women's expectations and reality lead to feelings of loss, with the extent of that loss being dependent on the extent of the discrepancy between expectations and reality.

Affonso and Stichler (1981) found that, following a caesarean, feelings of being anxious, fearful, worried and concerned about the baby, the self and the surgery were experienced by 92% of the women they interviewed. They also noted that women vividly recalled details of the procedures they underwent leading up to the caesarean. Feelings of unreality after the event are not

uncommon either. Mercer and Marut (1981) noted women experienced feelings of detachment about the event and stated that, "The unreality of the experience seemed like a nightmare" for women (p. 65).

Affonso and Stichler (1981) and Mercer and Marut (1981) also found that feelings were intensified when women had little time to prepare themselves for the caesarean and when a GA was needed. This was the situation Maria found herself in and her responses, therefore, are in accordance with research into caesarean birth.

Expectations of second health professionals.

As has been noted earlier the expectations of second midwives and doctors were fewer than for the primary midwife. That said it appeared that in several cases they did provide considerable support and assistance.

One respondent found that she tended to focus on her doctor's voice, rather than her midwife's, perhaps because he tended to be closer by her providing physical support and contact. In fact it could be argued that her GP went beyond the call of duty as she noted that, "I can remember him handing me a towel and saying, 'bite this'. I never realised until afterwards why he said that - it was because I actually bit him. He had toothmarks in his arm with blood in them, so I must have bitten him blimin' hard!" Her baby had had his hand up to his head and this had resulted in a large tear which her doctor also helped repair.

Another woman's second midwife had tapped on acupressure points on the base of her "tailbone", which provided some relief, along with general assistance as needed. Similarly a GP had fanned one respondent when she got very hot and she noted that he,

"Does what he sees needs to be done without being asked."

This blurring of the boundaries between the midwives' and doctors' roles occurred for several of these women (partly because the same doctor was present at three of the births). Some doctors are seen by domiciliary midwives to readily take on some of the tasks that are generally associated with midwives, such as psychological encouragement, massage, listening to the foetal heart, using hot or cold cloths and helping women to pant as the baby emerges. (It is interesting that in the

home situation it is generally the doctor or second health professional who monitors the foetal heart during the second stage of labour, while the midwife actually delivers the baby. In the hospital situation this is reversed.) Others doctors are seen to preserve a more traditional role, although providing such support if requested to (F.J.Barnett, personal communication, November 8, 1994).

Despite participating more actively in the birthing process, though, such doctors are not felt by midwives to be usurping their role. They are, rather, supporting it and providing assistance to the midwife, although they will take a more active medical role if circumstances dictate it (F.J.Barnett, personal communication, November 8, 1994). In the case of these births second health professionals provided support in much the same way a lay person would for most of the time and assisted the primary midwife as needed. There was an exception in one birth, however, when the doctor needed to take a more active medical role following the birth in the repair of a badly torn perineum.

The majority of women expressed satisfaction with how the birth was handled by their health professionals with only a minority feeling dissatisfied about some aspect of their care. Most women had found massage and hot cloths on their back, or perineum, or both, beneficial. The respondent who had laboured in the birth pool liked using it, while another had found the shower and bath soothing.

Several women also liked trying to implement the suggestions made by their midwife. For example, to try a different position to help ease the pain. The encouragement and feedback from midwives and others present was also commented on favourably.

There were also things specific to particular women that were beneficial. For example, one midwife had brought a rocking chair for her client to use and another woman commented favourably on the acupressure points in her back being tapped. Maria had a very difficult experience but found that the presence of her midwife was of great comfort.

Things that women would have liked or found helpful were few. One felt it would have been more satisfying for her husband if he had been more involved. Another had wanted hard massage, more hot packs on her perineum and her bowel motions caught rather than being left to fall into a kidney dish. She had also disliked it when her midwife's hands had moved lightly against her

skin. She felt this was like, "Adding insult to injury." She was aware, however, that that might not be the case for everyone. She said,

"It's very interesting [...] what I think is a good thing for me, if I do that for somebody else, they might not think that's a good thing for them. And that's the dilemma. And that makes it extremely difficult to judge."

However, apart from these comments all women expressed satisfaction with the way their labours were conducted.

Expectations of partners.

The majority of women expected and received support, both psychological and physical from their partners. Robyn's husband had been her main supporter at the births of their other children but due to circumstances was not at this birth. When he had arrived home she was already squatting on a support person's knee and she continued to give the bulk of the support throughout the labour. This was also partly because the birth pool, which Robyn used to labour in, needed attention. She noted that the birth pool was difficult to assemble and maintain the temperature of and that you really needed a person just to monitor it. Ben's lesser involvement in the birth did not pose a problem for Robyn, but had for him to some extent. By the time of the second interview, however, this had been resolved.

As stated previously, one woman's partner was not her main support person and, in fact, found the whole experience somewhat traumatic due to the respondent's reactions when in later labour. Her partner tended to be both physically and psychologically separated from the event. Physically he often sat apart from her and the three people attending her, although when asked to do something he responded well. Psychologically he found the situation very difficult as he could not cope with the pain he saw his partner in, a problem compounded by the fact that at one point she was abusive towards him. She noted that she,

"Wouldn't really have missed him if he hadn't been there",

and that in a hospital situation he at least could have felt he could go out for a period of time.

In contrast two other women felt their partners had fulfilled their expectations. One said,

"I was very proud of, he did very well. I think I was a bit apprehensive - maybe had too high an expectation of him, or whatever. But I was really proud of him, he did really well."

The other noted that at one point she was leaning over a bean bag with her partner massaging her back and commented that,

"Like it [the massage] was nice but it wasn't critical, it was just good to have him close to me."

Another respondent also had her partner's support. She held (and violently squeezed) both his and her second midwife's hands during contractions. During the descent of the baby she used the birth stool with her partner sitting and supporting her from behind. Lastly, one respondent's partner had provided physical support during the labour and birth, with him sitting on the sofa while she leaned into him. During second stage a mirror was positioned so that they could both see the baby descend. She had lifted the baby up as it was born so that it was between them and she commented that there were "cuddles and kisses", with both her partner and the baby crying.

Therefore, for four women their expectations of their partners were fulfilled and partners provided both physical and psychological support as needed. In fact, while partners' actions were often not commented on in detail, it was clear that their presence gave reassurance and security and that they formed an intricate part of the team which women gathered around them. As one said of her 'team' (partner, midwife and doctor),

"I couldn't do it without the support of those people."

Expectations of other support people.

At the first interview some women had not yet fully decided on who (apart from health professionals and partners,) were going to be present at the birth. Some that had decided had subsequently changed their minds. For example Maria had felt over the two weeks prior to the birth that "something wasn't right" and had asked her mother to be present as she felt that her

mother would provide her other children with greater support than the friend she had been going to ask. For all women, however, the prime person or people they had finally chosen to be at the birth were present and did fulfil expectations of them.

One respondent had asked two friends, one of whom was to care for the children. Purely due to circumstances her friend became her prime supporter, a role her husband had taken at other births. Another woman also had a friend, Shona, rather than her husband as her main support person. She had discussed the possibility her friend might react emotionally as the birth brought back memories of her own baby's birth and death. She thought, however, that her friend had "coped really well" and said she was "totally supportive and professional".

One woman had expected her partner and mother to share the tasks of supporting her in labour, and was not disappointed. She said that,

"People just assumed roles, they used their initiative and were just helpful and listened to what Margaret or[the second midwife] needed or what I thought I needed. Yer, I was really pleased with the support and how they reacted to me."

In general other people who were present at the births were there to assist as requested, take photographs and care for children. They appeared to fulfil these roles and no one expressed dissatisfaction with a support person.

As mentioned earlier all women who had other children expected them to be at the birth, and this occurred for all except two births. In one case the labour took place at night when her daughter was asleep and although her midwife did ask her if she wanted her daughter woken she decided not to. In retrospect she was glad due to her own response to the labour later on.

One respondent's three children had all been at the birth. She said,

"The funniest thing was, [aged 2], after the baby came out, he stopped watching and he came back and played with his lego and I could hear this kid off in the background singing and playing with his lego. And I sort of thought that my kids are so close to each other that the support had been there for him,

like 'my brother and sister aren't concerned about all this noise and carry-on so, you know, why should I be', and there were no problems at all."

Another said of her children,

"I didn't have any awareness of them being there. They were absolutely quiet. And I couldn't see them."

In one case the children had jobs to do to involve them in the birth, such as helping clamp the cord, cut it and dress the baby. The respondent noted that her two year old appeared to have a strong grasp on the notion that the baby came from her mother's body as she now came up to her and said, "Your baby, your [va]gina, the arms and the legs...."

The desire to involve children antenatally and at the birth forms part of the midwifery model of childbirth. The birth of a new child is seen to be a significant family event and to herald important changes for all family members, and consequently, to best take place within the family unit. It also illustrates that women see birth as a normal life event which is to be shared with significant others, rather than an event to be undertaken in a special place with specialised staff and equipment in attendance.

The sharing of the experience also had another side to it for several women. They said that involving their other children was important to them as the children would then view birth as a normal event rather than a secretive and medical one. In fact, women seemed to feel that their children had coped well with the birth and that a home birth made the process of adjustment for siblings much easier.

GENERAL COMMENTS ABOUT THE LABOUR AND BIRTH

Labours generally tended to be quite similar to what women had expected. Three women had first stages that were faster than they anticipated. One woman said she received more support from her midwives than she had expected and another commented that the birth was totally different from her first experience, and consequently from what she expected. Clearly Maria's experience was also completely different from her experience and expectations also. She said,

"It was really scary. I wasn't really prepared for a caesarean. I was sort of prepared to have to go to hospital. But I wasn't prepared for that."

Most women believed that they had made decisions during the labour and birth, either on their own or in conjunction with their midwife. For the majority of women, however, there were few decisions to be made. Two women had had their waters broken by their midwives but both said it was a joint decision between them and their midwife. Both were also having their fourth child and so had their previous experiences to guide them in their decision.

One woman felt that her midwives made decisions but noted that she was keen to try their suggestions, and that their suggestions "worked". Hence, she did not feel imposed upon but rather that she was "putting myself in their hands".

Another thought initial decisions were between her and her midwife but as the labour progressed and she became distressed that changed. She felt that decisions were then made between her midwife, doctor and support person (who was a midwife also). She said,

"So basically the only time I wasn't actually involved in the decision making was when I was out of control. Which was fair enough, because really they wouldn't have got a rational answer out of me anyway."

She also noted that they were "constantly explaining" what they were doing and why, as well as giving suggestions as to what she could try to see if that helped.

Maria was in a totally different position. She accepted her midwife's advice to go to hospital but decision making once there was out of her control due to the urgency of the situation.

THE POST-PARTUM PERIOD

The frequency of visits from health professionals after the birth varied between women, although not all women specified exactly how frequently their midwife came. For example one woman just said that her midwife was visiting without specifying how frequently, and that her doctor had visited "a couple of times". In contrast one respondent had been visited by her midwife twice daily for three days and once a day for the rest of the week, with visits from her doctor also. As

both mother and baby then became ill both her midwife and doctor increased contact again, with visits and phone calls gradually reducing as they recovered.

The two women receiving midwife only care, had twice daily visits, then daily and continued with weekly visits until the baby was six weeks old. (This occurs with midwife only care and also relates to whether midwife or doctor undertake the 6 weeks post-partum check that is a part of all maternity care in New Zealand.) Maria also received visits from her midwife and doctor when in hospital and, when she returned home, the doctor's practice nurse visited occasionally, and her midwife visited her for 10 days. She said that,

"It was really good seeing her, I used to look forward to her coming."

Another respondent also received visits from her midwife for 10 days and once from her doctor. She noted that she found the final midwife's visit difficult. She was not planning to have any more children and having had the same midwife for all four births had developed a real friendship with her midwife. She was also feeling some sadness that it was the last time she would be going through these experiences.

The majority of women had only one or two visits from their doctor, although this appeared to be because neither mothers nor babies were experiencing problems. This would also account for the larger number of visits which two women appeared to have. One as she recovered from the caesarean and the other from the large number of stitches she received and from her and her baby's later illness.

While several women did remark that they could phone their midwife or doctor if they were worried about anything, several also expressed some sadness about their midwife's visits ending. As one noted,

"There were so many questions to ask. When she came in the morning I had questions and when she came in the evening I had still more questions."

The majority of women were able to have time away from domestic and childcare responsibilities, generally through partners having time off work. As outlined earlier one woman preferred not to have time off, although she did receive help with domestic tasks from friends. She had reduced

her commitments prior to the birth and said, "I cope with change, basically by planning. And everything's planned."

Maria's partner took over household and childcare work for two weeks, with Maria in hospital for about a week of the time. She had come home on the fourth day but was readmitted due to an infection in the wound. She felt depressed at having to go back into hospital and noted that,

"At home Brent was helping me a lot with [the baby]. He was changing him and bringing him to me to feed and then taking him. And up there, I seemed to have to do a lot more. But I did have a very good midwife that night, she was really good. So that helped."

Maria also had some assistance after Brent returned to work, from her and Brent's parents and a neighbour taking the children to school and kindergarten.

In one case the respondent's partner had approximately two weeks off and this was followed by an aunt staying a week, as well as help being received from friends. One woman received a lot of assistance from her partner and parents. She said that she had helped out a few times with the cooking but, "there's no pressure for me to do so". Her mother would also take the baby sometimes at night so she could get some extra sleep.

Another partner largely took over domestic responsibilities and there was also assistance from family and friends. The respondent found her husband's parents more demanding, as they wanted to hold the baby and let her do the work. On their second visit she managed to ask them to help out with some tasks and she found that less tiring and stressful for her.

In one case the midwife had taken the respondent's 3 year old daughter for most of the day the day the baby was born, and she had friends who dropped by with food over the next week or so. Her partner could only take a week off work and she had arranged to have a nappy service for three weeks which she said was "just brilliant". Lastly, one partner worked from home but was in a "quiet phase" with his business, and family and friends were also helping out with food and childcare. The respondent was determined to spend the first week without these responsibilities, for as she said,

"You can't take it back. If you don't take it now you don't get it."

WOMEN'S FEELINGS ABOUT THEIR AND THEIR BABY'S CARE

All the women expressed a high degree of satisfaction with the care they received from their home birth health professionals. The only negative comments came from Maria and were directed at some hospital staff members.

One said the care was "great, wonderful". Another commented,

"I can't fault it really. I can't imagine any better care really. [...] The support that I needed was there, I felt it was safe because Margaret had the equipment and I really trust Margaret."

She did say, however, that she found it difficult to be organised enough to get to the hospital by 8.00 a.m. to have the baby's hips checked by the paediatrician. (All babies are checked but having a home birth means having to get to the hospital at the start of the paediatrician's rounds. Parents are encouraged to take their baby in the first few days for this check.) She also found the weekend following the birth "quite hard" as the children were so excited, and so was relieved when Monday and school came around.

Four respondents expressed great satisfaction with their and their babies care also, saying,

"Excellent. I was really really impressed. [...] I had three health professionals while I was in labour and most people don't have that. They were all very good and all got on well and communicated well. [...] I'm really pleased with how the whole thing went."

"Excellent care. I felt very confident in their skills."

"Oh, very good. Its been marvellous."

"Excellent. [...] Its really worked out very very well."

Maria's situation was obviously different. She said the care from her domiciliary midwife was,

"Excellent [...] it was so good having that familiar face, and knowing that someone's on your side and that they know what you want."

She noted that in hospital it was "always someone new" and she felt that having her own midwife had "made a huge difference". She had not experienced depression following the birth and felt that it was partly because she had had her own midwife and noted that,

"I don't think I would have coped very well if I hadn't had her there."

Maria's hospital experiences were mixed. She had some "really good" staff but had also had some who, essentially, neglected her and her baby. She said that she did experience some feelings of loss, loss because she was not able to have a vaginal birth and could not hold and breastfeed her baby immediately after he was born. However, the hardest thing for her was,

"Not being able to get up and do things for him, I found that really hard. 'Cause, you know, I had to ring the bell every time he cried and they weren't very good at coming. The first night I ended up, I just held him all night in bed because they were really busy and they couldn't come in and fix him up for me. So I ended up holding him all night and he was really unsettled. And it was really good to have that contact but it was a bit hard."

Mercer and Marut (1981) note that when women have caesarean births the difference between their expectations and experience of the birth make mother-baby interactions more difficult, with mothers having less physical and emotional "energy" for mothering (p. 77). Maria did not appear to have any problems bonding with her child but she certainly did experience both psychological and physical pain. Stichler's (1981) findings suggest that this is usual, and also that psychosocial factors, such as the attitudes of others, can increase feelings of both psychological and physical pain.

The day after her son's birth was also difficult, again perhaps due to staff being overworked. Maria said that,

"The day that I went up to Ward __ I was a bit of a mess by the time I got there. Because the woman who was looking after me, the nurse, she must have been having a bad day too. And every time I pressed the buzzer she came in and turned it off and went away again. [...] And I'd had her all day and baby hadn't been changed all day and I hadn't had a shower and I was feeling really yuk [...] and we got down to Ward __ and I had a really nice nurse on there and she bathed the baby because he was really smelly, he'd been wet and dirty all day. It was really horrible, I'd been really upset all day. And I had a shower."

Her son was taken to the nursery that night and brought to her when he woke for feeds, so by the next morning Maria was feeling a lot better.

ANOTHER HOME BIRTH?

All women except Maria felt sure that if they were to have another child they would have another home birth. Maria said her doctor would not consider home birth as she had now had a caesarean.

Consequently she was somewhat unsure about home birth as a viable option for herself but said that she would definitely have an independent midwife again.

Other comments included the following,

"To me the only reason for really going anywhere other than home is if there's any element of concern in terms of things going normally, and if things are then I think it's the right place to be. I think for me, in terms of being able to birth, I just know I need to be somewhere where I can be relaxed and that to me is home."

"Probably next time I'll scream for hospital again - that's just me. [...] [My partner] I think would probably like me to go into hospital [...] [but] yes I'd definitely have a home birth again."

"Well, why wouldn't I really? This was such a positive experience and the memories are so positive. I think when the time comes it'll be the first option for me."

"Most definitely. Because the experience is so positive, so much more relaxing."

One reply also pointed to future changes in home birth,

"I'd do it exactly the same way and I'd choose exactly the same team. If I was doing it first time now I'd choose midwife only [care]. Because Richard actually put himself on the line for me all those years ago I would always want him to be part of my birth and my antenatal care, in probably much the same way that you feel about And these days I could not say to him, 'sorry Richard I'm going to have midwife only'. Because that would be like a slap in the face to him when he's been through all those really important times."

It is interesting to note that very similar sentiments were expressed by both the two other women having their fourth babies towards their doctors. It is also interesting to speculate how this might change as midwife only care becomes more popular to a new generation of mothers.

ADDITIONAL COMMENTS

In response to the question as to whether women had anything else they would like to add or anything they felt I had missed, four women said no.

The other three women reiterated their satisfaction that everything had gone so well, as illustrate below.

"It's just been great. I just feel really blessed and very lucky."

"I think I'm aware - like things aren't going to be easy always over the next months. But I think this is the best start we could have got."

CONCLUSION

The length of women's labours varied a lot and as a consequence different women needed more or less support. While partners obviously formed an important part of the support network for most women, women's accounts of their labour typically focused more on their midwife's role.

Peterson et al. (1979) believes that home birth gives greater potential for the father's involvement in their child's birth and postnatally. This study certainly found that most fathers were intimately involved in the birth and provided most of the postnatal care for the family. Most births did appear to be family events as the midwifery model advocates.

The majority of women also did appear to have strong social networks, as suggested by McClain (1987, cited Pratt, 1990), and to have received support from these networks for the birth and postpartum period.

Midwives appeared to have given considerable support to women also. They respected women's preferences by providing care which was in accordance with the wishes and concerns which women had expressed prior to the birth. Women particularly seemed to appreciate the dedicated attention of health professionals in their attempts to help ease pain or alleviate discomfort. Feedback and encouragement was also commented on positively and, in general, it can be said that women expressed very high satisfaction with the care they and their babies received from home birth health professionals.

In fact the care which women received from their midwives seemed to reflect their expectations prior to the birth. As has been noted, the underlying assumption of care seemed to be that midwives would monitor women and babies, provide suggestions and give constant care and attention as needed or requested. This appeared to take place and the friendship which seemed to exist between women and their midwives suggests that New Zealand researchers studying home birth are correct in stating that the relationship between a woman and midwife is of crucial importance.

Postnatally women enjoyed the visits of health professionals. This perhaps reflects the importance of the friendship which had developed over the months, the quality of the individualised care which women received and the depth of the experiences which they had

shared. Satisfaction with post-partum care was extremely high and this may also explain why women were reluctant to see the end of such care.

With satisfaction so high it is timely to remember that two of the difficulties of measuring satisfaction noted by Green et al. (1988) were, firstly, that women are generally relieved, grateful and positive after the safe birth of a healthy baby. And secondly, that people have a need to rationalise adverse experiences. It is likely that the tendency to feel relief and gratitude is occurring with these women, and in fact Maria was very conscious of her gratitude to staff on hearing that her baby was healthy.

However, Maria was also vocal in expressing her dissatisfaction with aspects of the service she received. She rationalised the experience to the extent that she acknowledged the situation could have been a lot worse, but she was very clear in expressing both satisfaction and dissatisfaction about different aspects of her care.

Hence, it seems likely that Green et al. (1988) are correct that women may express very high levels of satisfaction due to feelings of relief and gratitude, but that it might not be the case that women's rationalisation of events means they will not express dissatisfaction.

Perhaps another reason for the level of satisfaction was that, not only were expectations of support people at the birth realised, but generally labours and births were fairly similar to what women had expected. This no doubt reflects the previous experience of birth which most women had. There were two exceptions to this, however, and the differences which these women experienced illustrate that the view that 'one can never tell what will happen in labour' is still relevant. It could also be argued that the fact that all but one labour progressed without any problems illustrates that birth, for the majority of women, is without complications. And, consequently, that home birth is safe.

While control did not appear to be a central concern for the women in this study I have argued elsewhere that the desire for control was, in fact, implicit in statements made by women. Hence, it was interesting to note that the majority of women believed that they had control over decision making. Some believed they had made decisions, others that they and their midwife had.

In fact, though, very few obstetrical decisions needed to be made. Because labours progressed without complications any issues had generally been discussed prior to the birth. Consequently, the relationship between women and midwives did provide women with the opportunity to gain control over the birth. That they could retain that control during the labour and birth illustrates that domiciliary midwives respected women's wishes. No doubt if midwives had violated their trust women's feelings of satisfaction would have been much reduced.

There were, however, two cases when women did not always feel in control. In one instance the midwife, doctor and friend (a midwife also) assumed the decision making role at a difficult stage in the labour. In the second case the urgency of the situation demanded that decisions were made by the hospital team. It should be noted, though, that this was not against Maria's wishes, as she was obviously extremely concerned about her child's welfare and accepted immediate action was necessary.

In both these cases, though, satisfaction was still expressed about the care received from health professionals. This is in accordance with research (such as by Basset-Smith, 1988; Green et al., 1988) which points to the crucial nature of the relationship between women and health professionals. That is, the significant thing may be how something occurs, rather than what occurs.

With the possible exception of Maria all women would choose to have a home birth again if expecting another child. Maria's ambiguity is because her doctor would not recommend home birth following a caesarean. In fact, vaginal births after caesarean births and whether they can occur at home reflects yet another controversy in obstetric practice and in the home versus hospital debate.

The decision of all the other women to choose home birth again were they having another child reflects the incredible degree of satisfaction which women expressed towards the experience and towards the care of those involved in their pregnancy, labour and birth. It is also in accordance with both international and national research into home birth (Abel and Kearns, 1991; MacFarlane et al, 1978; Maternity Action, 1993; Pratt, 1990). It suggests that a real partnership existed between women and health professionals. This could only have positive consequences for women in terms of feelings of increased self-confidence, efficacy and self-esteem.

Chapter 8
INTERVIEW THREE - REFLECTING BACK

"When women want and need services that institutions can not or will not provide, other women will create them" (Swenson, 1980, cited Edwards and Waldorf, 1984, p. 146).

INTRODUCTION

This chapter is divided into eight sections and a conclusion and is an analysis of material gathered in the third interviews. (See appendix 6 for interview questions.)

The first section gives details of the interviews, such as the length of interviews and ages of babies.

The second section is concerned with information. This includes whether women felt that they were able to discuss things with their health professionals and whether they received the right amount of information when discussing issues and concerns.

Section three outlines women's feelings of satisfaction with their care antenatally, during the labour and birth, and postnatally, along with feelings of satisfaction about their relationships with their health professionals. Also considered is satisfaction with the labour and birth, satisfaction with interventions and what women would change if they could.

The fourth section considers issues of control during the labour and birth, including whether women felt in control of what their health professionals were doing to them, whether women could get into the most comfortable position possible, whether women felt in control of their own behaviour and whether they felt in control during contractions.

Section five looks at emotions in two specific time periods. Firstly, women's feelings when they first found out they were pregnant. Secondly, feelings of depression postnatally are examined, such as feelings of depression since the birth, whether women felt they had been having more good days than bad and whether they felt things had been "getting on top of them".

Section six looks at different aspects of care. Women outline what they believe the most important aspect of the birthplace is, what they liked most, and what they liked least, about the care they received.

The seventh section considers a variety of issues. These include what advice women would give to a close friend who was considering different birth locations, whether women believed the interviewing process had affected them in any way and any additional comments women made. Also examined are the responses of the last two women interviewed who were asked some questions not asked in earlier interviews. Some of these questions were more reflective, such as asking women to imagine what their expectations would have been prior to having any children compared to their expectations now, and how they believed their husbands would answer the same question. Secondly, what advice they would give to another woman planning a home birth, a home birth that might end up as a hospital birth, and again, how they felt their husbands might answer the same questions. Finally, the women were asked what role their partner had during the labour and birth and how important that role was.

Lastly, the eighth section is in the form of a post script. It outlines Maria's experiences and changes of perception following the third interview. Maria had felt overwhelmingly negative about her experience of caesarean birth at the time of the third interview, but within the next three months she came to view the experience differently and to feel that it had given her a different outlook on life. It was felt that this change in feelings and perceptions was significant enough to warrant enclosure in this thesis.

BACKGROUND DETAILS

The third interviews took place between 20 April and 19 October 1994. They averaged 37 minutes in length, with the range being from 20 minutes to 1 hour. All took place at the women's home and all except one took place during the day.

The ages of the babies ranged from 3 months 1 day to 7 weeks 4 days. All babies appeared to be progressing well. Two had experienced some problems however. One had received antibiotics due to a recurring infection and another had failed to gain weight due to extreme difficulties with feeding. By the time of the third interview the first baby was well over the infection and, in the

second case, the problem had been resolved and the baby was feeding well and was gaining weight.

A fourth interview took place with one woman in January 1995. The interview lasted 20 minutes and her child was aged 11 months at the time it took place.

INFORMATION

All women felt that they had been able to discuss the things that they wanted to with their midwives. As one woman said,

"We discussed everything right the way through, and if one [i.e. midwife or doctor] felt differently from the other we discussed that too. Everything was very well discussed."

Six of the women had a doctor involved in their antenatal care and four of those women commented that they were better able to discuss things with their midwife. For example,

"I found my midwives a lot more approachable [...] I found that I would ask my midwives a lot of questions that I think if I didn't have them I would be a bit afraid to ask my GP."

Two women felt that one reason why they felt more comfortable talking to their midwife was because she was a woman. However, the main reason that women mentioned was the fact that the midwives' visits were considerably longer than antenatal appointment times with doctors and that this made relaxed discussion possible. One remark illustrated this well. The respondent noted that she discussed more things with her midwife,

"Probably because with Margaret it was at home and it was, sort of more like you were chatting. And you sort of remembered things. Whereas with Richard I always had to write things down and quite often I'd get to the last one and I'd think, 'Oh no, I can't ask'."

One woman noted that her midwife would visit and stay for one and a half to two hours, which allowed plenty of time for questions. Another felt that the greater ease of discussion between herself and her midwife, and between midwives and clients in general, was,

"Because of the way the system's set up."

She also said that when she was waiting for her antenatal appointments with her doctor she, "Was thinking at the time that the docs are just going to have to be careful. Because with the midwives offering that sort of alternative service they're going to lose antenatal care."

The ease of discussion women largely experienced is favourable compared to the findings of Green et al. (1988). In their study only 33% of women could always discuss things with their health professionals, although 51% could most of the time. Green et al. also found that there was a significant relationship between information and the psychological outcomes of satisfaction, fulfilment and emotional well-being. Women who had wanted more information or felt they had been given misleading information were less satisfied.

McSherry (1986) in her Manawatu study found that information exchange was seen as the most desirable characteristic in a GP, while unapproachability was viewed as the worst characteristic. She also found that women's information needs were not met.

Most women in this study also believed that they received the right amount of information from their health professionals. Several said that they felt confident in asking questions and were satisfied with answers.

One respondent felt she had received more information than she had wanted but noted midwives had to ensure clients did receive information in case problems arose later on. She said,

"Well, she'd give me the whole lot, because of the fact these days you've got to be very very careful on the professional side of things to make sure everyone knows everything."

Two women did feel that they had needed some additional information. Maria would have liked more information on caesarean birth but also recognised that, "there was no way that they could

have known" she would need to have a caesarean. Another respondent would have liked more information about breastfeeding. Unfortunately her problem developed after the midwifery visits officially ended and although she did speak informally with her midwife about the problem she would have liked more support.

Alternatively one respondent experienced huge problems with breastfeeding but said that,

"One of the things I really appreciated was the midwife was more inventive with dealing with issues, especially with this breastfeeding stuff. And unusually inventive. And it wasn't stuff that was necessarily in the book. But when I told the doctor about it he supported it."

While her own midwife had suggested a variety of strategies to help the situation the suggestion that finally led to a resolution of the problem was from one of the other domiciliary midwives. She suggested that the respondent and another mother swap babies once a day, rather than use a bottle to supplement breastfeeds. A home birth mother who was also involved in La Leche League agreed to do this and slowly the situation improved to the point whereby daily visits (to give the respondent's baby the extra feed) were no longer necessary. She noted that the suggestion that swapping babies might help was, "Quite an unusual piece of information to give to somebody. You have to choose the mother that you say that to and you have to choose the woman who is providing that extra breastfeeding carefully. And in both situations they did."

Green et al. (1988) found that 68% of women felt they received the right amount of information. It is interesting to note, though, that 86% of those who did believe they received the right amount of information felt in control "always" or "most of the time" compared to 64% of women who felt they did not receive the right amount of information. Also, that women satisfied with the amount of information they received gave more positive descriptions of their babies. They note that, "Information was important at every stage: before, during, and after labour" (p. 9.12).

SATISFACTION

Satisfaction with caregivers.

All women expressed satisfaction with their care, antenatally, during the labour and birth, and postnatally. One said she had, "No regrets about anything that happened. It doesn't put me off having another one and I'd be quite happy to go with the same professionals again." Another noted that she liked the flexibility of the midwifery care as it allowed her to spread the visits from her midwife out over a six week period.

One respondent felt the care was "really good" and commented that she would not be breastfeeding her baby if she had not received such good care. Not surprisingly she also said, "I'd love not to have had that dreadful breastfeeding start, I felt really pissed off about that and it made me feel really strange about[her baby]. Because it was dreadful, really dreadful. Just absolute agony. I don't think I've cried so much, you know days and days. Feeling like the kids couldn't be here. We got rid of the kids for a week and then I used to have to lock[aged 3] out of here when I was feeding so that I could be focused and concentrating."

Two women did express some dissatisfaction, however. One would have appreciated a wider range of options to help her overcome the problems she encountered breastfeeding and Maria still felt dissatisfied with hospital staff. Her concerns were that staff had not always attended to her when she rang for assistance, that she had needed more help to care for her baby than she received, that there was a lack of continuity of staff and that a blood test was carried out on her baby when she had specifically asked them to wait until her own midwife arrived. So, while Maria acknowledged that some staff were good she generally expressed dissatisfaction with her care in hospital.

Not surprisingly, given the high level of satisfaction which women expressed about their care, very high levels of satisfaction were also expressed regarding their relationships with their midwives (see Table 5). Four women said they would rate their relationship with their midwives as 10 out of 10. For example one remarked,

"There's no way really that I can think they could be better really."

Two women gave a mark of 9 1/2 out of 10 and 9 out of 10 respectively as "no-ones perfect" and one woman gave 9 out of 10 as she found her midwife "a bit waffly" at times.

Women's relationships with second health professionals were also viewed positively (see Table 5). The two women who had midwife only care rated them at 9 1/2 and 9 out of 10 "so that there's room for improvement". Three doctors were rated 10 out of 10 and one 9 out of 10. Two others scored lower. Firstly, a 6 out of 10 with the woman noting that,

"There wasn't much he could do about that because he was so busy. It's a different relationship you have with them."

Secondly, a 7 out of 10 for a doctor who provided antenatal care only. It was noted that,

"The main issue was the communication and giving information and explaining to me what was happening to me."

Table 5: Levels of Satisfaction.

Women	Satisfaction with Relationships with Health Professionals			Satisfaction with the Birth Experience
	Primary Midwife	GP	Second Midwife	
1	10	10	n/a	9
2	10	6	n/a	0
3	10	10	n/a	10
4	9	9	n/a	8
5	9	7 ⁽¹⁾	9	9
6	9.5	n/a	9.5	8
7	10	10	n/a	10

(1) Provided antenatal care only.

Satisfaction with the labour and birth.

Satisfaction with the birth experience also tended to be high (see Table 5). Two women rated their satisfaction as 10 out of 10, another two rated their satisfaction as 9 out of 10, and a further two rated their satisfaction as 8 out of 10.

While women rated their experiences as very satisfactory they also acknowledged the pain and discomfort which giving birth involves. (They still obviously preferred to undergo the pain of childbirth than select a location in which they could have pain relief.) For example,

"Well, I would have said 10 out of 10. And at the same time I would have said, probably 5 out of 10 because I didn't want to do it."

"You could give it 9 out of 10, the only thing you could want more is no pain!"

One respondent gave a 9 out of 10 because she felt the birth pool was awkward and needed to be so closely monitored. Another also rated the experience as a 9 and said,

"I think 9 or 10. Yes, the birth was really amazing, it was a really happy time, really enjoyable. It went so well. I suppose 9 because there's always room for improvement."

Similarly another woman rated her birth experience as 8 out of 10 because 10 out of 10 would be a birth without pain. One respondent gave her experience 8 out of 10 and noted,

"I absolutely loved giving birth at home, I really enjoyed it. I loved the care I received, I loved the fact that my family was around. I really liked the fact the once he was born he was there [at home]. But there was the stage in the middle where I just didn't cope and to me that's the only part that I'm sort of not satisfied by."

Finally, Maria rated her birth experience as a 0 out of 10. She said,

"Well, I suppose I'd have to give it a nought probably. The most important thing was that he was alright and if I had to mark it from that it would be 10. The actual birth experience wasn't very good at all!"

Maria's lack of satisfaction is in accordance with the research of Green et al. (1988). They found that women having emergency caesareans and caesareans under GA expressed very low levels of satisfaction.

When Green et al. (1988) excluded women who had had caesarean births from their analysis they found that two-thirds of their (hospital) sample rated their birth experience as either an 8, 9 or 10. Satisfaction with the birth experience was associated with having at least one midwife remain with women for the duration of the labour and birth; satisfaction with the amount of information received; and feeling in control. Also, women that had no choice of birth location expressed less satisfaction with the birth.

The women in this study who had their babies at home did have a midwife who remained with them throughout the labour and birth, were satisfied with the information they received and, mostly, did express feelings of control. Hence, it would be expected that they would also express high levels of satisfaction with the birth experience.

The majority of women did not have any interventions and several remarked how pleased they were that they did not require suturing. While women were not asked about damage to the perineum it was often an issue they mentioned. Only one woman required stitches and two others said they had small tears that were not sutured. In Green et al. (1988) study 73% of women suffered some kind of damage to the perineum. They also noted, however, that there were "striking differences" between maternity hospitals in the need for suturing.

Two respondents had artificial rupture of the membranes (ARM) and both expressed satisfaction that this occurred and felt that the decision was jointly made between them and their midwife. Even so, Ann noted that, "I was a bit tentative at the time as to whether the waters broken was the right decision because I thought that would have made it a bit fast and furious." Green et al. (1988) note that while satisfaction tended to be reduced by interventions, including ARM, the interventions themselves did not appear to be the important factor. Rather, what was important

was the way in which the decision was made to perform a procedure. That is, when women's wishes were disregarded and intervention occurred, satisfaction was reduced.

While Maria did not express satisfaction with the interventions she had she also did not express dissatisfaction. Rather, she said,

"It all had to be done. The only thing that I've been not quite so happy about since then was the internal monitoring they did. They put a monitor on his head and, I've sort of had doubts about it since then. [...] They told me afterwards he wouldn't have survived the birth, because there was no fluid. [...] But you've still got that doubt."

Given the general level of satisfaction with their relationships with their health professionals, and with their birth experiences, it is not surprising to find the responses to the question "If you could change something, what would you change?" tended to focus on peripheral issues. For example, "Only the pool." "The placenta took a long time to come. An hour and a half. But it wasn't stressful." And, "I think if I could change anything I would have realised the night before when I had an idea that I should have set up the birth pool, I would have followed my intuition and done it! And I would have rung my sister [in Wellington] the night before."

One woman had expressed some dissatisfaction at the second interview that her midwife's hands had been moving against her skin, which had increased the discomfort she experienced. On viewing photographs of the birth she realised that the irritation had been caused by a flannel which her midwife was using to cover her anus. She said that this was the only thing she would change, as the flannel had been too rough against her skin and she would have liked a soft cloth to have been used instead.

Two women would change more substantial things however. While Maria's response was brief it was also poignant. She said if she could change something it would be,

"The birth. That's the only thing I'd change."

Another woman's response was more focused, she said that,

"The hardest thing that I find, coping with afterwards is the fact - that I really didn't mind the birth and that but my husband found it difficult because he was stuck here with nothing to do. All he could do was watch me in pain and he feels helpless. [...] That's the only thing that I find very hard to cope with, is the fact that it was really hard on him, just the whole coping with it. [...] Out of the whole birth that would be the one thing that I do have a regret over, that he isn't the sort of person to actually get involved, and didn't know how to cope anyway, so he found it really difficult. After was born he was really really upset."

ISSUES OF CONTROL

Three women felt in control of what their health professionals were doing to them throughout the entire labour and birth, as illustrated below,

"Oh, certainly. Yes. It was pretty much hands off really. The only real part that Margaret really [pause] yes, would have been the waters, breaking the waters. And that definitely was my decision."

"Yes. Absolutely. In fact I was telling them what to do."

Two respondents felt in control of what their birth attendants were doing to them some of the time. Maria said that at home she "felt like I was the one in control" but that,

"As soon as we got to the hospital I just went to bits."

Another woman remarked that, "The only time I felt I wasn't in control of them was when I had completely lost it and they needed to move the anterior lip and I felt at that point in time that the decision was made between them and I sort of accepted it. I was just out of it. [...] They discussed it but they made the final decision, not me at that point." She also noted, however, that,

"We'd discussed it beforehand, if a situation arose [...] and we had discussed that so long as it was good for me and it didn't require anything major - it had previously been discussed. So it didn't worry me. I've got no regrets about it whatever."

Two women did not feel in control of what their health professionals were doing to them. One said,

"No, I was letting them help me as they could see what I needed. I was too concentrated on what was happening to be looking outside myself as well. But from my birth plan they knew what I wanted and what I didn't want. But they added in things which really worked well."

However, she also commented,

"I didn't feel out of control either, I just felt I was free to be where I was while they helped me. And I had faith in them to do that and I didn't feel like I was being manipulated or rushed along [...] we each had our roles to play as it were."

Another respondent expressed similar feelings. She noted that she "didn't know what they were doing sometimes" but also that,

"I could have said 'I don't like that' or 'please do this' or 'please do that'. I was doing that the whole way through."

It would seem from their remarks that both these women did not feel in control of what their health professionals were doing to them but did not feel deprived of control either. Rather they trusted their caregivers to use their initiative in trying different things as the situation demanded and to respond to their requests, while respecting previously discussed requests and parameters.

Green et als. (1988) study found that 27% of women always felt in control of what staff were doing to them, with 53% feeling in control most of the time. They also suggest that, "A woman's perception of the staff is a major determinant of her feeling of control" (p. 7.22). That is, women who described staff positively felt significantly more in control than women who described staff negatively. Green et als. findings also suggest that external and internal control "tend to go together" and they propose that external events which result in a loss of external control also bring

a loss of internal control. Feeling in control of what staff were doing to women brought increased levels of satisfaction, fulfilment, emotional well-being and satisfaction with the birth experience.

Certainly all six women who gave birth at home felt that they could get into the most comfortable position possible, and Maria felt that she was able to when she was at home too. For example typical replies included the following,

"Yes, I did. I was on my hands and knees basically the whole time."

"Yes. They were on the floor. They completely moved themselves to meet me."

It is interesting to note that Green et al. (1988) found that women who could get into the most comfortable position possible were more likely to have intact perineums. They found that being able to get into the most comfortable position was associated with increased feelings of satisfaction, satisfaction with the birth, fulfilment, emotional well-being and positive descriptions of babies, while lack of privacy was negatively related. Green et al. further suggest that there is a clear link between being able to get into comfortable positions and control, saying, "They could not get comfortable precisely because the staff, the drugs or the equipment were depriving them of that fundamental degree of control over their own bodies" (p. 9.8). They go on to note, "It is in this sense that 'external' control is important to most women rather than in the sense of women issuing orders to the staff" (p. 9.8).

The majority of women also felt in control of their own behaviour, although two women's comments perhaps sum up the tenuous nature of control at such a time.

"I don't think I felt out of control, [...] I mean you never really feel that in control. [...] Yes, I think I did."

"Yer I did [...] I felt like I was [...] I think I was."

There were two exceptions to this however. Karen believed she was throughout the first stage of labour and towards the end of the second stage, but not when she entered second stage. And Maria said she felt in control of her own behaviour at home but not in hospital.

Maria also felt in control during contractions when at home but not when she reached the hospital. Karen felt she was also in control during contractions and noted that when she lost control part of the problem was that contractions had actually stopped.

While the five other women did feel in control during contractions they also made a variety of remarks that, again, indicated their awareness that the pain of labour and birth mean that control is a relative concept. That is, they felt in control partly because they did not feel out of control and despite the fact that at times noises and movements that they made may have indicated the contrary. For example one said,

"Yes, yes you do. I don't like it. I think it's an awful thing, having this dreadful pain. But I was completely in control in my own way. [...] I wasn't trying to pretend to be stoic and at the same time I didn't scream in an uncontrollable fearful way."

Green et al. (1988) found that about half of the women they surveyed felt in control of their own behaviour most or some of the time, while 55% felt in control during contractions. They note that internal control was related to fulfilment, satisfaction and emotional well-being positively and, as has been stated, that there was a strong link between feelings of internal and external control.

EMOTIONS

Six women indicated that they had wanted another child and so were pleased when they found out they were pregnant. However, four of these women also said that they had mixed feelings about being pregnant, mainly due to the extra demands another child would bring. For example,

"We'd planned it. But when I found out I was pregnant I wasn't very happy about it for a while. Just the worry about postnatal depression and how I was going to cope with three. Because I was really tired too at the beginning."

"We were thrilled. Also, I suppose a mixture of feelings of, sort of, you know, 'you've done it now, you're going to have another child'. Generally really pleased."

"I was really pleased but trepidated. Because I knew exactly what was going to happen. [...] I wanted this child so I was delighted. [...] I was just really aware that I knew what I was in for in terms of the discomforts of pregnancy - the increase in weight, the nausea, the heartburn, the lack of libido, the lack of sleep, interrupted nights, pain of the birth."

One woman had not been planning to have a baby at the time she got pregnant. She was in her final year at Palmerston North College of Education and had planned to finish her degree at Massey University before teaching and gaining her teacher registration. Consequently being pregnant required a big adjustment to her plans. She said,

"I fluctuated between thinking, 'disaster, we've missed out' and 'it's okay, we'll just be doing something a bit different'."

There were further problems also. The respondent was quite ill at the beginning of her pregnancy and end of year examinations were fast approaching. In addition her relationship with her husband had been strained and she feared that a baby would increase the difficulties they were experiencing. Despite these feelings and problems she also said that she was at times "quietly excited". Generally, though, her feelings were of apprehension about the changes the baby would bring to her and her husband's lives and plans.

It would appear that mixed feelings are not unusual when women first find out they are pregnant. While 73% of Green et als. (1988) sample were either overjoyed or pleased they were pregnant, 22% experienced mixed feelings. Feelings were related to two psychological outcomes (fulfilment and emotional well-being), with those women who said they were unhappy or very unhappy when they found out they were pregnant having the lowest emotional well-being scores of all. McSherry (1986) found that 56% of her sample felt excitement and joy when they first found out they were pregnant. For 44% it was, "Unexpected and, to varying degrees, unwelcome news", while for 22% it was a cause of distress and disruption (p. 51).

Six of the women said that they had not been feeling depressed since the birth. However, five of those six women also spoke of low points when things had not been going well. Generally these low points occurred when women were unwell, as illustrated below.

"I go through stages where I get a bit down. But I think because I've been sick quite a bit, I'm sure that makes a difference. [...] It's just normal, I wouldn't call it postnatal depression that's for sure. I feel really good most of the time. I have times when I feel down."

"I haven't been feeling depressed. I haven't been very well though, I've had a string of breast infections. So, when I recover from them I feel wonderful, I feel like I'm alive again and then they come on [again] so quickly."

One woman's oldest child had been more demanding since the birth, as she adjusted to having a sibling. Again, she did not feel she had been depressed though. Rather,

"A bit strung out now and again with this one [touches child]. Because she's acting up a little, of course, and that's only to be expected. That's all really."

There was one woman who said that she had been feeling depressed, however, although she felt her depression had been due to the problems with breastfeeding she had experienced. She said,

"Yes, enormously so. Because of the real problems that I had with the breastfeeding that I just didn't seem to be able to overcome. [...] I cried a lot [...] just the desperation of not being able to figure it out and get it sorted out. But I feel fine now. And as soon as the problem resolved itself I felt fine too. So I think it was the problem that was making me feel depressed, not something inherent in just being newly delivered."

Now that the breastfeeding was progressing well the respondent also felt that she was having more good days than bad, which was the reverse of her feelings during the first 5-6 weeks after the baby's birth. In fact by the time of the third interviews all women said that they were having more good days than bad. Not surprisingly then, women also felt that things were not "getting on top of them". Again, women who had experienced times of sickness remarked that those times had been difficult. For example,

"When I was sick, that was the point I was low."

Maria had undergone a caesarean and felt that this made it more difficult to cope at times. She said,

"The only thing I've been finding is that people forget really fast that you've had a caesarean, and I mean I do too. Just now and again it would be good if people - my husband - would take it into account. You don't really get a chance to recover properly, well I don't think I did. [...] I do feel basically back to normal but I know in myself I'm still recovering. And it's probably part of the trauma of it as well. Still sort of working it out."

Again, the respondent who had experienced the breastfeeding problems felt that things had overwhelmed her but that once the problem was resolved she "got on top of things again". She also commented that this was aided by a number of factors. Firstly, her husband worked from home and so could be flexible in his work and able to help with the older children. Secondly, her parents cared for the older children for a week. Thirdly, friends and members of the MHBA provided most main meals for about a month. And, lastly, her association with the MHBA gave her a strong support network from both members and midwives. She believed that home birth challenges the orthodox view and that the people who are drawn to it are, therefore, open to different ways of doing things and that this gave her access to creative ideas and suggestions which enabled her to overcome the difficulties she faced.

Green et al. (1988) found that the majority of their (hospital) sample had some degree of depression post-partum, although only 9% had felt 'quite' or 'very' depressed. It is interesting to note that they also found that outside events, rather than the demands of a new baby, were associated with their measure of depression. That is, some women who had had to cope with events such as illness or a death in the family had higher levels of depression.

ASPECTS OF CARE

The question "Nominate the one most important aspect of the birthplace" brought two common responses. Firstly, that at home you were surrounded by people you love and who love you. For two women this was the most important aspect, with one commenting,

"For me I think the most important thing is being able to have people around me who love me and who trust in me and trust in my ability to give birth".

Three other women also mentioned this aspect as being important in the birthplace.

"The fact that the baby's born into your family and you haven't got to go anywhere. [...] It's a part of life."

"I can choose who I have here."

Another woman also mentioned this aspect, along with the second response which reoccurred in this question, namely the home environment. She said,

"Just the relaxed atmosphere, the lack of stress. People around that you love and want around. Lack of having to bustle around and get packed and move and then having to worry about what's happening at home."

Karen also commented on the home environment. She said,

"The nicest thing I liked was that it was my home [...] just being in my own environment was wonderful."

Maria felt that the most important aspect of the birth of her son had been safety, but that the most important aspect of birthplaces in general was,

"Oh being comfortable. Being in control and comfortable."

Miriam felt that the most important aspect of the birthplace for her was, "It was my environment." She also remarked,

"Because I believe that it's a normal event, if I have the baby at home it means that it's normal for me. If it wasn't normal I wouldn't be allowed to be at home to begin with. So actually being at home reinforces the normality of the process for me."

Miriam also commented that having her second daughter at home had been especially important psychologically for her as it reinforced the normality of the process after her son's death. (From cot death 18 months earlier.) By having a home birth she felt reassured that all was going well and that the baby would be alright.

Women's responses are in accordance with Cunningham's (1993) and Pratt's (1990) findings. Cunningham found that the home birth mothers saw emotional and psychological factors as the most important aspect of the birthplace. In contrast, women who gave birth in maternity hospitals believed health care facilities were most important. Similarly, Pratt notes that the concept of risk for home birth women includes both physical and psychosocial factors, as opposed to only physical.

While women gave a variety of responses to what they liked most about the care they received one common thread was the relationship that they developed with their midwives and the personalised care which midwives provided.

Antenatally one woman said she liked the fact that she was not told "you have to do" particular things, but instead that she could discuss issues with both her midwife and doctor. During the labour and birth she really liked the support and concern for both herself and the baby. And, post-partum, she liked the relaxed nature of care, with her caregivers dropping by to see all was well without the formality which could be associated with postnatal care.

Other comments included the following,

"Oh the personal [pause] knowing my midwife, as a friend. And being able to talk to her. That was probably the best part. And being at home was really good."

"Just the friendliness, knowing the people who were caring, which was really great. Just the understanding, I know about them they know me and the whole family as well."

"I enjoyed the friendship from my midwives and the understanding. Just the availability of them, and listening, and I suppose the professionalism of offering their opinion when needed and not when it wasn't. And information when it was needed and not when it wasn't."

One woman noted that the care she got,

"Enabled me to be me. There were no judgements put on me [...] they met my needs. And very reassuring."

One respondent felt what she liked best about her care was that her midwife visited her at home. She liked this "for really practical reasons more than anything else", but also said that it enabled her to more fully involve her youngest child in the process, as well as providing a relaxed atmosphere more conducive to discussion. In addition she commented that the home environment,

"Really helped me to re-establish that relationship with Margaret, which I think was one of the reasons the birth went so well. I just really trust her so much, I was able to feel confident in her and that she knows where I am and how that is different from where I was perhaps at other births. And a chance to talk about the fears, that are different of course with each birth, at different times. It's that sort of side of it I think that are the sort of thing I would put off at antenatal visits with Richard."

Finally, one woman said that she liked the continuity of care which having a midwife provided, that her midwife visited her at home antenatally and that her daughter could be more involved. She also liked the fact that her midwife,

"Was with me through my whole labour, she didn't just nip in, nip out or phone and things like that. She stayed with me and gave me that security and support that I needed."

Of her postnatal care she said,

"It just felt so neat after he was born, that everyone was here and helping. I got breakfast in bed by Margaret - different things like that, that was really neat. [...] And I also liked the fact that Richard is our normal GP and we know him quite well anyway. Where if it had been, say someone else, I don't think it would have been so special. And it meant it was much easier, my husband could say things to him that he probably wouldn't say to other people."

Three women said that they could not think of anything that they "liked least" about the care they received. For example,

"I can't really say that I liked anything least really. I mean it went on for the right length of time really, I didn't really need assistance after Margaret finished her visits. No, everything was really good."

"There wasn't really anything. I can't really think of anything I didn't like. It was all really good."

However, when questioned about the hospital care she received one of these respondents said,

"Well there wasn't much I really liked about being in hospital. I think one thing I thought since would have been really good - because there was nothing wrong with when he was born - would have been if he could have been beside me when I woke up in recovery. Or, Margaret. That was one thing, it would have been nice if Margaret could have been there, but then I think she was sort of taking care of Brent. That was important too, that was important to me. But that would have been really good, because it was quite a while after he was born. I had to go up to the ward to see him. It would have been quite good, even if he'd been there and I could have seen him, and Brent and Margaret. And then if they'd taken him."

In fact this request has a sound basis to it, as it has been found that when partners are in the room when women wake from a caesarean birth, the women express less fear and appear to have less

difficulty in integrating the experience postnatally (Mercer and Marut, 1981). It has also been recommended that babies be placed near mothers as they awake (Stichler, 1981).

One woman had shared care between her midwife and doctor but had primarily been visited by her midwife. Over the Christmas period when her midwife was away she had seen her doctor and she said she would have preferred to have had her midwife over this period as well, although she also felt that it was good to "link in with Richard" as well. That is, while she would have preferred one thing she also recognised that what occurred had a positive aspect to it also.

Her preference for the style of care which her midwife offered is echoed by another respondent. What she liked least about her care was,

"Well for the doc, just the way the systems set up in the rooms. [...] I think that midwives offer a better service to women, because they're more available, their knowledge base is much more focused on the norm."

Lastly, one said,

"The part I liked least was probably that it [care] stopped at two weeks. Like I felt, during the first two weeks, probably I could have done with far less visits. But I would have liked the visits to continue a bit longer. Even of once a week up to the six weeks. Just to have that person there that you can contact for something."

ADDITIONAL QUESTIONS

Four women were asked, "If your best friend was pregnant and considering different birth locations, what advice would you give her?"

One woman said her advice would be,

"Probably to consider having a midwife, or definitely to consider having a midwife, having that continuity of care. And also just - where are they going to be happiest as well."

She also thought she would advise her friend to "check out" prospective midwives to see what sort of care they offered, such as whether they would remain with her throughout her labour or not. Other advice included that her friend should not have too great expectations as things might not go according to plan, and to consider her husband and how he would cope in a given situation. In addition she said she would speak of her positive home birth experience, but acknowledged that "everyone's different" and women needed to make decisions which best suited them and their needs.

Advice other women would give included the following:

"Somewhere where you feel really comfortable, where you feel is a safe place and a special place. Yer, just those feelings of safety and security and control and a haven."

"I couldn't do anything but say how wonderful home birth is and certainly [say to] give it a great deal of thought. And I'd give her all my positive reasons why."

This respondent also commented that many people were unaware there is an alternative to "the hospital model" and so did not actively make a choice of birth location.

Miriam said her advice would be,

"Always to start at home, to plan a home birth and take that as the given until something else proves it to be not an acceptable option."

She also drew on her experience as a midwife, saying,

"I don't like birthing particularly, because of the pain that's associated with that, what it gives me is a really productive mother long-term. It's so much more powerful at home."

Miriam then discussed her philosophy to the pain of childbirth and women's experiences of this pain. Her quote illustrates well the philosophy of the midwifery model towards the pain of birth. Miriam's observations that childbirth without chemical pain relief tends to be empowering is supported theoretically. It may also be an important factor in explaining the greater satisfaction expressed by women who give birth without chemical pain relief. She said,

"Interestingly I've read several articles in mags [magazines] lately about various celebs [celebrities] that have had their babies and they've all had epidurals and painless births. [...] I feel like writing in and saying: why hand over something so normal to men, why take away your involvement in the process, and why limit your learning potential from the birth experience by succumbing to something like an epidural that takes [away] the fact that we actually learn so much about the strength of character of ourselves by succumbing to that pain and by doing the process.

"You actually gain a lot out of it. And the implication by having an epidural is that you can gain nothing by having a painful experience, well that's just rubbish! You can actually learn a lot from the experience of pain. Like you and I have both experience as mothers of lost [dead] children, that's a pain that I would not want for a minute to have been sedated through. And I feel exactly the same way for the births of my children too. That in fact experiencing that pain has given me something else.

"It's enabled me to have the strength to go through that really difficult period. Now if I hadn't had that I'd have given it [breastfeeding] away because it would have been too strong.

"So there's validity in experiencing pain and we can learn from it and I think if we can experience that pain positively and we work with it then we can actually face any of the other difficulties of parenting that we have without crumbling under the weight of that pressure - like you know you're a strong person.

"Like these birth experiences have made me feel really powerful as a woman. And it's worth suffering whatever I have to suffer in order to have that feeling. It's such a valuable personal growth thing. I think it's worthwhile to hang on to that."

Some questions were asked of only the last two women. The first one of these questions was, "If you were to imagine what it was like before you had any children, how would your expectations for the labour and birth be different from what they were for this one."

The first respondent said that it was like knowing (by listening to others, discussing things with health professionals, reading and watching videos) but not knowing. She,

"Wanted it to be like all the nice things I'd read but by the same token I didn't know, no experience behind me, and I had to put myself in the hands of those who knew. But with my plans that I wanted a home birth and the most natural birth. But within those parameters, what would actually happen and what it would be like - unknown territory."

Miriam felt that her expectations before she had a child would not have been different from her expectations after having one due to her knowledge and experience as a midwife. She added that she had to answer the question "...from a midwifery perspective rather than from a mother's, because my knowledge base is different and I was a long time midwife before I became a mother."

To the question "How do you think your husband might answer the same question if I asked him", the first respondent said,

"It's hard really, he has said to Margaret and a few other people just after the birth, that he felt a lot more ready this time and a lot more in control of things and sort of knew a bit more and could do a bit more [...] that he was really blown away the first time."

Miriam felt that her husband, "Very clearly handed over the responsibility to me. He said, 'You're the one that's doing it, you have more knowledge than I do. I will go along with what you want'."

The second question had two parts. It was, "Knowing what you know now, what advice would you give to a woman planning a home birth" and, secondly, "a home birth which might end up as a hospital birth". One woman said her advice would be to,

"Get organised. Follow your intuition if you can."

She felt women needed to be well prepared, such as having friends and support people organised, to be part of an organisation from which you could get support and information, to put meals in the freezer and, if you could afford it, to get a nappy service.

To the second part of the question she answered,

"Having the continuity of your own midwife would be really really important if you have to go into hospital, because that would really shake your confidence."

She felt that her husband's answers to the same questions would include the following advice: to be involved in a group, to have an established support network and "I think he'd swear by the nappy service!" She felt that in a transfer to hospital situation he would stress the importance of the support network as, "A lot would be thrown on you as a partner when you'd be feeling devastated too."

The other woman asked these questions answered both parts of the question together. She said,

"Get as much information as you can, read as much as you can, listen to as many birth stories as you can, that's always been really powerful for me. I've always encouraged women to attend the [MHBA] meetings [where women who have recently had a baby tell their birth stories] for that reason. Because what it does is that it actually makes people have a broad range of possibilities of normal rather than 'this is how it has to be'. You can be normal and still have this and this and this happen, and also it teaches you strategies for how to cope with things that aren't quite as expected as you had thought they would be."

"So attending meetings, staying away from anybody that's negative to the idea of home birth. [...] Don't go to regular antenatal classes, like stay away from the system as much as you possibly can. Get your midwife to show you the system so that you can cope with that contingency. [...] Having knowledge about all the possible contingencies. Like, alright I'm going to have a caesarean section, what can I do to be still in charge of that section? I can say that I want to have it under epidural, if at all possible. I want my partner to be there, if at all possible. I don't want the baby to be bathed - so that you can actually claim some of that birth experience for yourself. So I think you still look at contingencies [...] but still stay very focused on the normal."

The respondent felt that her husband's advice to others would be to,

"Go with the flow probably. [...] He'd say don't hesitate, give it a go. I think he feels it's a very safe option."

While this respondent did not answer the second part of the question, (i.e. what advice she thought her husband would give for a home birth that might end up as a hospital birth,) she did elaborate on the safety issue. She noted,

"That's one of the great lies about the whole birth thing, when they say you're much safer if you're in hospital. Women can prolapse their cords when they're in Pak-n-Save and they're at greater risk. [...] At any point one of us could bleed, at any point our membranes could rupture and our cord could prolapse. So that's bullshit, it's a washover from the system to keep people fearful."

Both these women were also asked what role their partner had in the birth and how important it was to them. They gave similar responses,

"Very much an anchor for yourself. Very much as a physical, as well as an emotional anchor."

"Very much as a support for me. By going through that experience with me he shares the responsibility of the parenting."

And, the partner's role was seen to be,

"Very important".

"Enormously important. Enormously important. I would not do it without him being there. And I would not want to do parenting without him taking an equal share of that, or a percentage of equal share. He doesn't do it 50/50. But he's a very active parent."

All women were asked whether they thought being interviewed had affected them in any way. Five women said that it had not, although one also commented,

"It's been just lovely to be able to share it. It's really nice to have an excuse to rabbit on about it."

Two other women had also enjoyed the experience of being interviewed, saying,

"I keep forgetting I have [been interviewed] actually. In fact I've quite enjoyed it. I think it's good to sit there and reflect back on the whole experience."

"Oh yer, it has actually. It's been really good. It's quite good, sort of being able to work it out, have someone to talk to about it. Yer, it's been good to talk about it."

To the last question, "Is there anything else that I haven't covered that you think is important" four women said they could not think of anything. One said, "To me it was important that she came at home because the family was there."

Another that, "In terms of home birth, the only area possibly is the whole area of siblings, of children being present." Finally, one woman remarked, "Probably just a bit about the breastfeeding." She noted that women sometimes chose home birth and midwifery care because

they wish to breastfeed and believe these choices will maximise the chances that they will breastfeed successfully.

POSTSCRIPT TO INTERVIEW THREE

As stated in the Chapter 5 all respondents were given the opportunity to read the interviews once they were written up and to discuss any concerns they may have had about anything written about them. When Maria was rung as part of this process she said that everything that was written was true at the point in time she was interviewed, but that since then she had changed her feelings about her birth experience and now thought of it as a "blessing". As a consequence of this conversation a fourth interview was conducted with Maria about her experiences when she was under GA and the consequent change in her outlook. She noted that,

"Well, now that it's not so fresh, the pain especially, it's like I wouldn't have it any other way. It was quite an enlightening experience. Because I had the dreams or whatever I had."

She also said that she had not spoken about her experience at earlier interviews because she initially found it difficult to talk about.

"I put it off. I keep putting it to the back of my mind. [...] It's taken me quite a while to sort of sort it out. 'Cause every now and again I'll remember something else. [...] And to tell people too. Because I'm not a particularly religious person but I've got a faith, I was worried that people might think I was just a nutter or something."

As was mentioned in the earlier interviews Maria had not been fully sedated when she underwent the caesarean. She recalled feeling the effects of the anaesthetic overcoming her and, next, of hearing the anaesthetist saying, "Alright, you can go [start] now." Her next awareness was of,

"The pain, the knife going right across. And I can remember thinking quite clearly, 'oh my god, this can't be happening', and then the voices saying, 'it's alright, come with us, we'll look after you'. It was such a relief, it was really nice."

Her experience consisted of,

"Just voices really, [...] I sort of saw it like my guardian angel really. And I remember music. It was like watching a film. And every now and again I'd hear the voices in the operating room, like from a far distance, from a long way. I remember getting born and everything. [...] I sort of felt like I was lying there and I could hear the voices right around me like that, sort of round my head. And it was like I sort of shot off, like I just went up. [...] I sort of remember looking back at my body too."

"It was like being taken back. [...] It was physical and mental, it was like a whole experience [...] it was more a feeling, a sensation. Sort of like getting sucked, like I got sucked away. But it wasn't scary, it was really nice. [...] I remember a really white bright light. Not like the ceiling, more like a glow, white glow."

"From the things that I remember of it it sounds like what a near death experience is like."

She noted that at times she seemed to be more aware of what was happening in the hospital theatre,

"I remember sort of flashing back and hearing things that they said in theatre. [...] I'm sure I came back for the birth, because I remember there was a lot of noise and I remember the crying, I could hear the baby crying."

Following the birth Maria discussed her experience with a friend,

"The first I remembered of it [the experience] was about - it must have been the next day, when I came off the morphine. I remember about an hour after I got back to the room a friend came up and I said, 'I had some really freaky dreams'."

While in hospital an anaesthetist came around the ward asking all the patients who had had an anaesthetic whether they had had any strange dreams. Maria told her of her experience and the anaesthetist talked to the doctor who performed the caesarean and to Maria's anaesthetist. They agreed that the things Maria had described, such as conversation she had heard, had taken place while she was under GA.

However, it was not until her baby was about six months old that Maria came to view her experience positively. She noted that,

"I had been scared before that, when they said I was having an emergency caesarean. [...] I was worried that I was going to die. But it's since then that I've had a different outlook on things, especially as it's gotten further since then."

"Just what things are important and what things aren't. It's given me something to believe in too, it's given me a renewed faith, a bit of an awakening or something. [...] Like I'm not scared of dying any more. Like the only thing that worries me is I don't want to leave my kids, my family. But it's not painful or anything, it was really really nice and I feel really lucky, for what I experienced there."

"We get pretty broke, with kids, with children, and before that I'd be in a big tizz, terribly worried and stressed out. But now I tend to think, 'it'll take care of itself, it'll work out' and it does, it always does. [...] It goes right across the board. [...] It's more of an awareness of the natural cycle, you know, life and death. [...] I feel like I'm out of sync [synchronization] a bit [...] I feel like it's given me more of an understanding of society, how it's out of sync. I feel like the whole of society's lost its way or something, it should be all in balance with nature [...] so it's given me a different view of that. I never would have even thought about things like that before."

When asked whether the experience of the pain of the birth had had an effect also, Maria said,

"It's [the pain] imprinted it [the experience] more on me. [...] I remember the pain as well as the rest of it."

"It's empowering to know you can live through it [the pain], you can handle it. It's like the power of the mind."

This observation is in accord with those Miriam made towards the experience of pain and how it can increase feelings of self efficacy. It also reflects the midwifery model's view that, despite the fact childbirth is a painful and difficult experience, it is still an experience that is satisfying and fulfilling.

CONCLUSION

In general very high levels of satisfaction were expressed about the amount and quality of information women received. However, two women would have liked more information and one felt she had received more than she needed. All women felt they were able to discuss issues with their midwives, although women felt less able to discuss things with their doctors. Generally this was seen to be due to differences of environment, although it is possible other factors could have also contributed to it. Midwives visited women in their own home which gave an atmosphere of privacy and relaxation. In addition their visits were much longer. During visits to doctors women were aware of other people waiting and the limited time of appointments.

All women expressed satisfaction with their care, although two women also felt dissatisfied to some extent. One of these women would have liked to have been presented with a wider range of options for a specific problem and the second woman was dissatisfied with the care she received from hospital staff following a caesarean birth. Women's satisfaction with the relationship they had with their primary midwife was very high, as was their satisfaction with their relationship with second health professionals in most cases.

Similarly satisfaction with the labour and birth was high and when lower ratings of satisfaction were given it was generally due to the pain associated with birth. One woman rated her experience as a "thoroughly unsatisfactory experience with nothing good to be said for it" and drew a distinction between her lack of satisfaction with the caesarean birth and her feelings of

extreme satisfaction with her baby. As has been noted, her feelings about the birth did change in the months following the third interview.

Most women did not require any medical interventions but did express satisfaction with caregiver's attempts to relieve pain. Two women had their membranes artificially ruptured but both felt they were fully involved in the decision for this procedure to take place. Clearly significant intervention occurred in the case of the caesarean birth, which took place under GA. Neither satisfaction nor dissatisfaction was expressed, but rather an acceptance of the necessity for the caesarean, although some of the procedures leading up to the caesarean were questioned.

The majority of women would not change anything about the labour and birth even if they could, although some did mention minor peripheral issues that they would change. Two women had more significant concerns. One woman expressed regret that her husband found the birth experience traumatic and another said she would change the entire birth experience.

In the months following the third interview, however, this woman underwent a change in her feelings about the birth. She felt that the paranormal experience she had while partially under GA had given her a new perspective and understanding of life. It would seem likely that a combination of factors would make psychologically adapting and adjusting to such an experience a difficult and drawn-out process. Firstly, scepticism of others towards unusual experiences, such as she experienced, would reduce the likelihood that the experience would be discussed openly. Secondly, the memory of her experience was fragmented and is still being recalled to some extent. Thirdly, the whole trauma of the labour and birth would tend to overshadow any positive feelings about the experience. That is, the memory of the fear for her own life, her baby's life and the pain of the operation would initially dominate thought processes.

That she could, in time, feel that the experience had been a valuable one which had enabled her to "change and grow" is a tribute to her adaptability. It perhaps also shows a willingness or predisposition towards personal development as suggested by human development researchers.

Only three women felt in control of what their health professionals were doing to them the entire labour and birth. Another two felt that, while they were not in control, neither was control taken out of their hands. Rather, that their health professionals used their experience and knowledge to the women's advantage and within the boundaries which had been discussed antenatally.

It could be argued, then, that all five of these women had a birth experience which enabled them to retain feelings of control throughout the entire labour and birth. Again, this must reflect the depth of the relationship that women developed with their health professionals, and primary midwife especially. Women did appear to be treated as equals by their midwives and certainly felt that they were active participants in the birth process. This is in accordance with the midwifery model of childbirth and also echoes research into satisfaction during childbearing which finds a correlation between levels of involvement and satisfaction.

Lastly, two women felt in control some of the time. One had a period during the labour when she felt out of control, although she later regained it. And, another felt she lost control when she entered hospital.

Apart from Maria all women also felt that they were able to get into the most comfortable position possible. Most women also felt in control of their own behaviour and in control during contractions. That said, women were aware of the tenuous nature of control during labour. Again, two women had times when they felt in control and times when they did not.

Women's initial feelings on discovering they were pregnant were usually positive as the baby had been planned. Several women said they also experienced a mixture of emotions, however, due to an awareness of the extra demands on them which another child would bring. One woman had not planned to get pregnant and, although at times excited and pleased at the prospect of a baby, generally felt considerable apprehension.

Most women had not been feeling depressed since the birth of their baby, although the majority also discussed low points. These generally occurred when women were unwell, although in Maria's case they were also associated with her recovery from the caesarean. Only one respondent said she had been depressed. She felt the depression had been due to a problem with breastfeeding which she struggled for several weeks to resolve.

Once the problem had been resolved, however, she did not feel depressed, felt she was having more good days than bad and felt that she was on top of things again. All other women also felt that they were having more good days than bad and felt that things were not getting on top of them.

Several women felt that the most important aspect of the birthplace was to be surrounded by people who you loved and who loved you. This included the notions of family involvement and being able to choose who was at the birth. Another common response was that it was important that the birthplace was a relaxed and comfortable environment. Both these attributes were applied to the home as a place of birth but not to the hospital.

What women liked most about their care brought a variety of responses, but most centred on the quality of the relationship which they had with their midwives and the personalised care which their midwives provided. Examples included the friendliness of midwifery care, the availability of midwives, the professionalism of midwives, home visits by midwives, continuity of care and midwives having knowledge and understanding about the woman and her family, within their home environment.

Three women could not think of anything that they did not like about their care. Reservations expressed included having a change in caregiver over the Christmas period, that the service offered by doctors is inferior to that offered by midwives, and that care ended at two weeks. In addition Maria thought it would have been preferable if her midwife, husband and baby had been in the recovery room when she awoke from the GA.

Women's advice to a close friend considering different birth locations included the following. That women consider having a midwife to gain continuity of care, but also to question prospective midwives on their practices; that women should not have too great expectations; to consider partners when thinking of different birth locations; that women consider where it is that they feel safe and comfortable; and to always plan to have a home birth and start to labour at home. Women also said how they would tell of their positive home birth experiences, while still acknowledging that every woman has different needs that must be considered.

For the two women asked, the advice they would give to a woman planning a home birth, and a home birth that might end up as a hospital birth, included the need to be well organised and prepared; to have an effective support network; to get as much information as possible; and to listen to birth stories so that women become aware of a diversity of experience and different coping strategies. Also, to avoid mainstream classes, while at the same time discussing various

scenarios with their midwife. Husband's roles in the birth were seen to be that of a support person for their partner and their role was seen as extremely important.

No woman felt that the interviewing process had negatively affected them and three women had enjoyed the chance it gave them to reflect back on their experiences.

Finally, three women had additional comments they wished to make. One stressed the importance of the baby being born into the family unit. Another would have liked more focus on the effect of home birth on siblings, although she also recognised that that was another whole area of research in itself. And one respondent would have liked more questions on breastfeeding as she noted that home birth and midwifery care were sometimes chosen because women wanted to breastfeed and believed such choices increased the chances that they would do so.

If all three interviews are considered it is apparent that women do believe in the midwifery model of childbearing. It can also be safely assumed that this viewpoint is shared by domiciliary midwives, and at least some of the doctors providing care. This assumption is based on the belief that if midwives (and doctors) did not share women's beliefs they would not have provided care that so clearly met women's needs. In such a case the satisfaction which women expressed about their care would clearly have been diminished.

Chapter 9

DISCUSSION AND CONCLUSIONS

"Assigning issues of childbirth to the political fringe ignores its importance to the rest of society" (Jowitt, 1993, p. 181).

While Pelvin's (1990) assertion that the 1990 Nurses Act changed the face of midwifery in New Zealand is undoubtedly true, it could be argued that the legislation had less impact on women wishing to birth at home than on those merely seeking continuity of care. That is, the numbers of women using the services of an independent midwife has risen dramatically, but the number of women having a home birth has risen only slowly.

Within this study there were four women who had had some of their children prior to 1990 and some after. One of these woman had antenatal care from her doctor and her two children were born in hospital with care being provided by hospital midwives and her GP. For her pregnancy after the law change, however, she planned a home birth and so used the services of a home birth midwife and her doctor. Consequently, she did experience a change in the care she received following the Nurses Act and stated that she felt the care she had received was positive and preferable. She stated she would use such services again if she had another child.

Three of the women who had had children prior to 1990 had selected home birth both before and after legislative changes and it appears that the Act made little difference to the care they received. They had a midwife and doctor as their caregivers both before and after the law change. However, they also expressed an awareness that different options were now available. In two cases the women volunteered the information that they felt it was important to include their doctor because he had been instrumental in enabling them to have their children at home at a time when doctors could effectively block women from home birth. Because their doctors had taken responsibility for their births, despite possible repercussions, women felt a great sense of loyalty to them. (These also appeared to be their feelings about their midwives.)

In areas of New Zealand where doctors were not able or willing to attend or take responsibility for home birth the Nurses Act would have had a greater impact. In addition, as the numbers of women seeking home birth have increased it has become less marginal. So, it would seem that there are positive outcomes arising from the Nurses Act 1990 for home birth women as well as for

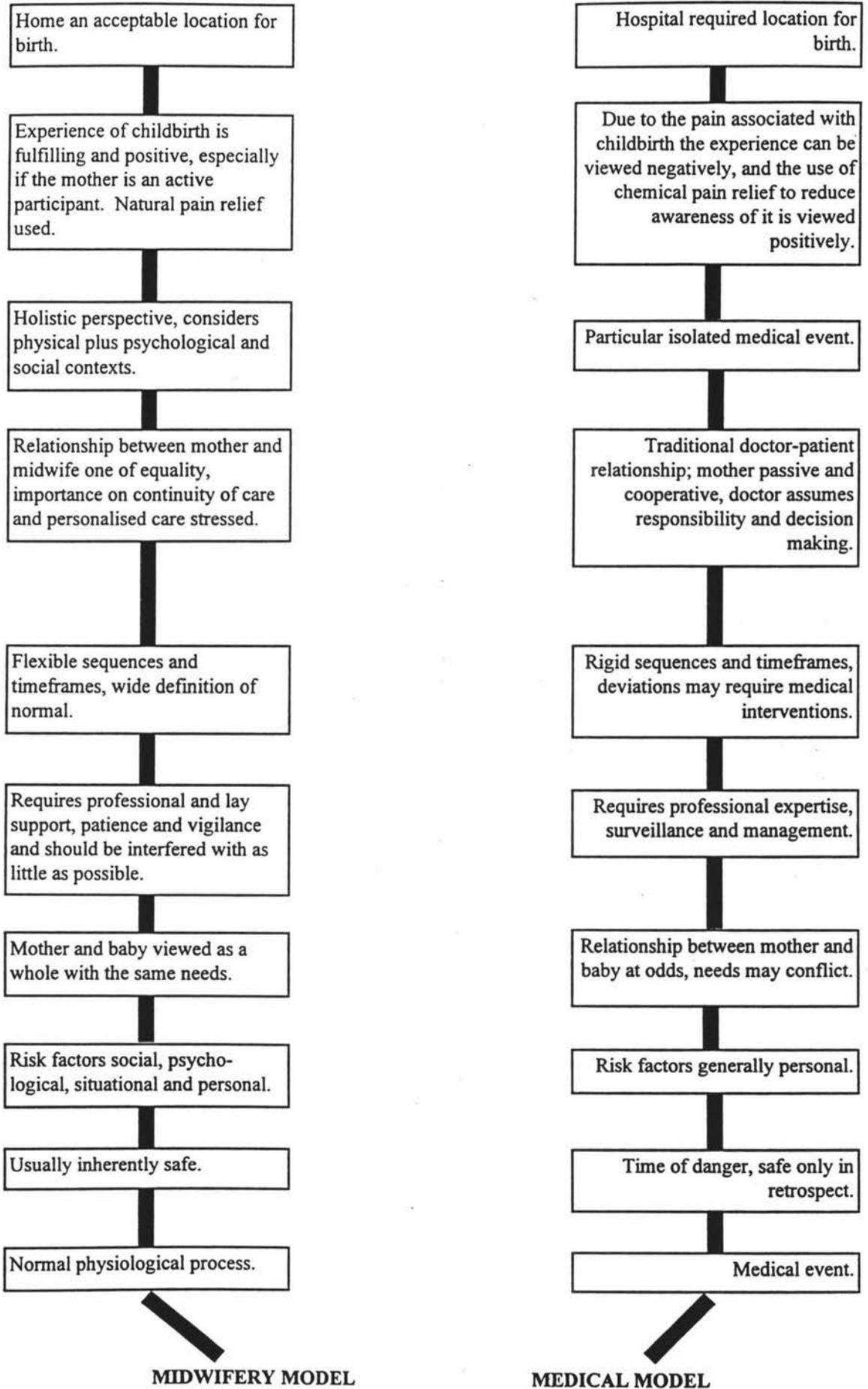
domiciliary midwives. Access to home birth is improved, particularly in some areas, and having a baby at home becomes more socially and obstetrically acceptable.

What will be interesting to see over the coming decades is whether doctors experience reducing demand for their services from expectant mothers, although such a situation would not necessarily mean an increase in home births. If so, two important factors could explain this. Firstly, the services which midwives provide could be viewed as more acceptable to women. Certainly several women in this study found this to be the case, as, presumably, do women who choose independent midwifery care. Midwifery care is provided in the home, allows ample time for questions and discussion, and is holistic. Women feel able to ask questions, seek information and develop a rapport with their midwife. Doctors on the other hand are seen to be pressured by time and other clients and to operate in an environment which is not conducive to relaxed discussion. It may be, then, that doctors will have to change the way in which they work if they wish to continue providing such services.

The second factor that could bring about a reduction in the caseload of doctors is if there is an increase in the numbers of women who see childbearing as a non-medical event in their life. And, consequently, see no need for a doctor to be involved (barring problems). Again, however, should this situation occur the number of home births would not necessarily increase. The belief that childbirth is a non-medical event relates to differences in viewpoints as illustrated by the medical and midwifery model of childbirth. While the differences have been discussed previously, Figure 1 provides a diagrammatic model of these two perspectives.

MODELS OF CHILDBEARING

The midwifery and medical models are not a recent phenomenon. Oakley and Houd (1990) note that traditionally midwives and physicians have had different styles of care for women in childbirth. But more fundamentally, the power battle that has taken place between the two groups is about the control of childbirth from two groups of health professionals with mutually exclusive views about pregnancy and childbirth (Kitzinger, 1991; Oakley and Houd, 1990). They note that both obstetricians and midwives believe that they give good care, but there is a large difference in what 'good care' is thought to be. Similarly, Roberts (1981) and others (such as McSherry, 1986; Mayers-Ciecko, 1991; and Page, 1991) believe that midwives and doctors have a, "Qualitatively



different way of looking at the nature, context and management of reproduction" (Roberts, 1981, p. 51).

Tew (1990) states that in the 1950s there was a redefinition of normality in pregnancy, with the consequence being that most births then had to take place in hospital, with obstetric management increasingly dominating care in the following decades. This concern with what is viewed as 'normal' continues, with Livingston (1987) noting that the expanding definition of 'high risk' has defined up to 70% of all birthing women in the United States into that category. For example poor women, non-white women, women under 21 years and over 35 years, breech presentation, multiple gestation and previous caesarean section all constitute high risk (Livingston, 1987).

It is not only high risk women who experience medical management when childbearing however. In her Manawatu study McSherry (1986) found that although the women she interviewed were all low risk, the maternity care they received was "consistent with the medical model" (p. iii). She also found that the type of care women felt they would prefer largely reflected a view of childbearing that was in accordance with the midwifery model.

McSherry (1986) notes that in New Zealand, "There appears to be the assumption that providing a high quality, efficient service by provider criteria would automatically benefit the consumers", but that such an assumption, "Fails to acknowledge that the standards and priorities of consumers and providers for a quality service do not necessarily coincide" (p. 3).

While McSherry (1986) found that the women she interviewed saw birth as a normal, non-medical event, only three of the 48 women had their babies at home. The strong opposition to home birth that she recorded centred around two main issues. Firstly, women believed home birth was unsafe and were unaware that secondary maternity units and home birth midwives have much the same equipment available to them at a birth. Secondly, women did not believe that birth was a family event. They wanted the involvement of partners but not other people, and especially not their other children.

McSherry (1986) noted that, "Using a methodology that focussed on women's personal experiences allowed a version of the reality of childbirth to emerge that often differed from, and at times contradicted, the prevailing obstetrical definition of the childbirth process" (p. 132). She found that women wanted a more holistic form of maternity care, a form that recognised and

incorporated the socio-emotional dimensions of pregnancy and birth. They also rejected the passive patient role and the association of childbirth with illness.

When asked to describe what they felt were the best conditions in which to give birth, the responses of 10 women indicated they felt specialist medical facilities were preferable. Thirty-two women, however, felt a small, locally sited hospital, physically separated from the general hospital and with its own staff and with homelike surroundings was preferable. Women's main requirements were for privacy, peace and quiet, and relief from other social roles. However, physical environment was less important to women than the quality of their relationships with staff.

It is interesting to note that McSherry (1986) found that nearly 75% of women who gave birth at the base hospital, "Couldn't get out of hospital quick enough", while only 10% of women using secondary hospitals felt this way (p. 125). The major reasons given were not being able to relax in the hospital environment, the lack of privacy and feeling they were under the scrutiny of a variety of strangers. Linked to this were McSherry's findings that 70% of women felt that the type of hospital they gave birth in did influence their overall experience of childbirth. Two-thirds of those women felt the hospital environment made a positive contribution to their experience and 19 of those 22 women had given birth in secondary maternity units.

It would seem then, that belief in the midwifery model of childbirth is not a sufficient condition of home birth, although it is probably a necessary one. It seems possible, though, that women giving birth at home have a stronger and more encompassing belief in the midwifery model and that their beliefs include the notion of birth as a significant family event. Pratt's (1990) study did find that there were differences in attitudes between New Zealand women giving birth at home and in hospital. Differences were found in attitudes to risk, the acceptability of interventions, anxiety about the birth and feelings of confidence in ability to care for the newborn. The most powerful of these factors, though, was perceptions about the risk attached to childbirth. She also found that women giving birth at home defined risk more liberally to include psychosocial aspects of the birthplace.

Consequently, it may be that the majority of New Zealand women do subscribe to the midwifery model of childbirth to some extent. And what singles out women who select home birth from

women who do not, is a deeper and more encompassing belief in the components of the midwifery model.

Figure 2 provides a diagrammatic representation of these factors. This graduated model illustrates that some aspects of the midwifery model are held in common by New Zealand women. However, women also sharply disagree on a number of factors. Particularly important are perceptions of risk, beliefs about whether birth should involve the whole family or not, and the extent of knowledge about maternity services and technology (see Figure 2).

THE CURRENT STUDY: PERCEPTIONS AND EXPERIENCES

Although the women in this study did not explicitly cite the midwifery model and their adherence to its beliefs, it does appear that they do share that philosophy about pregnancy and birth. The women strongly supported actively choosing how the birth would be conducted, who would be present, and what should or should not occur at the birth. This can be viewed as an attempt to control what takes place, and some women did explicitly say that they wanted control (to some degree or other) over the birth. A number of women felt that the maternity system had a particular way of working and that this reduced the options of women entering the system. Women wanted input into decision making and the flexibility which the care of home birth midwives provided. This means that they saw themselves as active participants in the process of pregnancy and birth and that they believed they had enough information and knowledge on which to base an informed choice.

It is also reliant upon there being equality in the relationship between women and their health professionals. That is, health professionals must believe that women have the right and responsibility to be involved in making decisions. This is another important aspect of the midwifery model. The women in this study all expressed satisfaction with their relationships with their primary midwives, and generally with their second health professionals also. They felt that the service midwives offered was friendly, professional and was tailored to their individual needs.

The ample time midwives allowed for visits was seen to facilitate relaxed, easy discussion, in contrast to visits to doctors' surgeries.

The partnership which women felt existed between them and midwives appeared to involve considerable trust by women. No woman in this study made any suggestion to indicate that their

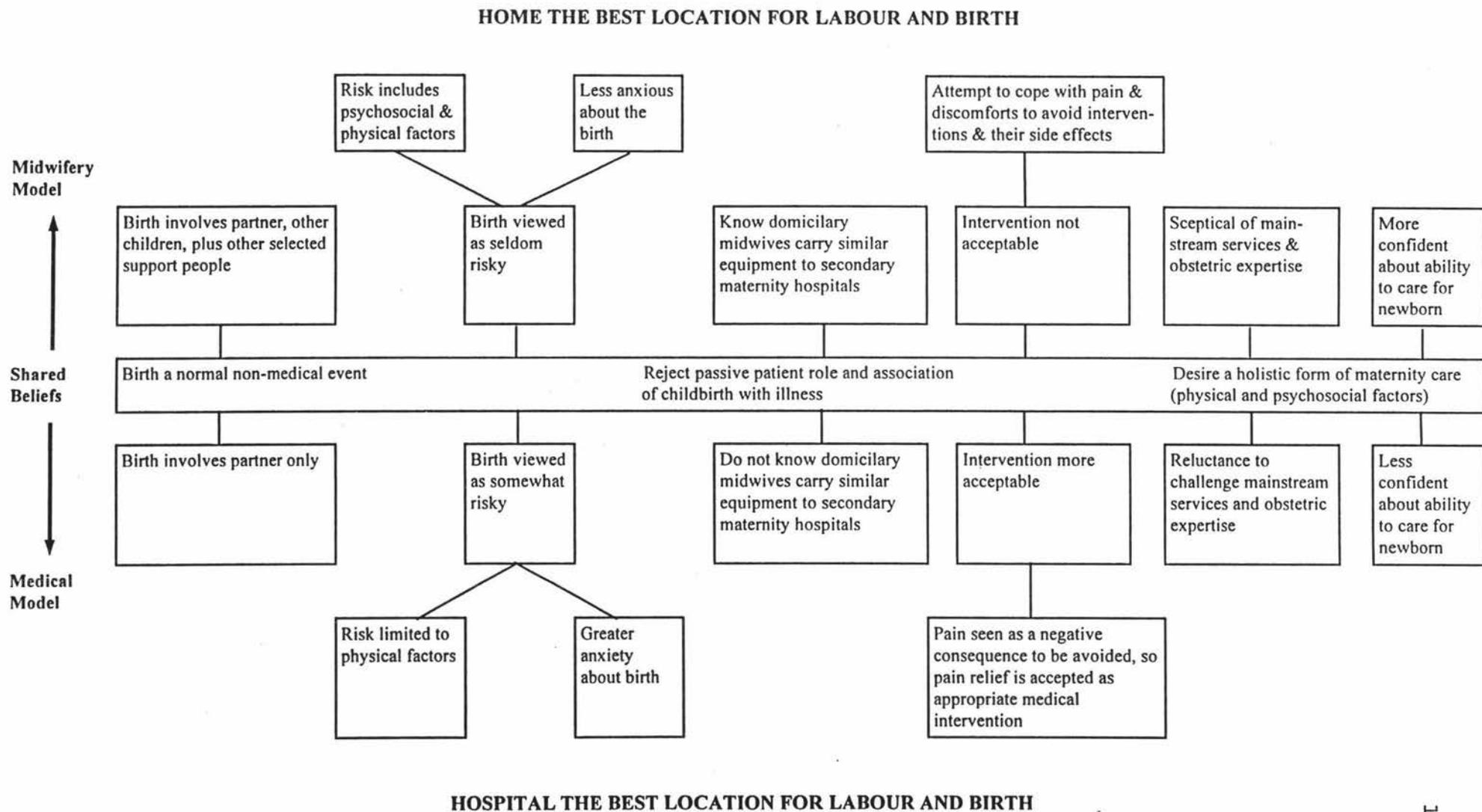


Figure 2: Differences in Perceptions between New Zealand Women giving Birth at Home or in Hospital

trust was misplaced. Rather, preferences were respected and requests fulfilled. Such a situation is obviously desirable whether women give birth at home or in hospital. From the experiences of the participants in this study, however, it could be argued that equality does not appear to exist in relationships in the hospital environment.

For example, women spoke of having their preferences ignored or having to argue for care to be provided in a particular way. They also gave examples of their children having to undergo routines and procedures which they did not request or feel were necessary. It could be argued that such disagreements represent a threat to the new mother's 'ownership' of her baby. Consequently, the feelings that would result from such encounters are likely to be extreme and long-lasting. This is backed-up by the research of Simkin (1991) who found that control and decisions about care were important factors in long-term satisfaction and in women's subsequent self-image.

Another important aspect of the midwifery model is continuity of care. All women received this from their midwives and all women indicated that it was important. Less frequently, the continuity of care doctors provided as the family doctor was also mentioned. Women felt that it was important that midwives had a view of them within their own environment and family, and were involved in providing care throughout the entire pregnancy, birth and postnatal period. They also indicated that it was important that the birth occurred within the family, and the involvement of partners was seen as crucial in most cases. Women also believed that since the birth of a sibling had far-reaching implications for older children, their involvement during the pregnancy and birth was positive.

Women also expressed a belief that it was preferable to allow labour to progress with as little interference as possible, particularly as they believed one intervention could lead to the need for further interventions. Women clearly saw pregnancy and birth as normal events and as safe. That is, the medical model's view of childbearing as inherently dangerous or risky was rejected.

Consequently, these home birth women at least, seemed to have a strong belief in the midwifery model. Their rejection of the medical model is a rejection of the dominant discourse of obstetric care in New Zealand. It mirrors other research into the beliefs and attitudes of women who have a home birth, such as that of Cunningham (1993), Klee (1986) and Pratt (1990).

It could also be argued that for all but one woman, expectations and beliefs were matched by experience. That is, for all but one woman, births were safe for both mothers and babies, with little or no interventions taking place and with labour being allowed to achieve its own momentum. The health professionals that attended women provided continuity of care, gave personalised care and relationships appeared to be based on the notion of partnership and equality. The birth experience was also viewed positively and as a fulfilling experience.

In the case of the caesarean birth the belief that birth is safe and generally does not require intervention was clearly contradicted. The birth was not 'safe' for the baby and it seems likely the child would have died had not immediate intervention occurred. It appears the caesarean would have occurred regardless of birth location, although if it had been a planned hospital birth the woman would have been at an advantage as she would have already been at the hospital when the baby's distress was first noted. However, as she pointed out, she might not have actually left home for the hospital at the time the baby's distress was first monitored and she might not have been monitored so closely in hospital that early in her labour.

Some expectations and beliefs were still realised for this woman however. In having a home birth she received continuity of care, personalised care and had a partnership relationship with her domiciliary midwife, and also her GP in some respects. Due to the urgency of the situation there was little time to psychologically prepare for having a caesarean and this, combined with the caesarean taking place under GA, meant that the birth experience was, for many months, viewed negatively and as unfulfilling.

Perhaps due to the trauma and unusualness of her experience this woman took several months to assimilate, come to terms with, and change her perceptions of her experience. What was initially viewed as a negative experience later came to be viewed positively as it was seen to facilitate personal growth and a change in perceptions. It appeared that the enormity of the experience made this woman reassess her perceptions and priorities and come to a deeper understanding of complex issues, such as the purpose of life, what is important in life and the balance between humanity and nature.

In general all women were pleased with the information they received and none felt they needed more in the antenatal period. All felt able to discuss issues with at least one of their health professionals and often with both. Some women felt more at ease discussing concerns with their

midwife than doctor, although this may have been due to the location of visits. The time which midwives allowed for visits was appreciated, as was having visits in the home environment. Generally, though, relationships with health professionals were viewed very positively.

During the birth the majority of women did not experience a loss of control. None felt that control was taken from them in a way that violated their trust in their health professionals and rendered them helpless and frustrated. In two instances feelings of being out of control were experienced. In one case the possibility of such a situation had been anticipated and discussed antenatally. In the other case (a caesarean birth) feelings of lack of control and great anxiety are known to occur in such situations. However, the woman involved did believe that her midwife had explained what was happening, had helped to alleviate her distress and helped her cope with the sudden turn of events.

In the post-partum period, again, women's expectations were largely met. Most women felt very happy about the care they received and the six that had home births did not appear to experience difficulties gaining adequate rest and support. In fact, in the case of the hospital birth lack of rest and assistance was associated with the hospital, rather than home, and care was at times clearly inadequate for someone recovering from a caesarean.

The New Zealand Nurses Association (1988) commented that there is "incredible" satisfaction from home birth consumers. Others also point to New Zealand women having home births experiencing very high levels of satisfaction (Abel and Kearns, 1991; Bassett-Smith, 1988; Hannah and Davis, 1990; Jakobsen, 1991; Pratt, 1990). This is no doubt due to the fact that many of the aspects of care which women say they want and are associated with greater satisfaction are present in the home situation. These include: the provision of information; being an active participant throughout pregnancy, in the process of labour and birth, and in decision making; having one person (especially a midwife) stay throughout the entire labour and birth; having adequate privacy; feelings of control; the presence of partners; support; and lack of chemical pain relief and interventions.

Clearly home birth allows women the opportunity to develop a strong and supportive relationship with their primary midwife (at least). This, in turn, means the possibility that many of the factors associated with greater satisfaction will be present or will have been discussed. Hence, there is

increased likelihood that they will occur, and that home birth women will have an enhanced sense of satisfaction and will find the experience of childbearing both positive and fulfilling.

SUGGESTIONS FOR FUTURE RESEARCH

Since there has been very little research undertaken in New Zealand on home birth there is ample opportunity for many aspects of it to be studied. One aspect that was not fully explored in this study was the notion of home birth as a joint undertaking from both partners. That is, father's accounts of the process of planning and having a baby at home were not given and the way in which partners interact and provide support was not particularly evident.

Given that McSherry (1986) found the majority of women she interviewed opposed home birth but did hold views consistent with the midwifery model of childbearing, it would be interesting to tease out in what ways the beliefs of home and hospital birth women did differ. Also, to further test Pratt's (1990) findings that perceptions of risk and the acceptability of intervention play important roles in attitudinal differences. For example, do women choosing hospital birth have only a partial agreement with the midwifery model? Or do they agree with the midwifery model but believe that the current maternity system holds the same philosophy and so can meet their needs? Similarly, do all women giving birth at home subscribe to the midwifery model and reject mainstream obstetrical beliefs and practices? How important is participating in decision making and having control to them and in what situations would they be willing to relinquish control? Just how do women giving birth in home or in hospital view the risk attached to childbirth? Do their concepts of risk include both physical and psychosocial factors? And how acceptable is intervention? It could be that the reasons women choose to have a home birth lie in the beliefs they hold about childbearing, and so understanding the differences in the belief systems of home and hospital birth women could explain their choices.

Further research is also needed into what the factors are that make a birth experience a satisfying and fulfilling experience. For example, is it knowing your midwife prior to entering labour or is it having one midwife who stays with you throughout the labour and birth? Is it being provided with information or is it being provided with information and having input into decision making? How important is privacy? Partners? What effect does the type and timing of interventions have? If such factors are understood to have an association with satisfaction then it becomes clearer

what birth location best provides them, and also, how the birth environment can be improved so as to enhance satisfaction.

Finally, longitudinal research into the long-term effects of different birth experiences is lacking. The change in perceptions which one woman in this study underwent in the six months following the birth of her baby illustrates that it is important for at least some research to take place over a lengthy time period. This might be especially so when examining negative experiences. In fact, research into long-term effects of birth location does not appear to exist. For example, how do birth experiences affect women's self-esteem, self-confidence, coping strategies? Does a positive experience always result in positive effects and a negative experience negative? Does home birth affect mother-baby or father-baby or mother-father interactions? What about relationships between siblings? How do home birth children born in the 1970s compare with their peers? It may be that the direct effects of home or hospital birth are minor for children compared to other influences on their development, but that the effect of different birth experiences on women is more profound. If so, this would have an effect on mother-child relationships. Certainly, if there are long-term effects for women or children it is important to know of them so that service providers can consider their implications.

RECOMMENDATIONS FOR SERVICE PROVIDERS

At the least it seems that some New Zealand women have partial belief in the midwifery model of childbearing. That being the case, the maternity system should be looking to provide care in a way that better caters for their needs. Such care should be holistic, and so consider the psychological and social aspects of childbearing along with the physical. For this to occur it is essential that women receive continuity of care. In this way they can then develop a relationship with health professionals, and health workers will have a deeper and wider understanding of their clients.

This would also enhance feelings of support women have during labour and childbirth. Feelings of support are greater when women already know staff and when they have the constant attendance of at least one staff member throughout the labour and birth. This may require a reorganisation of maternity care, but schemes do operate that provide for continuity of care and such care is already acknowledged as providing benefits to clients. Greater support may also

reduce the need for chemical pain relief, and it is likely that satisfaction would increase as a consequence of both that and increased support.

It is also important that women have adequate privacy during labour, and it could be argued that privacy would encourage feelings of relaxation and security. This can only have positive consequences. Small maternity hospitals could be viewed as having advantages over larger ones in that there is less noise and activity to intrude on women's consciousness. However, larger hospital could initiate procedures and practices which reduced subjective feelings of being surrounded by activity and ensured that women's privacy was not intruded into.

Women who have caesareans obviously have a great need for support. Studies have been undertaken which focus exclusively on caesarean births and these provide a better source of reference for service providers than this study. However, it is clear that it is important that women have a health professional remain with them the entire time and that they explain to women what is happening or what will happen to them. This health professional needs to reassure women by both their physical presence and psychological support. That is, women need to have physical contact with another person and partners may not adequately fulfill this role on their own. In fact, reassurance for partners can also be seen to be crucial both for their own sake and for the effects this may have on their interactions with their partners.

When women awake from a caesarean it is preferable if the same health professional who provided that support is there to further reassure them, along with women's partners. If at all possible a woman's baby should also be in the room so that they can feel reassured that their child is in good health and so that the bonding process can begin.

In the days following a caesarean birth it is essential that women receive adequate care. Women who have had caesareans often cannot properly care for their babies themselves and it is crucial that high quality care is provided by staff. To not do so is to increase possible feelings of inadequacy and sadness about the birth. Staff also need to be aware that such feelings may exist after a caesarean birth, along with the need for women to come to terms with the trauma of the experience. It is also the case that such needs will continue after women return home, as will the need for assistance with childcare and domestic tasks.

For women having a caesarean who have domiciliary midwives the situation is less clear, although obviously it is desirable that the midwives stay with women and provide information and

support. It is not always the case that they can accompany their client into theatre, however, due to hospital access arrangements. It is preferable that they do so, and it is unfortunate if the politics of childbirth override optimal care for women and midwives are not allowed to stay with clients. It is also preferable that midwives and partners, along with the baby, are present when women awake from caesareans. Following a caesarean, hospital staff should be sensitive to the relationship that exists between women and their domiciliary midwives and to the fact that there is a shared understanding between them as to how the women would like their babies to be cared for. This does not mean that hospital care should be minimal, just that acknowledgment and respect is required towards women about their decisions to engage the services of domiciliary midwives.

In terms of the home births which were examined in this study, it appears that midwives, and some doctors also, provided care which met the majority of needs of women. Care provided reflected belief in the midwifery model of childbearing. It was provided in a holistic way and involved the whole family. Home visits were especially valued and women felt well informed and able to discuss issues with midwives. Care provided in doctors' rooms was viewed less positively. It is possible this could be overcome by rescheduling visits so a morning or afternoon is used for antenatal care and visit times are made longer. Doctors could also do home visits.

Due to the nature of the home privacy was assured and only those people women invited were present. It is important that the type of relationship which appeared to currently exist between women and midwives continues to be developed and that women remain confident that midwives are readily available and will provide constant care throughout the labour and birth. If these factors continue to be present then it is likely that the trust which exists between women and midwives will remain. That is, women will continue to have faith in the skills and knowledge of their midwives and will feel confident in trusting them to provide care in the way in which they have requested. And, midwives will continue to provide care in a way that accommodates women's wishes while meeting their own professional standards.

The partnership relationships that existed also helped to ensure that women retained feelings of control and of participation. All these factors are important if the very high levels of satisfaction which were found in this study, are to continue to be present for future women planning home births in the Manawatu.

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Appendix 1

Mortality in high and low risk groups by place of birth, England and Wales.

Year	Level of Risk (1)	Hospital	GPU/Home	GPU
(a) Stillbirth rates per 1000 births:				
1969	Low	13.7	3.1	3.0
	High	17.6	6.4	5.2
	All	16.6	4.9	4.9
1981	Low	5.4	2.6	1.4
	High	7.2	4.8	1.4
	All	6.7	3.9	1.4
(b) Perinatal mortality rates per 1000 births:				
1985	Low	8.8	4.2	1.2
	High	11.1	10.7	2.4
	All	9.9	7.0	1.6

- (1) Low risk is defined in the case of stillbirths, as second and third legitimate births to mothers aged 20-9 and in the case of perinatal deaths, as legitimate births to mothers aged 20-9. High risk is defined in each case as the remainder.

Source: Tew (1990)

Perinatal mortality rates per 1000 births: Actual and standardized for risk factors.

Risk Factor	Hospital	GPU/Home ⁽¹⁾
Actual	27.8	4.9
Standardised for:		
Maternal age	27.5	5.2
Maternal parity	27.3	5.1
Maternal hypertension/toxaemia	27.6	4.8
Antenatal prediction score	26.6	5.4
Labour prediction score	23.9	7.7
Method of delivery	25.8	6.2
Infant birth weight	22.9	9.6

- (1) Excludes general practitioner beds in consultant hospitals.

Source: Tew (1990)

Appendix 2

WANTED PREGNANT WOMEN!

For my Masters thesis I need to interview women about why they have decided to have a home birth, what their expectations of home birth are and, following the birth, whether their expectations were met.

This will involve three interviews, with the first taking place between weeks 28-32 of pregnancy and taking about a half to one hour. Following the birth of their baby women will be interviewed again, within 1 month and within 3 months of the birth.

Women who take part in the research will remain anonymous.

If you would like to help or to know more please ring either evenings or during the day.

Helen Griffin
Phone 357 339

Appendix 3

Women's Expectations of Home Birth

Information Sheet.

My name is Helen Griffin and I am a graduate student at Massey University. I am currently undertaking research for my Masters thesis in psychology. My topic is home birth and I am interested in interviewing women planning a home birth.

I am interested in interviewing women regardless of whether it is their first or subsequent child and, if not a first child, whether previous births were home or hospital. Should women transfer to hospital during labour I would still wish to interview them after.

I am interested in this area because pregnancy and birth are times of great change and significance. They are often times when extremes of feeling occur, usually feelings of extreme joy, but sometimes extreme pain. I have had four children myself, three of whom have been born at home - hence my interest in home birth.

What the study is about

My aim is to talk with women about why they have decided to have a home birth and what their expectations of home birth are. This interview would take place sometime between weeks 28 to 32 of their pregnancy. Following the birth I would interview each woman twice - in the month after the birth and three months after. In these interviews women will be able to discuss in what ways the birth experience met their expectations and in what ways it did not.

What participants would have to do

If you wished to take part we would arrange a convenient interview time. The interview would take place at your home, unless you wished it to take place elsewhere.

After the birth of your child I would contact you to arrange a suitable time for the initial follow-up interview. This procedure would also occur when your child was about three months old.

All interviews would be taped, with tapes being erased at the completion of my study. Pseudonyms would be used in the tape transcripts and in my thesis to ensure anonymity. The names of participants would remain confidential to myself.

Your rights

You have the right to decline to take part in the study. Should you wish to participate you have the right to withdraw at any stage and you can refuse to answer any particular question. You would also have the right to ask any questions about the study during your participation. At the completion of my thesis you would have the opportunity to read it should you wish to and/or to read a summary of my research.

If you have any questions or would like to take part in the study please contact me either during the day or evenings at this phone number, 357 5339.

Helen Griffin Phone 357 5339

Appendix 4

Informed consent form

Project title: Women's Expectations of Home Birth

Researcher: Helen Griffin
Psychology Department
Massey University

I have read the Information Sheet for this study and have talked with the researcher about the study. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any time.

I understand that I am free to withdraw at any time and to decline to answer any particular question.

I agree to the taping of interviews on the understanding tapes will be erased at the completion of the study.

I agree to provide information to the researcher on the understanding that my anonymity will be assured to the best of her ability.

I agree to participate in this study.

Signed:

Date:

Researcher:

Date:

Appendix 5

Questionnaire Development

The research of Green et al. (1988) was similar in design to this research in that women were interviewed both before and after the event. There were also differences, such as Green et al. being a British study with a sample of over 700 women, all of whom had hospital births. However, I decided to build on some of the relevant factors which they had found to be significant, in an attempt to find out whether these factors were also important for New Zealand home birth mothers.

Green et al. (1988) had found that several psychological outcomes (such as satisfaction and emotional well-being) were associated with issues such as information, control and intervention. In accordance with their findings I hypothesized that the dissatisfaction their sample had expressed regarding the level of information they received would be unlikely to be expressed by the women I studied due to the nature of the client-midwife relationship. Also, that the home birth sample would be likely to experience a high degree of control and none or few interventions, and so would experience high levels of satisfaction.

Some questions from other research were also included as they seemed particularly well-put or relevant to home birth. In addition, following the first three third interviews an additional question was added. Two of the third interviews contained some extra questions also. This represented an attempt to elicit more information on partners' roles. The questions were also important in that they pointed to areas which could be further explored in other research.

The inclusion of extra questions in research of this type is accepted practice (Jakobsen, 1991; Mostyn, 1985). As data is collated and analysed it may be realised that there are facets to the topic that were not initially apparent but which need to be considered. Mostyn (1985) points out that qualitative researchers must be flexible and open to new possibilities and interpretations. Jakobsen (1991) notes that issues raised in one interview may need to be followed-up in subsequent interviews.

To conclude, in interview 3 (see appendix 5) questions 1, 2, 3, 4, 5, 6, 7, 11, 12, 14, 15, 16, and 17 are replications of Green et al. Some questions have been slightly changed, for example where the words "health professionals" were used the words "midwife and doctor" were substituted, and women were asked to apply the questions separately to midwives and doctors. Questions 8 and 9 are taken from Klee's (1986) research, question 13 from Romito and Zalateo's (1992) and question 18 from Cunningham's (1993). Questions 10, 19, 20, 21, 22, 23, 24, 25 and 26 were developed by myself.

Appendix 6

INTERVIEW 1

- 1 Age - self, partner
- 2 Occupation - self and partner
- 3 Ethnicity/nationality
- 4 Weeks pregnant/due date
- 5 Midwife and antenatal caregivers
- 6 Antenatal preparation
- 7 Number and ages of children
- 8 Stillbirths, miscarriages, complications associated with other births
- 9 Place of birth of other children
 - If home, why did you decide to have a home birth
 - If hospital, why home this time
- 10 Influence of others, who and in what way
- 11 Who will be at the birth, why those specific people and what's expected of them
- 12 Examples of what's expected of midwife and others (physical and psychological)
- 13 Birth plan or requests to do or not to do certain things
- 14 After the birth, what sort of things are expected of others (emotional and domestic support)
- 15 Differences between home and hospital birth
- 16 Anything else

INTERVIEW 2

- 1 Age of child now
- 2 Home or hospital
If hospital, stage at transfer and why
- 3 Was the labour and delivery pretty much like you thought it would be (plan/no plan)
If no, how was it different
- 4 Complications
- 5 Outline of labour and delivery, including what midwife and support people did (physically and psychologically) and whether helpful
- 6 Who made any decisions - what and why
- 7 What didn't they do that would have been helpful
- 8 After the birth what sort of assistance did you get and was it helpful
- 9 Who visited - visited or helped
- 10 What didn't they do that would have been helpful
- 11 Feelings about total care for self and baby
- 12 If you were to have another child would you choose home birth again
-If yes, why If no, why not
- 13 Anything else

INTERVIEW 3

- 1 When talking to your midwife/midwives and doctor were you able to discuss the things you wanted to with them.
- 2 From your midwife/midwives and doctor did you receive the right amount of information, too much, too little, or too little in some areas and too much in others.
- 3 Could you rate how satisfied you were with your relationship with your midwife/midwives and doctor by giving them a mark out of ten. Ten-out-of-ten would mean that they were absolutely wonderful and could not have been better, nought-out-of-ten would mean they were thoroughly unsatisfactory with nothing good to be said for them.
- 4 In general, did you feel in control of what your midwife/midwives and doctor were doing to you during labour.
- 5 Could you get into the most comfortable position possible.
- 6 Did you feel in control of your own behaviour.
- 7 Did you feel in control during contractions.
- 8 What did you like most about the care you received.
- 9 What did you like least about the care you received.
- 10 At the last interview you were satisfied/not satisfied with your care antenatally, during the birth, and postnatally, how are you feeling about the care you received now.
- 11 Could you rate how satisfactory an experience the birth was by giving it a mark out of ten. Ten-out-of-ten would mean an absolutely wonderful experience that could not be better, nought-out-of-ten would mean a thoroughly unsatisfactory experience with nothing good to be said for it.
- 12 How satisfied were you with any interventions you had.
- 13 If you could change something, what would you change.
- 14 What were your feelings when you first discovered you were pregnant.
- 15 Have you been feeling depressed since the birth.
- 16 Have you been having more good days than bad since the birth.
- 17 Have things been getting on top of you since the birth.
- 18 Nominate the one most important aspect of the birthplace. (eg health care facilities, psychological factors, knowing midwife)

- 19 If your best friend was pregnant and considering different birth locations, what advice would you give her.
- 20 If you were to imagine what it was like before you had any children, how would your expectations for the labour and birth be different from what they were for this one.
- 21 Knowing what you know now, what advice would you give to a woman planning a home birth : a home birth which might end up as a hospital birth
- 22 How do you think your husband might answer the same questions if I asked him.
- 23 What is your husband's role during the labour and birth.
- 24 How important is that role.
- 25 Do you feel being interviewed has affected you in any way.
- 26 Is there anything else that I haven't covered that you think is important.