

**Becoming a homebirther...smooth sailing or  
rocky road?**

**An exploration of Pakeha women's experiences  
on the path to homebirth.**

**By**

**Kassandra Jane Littlejohn Ozturk**

**A thesis submitted to the Victoria University of Wellington**

**in fulfilment of the**

**requirements for the degree of**

**Master of Midwifery**

**Victoria University of Wellington**

**2010**

## **Abstract**

This study explores the experiences of primiparous women on the path to planning the homebirth of their first child. There are many challenges along the way and although there are many supports, society does not generally view homebirth as a safe option. This study highlights the themes emerging about the relative ease or dis-ease of the journey. Was the experience smooth sailing on an undulating ocean or a testing trek along a rocky road?

There is a vast body of evidence about homebirth, with much of the quantitative literature being outcome focussed and most of the qualitative literature exploring women's experience of the homebirth-day. Birthing at home has been linked with increased maternal satisfaction compared with other birth venues and correlates with a feeling of maintaining power and control during the birth process. Homebirth has also been shown to have similar rates of intrapartum and neonatal mortality, as well as lower maternal intervention rates, in low risk populations.

This study principally investigates the experience of Pakeha New Zealand women on their way to planning a homebirth for their first baby. The findings of this narrative inquiry include that women make the journey to becoming a homebirther both before pregnancy and during pregnancy, and that they need good support and information. Hearing positive homebirth stories, having a midwife who professes a preference for homebirth, and having access to homebirth resources play integral roles in becoming a homebirther.

## **Key Words**

Homebirth, Primiparas, Midwifery, Narrative Inquiry

## **Dedication**

I would like to dedicate this thesis to Liz Brunton. Liz has been a constant source of inspiration to me since I first met her 17 years ago. She was my midwife, my impetus to become a midwife, my mentor and my friend. I became a homebirther and consequently a midwife thanks to her, and therefore she brought this thesis into being from our first meeting.

## **Acknowledgements**

Firstly and most importantly I would like to gratefully acknowledge the support of my daughter Rhia, without whom this thesis would not have been completed. The words of encouragement, the company when I needed it, the philosophical conversations, the vacuuming: everything little thing she did made this thesis possible, so huge thanks to you my love!

My thesis supervisors Robyn Maude and Jo Walton will, I'm sure, be pleased to have me out of their hair! Without their endless patience and belief in me, I would not have had the courage to complete something that was incredibly important to me. Thank you very much lovely ladies.

I would like to acknowledge the women who took part in my study. You are amazing women all of you and I learnt so much in the process of really hearing your stories and engaging with them during the analysis phase of my research. Without your participation this thesis would not have been possible, and I know that once the findings have been disseminated, you will make a difference to the birthing culture in this country, more publicly than you do now.

I have had conversations with several inspiring people during the write up of this thesis, but none more inspiring than Lesley Patterson. Thank you Lesley for talking with me about culture and stories, life, the universe and everything!

And lastly, a big thank you to all my wonderful friends and family who have done without me, or encouraged me, or read drafts over the final six months of writing up. Having your love and support has meant the world to me.

## TABLE OF CONTENTS

		<b>Page Number</b>
	Abstract	ii
	Dedication	iii
	Acknowledgements	iv
	Table of Contents	v
	List of Illustrations	viii
	List of Tables	ix
<b>Chapter 1</b>	<b>Genesis and Focus of the Inquiry: Charting the Course</b>	1
	Introduction	1
	Musings on Morphology and Metaphor	3
	My Journey	5
	Justification	11
	Research Question	12
	Impetus	13
	Chapter Summary	14
<b>Chapter 2</b>	<b>Context: Setting the Scene</b>	15
	Introduction	15
	The New Zealand Context	16
	History of Homebirth and Midwifery	17
	Our Maternity System	20
	The Place of Birth	21
	Physiological Birth	21
	A Rite of Passage	22
	A Family Event	23
	The Birth Environment	24
	Chapter Summary	26
<b>Chapter 3</b>	<b>Literature Review: Identifying the Landmarks</b>	27
	Introduction	27
	Considering the Evidence	28
	Conducting the Search	30
	Review of the Literature	31
	Safety	32
	Women's Perspectives	37
	The Midwife Effect	43
	Choice	46
	Chapter Summary	50

<b>Chapter 4</b>	<b>Research Framework: Exposing the Roots</b>	51
	Introduction	51
	A Feminist Woman-centred Approach	52
	Methodology	52
	Narrative Inquiry	53
	Ethical Considerations	56
	Ethical Approval	56
	Informed Consent	57
	Anonymity and Confidentiality	57
	Ethics and Narrative	58
	Data Collection	58
	Participant Recruitment	59
	Women from my own Practice	62
	Women from other Cultures	63
	Data Collection Method	63
	Semi-structured Interviews	64
	Interactive Interviewing	64
	Location of Interviews	65
	Length of Interviews	65
	Interview Process	65
	Pilot Interview	67
	Data Analysis	69
	Analysis and Interpretation Process	70
	Chapter Summary	73
<b>Chapter 5</b>	<b>Women's Stories: Crossing the Threshold</b>	74
	Introduction	74
	Alice: The Pioneer	76
	Jenny: The Maverick	80
	Gemma: The Evangelist	83
	Cate: The Conquistador	86
	Haley: The Rebel	90
	Chapter Summary	93
<b>Chapter 6</b>	<b>Findings and Discussion: Bridge to Beyond</b>	94
	Introduction	94
	Findings	95
	Themes	95
	Philosophy	98
	Birth Environment	101
	Choices/Choosing	103
	People	106
	Resources	110
	Discussion	113
	Genesis	116
	Genealogies	116

	Limitations	118
	Summary	119
	Reflection	119
	Recommendations and Conclusion	121
<b>Appendices</b>	One: Ethics Correspondence and Approval	123
	Two: Information Sheet	127
	Three: Consent Form	128
	Four: Transcriber Confidentiality Form	129
	Five: Ad for Birth Wise Journal	130
	Six: Interview Questions	131
	Seven: The Speed of Darkness	132
<b>References</b>		136

## **List of Illustrations**

Photo 1: Path in Central Park

Photo 2: View from Castle Rock

Photo 3: Castle Rock

Photo 4: Mangrove Roots

Photo 5: Sunset, Port Douglas

Photo 6: Bridge in Central Park

Photo 7: Free image from internet

Illustration: Free image from internet



## List of Tables

Table 1: Articles cited in *Safety*

Table 2: Articles cited in *Women's Perspectives*

Table 3: Articles cited in *The Midwife Effect*

Table 4: Articles cited in *Choice*



Photo 1: Path in Central Park

## **Chapter One**

### **Genesis and Focus of the Inquiry: Charting the Course**

#### **Introduction**

This thesis aims to explore the experiences of women on the path to planning the homebirth of their first child. From personal experience this journey is fraught with choices, decisions and defences. There are many challenges along the way and although there are many supports, society

does not generally view homebirth as the safest option. This study tells the stories of women on the path to homebirth and highlights the themes emerging about the relative ease or dis-ease of the journey. Was the experience smooth sailing on an undulating ocean or a testing trek along a rocky road?

This thesis takes the form of six chapters. **Chapter One: Charting the Course** introduces the study. In this chapter I will provide the reader with a snap-shot of the study before the focus is sharpened on the foreground, the middle-ground and the background: the way you might see a postcard of a great master(mistress)piece before seeing it up close in person. Framing this opus are the words used to depict, interpret and explore the experiences of the participants in the study. I will begin with a description of this frame in *Musings on Morphology and Metaphor*. I will then illustrate my own journey: what brought me to midwifery and to my deep interest in homebirth. The chapter concludes with an exposition of the research focus and the impetus for carrying out the study. In **Chapter Two: Setting the Scene** I will describe the socio-political and maternity context for this study: 21<sup>st</sup> century urban New Zealand. In depicting the New Zealand situation, the history of homebirth and midwifery will be outlined. An examination of place of birth follows this and includes a discussion about physiological birth, rites of passage, birth as a family event and the birth environment. **Chapter Three: Identifying the Landmarks** contains a review of the literature related to this study. A discussion of what constitutes 'evidence' is followed by an account of the literature search process. The literature is reviewed under the following categories: *safety, the midwife effect, women's perspectives* and *choice*. While a wealth of literature is available about

homebirth, I did not uncover any research specifically on my study topic. In **Chapter Four: Exposing the Roots** I present the framework for my study. A discussion about feminism is followed by an outline of narrative inquiry and how this research approach fitted my study. Ethical considerations are summarised, as are the methods for data collection, and the analysis and interpretation processes. In **Chapter Five: Crossing the Threshold** I relate the stories of the five women who participated in my study. The stories are told in the women's words as much as possible, and each is followed by excerpts from my field journal reflecting on that story and my own journey through the research process. **Chapter Six: Bridge to Beyond** concludes the thesis and presents the findings of the study. Here I elaborate on the key concepts that emerged from the thematic analysis: *philosophy, birth environment, choice and choosing, people, and resources*. Following this, the discussion section links my findings to the literature and elaborates on an unanticipated finding of this study 'the rare gem'. Recommendations follow an acknowledgement of the limitations of my study and conclude the thesis in its entirety.

### **Musing on Morphology and Metaphor**

In the beginning, when the topic for this thesis was germinating within me, I began thinking about the words I might use in my writing that convey movement and the transformation that journeying can bring. I started thinking about *morphology*<sup>1</sup> and metaphor, and I felt it to be very important to choose and use words throughout my thesis that denoted movement and transformation. I began to make a list of travel and movement words. I reflected on the word 'journey' and whether I would use it in my thesis, given that some would consider it overused in the

---

<sup>1</sup> Meaning: the structure of words (Merriam-Webster, 2009).

social and health science literature. However, no matter its popularity, I concluded that 'journey' is the right kind of word to use when discussing the experiences of women as they become homebirthers.

This list of travel words was followed closely by some questions about the homebirth journey in particular. I considered what the journey might be like: Is it like a seed being planted then growing to fruition? Was it a horizontal or a vertical voyage (an ascension? That sounded a bit too puritanical...but still...)? What was the terrain like on this trip? Descriptive phrases about travel followed the questions: smooth sailing, rocky road, highways and byways. On reflection I formed the opinion that perhaps the path to becoming a homebirther is neither horizontal nor vertical, but more concentric in nature. One drop into the pond is all it takes to become a homebirther. I concluded that for some women the genesis of their homebirth choice is a pebble dropped in their pond at some stage in their past. For others, the genesis is a boulder falling into their pond that triggers a big wave that lands them on the homebirth shore somewhat unexpectedly. What I actually discovered is something a bit different, and I will discuss this in depth in Chapter Six.

The use of metaphor also became increasingly important to me. Choosing movement and transformation words and metaphors was deliberate; the appearance of art historical terms and adjectives in my writing happened naturally, as did comparisons to being on a treasure hunt and finding hidden gems. The appearance of metaphor throughout this thesis may be perceived as a trite technique to amuse (or annoy) the reader with clever comparisons. In acknowledging the use of overused words and phrases, I beseech the reader to maintain an open mind to

metaphor within this thesis. A great deal of thought has gone into the use of almost every single word printed on these pages and I am convinced that metaphor augments and frames this thesis in an appropriate manner. Serious consideration was also afforded to every image that appears on these pages. The inclusion of photographs to illustrate and encapsulate each chapter was important to me as a visual learner, and I invite the reader to immerse themselves in each image as it appears. The photographs come mostly from my own personal collection and present another way to engage with the material arising from my study.

### **My Journey**

In keeping with the narrative method employed for this study, it seems fitting to start with my own story: my journey to homebirth, to midwifery and to me undertaking this research on becoming a homebirther. Near the end of this thesis, in Chapter Six, I will describe each of my participants' homebirth genealogy. Here, at the beginning, I will describe my own.

It actually all started when I was born in 1967. I have had some clear ideas about birth since the beginning, and my feeling is that these ideas tie in with my own birth and the stories my mother told me about the birth of my brothers after me. Here is my/our story:

I am the oldest of 3 children, all born by caesarean section. Mum said I was born on Easter Saturday, which was a great inconvenience for the doctor. Consequently, she had to wait until it was expedient for him to come and cut me out. Mum did not attend antenatal classes and had

little information about labour, birth or mothering, except for what my grandmother had told her. No-one was with her while she laboured and she was scared. Mum said her back hurt a lot in labour and it seemed to drag on for ages; she was glad when the doctor came to deliver me. Mum had a general anaesthetic and woke up hours later wondering where I was.

### *My Brothers' Births*

My brother was born two years after me and mum was told that she had placenta praevia<sup>2</sup>. She had no bleeding during the pregnancy, and was never monitored or hospitalised for this condition. She went into labour on the Saturday of Queens' Birthday weekend, which was a great inconvenience for the doctor. Consequently, she had to wait until it was expedient for him to come and cut my brother out.

When she was pregnant with my youngest brother, she went into labour a couple of weeks early (conveniently not on a major holiday weekend) and all went well. She was told when she got to hospital that she would need to have another caesarean because of the other two, despite the fact that she was pushing my brother out at the time.

My mother's experiences of pregnancy, labour and birth have had a huge effect on how I have come to view birth. Her stories of her births contain descriptors of disempowerment, fear, lack of information, choice and

---

<sup>2</sup> In placenta praevia, the placenta is located over or adjacent to the cervical os. This condition excludes vaginal birth, as the risk of haemorrhage is high when the cervix starts to dilate.

consent. This led me to be determined that things would be different for me.

### *Founding/Finding Midwifery*

When I was five years old my parents separated. That event (coupled with my own birth experience) had a discernible ripple effect on who I am as a woman and a midwife. I can see now that the foundations of my midwifery practice were laid early in my life, long before I crossed the threshold to my vocation at age 29.

First, I believe that birth should not merely take place when it is convenient for doctors to attend – it is a normal life event that need not take place in hospital (as I matured as a teenager, I distinctly remember articulating that I would be having my babies at home and certainly not under the influence of any doctor – thank you very much!). Second, I believe that women should have choice and information, in order to be powerful in decision-making around birth. Third, though my mother would not have called herself a feminist, she certainly acted like one in the 1970's, and as such, influenced me to choose the most feminist profession there is – midwifery, where I work with women, for women.

The birth of my own daughter in 1994 was, however, the crucial event in leading me to midwifery and where I am now in my life.

### *The Birth of my Daughter*

When I became pregnant with my only child I planned a homebirth in the hopes that I would strong enough to accomplish it. I had some small



seeds of self doubt, but I think it's only natural to wonder whether you can do something that you have heard is immense, whilst never having encountered anything like it before. Accepting that all things happen for a reason, I now look back on my daughter's birth as the event that changed the course of my life. She was not born at home. She was born in hospital, yet I remain a homebirther. A discrete portion of her birth was controlled by doctors, but overall I had the knowledge, information and support that was so important to me.

From the earliest time that my midwife could palpate her, my daughter was breech. Despite trying to convince her to turn with acupuncture and moxa<sup>3</sup>, she remained in this position and I accepted her choice to born breech. I laboured spontaneously near term, went into hospital at 7cm dilated and she was born vaginally (with the assistance of forceps) an hour after I started pushing. On holding my child for the first time, I said to my midwife that I would do it all again tomorrow!

I always did mean to do it again, but in the years after she was born a number of things happened that meant having another child was sidelined. Firstly, I separated from my daughter's father when she was 2 ½ and it took me a while to recover from this. I really started thinking about what I wanted to do with my life during this time and a career in midwifery emerged as a real possibility. Once I had made the decision to be a midwife, I felt like I was one already and all that was necessary to complete the picture was to do the training! It felt completely and utterly right. I applied, was accepted, and started training about four months

---

<sup>3</sup> Moxa is part of Traditional Chinese Medicine. Moxibustion is the technique where moxa (mugwort herb) is burnt near the skin to elicit change in the body, the same way that acupuncture might do.

later, just as my daughter turned four, thus effectively postponing further childbearing indefinitely!

### *Midwifery*

My aim in training to be a midwife was to work in the community in independent practice. I was lucky enough to emerge into independent practice at the same time as a fabulous woman, who had completed her direct entry midwifery training a few years before me, but had been working in the hospital for a couple of years. We teamed up together and forged a strong partnership that was to last five years. We complemented each other so well, and I miss her 'knowing' of me and her companionship to this day.

Within six months of starting out together we were invited to join an established group practice: a dream come true! I look back on my five years of full-time midwifery with my partner and this group of midwives as my 'hey day'. I steadily increased my homebirth numbers over this time, getting to the point where I am now an exclusively homebirth midwife.

### *Postgraduate Study*

Ever since I was a little girl I knew that one day I would do my Masters. My aunt (who is my godmother) was the first woman in our family to go to university. She had done this later in life (as well as get a tattoo!) and was determined to plant the seed in my wee brain early on, that education is the key to independence. She did a fantastic job on me, so much so that I truly always expected to 'do' a Masters in something.

Once I completed my undergraduate degree I gave myself a year to learn how to be a midwife, without the added pressure of starting the Masters. And then I did start it, making a conscious choice between the two universities in my home city. I chipped away at the papers over three years, before commencing a four paper thesis in 2005.

Most people thought I was crazy starting a Masters so early in my midwifery career, but by this time I was getting an idea of my potential and where I might let midwifery take me. I was not swayed by the dissuaders, but buoyed by the believers. I found that postgraduate study accelerated the integration of my midwifery knowledge and skills, aiding in my development as a truly post-modern midwife.

#### *Me, my Masters and Academia*

It has taken me a couple of false starts before settling on the topic of 'Becoming a homebirther'. As already stated, homebirth has been on my agenda since I was a young person, so there never seemed any doubt that I would explore a topic related to birthing at home. However, deciding on the right question (for a Masters project) proved challenging.

Also contributing to the false starts was my own 'start' at as an educator in the academic arena. I had developed academic aspirations during my undergrad days and when a lecturing position opened up at university I was encouraged to apply for it by my wonderful midwifery mentors. I thought it was too soon: I had just been granted a scholarship to enable me to study full-time and at that stage I only had just over 4 years of

practice under my belt. After due consideration I accepted the position, thereby sacrificing my scholarship (and many other things to boot), and I started teaching in 2005.

So here I am now in 2009, completing a thesis that has taken many more years of growth than I had anticipated. I find myself resolved about that. The germinating of the ideas posited in this thesis took time. This thesis is rooted in my homebirth genealogy and comes to fruition here and now.

### **Justification**

My interest in this topic stems from an obvious passion about homebirth. At my core I believe that home is the best birth setting for healthy women carrying healthy babies. Knowing what I know about the importance of the first birth experience in particular and its impact on self-esteem (Halldorsdottir & Karlsdottir, 1996; Parratt, 2002), I wanted to study something that would add to what we know about birthing a first baby at home. I wanted to generate information to refute the myth that first babies should be born in hospital. If midwives can support women to birth their first baby at home, then they are more likely to choose a homebirth for subsequent babies too (Pratt, 1990).

What I wanted to do at the outset was to bring to the foreground what it is that we say and don't say as women and midwives that influences women to choose homebirth. I intended to expose the challenge(r)s and uncover the support(er)s of women planning to birth their first baby at home. At the foundation of this study was my aim to raise the homebirth

rate in New Zealand and also to assist in the propagation of homebirth as a safe option for women having their first baby.

### **Research Question**

As stated earlier, there was never any doubt in my mind that I would pursue a topic related to homebirth for my research: foremostly because I am a homebirth midwife and I would like to see more women choosing homebirth; and secondly because of my own experience of planning a homebirth when I had my child.

An initial topic I came up with was: *Women's experience of a transfer to hospital from a planned homebirth*. This was in direct response to my own experience and I would have used heuristics to explore the subject. I hoped to uncover what women felt made a difference to the way they coped and/or integrated that transfer and to see whether it had an impact on their sense of self. On engaging in a literature search for this thesis, I discovered that studies had already been completed on this topic. I decided to change my focus in response to this and also in response to what I noticed unfolding in midwifery practice at the time. Two of my clients were becoming homebirthers before my eyes: one who seemed clear from the start that she wanted a homebirth, but who faced many challenge(r)s along the way, and another who initially wanted a hospital birth but changed her mind as her pregnancy progressed. The journey of these two women was my inspiration for the thesis topic I have ultimately pursued. My topic has therefore morphed to: *Becoming a homebirther...An exploration of Pakeha women's experiences on the path to homebirth*. I have decided that it is actually

most important to me right now to know more about what influences, challenges and supports women to plan to have their first baby at home.

The literature around homebirth is vast, yet in carrying out a literature search for my topic I have not discovered any research that principally investigates the path women tread on their way to planning a homebirth for their first baby. Much of the quantitative literature is outcome focussed (Johnson & Daviss, 2005; Olsen & Jewell, 1998) and most of the qualitative literature explores women's experience of the homebirth-day (Halldorsdottir & Karlsdottir, 1996; Morison, Percival, Hauck, & McMurray, 1999; Ng & Sinclair, 2002). The experience of New Zealand women has not been explored at all in relation to my topic.

### **Impetus**

Birthing at home has been linked with increased satisfaction compared with other birth venues (Janssen, Carty, & Reime, 2006) and correlates with a feeling of maintaining power and control during the birth process (Morison, Hauck, Percival, & McMurray, 1998). Homebirth has also been shown to have similar rates of intrapartum and neonatal mortality, as well as lower maternal intervention rates, in low risk populations (Johnson & Daviss, 2005). Why is it then that the national statistics for homebirth in New Zealand stand at only 5-7% (NZHIS, 2007; Homebirth Aotearoa, 2008)?

Jabaaij and Meijer (1996) found in their research that the midwife's opinion and attitude about homebirth influenced the numbers of homebirths she attended, stating that "it is tempting to conclude that it

is the midwife who decides where the birth is to take place” (p.134). Is this the case in New Zealand?

### **Chapter Summary**

In Chapter One I have introduced the study by outlining the structure and content of this thesis. I have introduced and situated myself on the path illustrated at the beginning of this chapter with a description of my journey to midwifery, motherhood and this Masters thesis. The research question has been introduced, as has the inspiration for the focus on the journey of first time mothers to homebirth. I have provided a justification for this study and outlined the impetus for indulging in yet another study about homebirth: New Zealand derived information is imperative for our unique maternity context. An investigation of this context is the focus of Chapter Two, as is a discussion about the place of birth.



Photo 2: View from Castle Rock

## **Chapter Two**

### **Context: Setting the Scene**

#### **Introduction**

This chapter sets the scene, providing background information for the study as a whole. Much like the picture above, which provides the viewer with an image of stunning scenery, this chapter provides an understanding of the New Zealand maternity and midwifery context, thus affording the reader a snapshot of our unique environment.

In setting the scene, I will briefly discuss the history of homebirth and midwifery in this country, as well as the unique maternity and midwifery



system that we have in place. In considering 'place of birth' I will outline physiological birth, rites of passage, birth as a family event and the impact of the birth environment on normal birth.

## **The New Zealand Context**

New Zealand has a colonial history, and thereby, a relatively new country. The European settlers who came here more than 150 years ago had to be physically strong and mentally determined so as to survive in this rugged terrain and sometimes harsh climate. It was necessary to adapt to this environment by formulating new ways of doing things and this attitude continues with fourth and fifth generation New Zealanders, such as myself. New Zealand has pioneered the way in many respects over the last century: we were the first country in the world to grant women the vote; we have proudly declared ourselves as 'nuclear free' and maintain this stance in the face of increasing nuclear-isation of the western world. Some would say that our maternity system is one of the best in the world being woman-centred and predicated on partnership<sup>4</sup>; however we seem no more immune to the cascade of intervention than other western countries. The thing we have in common with these other countries is our propensity to medicalise childbirth: it is not seen as a normal physiological event or a rite of passage anymore; birth is viewed primarily as a medical condition (Papps & Olsen, 1997). Homebirth has always been a legal option for New Zealand women, though for many years it was an almost inaccessible option. Currently 10% of women in New Zealand wish to birth at home, yet amazingly, only half these

---

<sup>4</sup> New Zealand midwifery most closely meets the International Definition of the Midwife (International Confederation of Midwives, 2005), by practising within the full scope of practice (Midwifery Council of New Zealand, 2004).

women will find the option is supported or available to them (Banks, 2000).

### **History of Homebirth and Midwifery in New Zealand**

In her book Home Birth Bound New Zealand homebirth midwife Maggie Banks, discusses the conflicting paradigms of hospital and homebirth, as well as the history of midwifery in this country. She relates that New Zealand European women from the 1840s until the early 1900s had their babies at home and were attended by lay midwives (Banks, 2000). Birth was a family event, but with the passing of the Midwives Act in 1904 (which required all midwives to be trained and registered), traditional birth practices and attendants experienced an enormous transformation and birth became an event that increasingly excluded family members (Banks, 2000). By the 1920's the majority of births still occurred at home, or in small private maternity homes, however the transition to hospital as the preferred birth environment was well underway and the numbers of hospital births continued to rise over the next decade (Banks, 2000; Abel & Kearns, 1991). By the 1930's most women gave birth heavily sedated, in hospitals, attended by obstetricians who were assisted by maternity nurses (Tully, Daellenbach, & Guilliland, 1998). Prior to this time the advice of doctors was only sought in emergencies, but by 1935 their attendance at births was routine (Abel & Kearns, 1991). Birth had shifted from the home environment, to home-like maternity hospitals but as the medicalisation of childbirth gained momentum, the environment went on to become much more hospital-like (Banks, 2000) and midwives became subordinated to the medical profession (Papps & Olsen, 1997).

As the management of birth became increasingly medicalised, women and midwives found themselves regulated by doctors who professed to 'know best'. Women were required to birth in hospitals and midwives were required to work under the supervision of doctors (Tully et al., 1998). From the mid-1930s the majority of New Zealand's midwives were working in hospitals, though they were still entitled to work independently until the Nurses Act 1971 was instituted. This Act required that all births, at home or in hospital, were supervised by a doctor (Tully et al., 1998).

Homebirth was on the verge of extinction until the 1970's when the women's movement began to focus on health: "the feminist movement, by its energy, determination and commitment to improving health services to women, opened the door for a groundswell of women who could no longer tolerate the 'crudity, arrogance and bullying' of doctors in providing maternity services" (Banks, 2000, p.125). Homebirth Associations sprang up around the country, as the consumer movement worked to regain control of birth as a normal life event and one that was 'women's work', not a medical crisis (Abel & Kearns, 1991). These Associations also worked to improve the pay and conditions for the few domiciliary midwives who were providing a homebirth service for New Zealand's women, in association with sympathetic doctors (Tully et al., 1998). From the Homebirth Associations sprang understandings between consumers and midwives about partnership, with these mutual perceptions subsequently informing the midwifery code of ethics (Tully et al., 1998).

At a similar time, the Save the Midwives Association became active in raising the profile of midwives and assisting them to overcome the obstacles that prevented autonomy and independent practice (Donley, 1986; Fleming, 2000). In working together, women and midwives lobbied for three aims: the reinstatement of midwifery autonomy; the enablement of women to choose midwifery care; and the development of direct-entry midwifery education which would train this new type of midwife who would be required to work autonomously (Pairman & Donnellan-Fernandez, 2006). The culmination of this political action was the formation of the New Zealand College of Midwives (NZCOM) in 1989, which unified midwives as a profession (separate from nursing), and the Nurses Amendment Act of 1990, which reinstated the legal autonomy of midwives.

With midwives now able to provide continuous care within a partnership model for New Zealand women, it would seem feasible that women begin the move back to their home environment for birthing. This was not the case however, with homebirth remaining as a minor choice for nearly 20 years since the law has changed. Currently homebirth rates stand at between 5-7% (NZHIS, 2007; Homebirth Aotearoa, 2008). It seems amazing that even though homebirth is legal, freely available and as safe as hospital birth (with other distinct benefits) it is not chosen more frequently by women. As far as New Zealand women have come in the last century, and no matter what proof they might have, the persistent culture around homebirth is that it is a dangerous undertaking (Tew, 1995). Is it the medical profession who continues to propagate this myth, is it medical-model midwives, or is it women themselves?

## **Our Maternity System**

Currently our maternity system is a fully funded model where women choose a Lead Maternity Carer (LMC) in the first trimester, who will then provide (or arrange the provision of) all her antenatal, intrapartum and postnatal care (Ministry of Health, 2007). This LMC is usually a midwife (NZHIS, 2007), though women in parts of the country can still elect a General Practitioner (GP) or a private obstetrician as their LMC, who would then work in a shared-care arrangement with a midwife or with hospital midwifery services. A private obstetrician is the only provider who can charge women for their services.

As stated earlier, midwifery in New Zealand is founded on a woman-centred, partnership model of care (Guilliland & Pairman, 1994). Within this partnership model, there is acknowledgment that the woman and the midwife have unique skills and knowledge to contribute to the relationship, with ultimate responsibility for decision-making remaining with the woman. There has been critique of this and much discussion over the last fifteen years about what working in partnership actually means. Is it a professional friendship, as advocated by Pairman (2000)? Is the partnership truly equal, as debated by Skinner (1999) and Freeman, Timperley and Adair (2004)? Is the relationship one of interdependence, as discussed by Fleming (1998)? Has partnership been taken too far and has women's choice led midwives up the garden path (Ozturk, 2004)? Whatever the outcome of philosophising about the nature of the partnership model, what stands is that women in New Zealand have a legal right to free maternity care, to choose their caregiver and place of birth.

## **The Place of Birth**

When I refer to 'place of birth' what does that actually mean? It could be taken to mean the place birth holds as a rite of passage for both woman and baby, or the place it has in the formation of positive self-esteem. It could also be seen in the context of family and the place birth has there. Perhaps the most obvious connotation is to the physical setting that birthing takes place within, though all are equally valid interpretations or explorations for this thesis. What is it that happens during birth that makes all of these points worthy of discussion?

## **Physiological Birth**

As Australian GP and homebirth mother Sarah Buckley says, giving birth is an hormonal event, and when birth is undisturbed this "exquisite hormonal orchestration unfolds optimally" (Buckley, 2002, p.51). Four major hormone systems come into play during labour and birth and involve the release of oxytocin, endorphins, epinephrine and norepinephrine, and prolactin. These systems are common to all mammals; originating in the limbic system and not within conscious control (Buckley, 2002; Odent 2001; Odent, 2002). For birth to proceed optimally the limbic system must take precedence over the rational brain (Buckley, 2002). Some suggest that to foster this shift from rational to limbic brain, a private, relaxing, familiar and holistically safe environment is necessary (Parratt & Fahy, 2004). In such an environment, the labouring woman will intuitively chose the positions and make the sounds that enable her to birth with ease (Buckley, 2002; Parratt & Fahy, 2004; Zander & Chamberlain, 1999). Buckley describes 'undisturbed birth' as that which has the evolutionary stamp of approval. It represents the smoothest hormonal orchestration of the birth process, and

therefore the easiest transition possible from pregnancy and birth to motherhood and lactation.

This complex hormonal interplay may be adversely affected by hospital settings and routines that do not aid the shift in consciousness that giving birth naturally requires (Buckley, 2002; Odent, 2001), often resulting in the fear cascade, which in turn leads to interventions (Rowley, 1998, cited in Foureur, 2008). Fahy (2008) discusses the concept of 'surveillance room' to describe a clinical environment which has been designed for the convenience of staff, with the purpose of watching over and monitoring the labouring woman. These hospital rooms are the exact opposite of the 'sanctum', which is a comfortable and familiar environment for the birthing woman (Fahy, 2008). A 'sanctum' experience reflects in "optimal physiological function and emotional wellbeing" (Fahy, 2008, p.18). What better 'place' for a normal event, like birth, to take 'place'?

### **A Rite of Passage**

Women remember their first birth experience many, many years after having given birth (Ogden, Shaw, & Zander, 1997; Simkin, 1991; Simkin, 1992; Thomas, 1997). This is because it is a formative event in a woman's life: she becomes a mother for the first time; she crosses the threshold to an unknown self in an unknown world (Rubin, 1984). It is the third of five of her rites of passage; the first having been her own birth, and the second being the onset of menstruation or the arrival of 'womanhood', the fourth being croning or the onset of menopause, and the fifth being death (Stein, 1999). Birthing for the first time brings with it great excitement and also an element of stepping into the unknown (Dahlen,

Barclay, & Homer, 2008). The first birth experience has particular significance for women and they often have high expectations (Green, Coupland, & Kitzinger, 1990; Halldorsdottir & Karlsdottir, 1996). The woman who engages with her birth, feels like she has control over the experience and has a caregiver who honours her, can emerge with increased positive self-esteem (Dahlen et al., 2008; Fowles, 1998; Green & Baston, 2003; Hodnett, 1989; Lavender, Walkinshaw, & Walton, 1999; Morison et al., 1998; Morison et al., 1999; Parratt & Fahy, 2003), thus easing the transition to motherhood. It is also a time when there is potential for long-term psychological harm to occur, in the form of Post Traumatic Stress Disorder (PTSD) (Bailham & Joseph, 2003; Creedy, Shochet, & Horsfall, 2000; Waldenstrom, Hildingsson, Rubertsson, & Radestad, 2004; Wijma, Soderquist, & Wijma, 1997). Experiencing a traumatic birth also has possible ramifications for future reproduction and fertility (Gotvall & Waldenstrom, 2002). It is so important to get the first birth right! Childbirth is a powerful experience and women want a sense of control over the circumstances in which they open themselves up to give birth. They want to be cared for and honoured during this transition; they need to be supported, loved and well informed about the things that matter to them. All of these criteria can be achieved in the woman's own home – it is, after all, her place.

### **A Family Event**

Birth originally had its place as a family event: it happened at home with women family members in attendance to support the woman during her labour and early mothering. Birth was a cross-generational event, with older women, as well as children being present (Kitzinger, 2005). The medicalisation of childbirth has meant that women are removed from



their homes, removed from their family members, removed to 'home-like' environments that are nothing like home. It has been shown that disruption during the birth process affects the oxytocin system and has consequences for birthing, bonding, breastfeeding and even long-term behaviour<sup>5</sup> (Foureur, 2008). The transition that is birth has huge consequences for the family, even if it unfolds completely normally, but with complications of bonding, breastfeeding and behaviour, these consequences can be dire.

The birth of the first child in particular "precipitates a major transition in the life of a family" (Bright, 1992, p.75). The extended family goes through a process of making a place for the new baby, and interpersonal patterns are reorganised, as boundaries are expanded (Bright, 1992). A physical place is prepared and a social space is created as the family prepares for and integrates the first baby (Bright, 1992). Birthing at home brings the baby directly into the physical and social space that has been created for them; bonding is less likely to be disrupted or disturbed, and the maternal task of identification with her child is achieved (Rubin, 1984).

### **The Birth Environment**

As mentioned earlier, New Zealand women can choose to birth either at home, in hospital or in a primary birthing unit (most are affiliated with hospitals, though some are free-standing midwifery-led units). In X city, where the study was undertaken, women only have the choice of a

---

<sup>5</sup> Several large population based cohort studies have identified behavioural correlations with events described as malfunctions of the oxytocin system. Consequences include mental health issues like autism, drug dependency and antisocial behaviours as well as cardiovascular disease (Carter 2003, cited in Foureur 2008).

homebirth or tertiary level hospital birth; unless they live in one of two adjacent cities (Y and Z), where a secondary level hospital (Y) and a primary unit (Z) are available to them. This means two things for women in city X: they are choosing between what some people would say are two extreme options, and access to specialised care is readily available, no matter which environment they choose to birth in.

Denis Walsh, an English midwife and author says “birth environment plays a pivotal role in the experience and outcome of childbirth and therefore the decision regarding place of birth is crucial” (2000, p.276). A recent mixed methods study by Miller (2008), highlights the difference in outcomes for primiparous women cared for by the same midwife in different settings: women who birthed in hospital had higher rates of labour augmentation, artificial rupture of membranes (ARM), more vaginal examinations and these were performed by more people, more pharmacological pain relief, they had higher rates of instrumental birth and caesarean section, and were more likely to give birth on the bed. What can be divined from these results is that the hospital environment not only has an effect on the woman, it also has an effect on the midwife. Fahy(2008) discusses the concepts of disciplinary power and the gaze of medical surveillance (as theorised by Foucault<sup>6</sup>) in regards to birth territory, and it is obvious that when in the hospital, midwives feel the gaze just as much as women do.

---

<sup>6</sup> Foucault was a French philosopher (1926-1984). One of his key insights was his recognition of the inseparability of knowledge and power. Foucault was interested in professional power and medical power within institutions, in particular. He termed this ‘disciplinary power’, and posited that much of this power comes from surveillance or ‘the gaze’. The central theory here was that, while on display, subjects become docile and obedient. Fahy (2008) states that both midwives and women are docile in relation to medical power and knowledge thus are complicit in medical control of the birth territory.

Many women who birth at home do so to avoid being 'put in their place'<sup>7</sup> by medical power. They value having control over the birth space, keeping it private and sacred (Walsh, 2007), creating a safe haven for themselves. Women consistently rate the homebirth experience as an incredibly satisfying one (Christiaens & Bracke, 2009; Janssen et al., 2006), and those who have their first baby at home are more likely to choose that setting for second and subsequent babies (Ng & Sinclair, 2002; Ogden, 1998). It is patently obvious from the literature that home is a place where normal birth flourishes (Fullerton, Navarro, & Young, 2007; Miller, 2008).

## **Chapter Summary**

This chapter has set the scene for my study. It has painted a picture, in layers, of the history of homebirth and midwifery in New Zealand. It has described the current maternity system and discussed partnership as the foundational factor between women and midwives in the continuity of care relationship we have here. The place of birth has also been examined, in the many different ways this could be interpreted. A portrayal of physiological birth preceded a depiction of birth as a rite of passage. Birth as a family event and the importance of the first birth experience as a positive indicator for good self-esteem was discussed, before a case was made for the birth environment to be a safe and private space, thereby allowing the oxytocin system to perform its magic and birth to unfold undisturbed. In Chapter Three I will now review and discuss the literature around homebirth, in order to contextualise my study further.

---

<sup>7</sup> One of the participants in my study phrased it this way.



Photo 3: Castle Rock

## **Chapter Three**

### **Literature Review: Identifying the Landmarks**

#### **Introduction**

In Chapter Two I presented an overview of the history of homebirth in New Zealand, as well as a snap shot of the current socio-political climate and the existent choices of birth environments in this country, thus providing some insight into the context of my study. In Chapter Three I will explore a selection of the background literature, thereby situating the study within a framework of what is presently known about choosing home as the setting for the first birth experience. In reviewing the

background literature I will highlight the deficit of research on the first homebirth experience and why women choose that setting.

### **Considering the Evidence**

Evidence-based practice is the catch-phrase of the new millennium in health care circles. The notion of practicing medicine in an evidence-based manner has actually been around for hundreds of years; however, the phrase 'evidence-based medicine' (EBM) was only recently coined in 1992 by the Evidence-Based Medicine Working Group, led by Gordon Guyatt (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). Premised on research, specifically the randomised controlled trial (RCT), the evidence-based care paradigm is care that is shown to be effective in trials of large populations. Maternity services led the way here due to the development of the Cochrane Pregnancy and Childbirth Database in the 1970's and 1980's (Sakala, 1995). This database championed the value of systematic reviews to produce convincing results of the effectiveness of various treatments.

To address the area of robustness of differing quantitative research designs, the hierarchy of evidence table has been developed where epidemiological studies are classified according to the grades of evidence on the basis of research designs. Internal validity (the correctness of the results) is the criterion for hierarchical ranking (Tracy, 2006). The highest level is for the RCT and the systematic review (with homogeneity of RCT's) and the lowest level is applied to case-series studies and expert opinions. By its nature the evidence hierarchy gives advantage to certain kinds of data and research methodologies, leaving other methods to be presumed less worthy (Tracy, 2006).

Not everyone is enthusiastic about the evidence paradigm, with the medical profession in particular objecting to the marginalisation of clinical practice and the professional's role in exercising clinical judgement and using intuition (Walsh, 2007). Critiques of the evidence paradigm have come not only from the medical profession, but also from sociologists. Their critique has centred on the reductionist nature of quantitative research, which usually focuses on measurable clinical outcomes sometimes "to the detriment of the woman's experience of her care, her assignment of meaning to that experience and her own priorities regarding health care delivery" (Walsh, 2007, p.3). Another weakness in quantitative research is its assumption that population studies are directly applicable to individuals and evidence-based guidelines are premised on this assumption (Walsh, 2007). Increasingly health care professionals are seeing the limitations of reductionist research methods when dealing with complex interventions (Walsh, 2007; Tracy, 2006). RCT's have limited value when evaluating all the nuances of the homebirth choice, for example and this is where qualitative research complements its quantitative cousin.

Qualitative research has been a legitimate field of inquiry for a century now (Kingdon, 2004). It is a research paradigm that collects data in the form of words rather than numbers, and aims to describe and attribute meaning to events and the relationship between them. In the words of two leading exponents "it consists of a set of interpretive, material practices that make the world visible" (Denzin & Lincoln, 2005, p.2). Qualitative researchers study things in their natural settings (rather than a laboratory), attempting to interpret phenomena in terms of the meanings people bring to them (Denzin & Lincoln, 2005). The value of

qualitative methods lies in their ability to uncover the answers to research questions that are not easily resolved by quantitative methods (Tracy, 2006).

Qualitative research can be undertaken with a variety of methods or approaches (Cluett & Bluff, 2006) such as grounded theory, phenomenology or narrative inquiry. Qualitative studies may not be given the credence they deserve by 'numbers focussed' researchers because they do not rate on the hierarchy of evidence tables. It should be noted however that this is because quantitative research aims to indentify 'what works' and qualitative research aims to explore 'what is going on' (Maude, 2003), thus both have equal value by demystifying a topic from different perspectives.

In undertaking a literature search to source and examine the evidence about homebirth, I uncovered a plethora of research from both the quantitative and qualitative paradigms. Midwifery knowledge is informed by both kinds of research evidence, as well as other ways of knowing<sup>8</sup>, and as such, both types of literature will be examined in this review.

### **Conducting the Search**

The literature search included a variety of electronic database searches: CINAHL, Pubmed, The Cochrane Library; this was followed up by accessing further articles by sifting through the reference lists of the material already sourced. According to Morgan (Morgan, 2004) any search process should involve accessing both primary and secondary

---

<sup>8</sup> Other ways of knowing include intuitive, embodied, experiential and anthropological (Walsh, 2007).

sources. In conducting the literature search I uncovered primary material in the form of journal articles, original published studies, clinical guidelines, systematic reviews and theses; and secondary material in the form of commentaries and editorials on some of the primary sources. I aimed to limit the literature search to material published in the last 10 or 15 years (Wickham, 2006), though some historical and seminal works have also been included.

A thorough search whilst formulating the research proposal for my study was followed up by another more recent search to ensure all pertinent material had been retrieved. The literature was then skim read and themed into categories before being entered into Endnote. The following categories were identified: *safety, the midwife effect, women's perspectives* and *choice*.

Having stated that an abundance of research is available about homebirth, I must also state that there were no studies retrieved that covered my study area in particular. There is an overall lack of New Zealand-based research and also those that focus on the first birth experience (with Miller's 2008 study being the notable exception), as most studies also include information from multiparous women. Aspects of certain pieces of literature do relate to my study however and are helpful in corroborating the findings of my research.

## **Review of the Literature**

As stated above, after completing the literature search, the material was sorted into categories. A more detailed read of each article then assessed



its suitability for inclusion in this review. Some of the excluded articles were greater than 15 years old and had been superseded by more recent research; others were not applicable, even though they had 'home birth' as key words; others had been the subject of open debate as to the reliability of results and were therefore excluded on those grounds. A variety of quantitative and qualitative research was retrieved within each category, with the exception of *safety*, where the reviewed studies are exclusively quantitative. The literature in each category will now be reviewed; a Table is included at the end of each section with selected details about each study provided for the reader.

### **Safety**

The safety of homebirth is judged predominantly on perinatal outcomes, using quantitative research methods. Some of the studies available are prospective, others retrospective, none are RCT's. The literature search also unearthed several commentaries and editorials critiquing or supporting various studies, as well as an integrative review (Fullerton et al., 2007), a meta-analysis (Olsen, 1997) and a Cochrane Library review (Olsen & Jewell, 1998). All of the prospective studies are European (Ackermann-Liebrich, Voegeli, Gunter-Witt, Kunz, Zulig, Schindler & Maurer, 1996; Wiegers, Keirse, van der Zee, & Berghs, 1996) or North American (Janssen, Lee, Ryan, Etches, Farquharson & Peacock, 2002; Johnson & Daviss, 2005). The retrospective study group (Anderson & Aikens Murphy, 1995; de Jonge, van der Goes, Ravelli, Amelink-Verburg, Mol & Nijhuis, 2009; Gulbransen, Hilton, McKay, & Cox, 1997; Parratt & Johnston, 2002) does include a New Zealand study where the data collected was from births 1973-1993 (Gulbransen et al., 1997) and an Australian study where the data collected was from births 1995-1998

(Parratt & Johnston, 2002). Hendrix et al (2009) suggest that there are no RCT's because women do not want to be randomised for place of birth; they choose their birth setting early in pregnancy or before and want to retain their autonomy about this choice.

All the researchers and critics tend to agree that, in order to ascertain the safety of homebirth, the women for whom the data is collected must be 'low-risk'. A definition of 'low-risk' is hard to pin down, but the term is usually applied to a pregnant woman who is receiving primary care, typically from a midwife. The researchers also agree that only data from planned homebirths, where a trained birth attendant is present, should be included in studies. The major finding from both prospective and retrospective studies over the last twenty years is that planned homebirth with low-risk women is as safe as planned hospital birth for a group of similar women. The maternal morbidity and mortality rates are no higher at homebirths; the neonatal morbidity and mortality rates are also no higher at home.

Other findings include that intervention rates are, not surprisingly, lower for homebirth women (Ackermann-Liebrich et al., 1996; Janssen et al., 2002; Johnson & Daviss, 2005; Miller, 2008), which is a major benefit in an age where we are aiming to avoid any unnecessary medicalisation of childbirth. Another finding is that homebirth is a more cost-effective option (Anderson & Anderson, 1999; Johnson & Daviss, 2005), with the recommendation that money saved by birthing at home could be reallocated to more needy health services.

Recommendations from these quantitative studies include that low-risk women should be offered the homebirth option, as long as they are the recipients of quality antenatal care, are attended by trained professionals during labour and have access to specialist services, should these be required (de Jonge et al., 2009; Olsen, 1997; Wiegers, 1998).

From these quantitative studies a profile of a homebirth woman begins to emerge and it is interesting to consider this profile and compare it to women's and midwives perspectives on why women choose homebirth. From the quantitative studies we know that homebirth women tend to be older, better educated, multiparous and not from an ethnic minority (de Jonge et al., 2009; Fullerton et al., 2007).

Table 1: Research Articles cited in *Safety*

<b>Author(s)</b>	<b>Design &amp; Method</b>	<b>Sample Size</b>	<b>Results</b>
Fullerton et al (2007)	Integrative Review	28 research articles	The studies demonstrate consistency in the generally favourable results of maternal and neonatal outcomes, both over time and among diverse population groups.
Olsen (1997)	Meta-analysis	6 observational studies were included	Homebirth is an acceptable alternative for selected pregnant women and leads to reduced medical interventions.

Olsen & Jewell (1998)	Systematic Review	1 RCT involving 11 multiparous women was included	No strong evidence to favour planned hospital or planned homebirth for low risk women.
Ackermann-Liebrich, et al (1996)	Prospective Cohort Study: Numerous data collection techniques on special forms <u>and</u> questionnaires for the women	874 women	Homebirth does not result in increased risk for low risk women and their babies.
Wiegers, et al (1996)	Prospective Study: Questionnaires for midwives and their clients	1836 women and their 97 midwives	The outcome of planned homebirth is just as good as planned hospital birth in low risk women.
Janssen, et al (2002)	Prospective Cohort Study: Database records	862 homebirth women	No increased maternal or neonatal risk associated with planned homebirth with a registered midwife.
Johnson & Daviss (2005)	Prospective Cohort Study: Survey of midwives practices	5418 women	Planned homebirth was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality rates to hospital birth.
Anderson, et al (1995)	Retrospective Study: Survey	11788 homebirth women	Planned homebirth is a safe alternative for healthy low risk women.

de Jonge, et al (2009)	Retrospective Cohort Study: Database records	529688 women	Planned homebirth has no increased risk of perinatal morbidity or mortality.
Gulbransen, et al (1997)	Retrospective Study: Data sheet analysis	9776 homebirths	Homebirth is a safe option for New Zealand women.
Parratt & Johnston (2002)	Retrospective Study: Data collection from midwives practices	440 homebirths	Planned homebirth with a qualified midwife is a safe option for women.
Hendrix, et al (2009)	Prospective Cohort Study: Questionnaire	107 nulliparous women	Pregnant women value their autonomy of choice and do not want to be randomised to place of birth.
Miller (2008)	Mixed Methods: Survey and focus group	225 women in the survey data set and their 12 midwives	Low risk first time mothers have a greater likelihood of achieving a normal birth at home.
Anderson & Anderson (1999)	Retrospective Study: Survey	11592 hospital births and 11788 homebirths	The average uncomplicated vaginal birth costs 68% less at home than in a hospital.
Wiegers (1998)	Prospective Study: Perinatal Outcome Index analysis	Index comprised 36 items	For low risk women, the outcome of planned homebirth for first time mothers is as good as the outcome of planned hospital birth, while for other mothers the outcome of planned homebirth is better.

### **Women's Perspectives**

The studies that tell us about women's perspectives on homebirth come from both quantitative and qualitative research methodologies. There have been numerous books written and projects carried out that examine women's experience of homebirth, but I have tried to steer away from those, given that my study is about the journey to homebirth, not the actual birth day and its impacts. The literature that I have sourced and will report on is confined to those studies elaborating on why women choose homebirth and what they value about birthing in that environment.

The studies about homebirth all include both primiparous and multiparous women. This is counter-productive for my purposes, as many women say they chose homebirth for second and subsequent babies because of what happened in hospital the first time. I personally believe there is much value in investigating the experiences of first time mothers on the path to homebirth, as it is with these women alone that perhaps the truest reasons for birthing at home will emerge. A recent New Zealand mixed methods study (Miller, 2008) comparing the outcomes for both first time home and hospital birth women, cared for by the same midwives provides some much needed data for primiparous New Zealand women. It does not survey the women themselves, but is a fantastic springboard for my study, in that Miller is interested the outcomes for similar women and in homebirth in New Zealand.

The authors of the quantitative studies (Borquez & Wiegers, 2006; Fordham, 1997; Longworth, Ratcliffe, & Boulton, 2001) concur that women see the home environment as a relaxing and familiar

environment in which to give birth. The home environment affords women the choice and control over their experience that they want, having them remain autonomous on their own turf. This relates to theories of power and control, as discussed by Fahy (2008). Other findings from these quantitative studies include that women who chose homebirth are more philosophically aligned with the ethos of natural childbirth, and that they highly value continuity of caregiver.

Authors of qualitative studies (Duke, 1982; Jakobsen, 1991; Ng & Sinclair, 2002; Ogden, 1998) found that women who chose homebirth often had a poor perception of the hospital (this is because they had birthed there before, compared with the women in my study who had a poor perception of it because they worked there or had attended hospital births as support people). A common finding was also that in choosing homebirth, women were making a considered and responsible decision and they felt they were doing something perfectly safe, regardless of cultural perceptions about the riskiness of homebirth.

The concept of control was a familiar thread through the qualitative research, as well as the quantitative. Women believed that giving birth at home would give them more control over their birth experience (Fullerton, 1982; Green, 1999; Jakobsen, 1991; Schiff & LaFerla, 1985). In order to give birth, one needs to lose control, yet in order to be relaxed enough to lose control, one needs to have control over the safe space of the birth environment (Parratt & Fahy, 2003). Home was seen as the place to be in control enough to lose control! Hospital was seen as a

place of being controlled, where one was at the mercy of the clock<sup>9</sup> and other 'unknown' people.

Homebirth women all spoke about the necessity of having good support to birth at home. Their relationship with their midwife was of critical importance, as was the backing of their significant others (Edwards, 2000). Through the discussions in the qualitative research it emerges that homebirth is seen as a satisfying, empowering and transformative experience, and one that has long term positive impacts on self esteem and maternal identity (Christiaens & Bracke, 2009; Jakobsen, 1991; Janssen et al., 2006; Lyons, 1998; Parratt, 2002).

Another aspect to the literature about maternal aspects of homebirth is the continued layering up of this image of a homebirth woman. I found four studies that had as their focus psychosocial factors as determinants for homebirth (Anthony, Buitendijk, Offerhaus, van Dommelen, & van der Pal-de Bruin, 2005; Bastian, 1993; Neuhaus, Kiencke, Gohring, & Mallman, 2002; van der Hulst, van Teijlingen, Bonsel, Eskes, & Bleker, 2004). Other studies cited in this category also included character descriptors as part of their discussion. The findings were varied and I am reluctant to describe the perfect homebirther for fear of excluding those women who do not see themselves as such, yet might choose a homebirth for less popular reasons (religious reasons, for example). One study (Anthony et al., 2005), states that there is a clear relationship between maternal demographic factors and the place of birth and type

---

<sup>9</sup>Many hospital labour timeframe protocols are based on Friedman's curve of labour progress, where the cervix is supposed to dilate at one centimeter per hour. If this does not occur, interventions are instituted in order to actively manage the labour (Walsh, 2007).



of caregiver, which influences the probability of a planned homebirth. Another study (van der Hulst et al., 2004) suggests that psychological factors, such as expectations and perceptions, influence both the birth environment decision and the actual outcome. An Australian study (Bastian, 1993) found that women who chose homebirth could not be stereotyped as belonging to a counterculture. For some, the homebirth choice was an extension of a non-traditional approach to life choices, while for others, the homebirth choice might be the only unconventional aspect of their lifestyle. The over-riding feeling I get from the research is that homebirth women have a strong desire for a normal, natural birth experience (Neuhaus et al., 2002; van der Hulst et al., 2004); one which they choose responsibly and one in which they participate fully (Bailes & Jackson, 2000).

Table 2: Research Articles cited in *Women's Perspectives*

<b>Author(s)</b>	<b>Design &amp; Method</b>	<b>Sample Size</b>	<b>Results</b>
Miller (2008)	Mixed Methods: Survey and focus group	225 women in the survey data set and their 12 midwives	Low risk first time mothers have a greater likelihood of achieving a normal birth at home.
Borquez & Wieggers (2006)	Descriptive Study: Questionnaire	193 women	The environment can have a positive effect on a woman's birth experience.
Fordham (1997)	No info about design: Questionnaire	340 women	Women show a wide spectrum of opinion about place of confinement.

Longworth, et al (2001)	Conjoint Analysis: Focus groups and survey	10 women in each focus group and 482 surveys	Women who chose a homebirth valued continuity of carer, a homely environment and the ability to make their own decisions about what happens during labour and birth.
Jakobsen (1991)	No info about design: Interview	7 women	Homebirth is an empowering experience.
Ng & Sinclair (2002)	Phenomenological study: Narrative	9 women	Birth at home was best illustrated by the metaphor 'a woman climbing a mountain' as this symbolised the lived experience of planned home birth.
Ogden (1998)	No info about design: Interview	25 women	The results of the study present a positive picture of homebirth and indicate that having a baby at home may make a rewarding event into an event which not only changes the individual, but also colours the way she understands her past and future lives.
Fullerton (1982)	Multivariate Analysis: Questionnaire	106 women	Flexibility is needed in hospital policies governing childbirth since individual freedom is so important to some women and since alternative birthing centres are so rare.

Schiff & LaFerla (1985)	Prospective Study: Interview	20 women	Women planning homebirths emphasised the issue of control and the risks in their hospital in their decision for homebirth. Women planning hospital births focussed on the issue of safety.
Parrat & Fahy (2003)	Pilot Study: Narrative	6 women	Women are more likely to trust enough to let go of mind control and body when supported within a midwifery model, rather than when cared for in the medical model.
Edwards (2000)	No info about design: Interview	30 women	The relationship between woman and midwife works best when common values about birth were shared.
Christaens & Bracke (2007)	Comparative Study: Questionnaire	611 women	Women who had planned a home birth were more satisfied (than those who planned hospital births).
Janssen, et al (2002)	Prospective Cohort Study: Database records	862 homebirth women	No increased maternal or neonatal risk associated with planned homebirth with a registered midwife.
Anthony, et al (2004)	Cross-sectional Study: Survey	160, 329 women	There is a clear relationship between maternal demographic factors and the place of birth and type of caregiver, and therefore the probability of a planned homebirth.

Bastian (1993)	No info about design: Questionnaire	552 women	Stereotypes of women who birth at home do not apply to the circumstances of substantial numbers of women.
Neuhaus, et al (2002)	Psychosocial Analysis: Questionnaire	132 women	Women planning a homebirth value freedom of choice, less anxiety in the home than the hospital, a more personal relationship with the midwife and making do without medical equipment.
Van der Hulst, et al (2004)	Prospective Study: Questionnaire	625 women	A more non-technological approach to childbirth was observed within the women opting for a home birth compared with women opting for a hospital birth.
Bailes & Jackson (2000)	Case Study	1 woman	Collaboration in homebirth practice is a dynamic interchange between the woman and the midwife, each bringing powerful authority to the experience.

### **The Midwife Effect**

A number of quantitative and qualitative researchers have studied 'the midwife effect', that is the influence the midwife has on not only place of birth but what transpires during the actual birthday (Floyd, 1995; Jabaaij & Meijer, 1996; Leap, 1996; Wiegers, van der Zee, Kerssens, & Keirse, 2000). What emerges quite clearly from the literature is the fact that midwives do have a profound effect on the choice women make around

place of birth, in particular. Midwives who have a positive attitude to and express a preference for homebirth, attend more homebirths than those working in the same practice or area who do not express this preference. One study (Jabaaij & Meijer, 1996) said it was tempting to conclude that it is the midwife who actually decides the place of birth (acknowledging that it is the woman who has the final say)!

Midwives who attend homebirths have positive feelings about this setting because they have confidence in their own role, as well as confidence in women's bodies to birth well and naturally. In a European study (Jabaaij & Meijer, 1996) researchers discovered that homebirth midwives usually have less births per year than their hospital birth counterparts but do not spend more time overall with their clients. A New Zealand study (Miller, 2008) found that midwives spent more continuous time with hospital birth women while they were in labour, than their homebirth counterparts. These findings are in contrast to midwifery anecdotes that homebirth women want or need more time from their midwives.

From the literature a picture of a homebirth midwife emerges, just as an image of a homebirth woman has. A homebirth midwife is one who sees birth as normal and has confidence in women to birth naturally (she also expresses this to the woman and her significant others). This midwife provides regular antenatal care and gets to know her clients, just as they get to know and trust her: a partnership is formed (Edwards, 2000). This midwife has confidence in her own skills to facilitate birth and has all the necessary emergency equipment at her disposal, should these be required (Anderson & Aikens Murphy, 1995; Harris, 2000). The

homebirth midwife also has sound clinical support or back-up from colleagues and has access to specialist services, should referral be necessary (de Jonge et al., 2009; Olsen, 1997). But most importantly, the homebirth midwife (like the homebirth woman) must be strong enough to withstand pressure from the current socio-political environment (in most western countries anyway) where homebirth is an uncommon choice for women.

Table 3: Research Articles cited in *The Midwife Effect*

<b>Author(s)</b>	<b>Design &amp; Method</b>	<b>Sample Size</b>	<b>Results</b>
Floyd (1995)	Mixed Methods: Questionnaire and interview	44 midwives	Positive feelings about homebirth resulted from the quality of previous experiences, education and knowledge. Negative feelings resulted from a lack of specific skills and inadequate support networks.
Jabaaij & Meijer (1996)	Cross-sectional Study: Questionnaire and data forms	115 midwives	Attending home births is no more time consuming for midwives than assisting at short-stay hospital births.
Wiegers, et al (2000)	Multi-level Analysis : Questionnaire	4420 births	Women's choice of birth location and the occurrence of complications that lead to referral to specialist care before or during labour were found to be the main determinants of the homebirth rate.

Miller (2008)	Mixed Methods: Survey and focus group	225 women in the survey data set and their 12 midwives	Low risk first time mothers have a greater likelihood of achieving a normal birth at home.
Edwards (2000)	No info about design: Interview	30 women	The relationship between woman and midwife works best when common values about birth were shared.
Anderson & Aitkins Murphy (1995)	Retrospective Study: Survey	11,788 births	Planned homebirth with qualified care providers can be a safe alternative for healthy lower risk women.
de Jonge, et al (2009)	Retrospective Cohort Study: Database records	529688 women	Planned homebirth has no increased risk of perinatal morbidity or mortality.
Olsen (1997)	Meta-analysis	6 observational studies were included	Homebirth is an acceptable alternative for selected pregnant women and leads to reduced medical interventions.

### Choice

Choice is linked to decision making, as one must consider one's choices before making a (truly informed) decision (Kirkham, 2004; van Weel, van der Velden, & Lagro-Janssen, 2009). In New Zealand, Section 88 (Ministry of Health, 2007) states that at the first visit the woman must be informed about her choices for pregnancy, birth and the postnatal period. This includes the choice of birth setting: home or hospital. But how many women are actually offered this choice in contemporary New Zealand? No data exists on this topic, though research from overseas deduces that

most women are not being offered the choice to have a homebirth, even though this is a legitimate option for them (Fordham, 1997; Lavender & Chapple, 2005; Madi & Crow, 2003). This harks back to *Birth by Design* (De Vries, 2001), where the author states that women will choose what they are offered, and if they are only offered hospital birth, then that is what they will choose. In order that more women choose homebirth, they must be made aware that it is an option for them. As mentioned earlier, choice correlates to control and women who make conscious life choices, such as birthing at home, invest in a positive and secure sense of self (Lennox, 2002; Ogden, 1998).

Having been offered the option of a homebirth, it is then up to the woman to choose that setting based on whatever information that she might want to consider before making that choice (Fordham, 1997; Ng & Sinclair, 2002). It emerges from the literature that the choice to birth at home can be made either before pregnancy, during pregnancy or during labour, and all are valid junctures at which to make the decision (Hendrix et al., 2009; Leap, 1996).

Informed decision making during the childbearing experience is a foundation of the woman-centred New Zealand maternity system (Ministry of Health, 2007; NZCOM, 1996). It is clear from the decision making literature that in order to make an informed decision, women need access to unbiased (or balanced) information and that they have time to consider their options before making that decision (Edwards, 2004).



It is worth considering the notions of ‘risk’ and ‘safety’ as part of the choice/decision making topic, as often the reason for decrying homebirth for the first baby in particular, is due to these (culturally/obstetrically/individually defined) concepts. As health professionals, we have reliable evidence that planned homebirth is just as safe as hospital birth for low-risk women and we are obliged to inform women of this fact without bias. The notion of ‘safety’ is individually defined, with women often not having the same perception of medical risk or safety that the obstetric doctrine prescribes (McClain, 1981). Cultural and social contexts also dictate how women perceive risk and safety and, to a certain extent, until we change the ‘story’ about homebirth, then it will continue to be a fringe activity (Leap, 1996).

Table 4: Research Articles cited in *Choice*

<b>Author(s)</b>	<b>Design &amp; Method</b>	<b>Sample Size</b>	<b>Results</b>
Fordham (1997)	No info about design: Questionnaire	340 women	Women show a wide spectrum of opinion about place of confinement.
Lavender & Chapple (2005)	No info about design: Questionnaire	2071 women	Midwives need to ensure that women are fully informed of all birth options available to them.
Madi & Crow (2003)	Grounded Theory: Interview	33 women	Midwives did not initiate the discussion of availability of homebirth but supported those who already knew and asked for it.

Ogden (1998)	No info about design: Interview	25 women	The results of the study present a positive picture of homebirth and indicate that having a baby at home may make a rewarding event into an event which not only changes the individual, but also colours the way she understands her past and future lives.
Ng & Sinclair (2002)	Phenomenology: Interview	9 women	Birth at home was best illustrated by the metaphor 'a woman climbing a mountain' as this symbolised the lived experience of planned home birth.
Hendrix et al (2009)	Prospective Cohort Study: Questionnaire	107 nulliparous women	Pregnant women value their autonomy of choice and do not want to be randomised to place of birth.
Edwards (2004)	No info about design: Interview	30 women	The women in the study pointed out that basic choices about engaging with maternity services, how care is provided, who might attend the birth and the environment for the birth are almost entirely missing.

## **Chapter Summary**

In reviewing the research around homebirth, what became apparent is that it is a safe undertaking for low risk women who are cared for by a trained birth attendant. Women value the home environment for autonomy, privacy and the intimacy of their experience. Women who choose homebirth do not fit a stereotypical picture, though they do place high value on a natural birth experience. Midwives have a huge impact on women's decision making around the homebirth choice, especially if they do genuinely offer it to women!

One of the meaningful findings from my study, that the homebirth decision is sometimes made before pregnancy, was not an unknown phenomenon in the literature (this was an incidental finding from one piece of research and has not been the subject of any particular study), and this is helpful in corroborating my findings. In searching for, sourcing and reviewing the literature what became clear was that the path to planning the first homebirth is under-researched, which justifies my study.



Photo 4: Mangrove Roots

## **Chapter Four**

### **Research Framework: Exposing the Roots**

#### **Introduction**

In Chapter Three I reviewed and summarised the literature around homebirth and now, in Chapter Four I will outline the process by which the study was undertaken: exposing the framework, or roots, as illustrated above. This study is predicated on a feminist woman-centred approach, and a brief discussion of this is followed by a description the methodology and ethical considerations for the study. Discussion of participant recruitment precedes an exposition of the data collection, analysis and interpretation methods.

## **A Feminist Woman-centred Approach**

Midwifery is the quintessential feminist profession, with the very word 'midwife' meaning 'with woman' (Merriam-Webster, 2009). According to Kaufmann (2004) a feminist midwife is one who is committed to supporting women. A feminist midwife understands the realities of women's lives; she also understands the power and powerlessness and how these shape women's (and midwives) experiences. A feminist midwife not only believes that supporting women's empowered decision making is a positive end in itself, but understands that by giving women agency and respect, she contributes to women's liberation. I am such a midwife, and therefore feminism predicated my research. Feminism was also identified as a key concept by one of the participants when she said "*I do believe that home birth is a feminist issue*" (Alice).

As discussed in Chapter Two, midwifery care in New Zealand is founded on a woman-centred approach (NZCOM, 2005). This basic tenet of woman-centred care is woven through our guiding documents, and is part of our every interaction with women. Following this principle, my research has at its core, a woman-centred approach.

## **Methodology**

The study design is that of a qualitative research project, and uses narrative inquiry as the methodology or guiding philosophy. Narrative inquiry is particularly appropriate for a midwifery research project, given that telling and listening to stories is a midwifery tradition. Early lay midwives had much of their knowledge regarding the childbearing year passed down to them through stories. The training of novice midwives

involved a process of listening to these stories, as well as observing the practices and traditions of the more experienced midwives (Papps & Olsen, 1997). Stories involving birth were not only passed down to midwives, but also to female relatives and friends, thus growing women's collective knowledge about birthing. This study continues the midwifery tradition of storytelling, adding to the current century's knowledge about 'women's work'.

### **Narrative Inquiry**

Narrative inquiry is "the study of the ways humans experience the world" (Connelly & Clandinin, 1990, p.2). It has its roots in Aristotle's examination of Greek tragedy, where the traditional tragic narrative has action, a sequence, a plot and characters (Connelly & Clandinin, 1990; Reissman, 2008). This tradition is carried forward by contemporary narrative researchers who, like Aristotle, see narratives as reflecting the world and making meaning of it (Chase, 2005; Reissman, 2008).

In narrative inquiry, storytelling is chosen over other forms of communication. The purpose of this is to highlight the social role of stories and how they are culturally connected and defined (Chase, 1996). Chase (2005) describes the distinctiveness of narrative inquiry from other forms of qualitative research by outlining five different lenses through which narratives researchers approach their material. Firstly she says that narrative researchers treat narratives as "a distinct form of discourse" (2005, p.656), where meaning is made retrospectively by the ordering of one's past experiences. Secondly Chase says that narrative researchers view narratives as "verbal action" (2005, p.657), where the participant, in telling the story, shapes and performs experience. Thirdly

Chase attests that researchers see stories as “enabled and constrained by a range of social resources and circumstances” (2005, p.657), which include the narrator’s setting, cultural and historical position. Fourthly “narrative researchers treat narratives as socially situated interactive performances – as produced in this particular setting, for this particular audience, for these particular purposes” (Chase, 2005, p.657). And lastly Chase posits that narrative researchers see themselves as narrators too, where they develop interpretations and publish their ideas about the narratives they have engaged with (2005, p.657). Incorporating these five lenses narrative researchers then “develop meaning out of...the material they (have) studied; they develop their own voice as they construct others’ voices and realities; they narrate results in ways that are both enabled by the social resources and circumstances embedded in their disciplines, cultures and historical moments; and they write...their work for particular audiences” (Chase, 2005, p.657). The symmetry of hearing a story, engaging and studying this story, and then becoming a narrator oneself appeals to my love of things coming full circle, thus using narrative inquiry as the guiding philosophy for my study seemed a perfect fit.

#### *Rigour and Generalisability in Narrative*

Storytelling and interpretative traditions are often described as being unscientific, biased and not generalisable (Koch, 1998). However, when narrative studies are conducted rigorously, they can be generalised and affect social change (Koch, 1998; Chase, 2005). Rigour criteria exist in the qualitative research field and are based on the work of Lincoln and Guba (1985, cited in Koch, 1998). These criteria are credibility, transferability

and dependability. Throughout the process of my study the rigour criteria were met in the following ways:

- Koch (1994) asserts that credibility is enhanced when the researcher is self-aware. This is best achieved through use of a journal and taking her advice, I did utilise a Field Journal throughout the entire research and interpretation process. I also include excerpts from my journal in Chapter Six. Credibility is also addressed by faithful descriptions of how the interpretations were arrived at, and a description of this is included later in this Chapter.
- Transferability (or applicability) is addressed through the provision of contextual information, thus allowing the reader to transfer the findings to other similar situations. Chapter Two paints a picture of the New Zealand socio-political context and also outlines the birthing culture, providing detailed information about the perspective here.
- Dependability is demonstrated by the study's capacity to be audited. A description of the research process is included in this chapter, whereby the decision trail is made explicit.

When credibility, transferability and dependability have been addressed, confirmability is established (Guba & Lincoln, cited in Koch, 1994) and the study can be deemed trustworthy. Keeping in mind the rigour criteria throughout my study and providing descriptions of how these have been met, will allow the findings to be generalised to similar contexts and for social change to occur.



## **Ethical Considerations**

Accountability for respecting the rights of participants is a significant responsibility for all researchers. The Cartwright Inquiry of 1987 uncovered a lack of robust ethical procedures around research proposals and treatments at National Women's Hospital in Auckland. In response to The Cartwright Report (Cartwright, 1988) legislation was passed by the New Zealand government in 1994 to institute the Office of the Health and Disability Commissioner. The first Commissioner developed a Code of Rights for Health and Disability Consumers; these rights extend to those participating in research. As a researcher, I am morally and legally obliged to respect the rights and dignity of participants, and as such a research proposal was submitted for ethical approval.

## **Ethical Approval**

Ethical approval for this study was gained from the Central Regional Ethics Committee. The application was considered at the Committee meeting of October 2007 and after some revisions were made, provisional approval was granted on 26 October 2007 (Appendix One) and final approval on 28 November 2007 (Appendix Two).

As part of the ethical approval process, I gave serious consideration to the potential for participants to experience psychological harm during the interview and thereafter. I iterated to the Ethics Committee that the potential for harm was minimal, with the only possible risk being that the women might find telling their story to be an emotional experience. I had contact details for a counsellor available at the interview, as well as

pamphlets from the NZCOM Resolutions Committee<sup>10</sup>. None of the women expressed a need to access counselling or Resolutions Committee services, either during the interview or in the months afterwards when they received their transcripts for verification.

### **Informed Consent**

An Information Sheet (Appendix Three) was sent to each participant before commencement of the study. After reading this, the participant could self-select into the study if they wished to, by calling or emailing me. Written informed consent (Appendix Four) was gained from each of the participants before starting the interview. It was clearly stated on the Consent Form that the participant could withdraw from the study at any time.

### **Anonymity and Confidentiality**

Each participant was assured of confidentiality and that their identity would be protected. A pseudonym was either chosen by the participant or assigned by myself, to be used during the analysis and discussion phases, and for any participant quotes in the body of the thesis.

As part of the ethical approval for the study I had to ensure that hard copy data would be stored in a locked cabinet and that soft copy data would be password protected on my computer. Raw data will be offered to the participants after five years, otherwise I will keep it securely stored for ten years. After this time it will be destroyed.

---

<sup>10</sup> A committee consisting of a consumer and a midwife, whose role it is to resolve issues between women and their midwives.

The participants were assured that only key personnel would have access to the raw data: myself as the principal investigator, the transcriber of the interviews who signed a Confidentiality Agreement (Appendix Five), and it was also possible that my thesis supervisors would have access to the data during the analysis phase of the study.

### **Ethics and Narrative**

As Josselson (1996) says “doing narrative research is an ethically complex undertaking” (p.70), as the study of personal stories renders participants more vulnerable to exposure than other qualitative studies might do. In exploring narratives, researchers are aiming to elucidate a concept, interpret findings and discuss theories generated from the stories they have been told by their participants. This can be unsettling for those participants, though it can also be empowering and pleasurable (Chase, 1996; Josselson, 1996). Sensitivity on behalf of the researcher is imperative, as is informed consent and the ability of the participant to control use of their transcript during the research process (Chase, 1996). With this in mind, I returned each participant’s transcript to them for verification and asked permission to use quotes from these transcripts before commencing the formal analysis and interpretation process. A couple of the participants asked that certain details about their profession, place of work or family’s names be omitted or changed, and these requests were honoured.

### **Data Collection**

The method of data collection takes the form of a semi-structured interview, which elicits a personal narrative from the participants at a

venue of their choice. The method of data analysis draws on thematic network analysis techniques described by Carter (2004), Attride-Stirling (2001) and Reissman (2008). A description of these processes follows an outline of the participant recruitment process for the study.

### **Participant Recruitment and Selection**

A call for participants was placed in the Birth Wise<sup>11</sup> Journal in December 2007. A copy of this advertisement (Appendix Six) was also placed on the notice board of a midwifery group practice. The criteria for selection for the study were as follows: participants should have planned (at the start of spontaneous labour) to have their first baby at home and this should have been since 2001. Participants should speak English and identify as Pakeha. I aimed to interview four to six women. The rationale for choosing this numerical target was based on the writings of Josselson and Lieblich (2003) who suggest this number as a guideline for narrative research interviews. They state that interviews should continue until 'saturation' is reached, that is "in the opinion of the researcher, additional interviews will only provide redundant results" (Josselson & Lieblich, 2003, p.267).

Nine women responded to the advertisements. Of these, three were not eligible for selection: one identified as part-Maori and the other two had transferred to hospital during the labour of their first baby. Two of the other respondents had gone on to have a second child at home since 2001, and of these two, I selected one to interview, wanting the emphasis of my research to be very much on the planning of the first

---

<sup>11</sup> Birth Wise is a natural birth and parenting, consumer-led group, in X city.

birth. The remainder of the respondents had only had one baby since 2001.

Through the process of choosing participants, I realised that my selection criteria had not been tight enough and that I had not made these criteria explicit in the call for participants, for example, I was not clear that not only must the women have planned a homebirth, but I needed them to have achieved it as well. The reason for this was so that any potential impact of unresolved issues about a transfer to hospital and a subsequent birth there could be eliminated.

When I first began thinking about the kinds of women who planned to have their first baby at home, I identified that there were at least two potential groups of women from which I could select participants.

#### *Group 1*

Those women who are clear from the outset that they want to have a homebirth, but at times during the pregnancy are challenged about the risks of having a baby at home. They then have to justify their decision and defend their responsible nature, in regards to their belief that birthing at home is safe and is the best option for them.

#### *Group 2*

Then there are those women who journey to a place during their pregnancy where they develop the confidence to plan a homebirth. These women may initially have not realised that homebirth was an option for them or thought that homebirth was a risky business, but with

information and support they come to realise that birthing at home is just as safe as birthing in a hospital setting, and is the right choice for them.

I had anticipated asking the first interview question when the women rang to register their interest (Did you always plan to have your first baby at home or did you change your plans as the pregnancy progressed?) and then select an equal number of women from each group. However, the first contact was made almost exclusively via email, which made it harder to gauge the women and ask this question. The call for participant's advertisement included both a phone number and email address, and given our electronic age, most people preferred to initiate contact in this way.

Another thing that I had not anticipated was that the bulk of the respondents would be in the first group: motivated, committed homebirthers. Once again, I believe this comes down to my not being clear enough regarding my selection criteria and therefore not articulating the kind of specific experience I was seeking in my call for participants.

After I had completed four interviews, I evaluated my 'saturation' level, as per Josselson and Lieblich (2003). I saw that the same themes were emerging from the interviews with the women in the first group and there would be little value continuing to converse with women who were clear from the outset that they wanted a homebirth for their first baby. I did identify however, that in order to draw any conclusions at all from the comments of the woman I had interviewed from the second group, I

would have to access another participant who had changed her mind about the birth venue as the pregnancy progressed. I did this and completed five interviews in total.

### **Recruiting Women from my own Midwifery Practice**

I had initially thought that I might recruit some ex-clients from my own midwifery practice as participants, but on the recommendation of the Central Regional Ethics Committee the only method of recruiting participants I employed was that of advertisement. Some of the women who responded to the advertisement were ex-clients, and after lengthy discussion with my supervisor I did select some of them to interview.

The manner in which I aimed to maintain an ethical distance from these participants was as such: at first contact (email) I iterated that they were under no obligation to participate in the study to 'do me a favour'. I also stated that my interaction with them as a researcher would be quite different to that of a midwife providing care for them. Once the ground rules were established to everyone's satisfaction, they were recruited into the study. When discussing consent with them prior to the interview, I stated that I was here to hear their story and they should tell it how it was for them, not just saying what they thought I wanted to hear. Ultimately I can't know if parts of their story would have been told differently to an unrelated researcher, yet the stories they told seemed full and vibrant, and were told without restraint. Even though I may have thought I knew what they were going to say prior to the interview, I was pleasantly surprised that this was not entirely the case. I thought I knew these women quite well, after having spent a few months in their lives, yet I discovered new and interesting things about them. I also had the

impression that it was a beneficial experience for them to tell me their homebirth story when I was no longer their midwife and no longer intimately involved with them.

### **Recruiting Women from other Cultures**

I sought women who identified as Pakeha (or European) to participate in my study. I have an underlying commitment to the principles of the Treaty of Waitangi (protection, partnership and participation), however in honouring Kaupapa Maori, I would not venture to analyse or interpret the homebirth stories of Maori women, given my Pakeha identity. I believe it is important that Maori researchers be the ones to do this.

I also sought participants who spoke English, as this is my own first language and it would be most convenient to interview (and transcribe) in this language.

### **Data Collection Method**

The method chosen to collect the data was that of an interview, where a personal narrative would be elicited from the participants on the specific topic of becoming a homebirther. "Interviewing is rather like a marriage: everybody knows what it is, an awful lot of people do it, and yet behind each closed front door there is a world of secrets" (Oakley, 1981, p31).

Using a narrative inquiry framework means that the interviewer needs to make a shift to considering the interviewee as the narrator of their story and thereby casting themselves as the listener to that story (Chase,



2005). During the interview, the listener asks questions in an interactive way to prompt the narrator to relate their story about a particular topic.

### **Semi-structured Interviews**

The format for the interviews was semi-structured. This flexible format has pre-determined questions, but these can be modified based on what the interviewer/listener perceives as most appropriate (Robson, 2002). Without this semi-structured design the interviewee/narrator could relate any story in their life history, thus the provision of some direction was necessary in order to elicit each participant's story on my area of interest. The questions (Appendix Seven) were kept open-ended, broad and used as more of a guide, in keeping with narrative inquiry principles (Reissman, 2002). The questions (or themes to be discussed) stemmed mainly from the topic itself and centred around support(er)s and challenge(r)s. After reading in the literature about the 'midwife effect' (Jabaaij & Meijer, 1996) I added in a question about that particular aspect (How did your midwife's opinion affect you?), which was fruitful.

### **Interactive Interviewing**

Interactive interviewing involves the sharing of personal and social experiences in a context of developing a relationship. Ellis, Kiesinger and Tillman-Healy (1997) posit that this style is particularly appropriate for gaining an understanding of sensitive topics, such as childbirth. Any self disclosure of the researcher in the interactive interview process is valid and tactical, thereby enabling the interviewee to reveal her experience (Ellis, Kiesinger, & Tillman-Healy, 1997). Both Ellis and Berger (2002), in their discussion of co-constructed narratives, and Reinharz and Chase (2002), in their chapter about interviewing women, state that the

insights and stories that the researcher brings to the encounter are considered just as important as the stories shared by the interviewee.

### **Location of the Interviews**

Each participant was offered a choice of venue for the interview: I could come to their home at a time convenient to them or they could meet me at another suitable venue at a time convenient to them. All of the participants chose to be interviewed in their own home.

### **Length of the Interviews**

The Consent Form (Appendix Four) indicated that the interview could take up to two hours. Robson (2002) states that “anything under half an hour is unlikely to be valuable; anything going much over an hour may be making unreasonable demands on busy interviewees” (p. 273), as such I aimed to complete the interview within an hour. The variation in the actual timing was between 1 hour 20 minutes, and 40 minutes in length.

### **Interview Process**

As stated earlier, before the interview each participant was sent an Information Sheet (Appendix Three), after which they could self-select into the study. I then rang each participant to arrange the interview at a mutually convenient time and venue. During this conversation I reiterated the potential length of the interview and that, whilst my focus was on the journey to planning a homebirth, I would like to hear their birth story at the conclusion of the interview, if they wished to tell it.

In order to prepare myself for the interview on the day, I practiced asking the questions aloud once again and reminded myself to listen more than

talk. I checked the recorder, made sure I had all the necessary paperwork and endeavoured to arrive at each participant's house on time.

On arrival I asked the participant to read and sign the consent form, asked if they had any questions and explained how the interview would proceed, that is: even though I would be recording the interview and have it transcribed, I may take notes as well. I then started the recorder and began the interview with the first question (Did you always plan to have your first baby at home or did you change your plans as the pregnancy progressed?).

After I had worked my way through the questions, I asked the women to tell me their birth story. The telling and the hearing of the stories was a rewarding experience for both parties: it illuminated the woman's current 'birth experience integration status' (for lack of a better phrase) and provided a context for her homebirth perspective for me; it appeared to consolidate the experience for the women and allowed for deeper realisation of their accomplishments. A couple of their comments follow and attest to this: *"I do feel like I achieved something you know"* (Alice) and *"I overcame fear and I managed to have that confidence that I wanted to have and trust in myself and...sort of...that proved to everyone that I could do it"* (Cate).

At the conclusion of the interview, I re-iterated that once the interview had been transcribed, I would send a copy to the participant for verification and allocation of a pseudonym before I commenced the formal analysis phase of the study.

### **Pilot Interview**

Josselson and Lieblich (2003) suggest that it is advantageous to perform a 'demonstration interview' in order to develop the competence of the interviewer in relation to empathetic listening and reflecting skills. Execution of a demonstration interview requires that the interviewer gains experience in keeping her research aims in mind whilst leaving space for the conversation to blossom into a meaningful narrative.

Robson (2002) states that "you don't become a good interviewer by reading about it" (p. 290), and practice in a 'low-risk' situation (such as a pilot interview) not only allows for feedback on the researcher's performance by the interviewee, but also ensures the validity of the chosen questions.

Acting on the advice of these authors, I therefore scheduled a pilot interview before undertaking the formal interviews. The pilot interview was with Sadie<sup>12</sup> who had not planned to have her first baby at home, but had birthed her subsequent children at home. As such, she was not eligible to participate in my research; however she was keen to provide me with a training ground for my interviewing skills.

Sadie signed a consent form for the pilot interview and I asked her similar questions (I adapted the questions somewhat to encompass Sadie's different circumstances) to those that I planned I would ask the actual participants. It was not surprising that the pilot interview provided many valuable insights into my interviewing technique, but it was a surprise to

---

<sup>12</sup> Not her real name.

me that a previously unthought-of and recurring ripple was uncovered during this interview.

At the conclusion of the interview I sought feedback from Sadie in regards to the process as a whole. She had some clear suggestions for me:

- Practice asking the questions before the interview
- Reformat the questions to be asked aloud rather than read to oneself
- Think of open ways to ask questions
- Repeat questions so that 'hormonally influenced' new mums are clear on what you want to know
- Nod and smile for encouragement when the respondent is going in the right direction
- Redirect if the respondent is rambling
- Be clear about time and have a clock available

Tolich and Davidson (1999) discuss the "inescapable necessity" (p. 142) of pre-testing or retesting. They state that qualitative researchers most often use a retesting process, whereby, after trialling interview questions, the questions are improved before the next interview and can be fine-tuned as necessary during the course of the entire data collection and analysis period. Acting on the recommendation of Tolich and Davidson, as well as Sadie, I adjusted the wording and order of the questions before the first formal interview.

## **Data Analysis**

Narrative analysis can take the form of any one a variety of methods for interpreting texts that have stories as their commonality (Reissman, 2008). Of these methods, thematic analysis was the most appropriate for my study, as my aim was to generate and theorise about common themes emerging from the collective narratives. Thematic analysis involves contextualising the life and times of the participants (Reissman, 2008), which was the topic of Chapter Two. Acknowledging our unique birthing culture has situated the participants in 21<sup>st</sup> century New Zealand and affords the reader a view of the specific context for this story (my story of their story).

Thematic analysis of narrative data involves methodical engagement with that data, where each interview or story is examined in a case-centred way and the sequence of each story is preserved (Reissman, 2008). In analysing the interviews I enrolled the help of Carter (2004) and Chase (2003) as, being a complete novice to data analysis, I needed some guidance as to how to go about this 'methodical engagement'. Chase's description of interpreting, coding and categorising narrative data is succinct and is conveyed in text. Carter's description of how to analyse qualitative data is generic and does not describe analysis specific to a methodology (like narrative inquiry), but is conveyed in pictures as well as text. This way of demonstrating an analysis process appealed more to my visual brain, thus I adopted Carter's method and it certainly provided a new analyser like me with a clear way to go about what could have been a daunting task without a road map.

Carter (2004) advises that a key course of action in the analysis of qualitative data is to be iterative and reflexive with the material, as analysis “is not something you do to your data...(but is a) reflective process that you do with your data” (p88). Three steps are described to assist in ‘methodical engagement’ (data reduction, data display and data complication), though these three steps are not necessarily compatible with the pure form of narrative thematic analysis, where the case is kept intact (Reissman, 2008). However, as Carter (2004) says, the connection between all the different approaches in qualitative research is their primary concern with transforming and interpreting the data so that meaning can be made from it. In acknowledging the difference between Carter’s generic analysis guidelines and Reissman’s specific narrative approach, I have drawn from both in order to gain the most insight from my data. In keeping with the narrative method, the women’s stories will be told in their entirety in Chapter Five and the common themes that emerged from the collective narratives (as defined through Carter’s analysis processes) will be discussed in Chapter Six.

### **Analysis and Interpretation Process**

The process of analysing and interpreting the data from the five interviews involved repeated reading and reflection on the stories both before and after they had been transcribed. I opted to have the interviews professionally transcribed, as taking on turning audiotapes into text is “fraught with hazards” (Price, 1999, p.13), thus I chose to focus on learning ‘analysis’, rather than learning ‘transcription’.

Use of my field journal was imperative in capturing my thoughts and insights as I returned again and again to the stories. Common themes

began to emerge and I began to focus on these, selecting nine as worthy of discussion. As a person who absorbs material best visually, I made posters with colours to help me identify links and dissimilarities across the five stories. Further engagement with each story and the selected themes saw me refine and reshape those nine themes into five inter-related common themes. The themes are:

- How it is that personal philosophy guides life choices
- Women's intrinsic attitudes to birth settings ultimately influences their choice of birth environment
- Having a choice and making a choice is imperative
- How it is that culture impacts on choice of birth environment, as do people in the woman's life
- Having access to homebirth and positive birth stories and resources is essential

Analysis of narrative data leads to interpretation and a discussion of interpretive authority is warranted at this point. Chase (1996) asserts that the narrative researcher's interpretation of interviews focuses on "how individuals' stories embody general cultural processes or phenomena" (p.45). This is not to say that researchers are seeking to prescribe a definitive interpretation on a participant's story or to challenge the meaning participants attach to their stories, but the researcher's goal is to turn our attention to the phenomenon under investigation. In spotlighting women's experience of becoming a homebirther, I have analysed the women's stories for the social processes they reveal. I declared my interest in this phenomenon from the outset and claimed my interpretive authority by acknowledging that their stories would be re-framed through connections to a broader



cultural context (Chase, 1996). Acknowledging my interpretive authority was achieved through discussion during the consent process and conclusion of the interviews. One of the participants (Alice) even commented on this saying *“cultural identity (and) the Pakeha experience of that is really under-sought...really underestimated and really under-discovered...it does matter”*.

Interpretation of the data came about through following Carter’s (2004) steps to analyse qualitative material, as stated above (data reduction, display and complication). Meaning was made of the women’s stories about becoming a homebirther during the analysis phase by bringing their stories into sharper focus (Denzin, 2002). Given my perspective as a researcher, I was able to interpret the stories and actions of the participants and “to see effects and power relationships, where (they) could see only emotion and personal meaning” (Denzin, 2002, p.264). My interpretation of the women’s experiences offers a contextualised account of their stories.

### *Reflection*

Being with the women’s stories during the analysis and interpretation process was an immensely pleasurable, yet introspective time. Looking back on that phase brings a fond memory to mind where I was lying on my back in a lake, looking up at the sky and then turning over and looking down through the water, at one horizon and then another and another: seeing the world from different perspectives and making some meaning from it because that’s what we do! I feel fortunate to have floated in that

lake and I feel privileged to have engaged with these women's stories and to be bringing their voices to a wider audience.

### **Chapter Summary**

Chapter Four has elucidated the design, methodology and processes by which my study was undertaken. In providing these descriptions rigour has been demonstrated and generalisability has been considered. Narrative inquiry has been discussed and highlighted as a particularly appropriate methodology for this midwifery research project, with storytelling being very much a part of midwifery traditions. As the poet Muriel Rukeyser<sup>13</sup> says "the universe is made of stories, not of atoms" (Kaufman, Herzog, & Levi, 2005).

---

<sup>13</sup> This poem, *The Speed of Darkness*, is attached as Appendix Eight.



Photo 5: Sunset, Port Douglas

## **Chapter Five**

### **Women's Stories: Crossing the Threshold**

#### **Introduction**

This chapter holds the stories of the five participants in my study: five women who have crossed the threshold to motherhood. As narrator, I will now tell each woman's story keeping intact the sequence and affording them the respect they deserve "as subjects with both histories and intentions" (Mishler, 1996, p.80). Each story will be illustrated with the woman's own words, enabling the reader to get as close as possible to the experience of each of the participants (Sandelowski, 1994). Each narrative will be followed by excerpts from my field journal, reflecting on the story at different junctions and illustrating reflexivity in the research

process (Koch, 1994; Maynard & Purvis, 1994). Telling each woman's story honours the feminist roots of the study by preserving their speech (Devault, 1990), and maintains the integrity of the 'case' in narrative terms (Reissman, 2008).

Each of the women has a moniker beside their (assumed) name. These monikers either emerged from the stories themselves, from the words of the women, or they surfaced with repeated reading of the transcripts and engagement with the language the women used. Having a moniker casts each woman clearly as a character in my interpretation of her story, as an active person in her own play. Without exception these characters are effecting transformation: the rite of passage to motherhood has transformed them, and now they are actively changing the wider world by telling their stories, not only to me but to others as well.

Alice is the **pioneer**: an originator; a person who prepares the way for others to follow (The Penguin Pocket English Dictionary, 1987). She calls herself this in her story and talks about opening doors and leading people past the assumption that babies have to be born in hospital. Jenny is the **maverick**: an independent thinker who refuses to conform to accepted views on a subject (The Penguin Pocket English Dictionary, 1987). I have cast her as the maverick, given her non-conformist views to the dominant medical model and system in which she worked. Gemma is the **evangelist**: one who tries to persuade others to join their cause, especially in a public forum (The Penguin Pocket English Dictionary, 1987). Like Alice, Gemma identifies herself as this character within her story. Cate is the **conquistador**: a person (ad)venturing outside their known territory to conquer foreign lands (The Penguin Pocket English

Dictionary, 1987). I have cast Cate as the conquistador, given her clear articulation of having a whole new world opened up to her by choosing to have a homebirth. Haley is the **rebel**: one who refuses to conform to the codes and conventions of society (The Penguin Pocket English Dictionary, 1987). I have cast Haley as the rebel, as she bravely rejected the expectations of her family and her colleagues in order to follow her own convictions.

### **Alice: The Pioneer**

Alice and her husband are inner city dwellers who identify themselves as 'alternative' in many of their lifestyle choices; they are vegetarians, environmentalists and politically active. Alice chose to have a homebirth because *"it's such a strong experience and I wanted that"*. She saw her homebirth as something she was completely responsible for, not an experience where she would devolve responsibility and rely on someone else to do it for her.

Even though Alice always assumed that she would have a homebirth, initially at the start of her pregnancy she was undecided. When she saw her GP to confirm her pregnancy, Alice came away feeling disempowered and realised that who she had as a midwife was going to be pivotal to her experience and committing to having a homebirth. Alice chose a midwife who provided both home and hospital birth services, just in case she *"chickened out"* and had a hospital birth. The midwife left it open for Alice and her husband to choose a homebirth by not convincing them, merely laying out their options and leaving it with them.

Throughout her pregnancy Alice was supported by her husband and both their parents to have a homebirth, though Alice said that *“all of our parents I think their first reactions were less than really whole heartedly positive”*. Alice’s parents, while professing their support, were both at times unsupportive of her decision. Alice’s mother was a nurse and kept reiterating that *“it was my decision, but she wanted me to be safe and the safety thing grated me after a while because the more I looked into (it) the more I realised actually that...for us homebirth seemed safer than going to hospital”*. Alice’s father didn’t think she would go through with it and Alice recalled an occasion when he wouldn’t stand up for her in a testing situation: a family dinner with friends. The topic of homebirth came up and the dinner guests *“absolutely took the piss out of me until...I had to walk out of the room crying because I was so upset...I just kept saying that’s so disrespectful”*. Alice felt unsupported because her parents would not stand up for her at that time, yet *“now they do because after I’ve done it and we didn’t have noise control called and we didn’t have police officers coming up and we didn’t have to get rushed off to hospital...now my mother actually goes to work and she gloats to other people”*. Alice said that she felt like a pioneer for leading *“her family to collectively get their head past it”*.

At times during her pregnancy Alice felt challenged about having a homebirth: she described her home environment as a stumbling block; she went through times of feeling deeply nervous and insecure about the birth; and sometimes the challenge came from her supporters (as illustrated above) or society as a whole. Alice pushed through these challenges one by one: firstly she came to terms with her inner city flat and its suitability for birthing and parenting. Secondly she read,

researched and educated herself about normal birth and homebirth. She invested in the experience of her first birth. Alice found books like Spiritual Midwifery (Gaskin, 1990) and her antenatal classes to be affirming of her homebirth choice and she integrated these resources until she reached the point where she trusted her body and trusted her baby *“I really got it through my head that the experience wasn’t just mine, that it was his experience too...it’s not all up to me but there is someone else involved in this”*. Thirdly Alice met the challenge(r)s of her support people and of society. Philosophically Alice felt that home was the best place to have a baby and if everyone did it *“society would be improved”*. Having this conviction aided Alice in overcoming the challenge from her family and people she met on a day-to-day basis. Alice saw the hospital as authoritarian and said *“I never fit very well with authority...so it just seemed like the natural decision to make, the natural progression of our lifestyle, the natural progression of our philosophies”*.

Alice went on to have her baby at home, as she planned. Alice’s waters broke late at night and she went into labour in the early hours of the morning. She laboured quietly, in a trance-like state until near dawn, when she woke her husband. They called the midwife who came over around 8am, at which time Alice felt like pushing. Alice pushed for four hours in different positions in the pool and her son was born in a directly occipitoposterior<sup>14</sup> position needing some resuscitation. Alice’s absolute trust in her midwife’s skills as a health professional meant that Alice took the resuscitation in her stride, and as it was done so calmly, Alice did not realise until months later that it was an unusual occurrence.

---

<sup>14</sup> Occipitoposterior (OP) position is a malpresentation where the baby’s back is against the woman’s back, with its head deflexed. The baby will either rotate to occipitoanterior or will be born with its face towards the woman’s pubic bone.

Believing that home was the best place to have her baby and having achieved a homebirth, Alice now wants to change the stories women hear about birth: *“I wish women would talk about these experiences more...and one of my friends...I think if she chooses to have a baby I think that our experience will actually (make a difference)”*. Having crossed the threshold to ‘mother’, Alice feels now that *“if there was a job that paid you to be a homebirth campaigner, that’s what I’d do”*.

### **Reflection**

Immediately after my interview with Alice I wrote: *Alice said that she had not had any challenges, she then went on to describe lots of challenges! I found it useful to have specific questions about who or what the challenges were in order to pull out the memories: the story about the family dinner as a great example. I was also surprised that what was happening in the media had little or no effect on Alice’s decision-making.*  
(01/02/08)

When reading through the data from Alice a few months later I wrote: *Alice is a pioneer. She is a very thoughtful woman whose data yields a rich crop. So many well articulated ideas and thoughts. I feel that this interview will be pivotal in delineating themes. It’s great that this is the first interview in the sequence and allows me to thread themes through to the others.*

(13/11/08)

And later still I write: *After discussion with my supervisor last week, I came to realise how important the re-reading of the data is. My initial impressions of what Alice had to say during the interview have changed*



*in light of the other data and time. I don't think the importance of Alice's data was obvious until that most recent re-read. So much more depth and 'realisation' becomes obvious with deeper analysis. I feel I could write my whole thesis just on Alice's data!*

(28/11/08)

### **Jenny: The Maverick**

Jenny and her husband are professional people who live in their own home (which just happens to be down about 90 stairs) in the suburbs of a metropolitan area. Jenny is in fact an allied health professional, and at the time of having her first child, was working within the health system. Jenny's homebirth plans stemmed from the need to have "*just family at home*", where she would not have to go somewhere unfamiliar, and where she could be the "*strong and bolshie*<sup>15</sup>" woman she was, without being faced with "*people who are going by the book*".

Jenny professes to not having thought about where she would have her babies until she was pregnant for the first time. Once pregnant though, she "*thought it would be good to have it at home and mostly because I suppose I knew my sister had done that*". What appealed to her about homebirth was "*not having anyone else...take control when I was in a compromised position*". Initially Jenny had some concerns about birthing at home, but once she and her husband talked with their midwife about what could go wrong during the birth and the midwife "*had answers...and allayed our fears*" they decided to birth at home. Part of their decision was realising that if they planned a hospital birth, then

---

<sup>15</sup> A humorous derivative of Bolshevik; in this circumstance, meaning a radical person (The Penguin Pocket English Dictionary).

they would certainly have to do their stairs while in labour, whereas with a home birth, there was only a small chance of having to traverse them.

Jenny articulated good support and positive reinforcement for her homebirth decision, with the exception of a neighbour who said *“oh you’re brave, I wouldn’t do it on my first baby sort of thing”* to which Jenny internally responded *“I didn’t actually think I was being brave, I was doing what was going to work for me because I knew the hospital, I’d have to be brave to go to the hospital”*. Interestingly, Jenny did not tell her colleagues that she was planning a homebirth.

Jenny’s philosophy about birth was strongly influenced by her sister and family, and reinforced by her midwife. Jenny sees herself as ‘anti-establishment’ and says *“I think one of the major things actually for me is that I’ve got maybe the anti-establishment thing in my head that I got...through my mum and (my husband)’s got a bit of that and my sister has as well. So we’ve got kind of ‘anti’ however one does stuff...and that supports stuff on birthing”*. Coming from this perspective had Jenny feel it would be better to birth in the privacy of her own home, outside of the influence the patriarchal hospital system where she felt it was better *“to keep away from it, otherwise I will get overtaken by it”* which is *“why it’s so difficult to have a normal birth in a hospital”*.

Jenny went on to have a homebirth for her first baby, which was not without its challenges. Jenny’s waters broke the night before she went into labour and after 18 hours Jenny was advised by her midwife to go

into the hospital for monitoring and antibiotics<sup>16</sup>. Jenny and her husband considered this recommendation and decided that they did not want to go to hospital. Soon after making that decision, Jenny went into labour and birthed her baby in the pool, almost exactly 24 hours after her waters had broken.

Jenny's story about her first birth is in contrast to others she had heard, and here she elucidates the difference between being an active participant and a passive recipient of one's life experiences: *"I've heard these stories from other women...about all the things that have happened to them and I think, well, why? They choose that stuff."*

### **Reflection**

Immediately after my interview with Jenny, I wrote in my journal that the theme of 'anti-establishment' had come up. This theme had come up in other interviews but had not been phrased as such, and I acknowledged it as a major thread through many of the interviews. I wrote that *Jenny could be seen as a maverick – a free-thinker – a dissenter – a rebel (in her own home!)*.

(06/03/08)

On reading the data a while later I reflected that: *Jenny sees herself as anti-establishment. Jenny expressed her anxiety about being influenced by medical power, so wanted to avoid the 'power-house' so to speak. If you are not subjected to the medical gaze, you cannot be influenced by it. Yet the midwife subjected them (and was subjected herself) to medical*

---

<sup>16</sup> Current protocol at the hospital in X city was that for women who had ruptured membranes for more than 18 hours to have intravenous antibiotics to prevent infection and neonatal morbidity.

*power by making recommendations regarding Jenny's pre-labour spontaneous rupture of membranes. It was hard for the midwife to give them a choice and this issue proved the biggest issue for Jenny and her partner.*

*(09/12/08)*

After re-reading the data and reflecting on that earlier reflection, I wrote the following: *In writing my reflection on Jenny I have realised how influenced that earlier reflection is by my starting to read the Fahy book (Fahy, Foureur, & Hastie, 2008). I have been talking about it with others too. But when I was reading Jenny's transcript it just became so obvious that what she was describing was so 'Foucault': power, disciplinary knowledge and control, surveillance, the obstetric gaze etc. Whilst I found that chapter easy to read, I feel a bit anxious about how to relate and integrate such a huge and complex subject into my thesis. I can't ignore that Jenny talks about it and I have a funny feeling it will come up with Haley too (given that she is also an allied health worker).*

*(09/12/08)*

### **Gemma: The Evangelist**

Gemma and her husband rent a flat in an inner city suburb. They both work in creative fields and both had attended births as support people before planning their own family. Both Gemma and her husband felt that having attended births before was formative to their own decision to birth at home. Gemma had attended two hospital births, whilst her husband had attended a homebirth before they supported at another homebirth together. As a result, Gemma's husband wanted to share their

birth experience with his good (male) friend and so they asked his partner too. Gemma saw this as her contribution to society, even though these people were not integral to her own birthing experience, and hoped to be part of a *“ripple effect”* to improve the rates of homebirth.

Early in the pregnancy Gemma’s husband was sure about a homebirth, quite a bit before Gemma was, leaping ahead in his decision-making. Gemma needed time and space to come to the decision herself, which she did after meeting with their midwife *“(she) was the only person who said you could do it this way and you could do it that way...it was great: here’s some space...I can make my decision”*.

Even though Gemma had a great supporter in her partner, she faced a multitude of challenges about her homebirth choice from her extended family and from society in general. It proved exhausting to be on the defensive continuously, so Gemma chose times not to engage with people about it: *“people felt they owned you and people thought you needed to know their opinion on it...and sometimes I found it easier to...not even get into conversations”*.

Gemma had her homebirth, but faced some health challenges during the last couple of weeks of her pregnancy and it was not until nearly two weeks past her days that she went into labour. During her labour Gemma faced yet another challenge, where the progress of her labour seemed to halt, even though the contractions were coming regularly. Gemma had to confront the idea that a transfer to hospital might be necessary. However, given the space (once again) to ask herself *“okay what’s really going on?”* she moved past the point of needing to change environment

and birthed her baby. Gemma now feels absolutely that homebirth was *“the best way to go”* and has garnered support from some of her biggest critics through education and experience: *“you know, people like the (American) brother-in-law came back and apologised and went, oh wow, maybe we just didn’t know...that there is another way”*. Gemma feels now that she *“is as evangelical as (husband) but I hope to continue to be that (ripple) effect”*.

### **Reflection**

Soon after the interview with Gemma I reflected on how diverse a family and experience base Gemma and her husband came from. People were very opinionated either way and it required a lot of energy for Gemma to be on the defensive all the time. I also wrote about how important it was that Gemma and her husband had attended births before having their own child. Gemma saw this as an important part of her decision-making and therefore decided to have another couple at her birth as support people, in order to expose them to homebirth. What generosity!

(15/02/08)

A while later, after reading the interview I reflected on Gemma’s story: *Gemma’s transcript is very hard to read – her style of communication is different to the others. She tends to ramble and doesn’t finish her sentences. In reading my responses to her answers, I see that I tried to lead her much more than the others. In my communications I tried to delineate what I thought she had to say so that some clarity would be evident at the end of it. Very frustrating for a data collector to participate in an interview with a person communicating in this way! However, this is Gemma’s style. From her transcript emerges a strong theme of challenge.*

*Just how to pull this out and string it together, when the sentences are so bitsy, will be my challenge!*

(30/11/08)

Further reflections include: *Gemma had fantastic support and she also faced huge challenges on her journey to planning her first homebirth. Gemma felt incredibly challenged by people in her extended family about her homebirth choice. Regular contact with her midwife, access to research and information, as well as support from her partner helped her overcome her challenge(r)s. She wasted energy defending her choices and at times chose not to engage with people about it.*

(30/11/08)

### **Cate: The Conquistador**

Cate and her husband rent a flat in the city. They both work as civil servants and initially homebirth was not on their agenda at all. Cate changed her mind as her pregnancy progressed and was supported whole-heartedly by her husband to birth their first baby at home. It turned out that Cate's husband came from a family of homebirthers; a fact that she did not discover until after her baby was born.

Before becoming pregnant, Cate's view of birth was influenced by what she had seen on TV: something that took place in a sterile environment with a medical presence. It wasn't until she started reading books during her pregnancy that Cate began to see birth as "*an intimate experience...(and an event that took place)...where you felt completely comfortable*".

Although at the outset of her pregnancy Cate was not at all attracted to homebirth, she chose a midwife who was open to attending her at either venue, but who professed a preference for homebirth. This was life changing for her: *“ I think a lot of people wouldn’t have considered a homebirth or going to a homebirth midwife, but might have gone through that same path as me if they ...had been given the opportunity to have that sort of world opened up to them.”*

Cate saw herself as a conservative person and also one who was not very confident at making decisions, yet with information, resources and support Cate came to a place where homebirth was the best choice for her. The decision was made not long after Cate and her husband went on a hospital tour with their midwife. Cate describes the hospital as *“a new place...out of your comfort zone...(where) the rooms were horrible and so small. It had this fluorescent light going and lino on the floors and squeaky pillows...and just no room to have anybody there really.”*

In addition to her ‘discomfort’ with the hospital setting, Cate’s growing confidence in her ability to have a homebirth was reinforced by the depth of the relationship with her midwife. Cate felt completely ‘known’ by her midwife and appreciated the way her midwife expressed confidence in her ability to give birth: *“if I’d had a midwife who didn’t sort of learn about me or understand me in the way that (she) did, then I wouldn’t, yes I wouldn’t have been able to do it”*. During the pregnancy Cate also overcame *“a preconception that midwives didn’t have the sort of knowledge you will get in a hospital”* by constantly asking questions and engaging with her midwife. She got to a place where she felt really



*“satisfied” with what midwives knew and saw that “midwives are the experts really”.*

Cate’s labour started spontaneously near her due date and over the day, before the contractions were coming regularly, Cate and her partner and support people went out for a walk in a nearby reserve. Cate recalls this walk in nature vividly, saying how much it added to her experience of her baby’s birth. Later that evening, after being in labour for most of the day, Cate’s midwife discovered that the baby was posterior (OP) and that Cate had an anterior lip of cervix<sup>17</sup>. The lip was able to be pushed back and the midwife encouraged Cate to talk to her baby and ask him to turn around, which he did.

Cate birthed her baby at home in the bath and says that *“it was such a positive birth I can’t think of any reason why I wouldn’t want to go through that again”*. In reporting a conversation with other women in her antenatal class after the birth, Cate identified how the choices we make influence the stories we tell: *“when I look at the births the others had, they all had some kind of intervention and tearing...and it seemed like it was kind of out of their control and there are very few who said, gosh, this was a positive experience, which is really sad”*. Cate’s satisfaction with her birth comes from the fact that she conquered her fears and made active choices about her experience: *“I overcame fear and I managed to have that confidence that I wanted to have and trust in myself”*.

---

<sup>17</sup> The anterior section of the cervix is nearly always the last part of the woman's cervix to be finally taken up into the lower segment of the uterus. An anterior lip occurs when the top of the cervix swells (like a 'fat lip'), but the rest of the cervix has completely dilated.

## Reflection

Soon after my interview with Cate I wrote in my journal about how important it is for midwives to learn about and believe in their women. Cate travelled a long road in a short space of time to birth her first baby at home; she overcame challenges in the form of her pre-conceived ideas about birth and her fears about not being able to cope with the sensations of birth. Without a supportive midwife, conquering these challenges was not achievable.

(15/02/08)

On reading the data a few months later I wrote: *This morning I have read Cate's transcript again. Having already commented on the importance of Alice's data, I feel I must now state the equal importance of Cate's data! I was struck by the poignancy of Cate's story and her relating of it. I think she has probably come to know herself at a new level by participating in the interview. I have a huge amount of admiration for her.*

(28/11/08)

Further reflections on Cate's data: *Cate takes things slowly and considers everything carefully before making decisions about things. Cate is like a sponge that soaks up information, knowledge, impressions. But Cate is a discerning sponge who knows what she likes and doesn't like. Like a sponge, Cate is flexible, malleable, adaptable and capable of huge shifts. Cate is a conquistador – a traveller who conquers whole territories that she did not even know existed before embarkation.*

(28/11/08)

## **Haley: The Rebel**

Haley and her partner rent a house in a metropolitan area. Both are in full-time employment; Haley works as an allied health professional. Haley had previously attended her sister's hospital birth as a support person and had a view that the women in her family had easy births. She had also heard the story of a friend's homebirth experience long before having her own child and this had made a significant impression on her.

Once Haley discovered she was pregnant, she rang the midwife who had attended her sister to enquire about midwifery care. Even though Haley describes herself as *"a fairly anxious person"* she expressed an interest in homebirth even at this early point. However, Haley reports the midwife's reaction was less than favourable. She said: *"I don't do homebirths in (city) because of the access...that's ridiculous...what if you haemorrhaged?"* Haley said *"this quickly taught me that there are quite different midwife approaches. I thought the midwife would just be open to whatever you wanted, but that certainly was not the case at all"*. Haley went on to find a midwife who *"laughed at the access and she said that everyone who wants a homebirth has access like that"*. Even though the seed of homebirth was there, Haley was undecided about her birthing venue, feeling fearful about her ability to cope with labour. She found support in her midwife who did not push her to make a decision: *"What I loved was that I didn't have to make a decision...she said no I can do whatever you want and that really took the pressure off...homebirth was my absolute ideal but my belief in myself was a little bit lower than that...some days I felt strong and other days I felt a little bit afraid."*

During her pregnancy, in an effort to counter her fears, Haley sought positive information and birth stories. She made the comment that it was difficult to access affirming birth stories and opinions about homebirth: *“I had to really seek out people that had a positive view of homebirth...and what I really liked was that these people were really open-minded to both sides, whereas I found that hospital people, they just would shut down any other (viewpoint). Pro-hospital people were very forthright with their comments, whereas people who were pro-homebirth were supportive if you approached them, but they just don’t come out and say it”*.

In addition to her own anxieties, Haley faced absolute opposition from her family and colleagues to homebirth. She describes getting a bit guarded about who she discussed her thoughts with, articulating: *“it’s just other people’s fears”* and *“I didn’t want to get into an argument about (it)”*. She reached the conclusion that *“it was easier to tell people I was going to hospital and I actually did plan to get there”*.

At the onset of labour everyone involved believed Haley to be having a hospital birth. However when the midwife arrived *“it was such a moment of clarity...she was confident and reassuring that I had been healthy and there was absolutely no reason why we couldn’t have a healthy baby at home and quite frankly the trip to the hospital just seemed like a nightmare to me. So I just said, well that sounds really good to me, and the decision was made, not without some conflict in the support team”*. Her partner was extremely supportive of Haley, and stood behind her ‘last minute’ decision to have a homebirth *“it was a special moment in our relationship because he backed me when he tells me later that he was shitting himself”*.

Haley achieved her homebirth, despite a long and gruelling labour. At the end, when a transfer to hospital looked imminent, Haley looked inward and recognised her birth story changing if something did not change in her labour: *“I’ve not gone 30 hours because then that wouldn’t be my (home) birth, it wasn’t that I’d survived 30 hours at home and pushed so long and it would be...a hospital birth...I was like, there’s no way...so out she came!”* Haley’s daughter was born with her hand up by her face, which explained the fiddly nature of her labour and long pushing phase (a wider diameter trying to negotiate the pelvis). Haley was transformed by her birth, sourcing a *“new confidence and belief and strength”*.

In birthing at home, Haley rebelled against her family and her colleagues. She describes telling her family and friends the news: *“It felt great calling on family members and friends...like my boss. She was really miffed when she heard I’d had the baby...she just hadn’t expected or thought that would be the way. So I really enjoyed telling all those people that had doubted me and questioned me that that’s how it had gone”*.

### **Reflection**

Immediately after the interview with Haley I reflected that although she stated that her homebirth was a spur of the moment decision, it became apparent that a lot of thought actually went into it. She found the support of her partner to be imperative, and as an anxious and fearful person, she overcame so much to accomplish her homebirth.

(26/08/08)

On reading the data later I wrote: *Haley’s struggles were more internal than the other participants - she struggled with confidence, anxiety and*

*her ability to cope. Haley was associated with the hospital and had also been an inpatient briefly during her pregnancy. She knew the hospital environment, systems, people, and she did not want to be subjected to their influence (gaze). Homebirth was there from the start and having a confident, open midwife; books and resources; and hearing good stories all helped her to make the decision. Haley kept her thoughts to herself until the last possible moment, and then pulled the homebirth out of the hat, slapping the doubters in the face with her positive outcome! A rebel in the truest sense of the word!*

(09/12/08)

## **Chapter Summary**

In this chapter I have introduced the five women who participated in the study: Alice, Jenny, Gemma, Cate and Haley. I have told the story of their stories and encapsulated each woman as herself in keeping with the feminist foundation and narrative philosophy. I have illustrated integrity, consistency and dependability by including reflections from my field journal on each woman and her story throughout the data collection, analysis and interpretation processes. I have also started painting the picture of the themes emerging from the stories, which are to be discussed in the next chapter.



Photo 6: Bridge in Central Park

## **Chapter 6**

### **Findings and Discussion: Bridge to Beyond**

#### **Introduction**

This chapter illuminates the findings of the study by discussing the emergent themes from the women's stories. As well as discussing the chosen themes, I will also consider the discarded themes and outline why they were abandoned. In discussing the findings, the limitations of the

study will be acknowledged. Recommendations will be made for New Zealand midwives and women, in regard to how we can increase the homebirth rate in this country and cross the bridge to beyond.

## **Findings**

Uncovering the findings of a piece of research is like being on a treasure hunt or a quest, crossing bridges to unknown places, exploring. Depending on the context of that quest, the seeker has some idea of what treasures they might find or what knowledge they might gather on their travels. They may also hope that they are going to find some unexpected treasures: rare items of great significance!

The treasures of this study emerged during the thematic analysis, like gold nuggets panned from the earth. These were the expected finds: I was, after all, panning for gold! Researching women's experiences on the path to their first homebirth made explicit what had been tacit.

The rare item of great significance that has emerged from my study is the discovery that homebirth is often conceived before conception of the first child, before the pregnancy journey even begins.

## **Themes**

When initially faced with the stories everything seemed quite simple. I had what I wanted, or so I thought. It seemed easy to pick out 'this' or 'that' significant phrase and place it with what I saw as the meaningful ideas emerging from what the women had told me. Delineating themes



or patterns in qualitative research can be problematic however, as researchers commonly do not state how their themes were arrived at (Sandelowski & Barroso, 2002). Study findings therefore can be deemed irrelevant, unless the thematic emergence process is adequately described. In finding the themes within my data I initially outlined a multitude of codes, themes, significant ideas (Attride-Stirling, 2001; Carter, 2004; Chase, 2003). Further engagement with each story and continued reflection in my Field Journal saw me refine the codes into nine themes, which were then distilled into five inter-related common themes. Once this process was completed, I evaluated the ongoing significance of each of those themes and realised that a couple of the areas that I thought would be significant, were not in fact significant to the women and were discarded.

Those discarded topics are still worthy of mention, if only to enlighten the reader as to their ultimate lack of significance in this context. I had anticipated that the word 'risk' would occur a lot in the transcripts, but in 44,072 words 'risk' occurred only 13 times, and 5 of those mentions was by me as the interviewer. The other times 'risk' did come up was in relation to what other people thought about homebirth, not the women themselves.

I had also anticipated that how homebirth is portrayed in the media might have an impact on women's attitudes about birthing at home. Even though women have a legal right to choose homebirth in New Zealand, only a minority of women do so, therefore it is not widely accepted and lauded as the preferred way to do things (in most circles anyway!). Media attention is often turned to the tragedies that can occur

during homebirths and I wondered whether this scaremongering would negatively influence the women against choosing homebirth for their first baby. When asking the women directly if the media had influenced their attitude towards homebirth, I received some interesting answers. Almost all of the participants commented on how the media contributes to a cultural construction of birth, but none of them said they felt at all intimidated by *“a media stigma associated with homebirth”* (Alice). The most commonly elicited response to the question about the media came in the form of a mention about negative hospital press and how this had influenced them to stay at home! Media sensationalism did not engender fruitful conversation during the interviews, and as such has been discarded as not significant in a discussion of themes arising from the women’s stories.

The theme of *how it is that personal philosophy guides life choices* has endured. The three women who planned a homebirth from the start all talk about their life philosophy and how it impacted on their decision making. The two women who changed their mind philosophised less, yet inferences can still be made from their stories. Philosophy is linked to the *how women’s intrinsic attitudes to birth settings ultimately influences their choice of birth environment*. It is important to explore how the women viewed each setting before discussing their choosing of home as their preferred birth environment. Choice and choosing are commonly mentioned, in that the women identified that *having a choice and making a choice were imperative* and they all went through this process in a conscious way during their pregnancy. Their thoughts on whom and what supported their choosing leads on to the role of people and resources. The theme of *how it is that culture impacts on choice of birth*

*environment, as do people in the woman's life* will be explored and the main people to be discussed are the woman's supporters, her challengers and the role of her midwife in it all. *Having access to homebirth and positive birth stories and resources is essential*, according to the participants. The main resources to be discussed are the role of antenatal classes, as well as written resources, visual resources, and most importantly, aural resources like stories.

### **Theme: Philosophy**

Personal philosophies about birth and life in general, were factors in becoming a homebirther for most of the women in my study and I have interpreted this as the theme: how it is that personal philosophy guides life choices. The participants all expressed sentiments of operating somewhat "*outside of the square*" (Cate) as homebirthers; some went as far as saying they considered themselves as "*anti-establishment*" (Jenny). It would seem then that a stereotype of a 'homebirther' is emerging: an alternative lifestyle, middle-class hippy, earth mother, greeny environmentalist type. I could construct a story of homebirth women using these descriptors, but would that truly reflect New Zealand's Pakeha homebirth population? I concur with Bastion (1993), who concluded from her Australian study of homebirth women that homebirthers actually come from diverse backgrounds and "the belief that women who give birth at home belong predominantly to the counterculture does not appear to be justified" (p191). The women in my study cannot be pigeon-holed; they are all individuals with their own reasons for choosing homebirth, with personal philosophy being just one of those reasons.

Alice was one of the participants who did wax lyrical regarding how her *“alternative lifestyle”* philosophy influenced her decision to have a homebirth. Alice saw her homebirth plans as the natural progression of her philosophy. She says: *“being a vegetarian, doesn’t mean that I’m probably more predisposed to having a homebirth, but understanding why I am a vegetarian is complementary to why I want to have a homebirth”*. As a continuation of her personal philosophy, Alice believes *“if more women took the opportunity to have a homebirth I think we’d have, not only a better health system in general you know with better allocated resources, we’d also have probably happier babies and a lot stronger women”*, with which I agree.

Alice makes some astute comments about how birth and mothering are important cultural rites. She laments that *“we don’t grow up in villages where our sisters and our aunts and our mothers give birth and we’re there to watch and to help...we don’t sit there watching our family members breastfeeding, so we don’t know how to breastfeed. We have to have someone teach us or someone to oversee us doing it (now)”*. She wishes that Pakeha women would talk more about birth: *“I just wish...women in general would talk more about this type of thing because I would really love to know that other women got really excited about it...I really want them to know that its possible to get excited about something that society thinks is going to be the worst experience in their life”*. Alice goes on to tell a story about the stories we tell: *“a lot of the fear that you have is a fear that has been induced and you know just made more powerful because of society and it’s not because of you. It’s this society which raised you really. The fear is theirs, not yours...and every woman thinks ‘well, that’s how it’s going to happen’”*.

Gemma also talks about *“the tide of ignorance”* and how we are hopefully moving away from that and how we are more open to homebirth here in New Zealand. Gemma explains why she feels things are different here, saying *“(New Zealand) is a younger country and so ‘the way’ is not set in stone...(there is) a change of culture and New Zealand women were looking for more...than they were getting”*. She felt so strongly about contributing to this change in culture, that she invited a couple to be at her homebirth purely to expose them to this. In reflecting on the effect of this she philosophises about the temporal nature of stories and experiences and the effect they have over ones lifetime: *“(these stories were around) long before you came, but you know the effect you have from now, to in the future...by doing what you are doing. So you’re part and parcel of what happened here and then that ripple effect sort of carries on from that”*.

Jenny describes her personal philosophy as *“anti however one does stuff”* and applies this to birthing as well. She also talks about the ‘normal’ culture of birth: *“You know I’ve heard these stories from other women about all the things that have happened to them and I think well, why? Its weird, isn’t it. They choose that stuff”*.

The five participants in my study all articulated in their own way how it is that personal philosophy guides life choices, and they applied their beliefs to choosing a homebirth for their first child. While all extraordinary women, they are the same kinds of women who are exemplified in the literature as homebirthers. Women become homebirthers because they want a natural birth experience (Neuhaus et

al., 2002; van der Hulst et al., 2004); others see it as a powerfully transformative experience (Jakobsen, 1991); while others are just aiming to avoid technology and the hospital setting (Bastion, 1993; Edwards, 2005), just as my participants are.

### **Theme: Birth Environment**

All of the women who participated in my study had a poor opinion of hospital as a birth setting, which is a common finding in the literature too (Duke, 1982; Jakobsen, 1991; Ng & Sinclair, 2002; Ogden, 1998). They also had some ideas about why they wanted to birth at home, or why they had initially thought that home wasn't an ideal environment. I have interpreted this as the theme: how women's intrinsic attitudes to birth settings ultimately influences their choice of birth environment

Haley's choice to have a homebirth stemmed from her work as an allied health professional and also from her impression of the women's part of the local hospital when she was admitted for a short stay during her pregnancy. She says *"It was terrible. I just remember one room being all silver...and that was just absolutely horrific to me. I couldn't even picture myself in there...it was really scary to me that you can't guarantee what kind of environment you're going to be in"*. She also feared the interventionist timeframes in the hospital and *"not having any control over it"*. This feeling of loss of control in a hospital environment is well documented in the literature (Fullerton, 1982; Green & Baston, 2003; Jakobsen, 1991; Schiff & LaFerla, 1985).

Jenny relates similar sentiments about control when she says *"I know that when I'm faced with strong people who are going by the book...I'm*

*often overtaken by it and get upset by it and I can't stand up to it sometimes, especially if they're men, white men. It's kind of like my mother ingrained in me you should obey your father, you know, it's like that, so I know that's a weakness for me, so I have to avoid that".* Choosing a homebirth meant that Jenny was able to control what went on in her environment, having just family there and being able to say 'no, don't come in' if that was what she wanted.

Cate's view of both her home environment and the hospital also impacted on her decision making. Once she moved away from thinking of birth as a sterile event and began to see it more like an intimate experience, Cate began to consider the suitability of her flat for birthing. She went through a process of thinking *"What's the right kind of house (for a homebirth)?"* It wasn't until she went on a hospital tour that she was confronted with the environment there: *"when I went there I felt like it wasn't a comfortable place and in particular how horrible the rooms were...and you could hear other women"*, which did not equate with Cate's new idea of birth being *"intimate"*.

Gemma had attended hospital births previously and her ideas about that environment grew from those experiences, seeing them as the *"clinical operation type approach to having a baby"*. She states that it was definitely her ideal to be at home for her own birthing *"the more I learnt about (the) hospital...(the more I saw) it's just not a very nice place to be when such an amazing thing (is happening)"*.

Alice really wanted a familiar place to give birth, and once she got over her initial qualms about the suitability of her inner city flat, she felt

settled about homebirth and enjoyed taking complete responsibility for herself and her labour. Alice's view of the hospital was that it was a place of male authority (which she did not fit well with) and that *"it's no place for a normal happy birth"*.

In pondering on how our intrinsic attitude to birth settings ultimately influences our choice of birth environment, it began to emerge that a positive view of homebirth before having children has an impact when women do conceive. It was while analysing this theme that the 'rare gem' of the homebirth genesis was uncovered.

#### **Theme: Choices/Choosing**

The choice to birth a first baby at home can only be made if homebirth is offered, and it is clear in much of the literature, that although many women have a legal right to homebirth, many are not offered it (Edwards, 2004; Kirkham, 2004; van Weel et al., 2009). Choice and choosing were common topics of discussion during the interviews with my participants and I have interpreted this as the theme: having a choice and making a choice is imperative. When responding to the call for participants, three of the women (Alice, Gemma and Jenny) said that they had planned to have their baby at home from the outset; the other two women (Cate and Haley) said that they changed their mind as the pregnancy progressed. What emerged during the storytelling process was the fact that although Alice, Gemma and Jenny articulated being sure from the start, all of them went through the process of making a conscious choice about their birth environment during their early pregnancy.



Alice said *"I think it was an assumption that we would have a home birth but it wasn't something I'd committed myself to before we got pregnant...and then I actually realised how much I didn't want to be in hospital unless I really had to be and then, you know, and then I realised how simplistic the choice was"*.

Jenny said *"I should say that before we made the decision to do a homebirth we were, we could easily have gone to the hospital. When we talked to (midwife) we were saying we haven't made our minds up and that we were nervous about doing it anywhere because (of) not knowing anything, you know. I think at that stage I was willing to look, I really wanted to look at the homebirth thing but I wasn't sure where (husband) was in it. So I needed both the options"*. As it turned out Jenny's husband was also open to having a homebirth and she says for him it was *"a clear factual decision, you know he's a logical man"*.

Gemma's husband leapt ahead of her in his decision making for a homebirth *"the way that (he) talked you know, it was a given I guess"*. Gemma had a conversation with him where she said *"I just don't want you to say you've made your mind up for us kind of thing...we need to go through this process. Let's look at all the options, let's look at all the possibilities"*. Gemma found her midwife to be the perfect person to bounce ideas off: *"(midwife) was the perfect person...she was the only person (who said) well you could do it this way; you could do it that way. And the so it was great, okay here's some space...I can make my decision"*.

Both Haley and Cate had different journeys to homebirth. Haley professed to be *“really undecided. I liked the idea of homebirth and just intended to find out as much as information of both choices through my pregnancy”*. She struggled with self-doubt and anxiety about her ability to cope with labour and birth throughout her pregnancy, saying: *“I was afraid of the labour and I really wanted to be natural but I was scared of not having the choice and that was a big factor...I was afraid to make a decision, that it would definitely be homebirth because I was in turmoil, because I was afraid of the pain...homebirth was up here as my absolute ideal but my belief in myself was a little bit lower than that, so I always wanted it and the days that I felt strong I said ‘that’s what I am going to do’ but then other days I would feel a little bit afraid, and if I’d made the commitment, I think I would have panicked you know”*. Hence it wasn’t until Haley was in labour that the final decision was made and *“not without some conflict in the support team”*.

Cate admitted to not even be thinking about homebirth early in her pregnancy, and felt she was not even in the mindset to have a natural birth. Her view of birth had been influenced by what she had seen on TV: *“and the things that I knew about that, you needed to be in quite a sterile environment and things go wrong and you can have a stillborn baby and just that there’s a need to have a medical presence...(in case) you need it in a hurry”*. She went on to say *“there’s a whole bunch of things that led to me changing my mind and I’m a pretty, I’m very slow to make decisions...I’m not very confident at making decisions. I need lots of, lots of proof and backup before I will decide something”*. It was not until Cate went on a hospital tour that she began to seriously consider a homebirth: *“yes I had that hospital visit (that) was where the big change (occurred)”*.

Becoming a homebirther can be a slow process (much like a ripple effect from a pebble dropped in a lake long ago) or it can be a rapid process (like a boulder dropped in that same lake, where the ripple is larger and travels more quickly to the homebirth shore). The becoming begins with an awareness, a choice is then offered and consciously made.

### **Theme: People**

People cannot be separated from culture: we are culture; we create our culture with our words, our stories. It's not surprising that people were both the main supporters and the main challengers to the women in my study, and sometimes these roles were combined in one person! Family members, partners, friends, acquaintances, colleagues, neighbours, strangers, midwives, GP's: you name it, they had an opinion! My interpretation of this theme focuses on how it is that culture impacts on choice of birth environment, as do people in the woman's life. Many of the women stated feeling like "*public property*" (Gemma) while pregnant; others felt that they were treated disrespectfully for choosing a homebirth (as if they weren't making a considered, adult decision to ensure the best possible outcome for themselves and their baby); others chose not to engage with the people around them in order to conserve their energy.

### *Supporters*

The women all stated that the support of their partner was imperative in choosing a homebirth, and the literature concurs with this (Edwards, 2005). Having this one solid person to absolutely back them without

question was of utmost importance, as in Haley's situation, where her decision to birth at home was made while in labour. A couple of the partners were confident about homebirth, leading the way in this choice. Cate says *"he's not kind of an institutionalised person...he was supportive right from the beginning...I shouldn't have been surprised by that"*. It was also important that partners supported their woman to do what felt best for her at the time. Gemma says *"I needed to hear him say, yes it's ok if we do end up at the hospital if I can't handle the pain"*.

Family were mentioned by everyone as the biggest supporters; sometimes parents were thoroughly disdainful of homebirth, yet thoroughly behind their daughter (or son) to be autonomous in regards to decision making. Alice relates how her parents were not initially enthusiastic of her homebirth choice; they did not try talking her out of it or saying 'this is the wrong thing to do', but they would not stand up for her either. Alice wanted her mother to be at her birth as a support person and therefore invited her to participate in an active birth class and *"it made a huge difference on her...then she was very supportive of (homebirth)"*. Cate was reluctant to tell her mother she was planning a homebirth, yet her mothers' support was very important to her. When she initiated the conversation with her mother, she was surprised when her mother asked Cate directly if she was thinking of a homebirth, saying 'that's great'. Having her mothers' approval was a huge relief and Cate says from then on *"I had all my ducks in a row"*.

Friends were also important supporters of the women in my study. Having the support of like-minded people who had either experienced a homebirth themselves or people who were prepared to take their friends

wishes on and actively support them to achieve their goal was important. Sometimes these friends were to be support people at the birth and others were more on the periphery.

### *Challengers*

The people who provided the most challenges were once again family: those closest to the women, as well as those in the extended family. Haley recounts how her sister and mother were particular objectors to homebirth, and these women were to be support people at her birth! She says *"I really had to seek out people who had a positive view of homebirth, it wasn't (easy), all my immediate support people would make (negative) comments without me even asking"*. Gemma relates how family members and friends would make disparaging comments *"sometimes people were much more vocal and passionate than I thought (and) I'd try not to engage with it...energy-wise I couldn't necessarily take on every single argument that (was) coming"*.

Other challenges came from more distant people: colleagues, neighbours, family friends. Most women took the tack of not discussing their choice with anyone they did not have to. Alice tells a story of an encounter she had with an acquaintance, where the woman expressed dismay that Alice was planning a homebirth: *"(she said) the hospital is where you have a birth when you consider the child first...homebirth is for the mother but the hospital for the baby and I remember thinking...I'm deeply disagreeing with that"*.

### *Midwife*

All of the women articulated that their midwife had an integral part to play in the planning of their homebirth and that event unfolding, which once again is supported in the literature (Edwards, 2000; Edwards, 2005). Both Alice and Haley needed their midwife to be flexible and not to press them or convince them to birth at home; they needed to choose freely and to make the commitment when the time was right for them. Haley said *“(midwife) was very reassuring... when I felt like I had to make a decision you know somewhere early down the track, but she said she always has the stuff with her...”*, which left space for Haley to make the decision when she was ready.

Most of the women said that they found it reassuring to know that their midwife did hospital births as well as homebirths; they also found it good to know what the midwife’s preference was and that she was clearly able to articulate why homebirth was a safe option for them, even if it did not attract them initially. Gemma says that her midwife had stated *“that (homebirth) was (her) preferred sort of thing”* and that the midwife *“influenced me all the way along, but in the best possible way”*. Cate recounts how her midwife encouraged her to view birth differently: *“a really key part in our relationship was that (she) was able to challenge me...(she) got to know me really well, and (she) knew what would work”*. All of the women expressed a deep connection with their midwife, where they trusted her and felt trusted by her. In most cases the trust grew out of the midwife getting to know the woman, and the participants all relate instances where they told their midwife *“something a bit more personal”* (Haley). The frequency of antenatal visits allowed this relationship to develop and strengthen. Jenny and Cate mention that their midwife

trusted them and provided reassurance along the way: Cate says *“she believes in me, which was massive because that’s the stuff that gave me the confidence to think that, yes, I can do this”*. While Jenny articulates her thoughts about midwifery expertise: *“(midwife) had a profound effect on us doing it. It’s about midwives being absolutely confident that we’d be fine, that we could do this and if something was really wrong, she needed to have an answer to that too”*.

When women have supportive partners they can surmount almost any challenge from friends, family, acquaintances or even strangers who might have opinions about homebirth. When women choose midwives who are open to and supportive of homebirth, they will become homebirthers (Jabaaij & Meijer, 1996) regardless of cultural constructs around the safety of homebirth. The story about homebirth can be changed if we change it, and some of the women in my study are determined to do just that!

### **Theme: Resources**

All of the participants mentioned having access to information, education and research about homebirth as being an important part of both their decision-making and their support mechanisms. I have interpreted this as the theme of having access to homebirth and positive birth stories, as well as other resources, is an essential aspect to making the homebirth decision. Having access to unbiased resources in order to make an informed choice on a subject is well documented in the literature (Fordham, 1997; Kirkham, 2004; Ng & Sinclair, 2002), so it is not surprising that the women in my study identified this as an important aspect of their homebirth choice.

Gaining knowledge was seen as a way of investing in the birth and having a positive experience. Alice says *“it was a good five months of investing in something that could only last a few hours that we were prepared to do it and knew that it was important”*. Gemma relates how it *“was just a process of education I guess, learning more about it...its just like parenting, you don’t know anything until you start looking into it or until you start getting experiences”*.

Affirming books, such as Spiritual Midwifery (Gaskin, 1990), Tummy Talk (Tummy Talk, No Date) and anything written by Sheila Kitzinger were of great value to the women<sup>18</sup>. Haley felt she needed to be reading positive material all the time to keep her on track and was bolstered by reading Tummy Talk in particular *“I just pulled (Tummy Talk) out when I was feeling a bit anxious before bed and would read a little story. I really wanted to believe in them (those stories), because they fit with me”*.

Many of the participants stated that their antenatal class had been affirming of their homebirth choice. Alice says *“I do remember the antenatal classes were really important and I do remember...those antenatal classes as ammunition...there were tools to give you confidence to do it...that made an impact and made me feel more confident to have a homebirth”*. Jenny says *“the antenatal group were quite supportive. No one seemed to question that we were going to do that (have a homebirth)”*.

---

<sup>18</sup> Ina May Gaskin is an American midwife and *Spiritual Midwifery* is an iconic book about natural birth on The Farm in Tennessee. *Tummy Talk* is a publication by Active Birth Taranaki that focuses on a positive approach to pregnancy, labour and birth in New Zealand. Sheila Kitzinger is an English social anthropologist and prolific writer on childbirth issues.



At times being supplied with research about homebirth allowed the women to consolidate their choice, and sometimes it allowed them to defend that choice. Cate's midwife supplied her with some statistics about home and hospital birth outcomes during her decision-making process. Cate says *"yes those stats, I think I felt like maybe I had already made the decision by then, yes it is interesting...I was on the cusp"*. Gemma's brother-in-law challenged her about the risks of homebirth and she says *"luckily I saw (midwife) a little bit later and (she) directed me to a particular study in a science journal and so I was able to direct him to that"*.

Whether the women found books, CD's, antenatal classes or positive birth stories most effective, they all engaged actively in seeking information before choosing a homebirth and then in the preparation for that homebirth. Cate reiterates that *"the resources and support were integral"*.

What was seen as more important however was having the opportunity to talk with others about homebirth and/or knowing someone who had achieved a homebirth, thereby personalising the experience. Having positive conversations about homebirth, either during the pregnancy or before becoming pregnant, made an enormous difference to most of the participants and these conversations allowed the homebirth seed to germinate.

Alice and her husband had heard a positive homebirth story from a mutual male friend a few years before conceiving their first child. This story had influenced her to consider homebirth as an option for herself,

though she did not actually speak with this person at all throughout her pregnancy. *“It was the experience of our friends which gave me some light on the homebirth option...it was knowing someone who had had a successful homebirth that made all the difference...it wasn’t something other people did, but because it was people I knew quite well, I was instantly able to assess if I would be able to do it too.”*

Haley had heard the story of a friend’s homebirth experience long before having her own child and this made a significant impression on her. *“My good friend...I think very highly of her...had a homebirth and raved about it...she must have had a fairly big influence really.”* Haley was also bolstered by a positive attitude from a woman at her pregnancy yoga class *“I met a person at my yoga class and she was really excited by her birth.”* Being a fairly anxious person, Haley found this kind of reassurance stabilising. Jenny had a family member who had birthed at home, which provided her with positive ideas about homebirth.

Resources come in many forms and the women drew on whom and what they needed as their own personal journey to becoming a homebirther progressed. Positive stories (personal and written) and the positive attitudes of midwives and antenatal classes went a long way in supporting these women to become homebirthers.

## **Discussion**

The path to planning the homebirth of your first baby is fraught with choices, decisions and defences. There are many challenges along the way, and although there are many supports, our culture does not

necessarily support homebirth as a safe option, despite evidence to the contrary. What I wanted to accomplish in this study was the exposure of the challenge(r)s and the uncovering of the support(er)s of women planning the homebirth of their first baby. I also wanted to bring into the foreground what it is that we say and don't say as midwives that enables women to choose homebirth. I wanted to understand the experience of women on the path to homebirth, particularly Pakeha women's experience. Knowing how important it is to get the first birth experience right, I sought the stories of primiparous women, focussing on the relative ease or dis-ease of their journey to becoming a homebirther. Have I accomplished my aims?

What I have discovered is that one's life philosophy is important and plays a role in choosing a homebirth for your first baby: those women who value the intimacy and safety of the home environment and who want as natural a birth as possible will aim for a homebirth. One's intrinsic attitude to different birth settings impacts on the choice of where to birth: if a person has a favourable impression of home birth it is a more attractive choice and if one has a poor perception of hospital, they are less likely to want to birth there. People in one's life have an impact on confidence to plan a homebirth: partners and midwives who express trust in the woman and a belief that birth works well are the greatest supporters. Being offered a homebirth and then given time to consider this as an option is imperative: making an informed and conscious choice is empowering in itself. Having access to positive resources, both before and during pregnancy, enables the homebirth choice: books, antenatal classes and positive homebirth stories play an important role in the support of women becoming homebirthers.

What has emerged from my interpretations of the themes is that the biggest challenge(r)s for women planning the homebirth of their first baby are people: individual people in the woman's life and the people who have constructed a negative homebirth culture. The greatest supporters for women are midwives who are confident about birth and homebirth in particular. Women's partners play an important support role too, as do those who narrate positive homebirth stories and express general excitement about birth as being an important rite of passage.

The findings of my study are in alignment with the findings of other qualitative studies about homebirth, though no-one to my knowledge has researched my topic specifically. The only point of divergence from the literature that I can identify in my study is that some of the participants clearly saw themselves as 'anti-establishment'. Whilst I do concur with Bastion (1993), that there is no particular type of woman who plans a homebirth, this opinion stems from my perspective as a midwife and a researcher who sees many people across the spectrum. Each woman herself has an estimation about where she stands on the continuum of conservative-alternative, and some of the women in my study saw it as important that their homebirth choice was a continuation of their alternative lifestyle philosophies. In discussing this during some of the interviews, agreement was reached that the picture of a modern day 'alty'<sup>19</sup>/hippie differs markedly from the hippies of the 20<sup>th</sup> century. Those people who choose to conserve energy and preserve the environment, who vote 'left', are vegetarian and have homebirths are slowly becoming the majority – New Zealand is after all the clean-green, nuclear-free example to the rest of the world.

---

<sup>19</sup> 'Alty' is a slang word for alternative person.

## **Genesis**

What I came to realise during the course of the interviews for my study was that the journey to becoming a homebirther takes place in two distinct phases: the road travelled before conception and the road travelled during pregnancy. This was an unanticipated finding – the rare gem. During the analysis and interpretation stages of my study I delved deeper into this discovery and I would like now to explore the first part of this journey: the genesis of the homebirth choice. Each woman has her own homebirth genealogy and I will start by describing these before drawing some conclusions.

## **Genealogies**

Some common stories surfaced during my conversations with the women in my study and I will now describe a series of events or encounters that lead each woman to her homebirth choice.

### *Alice's Genealogy*

Alice's became a homebirther in two stages: pre-conception and post-conception. Knowing someone who had had a homebirth was very important to her, in effect it put homebirth on her radar. Having the support of an open midwife clinched the deal.

### *Gemma's Genealogy*

Gemma also became a homebirther in two stages. Her (and her partner's) attendance at births prior to having children was formative to their own decision to birth at home, thus planting the seed. Choosing a midwife whose preference was homebirth brought that seed to fruition.

### *Jenny's Genealogy*

Jenny became a homebirther because her sister had birthed some of her 5 children at home and had shared her experiences with Jenny. Homebirth became the norm in Jenny's family and her choice to birth at home was supported by her husband and midwife.

### *Haley's Genealogy*

Haley became a homebirther long before she gave birth at home, though she did not realise the significance of hearing her friend's homebirth story until she was pregnant herself. Not having the confidence to commit to homebirth during her pregnancy makes her accomplishment even more laudable.

### *Cate's Genealogy*

Cate became a homebirther over the course of her pregnancy: it was a fast trip on a speedy vessel! Cate's sister is a midwife and had spoken favourably about homebirth. She also supplied Cate with resources. Cate's midwife also made the time to get to know her and expressed her belief in Cate to give birth. Cate's husband had homebirth as part of his family history and was therefore grounded in this, offering his complete support.

What springs from each woman's genealogy is a possible picture of the genesis of the homebirth choice itself.

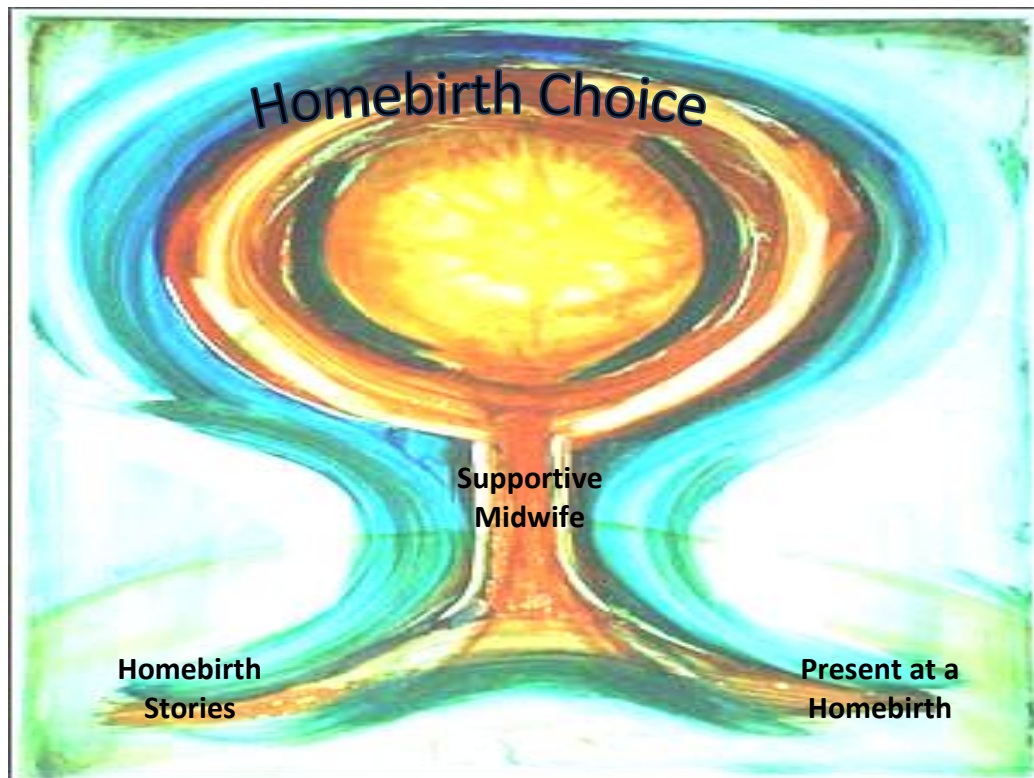


Illustration: Background image sourced from free images on the internet

Hearing homebirth stories and/or being present at a homebirth and/or knowing someone who has had a homebirth before conceiving, form the roots of the genealogical tree. Once pregnant, having a supportive midwife, as well as access to resources, form the strong trunk of the tree. The branches and leaves that reach for the light are the fruition of the homebirth choice. In flower this tree will drop its seeds and grow the next generation of homebirthers.

### **Limitations**

As stated in Chapter Four, storytelling and interpretive traditions are often described as being unscientific and biased (Koch, 1998). The small

scale of this qualitative study could be considered a limitation to the generalisability of the findings to a wider population of birthing women, though both Koch (1998) and Chase (2005) assert that when narrative studies are conducted rigorously, they can be generalised and they can affect social change.

My aim was to hear the stories of women on the path to planning the homebirth of their first baby, and from this to generate some recommendations for midwifery practice around promoting and supporting homebirth for primiparous women. I have completed a rigorously conducted narrative study and my ultimate aspiration now is to affect social change by disseminating of the findings of this study and that a new story about homebirth will begin to emerge.

### **Summary**

In exploring Pakeha women's experiences I discovered that the path to becoming a homebirther is sometimes a rocky road and conversely sometimes smooth sailing. Women make the journey both before pregnancy and during pregnancy, and to do so they need good support and information. Hearing positive homebirth stories, having a midwife who professes a preference for homebirth, and having access to homebirth resources play an integral role in becoming a homebirther.

### **Reflection**

Being now at the end of my story I reflect on how this tale started: the characters, the plot, the climax and the denouement. Like a good novel,



there were stories within stories and a satisfying conclusion (I feel satisfied anyway!). I have accomplished what I set out to do, even though it felt like the odds were against me some of the time.

The research process was a thoroughly enjoyable one and I would do it again tomorrow....dèjà vu...that's what I said a few minutes after my daughter was born! Like the women in my study who transformed into mothers, I too feel I have crossed a threshold. I feel just as ecstatic and triumphant seeing this thesis, as a woman holding her baby in her arms for the very first time. And now that my baby/thesis is born, I am reluctant to part with it; it has grown to be part of me after all these months together. I wonder if a lotus birth<sup>20</sup> is in order?

---

<sup>20</sup> Lotus birth is when the umbilical cord is not cut, separating the baby and placenta after birth. The baby and placenta are left connected until the cord separates naturally a few days after the birth.

## **Recommendations and Conclusion**

When does the becoming begin? I have come to the conclusion that becoming a homebirther begins long before women (and men) contemplate starting a family.

It begins as a ripple....

.....from a pebble dropped in a pond.



Photo 7: Sourced from free images on the internet

### **How to be a pebble**

As home birth women:

- We need to share our stories with our sisters, our family, our friends both male and female
- We need to share our birth experiences with other women, especially young women
- We need to have our children present at our births

### **How to be a pebble**

As home birth midwives:

- We need to discuss homebirth as a real choice for women and declare our preference for it
- We need to supply women with resources and send them to antenatal classes where homebirth is supported
- We need to be flexible and patient!

How do we increase the homebirth rate in New Zealand? How do we encourage and support women to plan the birth of their first baby at home? How do we change the story about homebirth?

The answer is simple: The 'becoming' begins with all of us.

## Appendix One



### Central Regional Ethics Committee

Ministry of Health  
Level 2, 1-3 The Terrace  
PO Box 5013  
Wellington  
Phone (04) 496 2405  
Fax (04) 496 2191

16 October 2007

Ms Kass Ozturk  
2/21 Bidwill Street  
Mt Cook  
Wellington

Dear Kass

CEN/07/10/070

**Becoming a homebirther...smooth sailing or rocky road? An exploration of women's experiences of the journey to homebirth. Ms Kass Ozturk  
Victoria University of Wellington**

Thank you for the above application which was considered by **Central Regional Ethics Committee** at its meeting on 09 October 2007 and approved subject to the following conditions.

1. Page 9, B10 & F3.1 (OSEC, 2.4, 2.5 & 2.7). The exclusion criterion is based on Ethnicity, this needs to be included in the research question and made transparent. For example 'Exploration of Pakeha Women', this needs to also be evident in the information sheet, consent form and advertisement.
2. **Study Title.** Please simplify the title to read: *An exploration of Pakeha Women's experiences of the journey to homebirth.*
3. Page 8, B.5 Please provide further clarification on the basis of this academic justification.
4. Page 9, B.12. (OSEC 2.5, 66). Please clarify further what steps will be undertaken to minimize harm for potential psychological risks i.e. harm may include things as pain, stress, embarrassment, cultural dissonance and exploitation.
5. Page 11, D1 (OSEC 2.3). The identifying of ex-clients from your own samples as potential participants is not acceptable.
6. The committee has concerns about the use of personal contact details and recommends that work contact details only be supplied. Will the free phone listed on the information sheet be available for participants also?

Please forward your response in letter format with amended information sheet/consent form or other required forms to the Committee administrator. Your response will be given final ethical approval by the Chairperson under delegated authority if all the above points have been addressed to the satisfaction of the Chairperson.

If you have any queries, please contact me.

Yours sincerely

A handwritten signature in blue ink that reads 'Jiska van Bruggen'.

**Jiska van Bruggen**  
Central Regional Ethics Committee Administrator

Email: [jiska\\_van\\_bruggen@moh.govt.nz](mailto:jiska_van_bruggen@moh.govt.nz)

2/21 Bidwill Street  
Wellington 6021  
08 November 2007

Dear Jiska van Bruggen,

Thank you for your letter regarding my application for ethical approval for my study (CEN/07/10/070). In response to the Committee's request for amendments:

1. The exclusion criteria based on ethnicity has now been included in the research question and all relevant forms.

2. The study title now reads: *Becoming a homebirther: An exploration of Pakeha women's experiences on the path to home birth*. I have simplified the title and included the ethnicity criteria. I have also changed the wording slightly, so that the focus of the project is evident from the title. I hope this meets with the Committee's approval.

3. B5: This project is a small thesis, equal to 9 months of full time work. The small number of participants is indicative of narrative inquiry, with small numbers of deep interviews providing rich, multilayered data. Josselson & Lieblich (2003) recommend that the researcher sets a numerical target on the number of participants, but that they stop interviewing when they feel 'saturated' – that is, when the researcher has learned more that they will be able to write about. Given the scope of this project and the exclusion criteria, I am not aiming to generalise the findings to the whole population, merely to describe the themes emerging from these interviews.

4. B14: The potential for psychological harm is minimal, with the only possible risk being that the women find telling their story to be an emotional experience. I will have contact details for a counsellor available at the interview, as well as the contact details for the NZCOM Midwifery Resolutions Committee.

5. I acknowledge the Committee's advice, in regards to identifying my own ex-clients as participants, and will only seek participants for my project through advertising.

6. I have amended the Participant Information Sheet and advertisement to reflect the use of a work contact number, rather than a personal contact number. The free phone number will also be available to participants.

Yours sincerely,

Kass Ozturk.



## Central Regional Ethics Committee

Ministry of Health  
Level 2, 1-3 The Terrace  
PO Box 5013  
Wellington  
Phone (04) 496 2405  
Fax (04) 496 2191

**28 November 2007**

**Ms Kass Ozturk  
2/21 Bidwill Street  
Mt Cook  
Wellington**

Dear Kass

**CEN/07/10/070**

**Becoming a Home Birther: An exploration of Pakeha women's experiences on the path to homebirth.  
Ms Kass Ozturk, Victoria University of Wellington**

The above study has been given ethical approval by the **Central Regional Ethics Committee**. A list of members of this committee is attached.

### **Approved Documents**

- Information Sheet and Consent Form Version 2, dated November 2007
- Advertisement for Birth Wise Journal Version 2, dated November 2007

### **Certification**

The Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out.

### **Accreditation**

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

### **Progress Reports**

The study is approved until **1 December 2008**. The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project in **28 February 2009**. The report form is available on <http://www.newhealth.govt.nz/ethicscommittees>. Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

### **Amendments**

All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

**Please quote the above ethics committee reference number in all correspondence.**

The Principal Investigator is responsible for advising any other study sites of approvals and all other correspondence with the Ethics Committee.

**It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.**

Yours sincerely

A handwritten signature in cursive script, appearing to read 'J. van Bruggen'.

**Jiska van Bruggen**  
**Central Regional Ethics Committee Administrator**

Email: [jiska\\_van\\_bruggen@moh.govt.nz](mailto:jiska_van_bruggen@moh.govt.nz)



## Appendix Two



### PARTICIPANT INFORMATION SHEET

Becoming a homebirther: An exploration of Pakeha women's experiences on the path to homebirth.

Researcher: Kass Ozturk.

I am a Master of Midwifery student at the Graduate School of Nursing and Midwifery and Health at Victoria University of Wellington. As part of my degree I am undertaking a research project leading to a thesis. You are invited to take part in this research about the journey to homebirth.

What is this study about? This study aims to hear the stories of these women on the path to homebirth. I aim to interview 4-6 Pakeha women about their experiences of the journey to planning a homebirth for their first baby since 2001. The stories will then be analysed for the themes emerging about the ease or dis-ease of the journey.

Why do this study? Very little research has been done on this particular subject, and none at all pertaining to New Zealand women's experiences. This study aims to generate understanding of the journey women go on to plan their first homebirth. Findings will be used by midwives working with women who plan home birth, so that they can better support them along the way.

What is involved? I will meet with you and interview you at your convenience. The initial interview will take up to 2 hours. The interview will be taped and transcribed. This transcript will be returned to you for verification, after which a further interview may be necessary to make additions. Once the information from all the participants has been gathered and analysed, it will be returned to you to ascertain whether you agree with the findings. You may withdraw from the study at any time.

What about the results? All of the information will be analysed anonymously, where no names or identifying factors will be utilised. Tapes will be erased once the study has been completed. A copy of the results of the study will be sent to you on completion of the project.

Any questions? For further information, contact me, Kass Ozturk, on 027 6696736 or my supervisor Jan Duke on 463 5034.

This study has been approved by the Health Research Council of New Zealand Ethics Committee.



## Appendix Three



### INFORMED CONSENT TO BE A RESEARCH PARTICIPANT

The journey to becoming a homebirther...smooth sailing or rocky road? An exploration of women's experiences on the path to homebirth.

Researcher: Kass Ozturk.

The purpose of this study is to generate understanding of the journey women go on to plan their first homebirth. Findings will be used by midwives working with women who plan home birth, so that they can better support them along the way.

As a participant, you will be interviewed for approximately 2 hours. The interview will be taped and transcribed. This transcript will be returned to you for verification, after which a further interview may be necessary to make additions. Once the information from all the participants has been gathered and analysed, it will be returned to you to ascertain its accuracy.

Information recorded on the tapes will not be shared. Tapes and transcripts will be securely stored. Anonymity and confidentiality of participants will be maintained at all times.

#### Consent Statement

- ◆ I have read the above and have had the opportunity to discuss this study and clarify any questions with the researcher.
- ◆ I agree to be interviewed initially for approximately 1 hour. I understand that this interview will be taped and that the tape will be erased at the conclusion of the study.
- ◆ I understand that steps will be taken to protect my anonymity, and that all information will be treated confidentially.
- ◆ I understand that I may withdraw from this study at any time.
- ◆ I agree to participate in this study.

Participants Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Researchers Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Appendix Four



### TRANSCRIBER CONFIDENTIALITY AGREEMENT

I Brenda Watson  
OF 111 Whitby Road, Wakefield, Nelson

Understand that the information contained in these recordings and transcripts is confidential and the contents will not be disclosed to anyone, other than the researcher, at any time.

I will also ensure that when I am transcribing from the recordings, that it will be in an environment where they cannot be heard by anyone else.

In regards to the files:

- I will keep them locked up in a safe, secure place,
- I will not copy them,
- I will return them on completion of the transcribing.

*or delete as may be applicable.  
B. Watson.*

Date 05/02/08

Signature *B. Watson.*

GRADUATE SCHOOL OF NURSING, MIDWIFERY & HEALTH

PO Box 600, Wellington, New Zealand

Phone +64-4-463 5363 Fax +64-4-463 5542 Email nmh@vuw.ac.nz Website www.vuw.ac.nz/nmh

## **Appendix Five**

### **Advertisement for Birth Wise Journal**

You are invited to participate in a research study entitled:

Becoming a homebirther: An exploration of Pakeha women's experiences on the path to homebirth.

This study seeks to hear the stories of women on the path to homebirth. I would like to interview 4-6 women about their experiences of the journey to planning a homebirth for their first baby since 2001. The stories will then be analysed for the themes emerging about the ease or dis-ease of the journey.

If you are interested in being part of this research, please contact the researcher Kass Ozturk for a copy of the Participant Information Sheet. The thesis generated from this research will be used to complete a Master of Midwifery degree at Victoria University of Wellington. Ethical approval for this study has been gained from the Health Research Council of New Zealand Ethics Committee.

**Contact Details:**

Kass Ozturk      027 669 6736 or [k.j.ozturk@massey.ac.nz](mailto:k.j.ozturk@massey.ac.nz)

## Appendix Six

### Interview Themes

The following question will be asked of the women at initial contact, in order to screen them into one group or the other:

1. Did you always plan to have your first baby at home or did you change your plans as the pregnancy progressed?

Why did you choose to have your baby at home?

Let the participant know that I will want to hear her birth story, but after we have discussed the road to homebirth.

The following questions will be used to direct/focus the interview (for both groups):

2. Tell me about the experience of planning to have your first baby at home.
3. What sorts of things influenced your decision making?
4. Did you face any challenges along the way and if so, what were they?  
How did other people effect your decisions?  
Did your home environment play a role?  
How about society or the media?  
Were you influenced by any pregnancy issues (like your Group B Streptococcus status)?  
How about your perceptions of your ability to cope with labour?  
How did your midwife's opinion affect you?
5. What helped you overcome these challenges?  
How were you supported?  
Was your partner or family supportive? How about your midwife?  
Did information, like research findings supporting homebirth, help?  
Was there anything else?
6. Tell me about your actual birth experience.
7. What is your perception of homebirth since the birth of your baby?

## Appendix Seven

### The Speed of Darkness

By Muriel Rukeyser

1

Whoever despises the clitoris despises the penis  
Whoever despises the penis despises the cunt  
Whoever despises the cunt despises the life of the child.  
Resurrection music, silence, and surf.

2

No longer speaking  
Listening with the whole body  
And with every drop of blood  
Overtaken by silence  
But this same silence is become speech  
With the speed of darkness.

3

Stillness during war, the lake.  
The unmoving spruces.  
Glints over the water.  
Faces, voices. You are far away.  
A tree that trembles and trembles.

4

After the lifting of the mist  
after the heavy rains  
the sky stands clear  
and the cries of the city risen in day  
I remember the buildings are space  
walled, to let space be used for living  
I mind this room is space  
whose boundary of glass  
lets me give you drink and space to drink  
your hand, my hand being space  
containing skies and constellations

your face carries the reaches of air  
I know I am space  
my words are the air.

5  
Between between  
the man: act exact  
woman: in curve senses in their maze  
frail orbits, green tries, games of stars  
share of the body speaking its evidence

6  
I look across at the real  
vulnerable involved naked  
devoted to the present of all I care for  
the world of history leading to this moment.

7  
Life is the announcer.  
I assure you  
there are many ways to have a child.  
I bastard mother  
promise you  
there are many ways to be born.  
They all come forth  
in their own grace.

8  
Ends of the earth join tonight  
with blazing stars upon their meeting.

These sons, these sons  
fall burning into Asia.

9

Time comes into it.  
Say it. Say it.  
The universe is made of stories,  
not of atoms.

10

Lying  
blazing beside me  
you rear beautifully up—  
your thinking face—  
erotic body reaching  
in all its colors and lights—  
your erotic face  
colored and lit—  
not colored body-and-face  
but now entire,  
colors lights the world of thinking and reaching.

11

The river flows past the city.

Water goes down to tomorrow  
making its children I hear their unborn voices  
I am working out the vocabulary of my silence.

12

Big-boned man young and of my dream  
Struggles to get the live bird out of his throat.  
I am he am I? Dreaming?  
I am the bird am I? I am the throat?

A bird with a curved beak.  
It could slit anything, the throat-bird.

Drawn up slowly. The curved blades, not large.  
Bird emerges wet being born  
Begins to sing.

13

My night awake  
staring at the broad rough jewel  
the copper roof across the way  
thinking of the poet  
yet unborn in this dark  
who will be the throat of these hours.  
No. Of those hours.  
Who will speak these days,  
if not I,  
if not you?



## References

- Abel, S., & Kearns, R. (1991). Birth places: a geographical perspective on planned home birth in New Zealand. *Social Science Medicine*, 33(7), 825-834.
- Ackermann-Liebrich, U., Voegeli, T., Gunter-Witt, K., Kunz, I., Zulig, M., Schindler, C., et al. (1996). Home versus hospital deliveries: follow up study of matched pairs for procedures and outcome. *British Medical Journal*, 313, 1313-1318.
- Anderson, R., & Aikens Murphy, P. (1995). Outcomes of 11,788 planned homebirth attended by certified nurse-midwives: a retrospective descriptive study. *Journal of Nurse-Midwifery*, 40(6), 483-492.
- Anderson, R., & Anderson, D. (1999). The cost-effectiveness of home birth. *Journal of Nurse-Midwifery*, 44(1), 30-35.
- Anthony, S., Buitendijk, S., Offerhaus, P., van Dommelen, P., & van der Pal-de Bruin, K. (2005). Maternal factors and the probability of a planned home birth. *British Journal of Obstetrics and Gynaecology*, 112, 748-753.
- Attride-Stirling, J. (2001). Thematic Networks: an analytic tool for qualitative research. *Qualitative Research*, 1(3), 385-405.
- Bailes, A., & Jackson, M. (2000). Shared responsibility in home birth practice: collaborating with clients. *Journal of Midwifery & Women's Health*, 45(6), 537-543.
- Bailham, D., & Joseph, S. (2003). Post-traumatic stress following childbirth: a review of the emerging literature and directions for research and practice. *Psychology, Health & Medicine*, 8(2), 159-168.
- Banks, M. (2000). *Home birth bound*. Hamilton: Birthspirit Books.
- Bastian, H. (1993). Personal beliefs and alternative childbirth choices: a survey of 552 women who planned to give birth at home. *Birth*, 20(4), 186-192.

- Borquez, H., & Wieggers, T. (2006). A comparison of labour and birth experiences of women delivering in a birthing centre and at home in the Netherlands. *Midwifery*, 22, 339-347.
- Bright, M. (1992). Making place: the first birth in an intergenerational family context. *Qualitative Health Research*, 2(1), 75-98.
- Buckley, S. (2002). Ecstatic birth: the hormonal blueprint of labour. *Mothering*, March/April, 51-60.
- Carter, B. (2004). How do you analyse qualitative data? In T. Lavender, G. Edwards & Z. Alfirevic (Eds.), *Demystifying qualitative research in pregnancy and childbirth* (pp. 87-107). Salisbury: MA Healthcare Ltd.
- Cartwright, S. (1988). *The report of the cervical cancer inquiry*. Auckland: Government Press.
- Chase, S. (1996). Personal vulnerability and interpretive authority in narrative research. In R. Josselson (Ed.), *Ethics and process in the narrative study of lives* (pp. 45-59). Thousand Oaks: Sage Publications.
- Chase, S. (2003). Learning to listen: narrative principles in a qualitative research methods course. In R. Josselson, A. Lieblich & D. McAdams (Eds.), *Up close and personal: the teaching and learning of narrative research*. (pp. 79-100). Washington DC: American Psychological Association.
- Chase, S. (2005). Narrative inquiry: multiple lenses, approaches, voices. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research*. (3rd ed., pp. 651-679). Thousand Oaks: Sage Publications.
- Christiaens, W., & Bracke, P. (2009). Place of birth and satisfaction with childbirth in Belgium and the Netherlands. *Midwifery*, 25, 11-19.
- Cluett, E., & Bluff, R. (2006). From practice to research. In E. Cluett & R. Bluff (Eds.), *Principles and practice of research in midwifery*. Edinburgh: Churchill Livingstone.

- Connelly, F., & Clandinin, D. (1990). Stories of experience and narrative inquiry. *Educational Researcher*(June/July), 2-14.
- Creedy, D., Shochet, I., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: incidence and contributing factors. *Birth*, 27(2), 104-111.
- Dahlen, H., Barclay, L., & Homer, C. (2008). The novice birthing: theorising first-time mothers' experiences of birthing at home and in hospital in Australia [Electronic Version]. *Midwifery*.
- de Jonge, A., van der Goes, B., Ravelli, A., Amelink-Verburg, M., Mol, B., Nijhuis, J., et al. (2009). Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births. *British Journal of Obstetrics and Gynaecology*, 116, 1177-1184.
- De Vries, R. (2001). Why maternity care is *not* medical care. In R. De Vries, C. Benoit, E. Teijlingen & S. Wrede (Eds.), *Birth by design*. New York: Routledge.
- Denzin, N. (2002). The interpretive process. In A. Huberman & M. Miles (Eds.), *The qualitative researcher's companion* (pp. 349-366). Thousand Oaks: Sage Publications Ltd.
- Denzin, N., & Lincoln, Y. (2005). The discipline and practice of qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks: Sage Publications Ltd.
- Devault, M. (1990). Talking and listening from women's standpoint: feminist strategies for interviewing and analysis. *Social Problems*, 37(1), 96-116.
- Donley, J. (1986). *Save the midwife*. Auckland: New Women's Press.
- Duke, J. (1982). *Homebirth: a survey of consumers of an alternative obstetric care system*. Unpublished Honours Thesis, University of Sydney, Sydney.

- Edwards, N. (2000). Women planning homebirths: their own views on their relationships with midwives. In M. Kirkham (Ed.), *The Midwife-Mother Relationship*. London: MacMillan Press Ltd.
- Edwards, N. (2004). Why can't women just say no? And does it really matter? In M. Kirkham (Ed.), *Informed Choice in Maternity Care*. New York: Palgrave MacMillan.
- Edwards, N. (2005). *Birthing autonomy: women's experiences of planning home births*. London: Routledge.
- Ellis, C., & Berger, L. (2002). Their story/my story/our story: including the researcher's experience in interview research. In J. Gubrium & J. Holstein (Eds.), *Handbook of interview research: context and method*. (pp. 849-876). Thousand Oaks: Sage Publications, Inc.
- Ellis, C., Kiesinger, C., & Tillman-Healy, L. (1997). Interactive interviewing: talking about emotional experience. In R. Hertz (Ed.), *Reflexivity and voice*. (pp. 119-149). Thousand Oaks: Sage Publications.
- Fahy, K. (2008). Power and the social construction of birth territory. In K. Fahy, M. Foureur & C. Hastie (Eds.), *Birth territory and midwifery guardianship: theory for practice, education and research*. Edinburgh: Butterworth Heinemann.
- Fahy, K., Foureur, M., & Hastie, C. (Eds.). (2008). *Birth territory and midwifery guardianship: theory for practice, education and research*. Edinburgh: Butterworth Heinemann.
- Fleming, V. (1998). Women-with-midwives-with-women: a model of interdependence. *Midwifery*, 14, 137-143.
- Fleming, V. (2000). The midwifery partnership in New Zealand: past history or a new way forward? In M. Kirkham (Ed.), *The midwife-mother relationship*. Basingstoke: Macmillan Press Ltd.

- Floyd, L. (1995). Community midwives' views and experience of home birth. *Midwifery, 11*, 3-10.
- Fordham, S. (1997). Women's views of the place of confinement. *British Journal of General Practice, 47*, 77-81.
- Foureur, M. (2008). Creating birth space to enable undisturbed birth. In K. Fahy, M. Foureur & C. Hastie (Eds.), *Birth territory and midwifery guardianship: theory for practice, education and research*. Edinburgh: Butterworth Heinemann.
- Fowles, E. (1998). Labor concerns of women two months after delivery. *Birth, 25*(4), 235-240.
- Freeman, L., Timperley, H., & Adair, V. (2004). Partnership in midwifery care in New Zealand. *Midwifery, 20*, 2-14.
- Fullerton, J. (1982). The choice of in-hospital or alternative birth environment as related to the concept of control. *Journal of Nurse-Midwifery, 27*(2), 17-22.
- Fullerton, J., Navarro, A., & Young, S. (2007). Outcomes of planned home birth: and integrative review. *Journal of Midwifery & Women's Health, 52*(4), 323-333.
- Gaskin, I. (1990). *Spiritual midwifery* (3rd ed.). Summertown: Book Publishing Co.
- Gotvall, K., & Waldenstrom, U. (2002). Does a traumatic birth experience have an impact on future reproduction? *British Journal of Obstetrics and Gynaecology, 109*, 254-260.
- Green, J. (1999). Commentary: what is this thing called "control"? *Birth, 26*(1), 51-52.
- Green, J., & Baston, H. (2003). Feeling in control during labor: concepts, correlates, and consequences. *Birth, 30*(4), 235-247.

- Green, J., Coupland, V., & Kitzinger, S. (1990). Expectations, experiences and psychological outcomes of childbirth: a prospective study of 825 women. *Birth, 17*(1), 15-24.
- Guilliland, K., & Pairman, S. (1994). The midwifery partnership - a model for practice. *New Zealand College of Midwives Journal, 11*, 5-9.
- Gulbransen, G., Hilton, J., McKay, L., & Cox, A. (1997). Home birth in New Zealand 1973-93: incidence and mortality. *New Zealand Medical Journal, 110*, 87-89.
- Halldorsdottir, S., & Karlsdottir, S. (1996). Journeying through labour and delivery: perceptions of women who have given birth. *Midwifery, 12*(2), 48-61.
- Harris, G. (2000). Homebirth and independent midwifery. *Australian College of Midwives Incorporated Journal, June 2000*, 10-16.
- Hendrix, M., Van Horck, M., Moreta, D., Niemen, F., Nieuwenhuijze, J., Severens, J., et al. (2009). Why women do not accept randomisation for place of birth: feasibility of a RCT in the Netherlands. *British Journal of Obstetrics and Gynaecology, 116*, 537-544.
- Hodnett, E. (1989). Personal control and the birth environment: comparisons between home and hospital settings. *Journal of Environmental Psychology, 9*, 207-216.
- Homebirth Aotearoa. (2008). <http://homebirth.org.nz/>
- International Confederation of Midwives. (2005). <http://internationalmidwives.org>
- Jabaaij, L., & Meijer, W. (1996). Home births in the Netherlands: midwifery-related factors of influence. *Midwifery, 12*(3), 129-135.
- Jakobsen, L. (1991). *Is home birth an empowering experience?* Wellington: Victoria University of Wellington.

- Janssen, P., Carty, E., & Reime, B. (2006). Satisfaction with planned place of birth among midwifery clients in British Columbia. *Journal of Midwifery & Women's Health, 51*(2), 91-97.
- Janssen, P., Lee, S., Ryan, E., Etches, D., Farquharson, D., Peacock, D., et al. (2002). Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia. *Canadian Medical Association Journal, 166*(3), 315-323.
- Johnson, K., & Daviss, B. (2005). Outcomes of planned home births with certified professional midwives: large prospective study in North America. *British Medical Journal, 330*(7505).
- Josselson, R. (1996). On writing other people's lives: self-analytic reflections of a narrative researcher. In R. Josselson (Ed.), *Ethics and process in the narrative study of lives* (pp. 60-71). Thousand Oaks: Sage Publications.
- Josselson, R., & Lieblich, A. (2003). A framework for narrative research proposals in psychology. In R. Josselson, A. Lieblich & D. McAdams (Eds.), *Up close and personal: the teaching and learning of narrative research*. (pp. 259-273). Washington DC: American Psychological Association.
- Kaufman, J., Herzog, A., & Levi, J. (Eds.). (2005). *The collected poems of Muriel Rukeyser*. Pittsburgh: University of Pittsburgh Press.
- Kaufmann, T. (2004). Introducing feminism. In M. Stewart (Ed.), *Pregnancy, birth and maternity care: feminist perspectives*. (pp. 1-10). Edinburgh: Books for Midwives.
- Kingdon, C. (2004). Why carry out qualitative research? In T. Lavender, G. Edwards & Z. Alfirevic (Eds.), *Demystifying qualitative research in pregnancy and childbirth*. Wiltshire: MA Healthcare Ltd.
- Kirkham, M. (2004). Choice and bureaucracy. In M. Kirkham (Ed.), *Informed choice in maternity care*. Basingstoke: Palgrave Macmillan.

- Kitzinger, S. (2005). *The politics of birth*. Edinburgh: Elsevier Butterworth Heinemann.
- Koch, T. (1994). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing, 19*, 976-986.
- Koch, T. (1998). Story telling: is it really research? *Journal of Advanced Nursing, 28*(6), 1182-1190.
- Lavender, T., & Chapple, J. (2005). How women choose where to give birth. *The Practicing Midwife, 8*(7), 10-15.
- Lavender, T., Walkinshaw, S., & Walton, I. (1999). A prospective study of women's views of factors contributing to a positive birth experience. *Midwifery, 15*, 40-46.
- Leap, N. (1996). 'Persuading' women to give birth at home - or offering real choice? *British Journal of Midwifery, 4*(10), 536-538.
- Lennox, S. (2002). *Honouring the sacred in childbirth: a midwife's stories of women's developing sense of self*. Unpublished Master of Arts (Applied), Victoria University of Wellington, Wellington.
- Longworth, L., Ratcliffe, J., & Boulton, M. (2001). Investigating women's preferences for intrapartum care: home versus hospital births. *Health and Social Care in the Community, 9*(6), 404-413.
- Lyons, S. (1998). Post-traumatic stress disorder following childbirth: causes, prevention and treatment. In S. Clement (Ed.), *Psychological perspectives on pregnancy and childbirth* (pp. 123-144). Edinburgh: Churchill Livingstone.
- Madi, B., & Crow, R. (2003). A qualitative study of information about available options for the childbirth venue and pregnant women's preference for a place of delivery. *Midwifery, 19*, 328-336.



- Maude, R. (2003). *It's beyond water: stories of women's experiences of using water for labour and birth*. Unpublished Master of Arts (Applied), Victoria University of Wellington, Wellington.
- Maynard, M., & Purvis, J. (1994). Doing feminist research. In M. Maynard & J. Purvis (Eds.), *Researching women's lives from a feminist perspective*. London: Taylor and Francis.
- McClain, C. (1981). Women's choice of home or hospital birth. *The Journal of Family Practice*, 12(6), 1033-1038.
- Merriam-Webster. (2009). [www.merriam-webster.com/](http://www.merriam-webster.com/)
- Midwifery Council of New Zealand. (2004). <http://midwiferycouncil.org.nz>
- Miller, S. (2008). *First birth at home or in hospital in Aotearoa/New Zealand: intrapartum midwifery care and related outcomes*. Unpublished Master of Midwifery, Victoria University of Wellington, Wellington.
- Ministry of Health. (2007). *Notice pursuant to Section 88 of the New Zealand Public Health & Disability Act 2000*. New Zealand.
- Mishler, E. (1996). Missing persons: recovering developmental stories/histories. In R. Jessor, A. Colby & R. Schweder (Eds.), *Ethnography and human development: context and meaning in social inquiry*. (pp. 74-99). Chicago: University of Chicago Press.
- Morgan, J. (2004). Planning your research. In T. Lavender, G. Edwards & Z. Alfirevic (Eds.), *Demystifying qualitative research in pregnancy and childbirth* (pp. 48-62). Salisbury: MA Healthcare Ltd.
- Morison, S., Hauck, Y., Percival, P., & McMurray, A. (1998). Constructing a home birth environment through assuming control. *Midwifery*, 14(4), 233-241.
- Morison, S., Percival, P., Hauck, Y., & McMurray, A. (1999). Birthing at home: the resolution of expectations. *Midwifery*, 15(1), 32-39.

- Neuhaus, W., Kiencke, P., Gohring, U., & Mallman, P. (2002). A psychosocial analysis of women planning birth outside hospital. *Journal of Obstetrics and Gynaecology*, 22(2), 143-149.
- New Zealand Health Information Service (NZHIS). (2007). *Report on maternity: maternal and newborn information 2004*. Wellington: Ministry of Health.
- Ng, M., & Sinclair, M. (2002). Women's experience of planned home birth: a phenomenological study. *RCM Midwives Journal*, 5(2), 56-59.
- NZCOM. (1996). NZCOM Consensus Statement: informed consent and decision making: NZCOM.
- NZCOM. (2005). *Midwives handbook for practice* (Updated version ed.). Christchurch: New Zealand College of Midwives.
- Oakley, A. (1981). Interviewing women: a contradiction in terms. In H. Roberts (Ed.), *Doing feminist research* (pp. 30-61). London: Routledge & Kegan Paul.
- Odent, M. (2001). New reasons and new ways to study birth physiology. *International Journal of Gynecology and Obstetrics.*, 75, 39-45.
- Odent, M. (2002). Fish can't see water: the need to humanize birth. *MIDIRS Midwifery Digest*, 12(2), 213-220.
- Ogden, J. (1998). Having a homebirth: decisions, experiences and long-term consequences. In S. Clement (Ed.), *Psychological perspectives on pregnancy and childbirth* (pp. 101-122). Edinburgh: Churchill Livingstone.
- Ogden, J., Shaw, A., & Zander, L. (1997). Part 1. Women's memories of homebirth 3-5 years on. *British Journal of Midwifery*, 5(4), 208-211.
- Olsen, O. (1997). Meta-analysis of the safety of home birth. *Birth*, 21(1), 4-13.
- Olsen, O., & Jewell, D. (1998). Home versus hospital birth (Review), Cochrane Database of Systematic Reviews 1998, Issue 3. (Publication. Retrieved 4 August 2009, from The Cochrane Collaboration. John Wiley & Sons, Ltd).

- Ozturk, K. (2004). *Woman-centred care: how far have we come?* Paper presented at the NZCOM Conference.
- Pairman, S. (2000). Woman-centred midwifery: partnerships or professional friendships? In M. Kirkham (Ed.), *The midwife-mother relationship*. Basingstoke: Macmillan Press Ltd.
- Pairman, S., & Donnellan-Fernandez, R. (2006). Professional frameworks for practice in Australia and New Zealand. In S. Pairman, J. Pincombe, C. Thorogood & S. Tracy (Eds.), *Midwifery: preparation for practice*. Sydney: Churchill Livingstone.
- Papps, E., & Olsen, M. (1997). *Doctoring childbirth and regulating midwifery in New Zealand*. Palmerston North: The Dunmore Press.
- Parratt, J. (2002). The impact of childbirth experiences on women's sense of self: a review of the literature. *Australian College of Midwives Incorporated Journal*, 15(4), 10-16.
- Parratt, J., & Fahy, K. (2003). Trusting enough to be out of control: a pilot study of women's sense of self during childbirth. *Australian Journal of Midwifery*, 16(1), 15-22.
- Parratt, J., & Fahy, K. (2004). Creating a 'safe' place for birth: a empirically grounded theory. *New Zealand College of Midwives Journal*, 30, 11-14.
- Parratt, J., & Johnston, J. (2002). Planned homebirths in Victoria, 1995-98. *Australian Journal of Midwifery*, 15(2), 16-25.
- Pratt, R. (1990). *Factors influencing women's choice of birth location*. Unpublished Master of Arts (Applied), Victoria University of Wellington, Wellington.
- Price, J. (1999). In acknowledgement: a review and critique of qualitative research texts. In R. Josselson & A. Lieblich (Eds.), *Making meaning of narratives* (pp. 1-23). Thousand Oaks: Sage Publications.

- Reinharz, S., & Chase, S. (2002). Interviewing women. In J. Gubrium & J. Holstein (Eds.), *Handbook of interview research: context and method*. (pp. 221-238). Thousand Oaks: Sage Publications, Inc.
- Reissman, C. (2002). Narrative analysis. In A. Huberman & M. Miles (Eds.), *The qualitative researchers companion* (pp. 217-270). Thousand Oaks: Sage Publications Ltd.
- Reissman, C. (2008). *Narrative methods for the human sciences*. Thousand Oaks: Sage Publications, Inc.
- Robson, C. (2002). *Real world research: a resource for social scientists and practitioner-researchers*. (2nd ed.). Oxford: Blackwell Publishing.
- Rubin, R. (1984). *Maternal identity and the maternal experience*. New York: Springer Publishing Company Inc.
- Sackett, D., Straus, S., Richardson, W., Rosenberg, W., & Haynes, R. (2000). *Evidence-based medicine: how to practice and teach EBM*. (2nd ed.). London: Churchill Livingstone.
- Sandelowski, M. (1994). The use of quotes in qualitative research. *Research in Health & Nursing*, 17(6), 479-482.
- Sandelowski, M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship*, Third Quarter, 213-219.
- Schiff, M., & LaFerla, J. (1985). Childbirth at home or in the hospital: a prospective study of decision-making. *Journal of Psychosomatic Obstetrics and Gynaecology*, 4, 41-50.
- Simkin, P. (1991). Just another day in a woman's life? Part one: women's long-term perceptions of their first birth experience. *Birth*, 18(4), 203-210.
- Simkin, P. (1992). Just another day in a woman's life? Part two: nature and consistency of women's long term memories of their first birth experience. *Birth*, 19(2), 64-81.

- Skinner, J. (1999). Midwifery partnership: individualism, contractualism or feminist praxis? *New Zealand College of Midwives Journal*, 21, 14-17.
- Stein, D. (1999). *Casting the circle: a woman's book of ritual*. California: Crossing Press.
- Tew, M. (1995). *Safer childbirth? A critical history of maternity care*. (2nd ed.). London: Chapman & Hall.
- The Penguin Pocket English Dictionary. (1987). (2<sup>nd</sup> ed.). London: Penguin Books.
- Thomas, P. (1997). Foreword. In P. Thomas (Ed.), *Every Birth is Different*. London: Headline Book Publishing.
- Tolich, M., & Davidson, C. (1999). The basics of social science research. In C. Davidson & M. Tolich (Eds.), *Social science research in New Zealand: many paths to understanding*. Auckland: Pearson Education New Zealand.
- Tracy, S. (2006). Ways of looking at evidence and measurement. In S. Pairman, J. Pincombe, C. Thorogood & S. Tracy (Eds.), *Midwifery: preparation for practice*. Sydney: Churchill Livingstone Elsevier.
- Tully, L., Daellenbach, R., & Guilliland, K. (1998). Feminism, partnership and midwifery. In R. Du Plessis & L. Alice (Eds.), *Feminist thought in Aotearoa/New Zealand: connections and differences* (pp. 245-253). Auckland: Oxford University Press.
- Tummy Talk*. (No Date). New Plymouth: Active Birth Taranaki.
- van der Hulst, L., van Teijlingen, E., Bonsel, G., Eskes, M., & Bleker, O. (2004). Does a pregnant woman's intended place of birth influence her attitudes toward and occurrence of obstetric interventions? *Birth*, 31(1), 28-33.
- van Weel, C., van der Velden, K., & Lagro-Janssen, T. (2009). Home births revisited: the continuing search for better evidence. *British Journal of Obstetrics and Gynaecology*, 116, 1149-1150.

- Waldenstrom, U., Hildingsson, I., Rubertsson, C., & Radestad, I. (2004). A negative childbirth experience: prevalence and risk factors in a national sample. *Birth, 31*(1), 17-27.
- Walsh, D. (2000). Evidence-based care series 1: birth environment. *British Journal of Midwifery, 8*(5), 276-278.
- Walsh, D. (2007). *Evidence-based care for normal labour and birth: a midwives guide*. London: Routledge.
- Wickham, S. (Ed.). (2006). *Appraising research into childbirth: an interactive workbook*. Edinburgh: Elsevier Butterworth Heinemann.
- Wiegers, T. (1998). Home or hospital birth: a prospective study of midwifery care in the Netherlands. *European Journal of Obstetrics & Gynecology and Reproductive Biology, 79*, 139-141.
- Wiegers, T., Keirse, M., van der Zee, J., & Berghs, G. (1996). Outcome of planned home and hospital births in low risk pregnancies: prospective study in midwifery practices in the Netherlands. *British Medical Journal, 313*, 1309-1313.
- Wiegers, T., van der Zee, J., Kerssens, J., & Keirse, M. (2000). Variation in home-birth rates between midwifery practices in the Netherlands. *Midwifery, 16*, 96-104.
- Wijma, K., Soderquist, J., & Wijma, B. (1997). Posttraumatic stress disorder after childbirth: a cross sectional study. *Journal of Anxiety Disorders, 11*(6), 587-597.
- Zander, L., & Chamberlain, G. (1999). ABC of labour care: place of birth. *British Medical Journal, 318*, 721-723.