

The paradox of contemporary midwifery practice:
Promoting an out-of-hospital birth setting

By

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Abstract

In New Zealand women choose their place of birth in partnership with their Lead Maternity Care (case loading) midwife, with most choosing a hospital regardless of their lack of risk factors. The reasons why most women in western countries choose to birth in hospital have been widely investigated. Risk aversity is most commonly implicated. For both women and health professionals this powerful discourse persists despite consistent research findings indicating higher rates of normal birth, and lower rates of maternal morbidity associated with interventions for healthy women who birth in out-of-hospital (primary) maternity units, with no difference in neonatal outcomes. There is however a gap in the literature regarding what is known about how midwives might positively influence the choice to birth in a primary unit.

A qualitative descriptive design through an appreciative inquiry lens enabled insight from 12 midwives who have a higher ratio of women within their caseload who choose to birth in a primary unit. Four focus groups were formed with these midwives to explore their perspectives and approaches as they assist women to make their place of birth decisions. From thematically analysed data, five themes emerged, *Ways of knowing: woman, art, science and research; Trusting in you, me, and the process of childbirth; Setting boundaries as a 'primary birth midwife'; and Delaying and diverting, a malleable approach*, centered around the theme *When it matters what we say: reframing safety and risk*.

Alongside supporting current research, this study adds to the body of knowledge about birthplace choice by bringing to the fore the notion of paradox in practice, setting boundaries whilst remaining malleable for example. In a contemporary maternity context, these midwives dance between two worlds fundamentally at odds with one another, effectively managing contradiction, complexity and uncertainty to achieve a high primary unit caseload. The experience of what works to promote the primary unit for a cohort of New Zealand midwives is uncovered in this research.

The social recalibrations needed to adjust the hospital birth norm are much broader issues than midwives alone can change, but in this study, we see they are staying the course in order to protect and promote normal birth. How midwives might inform decision-making for place of birth choice is described.

Keywords: Birth centers (primary maternity unit, freestanding / alongside midwifery-led unit), birthplace, outcomes, decision-making, informed choice, midwife, conversation, discussion, perspective, experience, and promotion.

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Definitions & Abbreviations

Place of birth options for women at low risk of developing complications in New Zealand include home and three levels of maternity facilities:

- A primary maternity facility (unit) provides care to low risk women expected to experience normal birth with care provision from midwives and no doctors on site. They are usually community-based and access to specialist secondary services will require transfer to a secondary / tertiary facility. They do not provide epidural anaesthesia or operative birth services (Ministry of Health, 2017a). Also referred to in this thesis as primary unit.
- Secondary facility refers to a hospital that can provide care for normal births, complicated pregnancies and birth including operative birth, and paediatric services (Ministry of Health, 2017a). There is no secondary hospital in the study setting.
- Tertiary facility refers to a hospital that can provide care for women with high risk, complex pregnancies by specialist multidisciplinary teams. In addition to the services described for a secondary hospital, it always includes a specialist (or registrar) on site and level three (intensive care) neonatal services (Ministry of Health, 2017a). Also referred to in this thesis as hospital or the Women's Hospital.

- Access Agreement: Issued by a DHB to enable a Lead Maternity Carer to access facilities and to provide inpatient care to their clients.
- Aotearoa: Long white cloud, the Māori (indigenous people) name for New Zealand.
- Core Midwife: Employed by DHB to work in outpatient clinics and provide inpatient care to women and babies in collaboration with LMC.
- District Health Board (DHB): Delegated responsibility for health service provision in each region of New Zealand.
- Epidural Certificate: Local DHB requirement of midwives to undertake competency and agree to provide epidural care to women in labour.
- Lead Maternity Care (LMC): Self-employed and nominated by the woman to provide continuity of carer and coordinate maternity care throughout the childbirth experience.
- Midwifery Council of New Zealand (MCNZ): Regulating body for midwives.
- Ministry of Health (MOH): Governing body for health care in New Zealand.
- New Zealand College of Midwives (NZCOM): Professional body for midwives

Chapter 1. Introduction

In Aotearoa New Zealand most women choose their place of birth in partnership with their midwife. Despite having a robust model of midwifery led care, free access to out-of-hospital birth, and clear evidence indicating healthy women should birth out-of-hospital, the majority of women still choose to birth in hospital (Ministry of Health [MOH], 2017a). This study concerns itself with this dilemma. Instead of looking at the problem directly, I have decided to take a more positive approach by looking at the practice of midwives who often care for women who choose a primary unit as their place of birth. I wanted to see how these midwives worked with women, especially how they assisted them with their place of birth decision.

The way maternity care in general and midwifery care in particular are provided is likely to impact on place of birth decisions. The midwifery model of care, in keeping with a social model of childbirth, is based on the premise that birth is a natural physiological event; it is safe and usually requires little or no medical intervention. Taking this approach, midwives attempt to predict those who are very likely to have a normal birth. This approach is contrasted with the medical model which assumes that childbirth can only be described as normal in retrospect (van Teijlingen, 2005). Midwives in New Zealand (NZ) have been described as occupying a “complex and liminal space of midwifery praxis” (Surtees, 2008, p. 11). Midwives are professionally bound as guardians of normal birth. In having to ‘work’ both sides of these models in contemporary midwifery-led practice, paradox is inherent. Perception of risk for example, also affects how women, midwives and obstetricians view place of birth (Chadwick & Foster, 2014; De Vries & Vedam, 2013; MacKenzie-Bryers & van Teijlingen, 2010). Perception of risk is an important concept for midwives to be aware of during place of birth discussions, the ‘reframing of safety and risk’ unsurprisingly, identified as a central theme in this study.

The World Health Organisation, in aiming to improve the quality of maternity care globally, state that the medicalisation of the normal process of childbirth “may undermine a woman’s own capability in giving birth and could negatively impact her experience of what should normally be a positive, life-changing experience” (WHO, 2018, p. 1). Tasked with the same

mandate nationally, Ministry of Health reports indicate that place of birth is an important modifiable factor in addressing the rising rates of intervention with concomitant morbidity in New Zealand (MOH, 2017a; 2017b). Both authorities recommend the appropriate level of care (WHO, 2018; MOH, 2011). Levels of care correspond to different birth settings including home, primary maternity units, and maternity hospitals. A woman's right to make informed choices, including her place of birth, is reflected in legislation (MOH, 2007), and protected within the Health and Disability Commissioner Statement on Consumer Rights (1996), the Midwifery Council of NZ Code of Conduct (2010), and NZ College of Midwives Standards for Practice (2015).

Most women in developed countries are now birthing in hospital environments geared to manage complex labour and birth for women with a high level of risk (Coxon, Sandall, & Fulop, 2014; MacKenzie-Bryers & van Teijlingen 2010). This has followed the medicalisation of childbirth in the mid-20th century with a proliferation of technology and intervention, and alongside a rise in risk aversion (MacKenzie-Bryers & van Teijlingen 2010; Skinner & Lennox, 2006). New Zealand is no exception. Although no one would argue the judicious use of intervention and operative delivery saves lives, the evidence suggests hospitals fail to deliver the appropriate level of care to healthy women and babies (Bailey, 2017; Birthplace in England Collaborative Group, 2011; Dixon, Prileszky, Guilliland, Miller, & Anderson, 2014).

Further, and more contentiously, this evidence indicates that for low risk women who birth in hospitals there is a higher rate of maternal morbidity, associated with higher rates of intervention, and no conferred benefit regarding maternal and neonatal outcomes, when compared to primary units (Scarf et al., 2018). Acknowledging a woman's own capability in giving birth (WHO, 2018) may be a standard more easily met for well women, in out-of-hospital settings (Davis & Homer, 2016; Hunter, 2003; Mondy, Fenwick, Leap, & Foureur, 2016). Women are less likely to have intervention and more likely to have a normal birth when it is planned in a primary unit (Birthplace in England Collaborative Group, 2011; Davis, 2011; Grigg et al., 2017; Monk, Tracy M, Foureur, Grigg, & Tracy, 2017).

Health system initiatives and evidence alone have not been enough to significantly increase the number of women birthing in out-of-hospital settings (Houghton, Bedwell, Forsey, Baker, & Lavender, 2008; Rogers, Villar, & Harman, 2015), yet little is known about what role midwives play in this decision. This study describes how 12 midwives with a high primary maternity unit caseload discuss place of birth with women. It seeks insight for other midwives wanting to promote birth in their community's primary unit. It may be useful to inform midwifery education and maternity service initiatives that aim to support women to birth in settings other than hospitals.

The impetus for the study

The advantages and disadvantages of the actual settings, and the potential for transfer in labour or after birth requires midwives also draw on local resource information to inform women's birthplace choice. In April 2017, the local District Health Board in the region where this study took place implemented a strategic change project to promote primary units, with the focus on a unit located 10 minutes from the hospital, a popular choice for postnatal care. Postnatal transfers from the hospital were reduced there to increase capacity for birth. The project aimed to create a safer tertiary hospital, currently over capacity, and a more efficient, clinically appropriate model of service at all facilities.

Such health service initiatives are reliant on the assumption that more women will choose to birth in primary units and that their midwives will support them to do so. How this type of planning can be validated provided the impetus for this study, and as Skinner (2008) noted, midwifery is perfectly positioned to make a real difference here, with protection and promotion of normal birth, the core tenet of our profession. Few quality studies report the content of birthplace discussions that may positively influence the choice of a primary unit (Grigg et al., 2015a; Henshall, Taylor, & Kenyon, 2016), and due to the unique continuity of care model in New Zealand (Grigg & Tracy, 2013), they are of limited application in this context.

This qualitative descriptive study was approached by actively searching out ‘the best’ of what is already being achieved (Carter, 2006) by using an Appreciative Inquiry (AI) lens. AI is a strength-based approach to organisational change, more recently utilised in health research (Trajkovski, Schmied, Vickers, & Jackson, 2012). The underpinning philosophy (in keeping with the researcher’s own), recognises the best in people and values what “gives life, health, vitality and excellence to living human systems” (Whitney & Trosten-Bloom, 2010, p 2). Taking this approach, the research question was developed.

Research Question

How do midwives with a high primary unit caseload, discuss place of birth with the women they care for?

The purpose of this qualitative descriptive study was to describe how midwives discuss place of birth with women. As the study aimed to focus on the successes of an approach, an appreciative inquiry lens was used to explore the midwives’ perspectives of how they support and encourage the use of primary units. Taking an appreciative inquiry approach enabled a re-framing of the research problem (most low risk women choose to birth in hospital where intervention rates are high), into a more positive light to examine achievement rather than failure (Carter, 2006).

My position in the work

The subjective author is inherent in qualitative studies. This aspect requires the researcher acknowledge, declare and reflect upon their perspective, through which meaning is interpreted (Tracy, 2010). I have practised as a midwife in the region of this study for more than 20 years. For many of those I was employed in the tertiary hospital birthing suite, and in more recent years in primary maternity units. Working across settings, I have observed the undeniable implications of the environment, described next. This belief is reinforced by another observation, that without exception and regardless of the setting or discipline, we

all want the best outcome possible for women and their babies. With a grass roots philosophy, I believe that those 'doing the business', know best how it can be improved.

The importance of the birth space

What midwives have begun to understand more clearly, both from our experience and now from research, is the crucial part the hormonal balance plays in birthing (Foureur, 2008). Busy, clinical hospitals will do what they are set up to do, which in the case of maternity hospitals, is to provide obstetric care and perform interventions. One intervention can lead to another, commonly referred to as the cascade of intervention. For example, an epidural may lead to the need for oxytocin augmentation to progress labour, which may in turn lead to instrumental birth (Tracy, Sullivan, Wang, Black, & Tracy, 2007). Thus, the natural hormonal flow of birth is disrupted. The emerging science of epigenetics proposes that exogenous oxytocin may not be as innocuous as the frequent use in modern day obstetrics would suggest. Administration interferes with naturally occurring (endogenous) oxytocin, which may have lifelong implications for the new-born in terms of switching on and off genetic predisposition to health issues (Foureur, 2008).

It is theorised that a typically busy stressful hospital environment may itself induce the need for intervention (Foureur et al., 2010). The production of endogenous oxytocin is generally understood by midwives to require a calm and comfortable environment, conducive to the woman's relaxation (Davis & Walker, 2010). The function of this pivotal hormone is to stimulate contractions to progress labour, contract the uterus after birth to prevent haemorrhage, and support bonding and breastfeeding (Stables & Rankin, 2010). Fear and anxiety cause catecholamine release, such as adrenalin, which also serves to inhibit production of oxytocin and cause vasoconstriction, potentially restricting uterine blood flow. As well as epidural for pain relief, the two most common reasons for intervention in labour are delayed progress and fetal distress (Foureur, 2008).

This hormonal interplay may also influence the practice of midwives, with workplace stress that maybe experienced in a hospital environment, suggested to impair emotionally

sensitive care and communication with women (Hammond, Foureur, Homer, & Davis, 2013). Another factor researchers' have contended may impact on midwives' practice, is the culture of the birthplace environment. Midwives have described being more able to enact women-centered (Davis & Homer, 2016), and evidence-based care in out-of-hospital settings (Miller & Skinner, 2012).

The design of the hospital environment has been found to cause both women and health professionals to assume active and passive roles in the birth space (Mondy, Fenwick, Leap, & Foureur, 2016). The typically placed hospital bed in the center of the room implies the woman should birth on it (Tracy & Grigg, 2019), with equipment for surveillance and intervention at the ready. The Cardiotocograph machine (CTG) at the bedside, with its routine use found to lead to unnecessary intervention (Maude & Fouruer, 2009), is an example of this. Although attempts have been made to recreate optimal spaces within hospital settings such as Snoezelen rooms, independent conclusions cannot be drawn about their effectiveness due to confounding variables such as different models of care (Hodnett, Downe & Walsh, 2012).

Cross-disciplinary research has aimed to understand how maternity unit design might support normal undisturbed labour and birth by investigating the way women move within and interact with the birth space and the people in it (Joyce, 2018; Lepori, Foureur, & Hastie, 2008). Although this very interesting line of inquiry is not within the scope of this research, suffice to say that primary units (aside from home), more closely align to designs drawing from concepts of domesticity, when compared to hospital settings (Mondy et al., 2016). Some of the newer privately owned (also publicly funded) primary units in New Zealand however, more closely resemble hotel-like rather than home-like settings. This notwithstanding, their designs promote a level of comfort thought to afford relaxation. Also common to all, is the absence of available intervention other than emergency support.

Research Context

Maternity care in Aotearoa New Zealand is publicly funded, except for the few who choose to register with a private obstetrician. Case-loading self-employed midwives, termed Lead Maternity Care (LMC) midwives, practice autonomously in the community, ordering tests and ultrasound scans under their own authority, and referring to specialist care where indicated, from pregnancy through to six weeks postpartum. District Health Boards (DHB) issue Access Agreements to LMC midwives in all levels of maternity facilities to enable them to arrange admission in labour and provide care to their clients.

Funding occurs under the provision of Section 88 Primary Services Notice which also includes homebirth (MOH, 2007). Section 88 states the aim of LMC care is to “provide the woman with continuity of care through her LMC who is responsible for assessment of her needs, planning of her care with her and the care of her baby” (MOH, 2007, p.1033). Underpinning this system are the *Guidelines for Consultation with Obstetric and Related Medical Services*, commonly known as the Referral Guidelines (MOH, 2012), used in conjunction with this notice. The Referral Guidelines list conditions that require either consultation or transfer of care to an Obstetrician or other specialist, termed secondary care.

There is government policy level support for the promotion of birth centres, commonly called primary (maternity) units in New Zealand. Primary units are publicly funded, tend to be some distance from maternity hospitals, are ‘free-standing’, and are midwifery-led (Dixon et al., 2012). The number of women birthing in primary units has declined from 16% in 2007 to 10% in 2017. Although this figure plateaued during this decade, there has been a corresponding decline in the number of primary units from 61 to 51 (MOH, 2017a). Funding issues due to underutilisation the most likely factor for this decline but analysis is beyond the scope of this study.

In balance, the accumulated costs of the rising rates of intervention in childbirth have been estimated overseas, to result in increases of up to two-fold and are not associated with improved outcomes (Allen, O’Connell, Farrell, & Baskett, 2005; Dahlen et al., 2012). Free-

standing midwife-led (primary) units have been found less expensive when compared to hospital maternity services (Shroeder, Petrou, & Petel, 2012).

The location of primary units in rural and remote rural areas enables women the choice to birth within their own community. Primary units in urban areas however, may be some distance from the woman's own community and are limited in number. Configuration of primary units in New Zealand would seem to be based more on geography than provision of an alternative birth setting (Hendry, 2009; Skinner & Lennox, 2006), and in some cities there are no primary units.

Maternity systems that support birth in out-of-hospital settings, are reliant on a good system of transfer should it be required. The rugged mountainous terrain, characteristic of parts of remote rural New Zealand, along with associated weather patterns, can present barriers by land or air to expedient transfer to hospital when required. The setting for this study however, does not include such remote rural regions, although two of the participants may have drawn from previous experience in these parts. The ambulance service is mostly (anecdotally) considered efficient in the study setting.

As well as a robust process of referral (Referral Guidelines), and system for transfer, New Zealand has a world leading model, with continuity as the national standard of maternity care. Continuity models of midwifery care are hailed as resulting in improved outcomes for women, including a higher chance of normal birth (Sandall, Soltani, Gates, Shennan, & Devane, 2016). Fundamental to this model, midwifery is articulated as a professional partnership with a woman, a foundation from which trust and an understanding of the woman's needs and wishes will enable informed choices to enhance her wellbeing and that of her baby (Guilliland & Pairman, 1995).

Following the Nurses Amendment Act 1990 that enabled midwives to practise autonomously (MOH, 1990), LMC midwives formed practices with like-minded colleagues in the community, varying in size and business arrangements. Just over a third of midwives are in LMC-case-loading practice (Midwifery Council of New Zealand, [MCNZ], 2016), but few studies were

located to describe such practice arrangements, an area that would benefit from research (Davies, 2017; Donald, Smythe, & McAra-Couper, 2014; McAra-Couper et al., 2014). Supporting this system, around half of all midwives practising in New Zealand are employed to staff hospitals and primary units, termed core midwives, most provide inpatient care to women (MCNZ, 2016).

In midwifery practice there are some variations in the scope of how and where midwives practice (Grigg, 2019). This is over and above what are considered the basic midwifery competencies required of midwives in New Zealand (Midwifery Council of New Zealand, n.d). Individual practice is influenced by beliefs, philosophy, comfort in different settings, experience, skills and knowledge. The expectation is that during the initial contact with a woman, the LMC midwife will share information including scope of practice, professional boundaries and practice arrangements. The woman shares her health information, preferences, beliefs and expectations with the midwife in this screening process so that both parties make a choice to work together (or not), based on information sharing toward a 'negotiated partnership' (Grigg, 2019).

Sometimes women will need obstetric consultation and the midwife has the choice to continue some care or to hand over the care to the doctor and the hospital system. A survey in 2010 indicated that most midwives chose to continue to provide midwifery care after consultation with obstetric services (Skinner & Foureur, 2010). This would appear to still be valid in some regions. A very recent study conducted in South Auckland reported that the midwives continued care after consultation and transfer to hospital (Farry, McAra-Cooper, Weldon, & Clemons, 2019). In the region of this study (described in Chapter 3) however, there has been a change in the number of midwives providing epidural care which means that more than half of the LMC midwives now hand over to their hospital counterparts for epidural care, viewing this as secondary care (Carpenter, 2018).

Chapters of this Thesis

In this first chapter, the New Zealand maternity system and midwifery model of care has been described, with a focus on primary units and the place of birth environment. My personal perspective followed an explanation of the local context that together led to the conception of the study and research question. Chapter two begins with a table of the outcome studies that justify the promotion of primary units, informing women and midwives about the implications of place of birth choice. Studies examining the concept of informed choice are then reviewed. Further research into birthplace decision-making is examined from the perspectives of women and midwives, raising the concept of risk. These all inform the study design. Chapter three outlines the approach taken to answer the research question, qualitative description using focus groups with midwives. This chapter describes the fieldwork in detail, the lens used and the process of data analysis. The criteria that ensured rigor, ethical and culturally ethical processes were adhered to, conclude this chapter.

Chapter four describes the findings, beginning with a concept map that visually demonstrates the connection between the five themes and subthemes and provides clarity for the reader, as an overview. It is in this chapter the midwives' voices bring the study to life. The final chapter draws this thesis together in a discussion that by comparison, positions the study in the existing place of birth research literature. In examining the themes, I was able to see that these midwives dealt unconsciously but quite comfortably, with significant paradox in their practice. Thus, the title of this research found. The thesis is concluded with a reflection of the research process and provides some recommendations for practice, for policy and for education.

Chapter 2. Literature Review

Overview

In developed countries, most healthy women choose to birth in hospital where high intervention rates do not necessarily confer any health benefit. Research findings consistently indicate that women who plan to birth in a primary maternity unit are more likely to have a normal birth, with no increased risk to their babies (Scarf et al., 2018). To explore how to encourage women to choose this setting, this research focuses on the midwives who have a high proportion of their caseloads planning primary unit births and how they think they might influence or support this choice. This chapter explores the literature in relation to this question and looks at 'place of birth' research, specifically related to primary maternity units and reviewed in the Aotearoa New Zealand context.

It is divided into three parts, beginning with the outcome studies that support the underlying premise of the research, justify the research question, and inform women and midwives about the implications of choice of birthplace. As women choose their place of birth, the two key issues related to the research question are informed choice and decision-making. These concepts are therefore explored in the second part to guide the focus group discussion with midwives. In the third part, the research on what makes an impact on birthplace decision-making will be reviewed from the perspectives of both women and midwives, particularly what influence the midwife may have. Finally, how the literature has informed and guided this study is consolidated to identify where it fits with current knowledge and how it may contribute to it.

The search strategy began with searching the databases CINAHL, Cochrane, PubMed, and online peer reviewed midwifery journals and theses via Victoria University of Wellington (VUW) Research Archives, to look initially for relevant outcome studies that I was not aware of. The established MeSH term 'Birthing Centers' (including birth centre, free-standing midwife-led unit, primary maternity unit), failed to generate much extra relevant literature in the 190 matches. Using the search term 'birthplace' yielded 1,522 articles, which were then

refined by using the Boolean operator 'AND' followed by the keyword 'outcomes', resulting in a more manageable 366 hits. Fortunately, these included some research related to the second two topics of the review, as well as most of the key outcome studies.

Other keywords and terms for parts two and three of the review, combined the MeSH term Birthing Centers and variations of this, as above, AND 'birthplace', with (AND) midwife; decision-making; informed choice; conversation; discussion; perspective; experience; and promotion. This located 143 and 157 articles respectively. Through reading the abstracts of titles deemed relevant to my research question for all three parts of this review, 57 articles and three theses were retrieved. After reading the full text this number further reduced to 21. Subsequent scrutinising references manually from within these, resulted in a total of 36 studies and one discussion paper. As 50% were qualitative, 33% quantitative, and 17% mixed methods, I considered a balance of the different forms of knowledge were selected, to inform this research.

Why these were selected (inclusion / exclusion criteria), and specifically what I was looking for and what was found, is defined at the beginning of each section of the review. Rationale for the inclusion of three studies that did not meet the criteria is also provided. During this process of selection, all reading of the literature, including two theses have informed my thinking and consequently this study. The quality of the research selected was determined using a Critical Appraisal tool (Joanna Briggs Institute, 2017) for the qualitative studies and systematic reviews. An equivalent checklist was not used for the quantitative research but was also ascertained for some from the findings of reviews.

Place of birth outcomes studies

In this first search of the literature, evidence of maternal and neonatal outcomes was sought to support or refute an approach that encourages birth in a primary maternity unit. Research comparing perinatal and maternal outcomes for low risk women with singleton pregnancies greater than 37 weeks' gestation, between planned place of birth that included the options of primary maternity unit and tertiary hospital, from 2011 to date (2019) were selected. This date range was chosen because 2011 was the year the pivotal Birthplace in England study

(BPE) was published. The BPE was the first large population-based study comparing perinatal and maternal outcomes between planned place of birth and is considered as ground breaking in providing this evidence. One study selected was not comparative but was included due to its size and alternative context (USA). A Cochrane systematic review comparing alternative versus conventional institutional settings for birth was excluded because no studies included a Free-Standing Midwife-led Unit (FMU) (Hodnett, Downe & Walsh, 2012), the equivalent of a primary maternity unit in New Zealand.

Twelve studies met the inclusion criteria. All were observational, five prospective cohorts (Birthplace in England Collaborative Group, 2011; Grigg et al., 2017; Monk et al., 2014; Overgaard, Moller, Fenger-Gron, Knudsen, & Sandall, 2011; Stapleton, Osborn, & Illuzzi, 2013), and five drew from retrospective data bases (Bailey, 2017; Davis et al., 2011; Dixon et al., 2014; Farry et al., 2019; Hunter et al., 2011). One structured review (Dixon et al., 2012), and one systematic review and meta-analysis (Scarf et al., 2018), substantiate the high quality of three of the studies included (Birthplace in England Collaborative Group, 2011; Davis et al., 2011; Overgaard et al., 2011). Collectively, the research on outcomes by planned place of birth provide evidence that strongly justify the current study because their findings indicate maternal and perinatal outcomes are improved or no different (respectively), in a primary maternity unit setting (see Table 1).

Outcome studies examine birth interventions such as augmentation, mode of birth, postpartum haemorrhage, transfer to hospital, Apgar score <7 and admission to neonatal intensive care units (NICU). The findings of these studies have informed international guidelines (National Institute for Clinical Excellence [NICE], 2014), recommending that women at low risk of developing complications should not birth in hospital. Whether they can be applied to a New Zealand context and consequently inform this study, will also be reviewed in this part.

Table 1. Outcome studies

Study	Aim	Sample	Study Design	Analysis Methods	Results
Author & Setting		Planned if stated, are outcomes regardless of actual PoB		Adjusted odds ratios with 95% CI given for:	Transfer rate % rounded to nearest number.
Bailey et al. (2017) South Auckland NZ	Investigate maternal & neonatal outcomes for women with low-risk pregnancies labouring in free-standing birth centres compared with TMH	47,381 births to low risk women	Retrospective cohort	Instrumental delivery, CS, blood transfusion, NICU admission & perinatal mortality	Birth in free-standing birth centre's associated with significantly lower maternal intervention & complication rates than in TMH & was not associated with increased perinatal morbidity or mortality. Transfer: primip-39%; multip- 9%; overall-19%, most commonly for delayed progress.
Birthplace in England Collaborative Group (BPE) (2011) UK	Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies	64,538 eligible low risk women with a singleton, term, booked pregnancy	The Birthplace in England national prospective cohort study	Composite primary outcome of perinatal mortality & intra-partum neonatal morbidities. Secondary of mode of birth, intervention & associated morbidity	No significant difference in primary outcome between settings, with the exception of nulliparous women having a planned homebirth. Women planning birth in a midwife-led unit experienced fewer interventions & were significantly more likely to have a normal birth. Transfer: primip-36%; multip- 9%; overall-22%.
Davis et al. (2011) NZ	To compare mode of birth & intrapartum intervention rates for low-risk women in different settings under the care of midwives	16,453 women met low-risk criteria. Data from MMPO data-base	Retrospective cohort	Mode of birth, intervention and associated morbidity, 5-minute Apgar <7, admission to NICU	The risk of emergency CS for women planning to birth in a TMH was 4 times that of a woman planning birth in a PMU, they also had a higher chance of intervention & their newborns had a higher chance of admission to NICU

Dixon et al. (2014) NZ	Determine demographic difference between planned birthplace setting, neonatal outcomes & transfer rates, compared to BPE study	61,072 women met low risk criteria. Data from NZCOM-CORD database	Retrospective cohort	Comparisons between place of birth, ethnicity, age, BMI, transfer rates & neonatal outcomes	Fewer women in NZ were transferred in labour, a greater proportion of Māori women plan birth in a PMU. Where low risk women plan to birth did not increase adverse outcomes for their baby.
Farry et al. (2019) South Auckland NZ	To identify if place of birth affected 3 maternal & 2 neonatal morbidity outcomes	4,207 low risk women birthing in one of 3 PMUs or a TMH	Retrospective cohort	CS, PP admission to HDU / ICU, PPH, 5-minute Apgar <7, admission to NICU	Statistically significant association with place of birth. All 5 morbidity outcomes measured were fewer for women birthing & babies born in a PMU. Transfer: primip-18%; multip- 3%; overall-9%,
Grigg et al. (2017) Canterbury NZ	To compare maternal & neonatal outcomes & morbidities associated with the intention to give birth in a PMU or TMH	407 women planning to give birth in a PMU & 285 in TMH	Prospective cohort	Primary outcomes Apgar score <7 & admission to NICU. Secondary outcomes of interventions, morbidity & mortality	Significantly more likely to have a normal birth & less likely to have instrumental birth if planned in a PMU. No difference in CS, Apgar scores or admission to NICU. Transfer: overall-17%, most commonly for delayed progress.
Hunter et al., (2011) NZ	Compare how planned place of birth (PoB) matched actual PoB & to identify if ethnicity influences women's choices in relation to planned PoB	16,453 met low-risk criteria Data from MMPO database	Retrospective cohort	Planned place of birth compared with actual place of birth & ethnicity	Just over 90% of women planning to birth in a PMU birthed in this setting. 23% of Māori women compared with 18% of European women chose to birth in a PMU
Monk et al. (2017)	To compare maternal & neonatal birth outcomes & morbidities associated with the intention to give birth in 2 FMUs & 2 TMHs	494 women planning FMU & 3157 TMU low risk pregnancy	Prospective cohort study	Primary outcomes of mode of birth, Apgar <7, NICU admission. Secondary outcomes of interventions, morbidity & mortality	Women who planned freestanding Midwife-led unit were significantly more likely to have a normal birth & less likely to have CS or baby admitted to NICU. Also reduced odds of intra-partum interventions.

New south Wales Australia					
Overgaard et al. (2011) North Jutland Denmark	To compare perinatal & maternal morbidity & birth in 2 FMUs & 2 TMHs	839 low risk women in each group included at the start of labour	Prospective cohort study with matched control group	Perinatal & maternal morbidity & interventions	No significant difference in perinatal morbidity between groups, significant reduction in maternal morbidity, interventions, and increased likelihood of normal vaginal birth for FMU group. Transfer: primip-37%; multip- 7%; overall-15%,
Stapleton et al. (2013) 33 States USA	Examine outcomes of Birth Center care	15,574 eligible women from 79 midwifery-led Birth Center's	Prospective cohort Non-comparative study	Maternal & Neonatal outcomes for all women presenting in labour, included transfer	92% normal vaginal birth rate, low incidence of obstetric intervention & neonatal mortality. Transfer: overall-12%, most commonly for delayed progress.

Note. Abbreviations: PMU-Primary Maternity Unit; FMU-Freestanding Midwife-led Unit; TMH-Tertiary Maternity Hospital; NICU-Neonatal Intensive Care; CI-Confidence interval; CS-Caesarean Section; PP-Post-partum; HDU-High Dependency Unit; ICU-Intensive Care Unit; PPH- Post-partum haemorrhage; primip-first baby; multip-subsequent baby; PoB-Place of Birth; BMI-Body Mass Index.

The BPE study was robust and powered to detect differences in outcomes between settings (Birthplace in England Collaborative Group, 2011). It is also relevant as the United Kingdom (UK) maternity system bears similarities to New Zealand in the range of birthplace options available to women. The model of midwifery care however, is different in the two countries and although non-hospital settings are midwifery-led, and some continuity options are available, continuity is not standard for all women in the UK. Most midwives are employed by the National Health Service (NHS). Consequently, research into place of birth undertaken in New Zealand can more readily be attributed to place due to the absence of the confounding factor of different midwives / models of care.

The Danish study (Overgaard et al., 2011) that reported findings consistent with the BPE study, has a similar continuity of care model to New Zealand. Midwives work across settings and carry a similar sized caseload (Overgaard et al., 2011). Two studies demonstrated findings consistent with the other outcome studies that comprise this body of knowledge, but in isolation are not able to be generalised to New Zealand due to the disparate (highly medicalised) differences in maternity systems in Australia and USA (Monk et al., 2014; Stapleton et al., 2013).

An important demographic difference between participants reported in the New Zealand studies and the BPE study, is ethnic diversity (Dixon et al., 2014). In the BPE study 91% of women were of European descent, whereas a higher proportion of Māori women (range from 23% to 32%), chose to birth in primary maternity units in New Zealand (Bailey, 2017; Farry et al., 2019; Grigg et al., 2017; Hunter et al., 2011). This indicates that although continued choice including primary maternity units is important for all low risk women, it may be especially so for indigenous New Zealand women.

The level of evidence is limited by the non-feasibility of randomising place of birth (women's choice), and consequent lack of control for confounding variables. A degree of self-selection is a likely confounder inherent in observational studies where place of birth is a choice, that is, the women choosing not to birth in hospital are more likely to be motivated to have a normal birth and avoid intervention. How this bias may impact this study therefore, will be

further considered when reviewing the perspectives of women in part three of this review and in informing the focus group discussions. Other common confounders are the policies, practices and models of care within the maternity service. A limitation of the New Zealand studies, except for one (Grigg et al., 2017), is the retrospective design and therefore reliance on existing variables and databases, prone to error.

This notwithstanding, a systematic review and meta-analysis of maternal and perinatal outcomes by planned place of birth, found the quality to be mostly high (Scarf et al., 2018). The evidence indicates higher rates of normal vaginal birth, lower rates of intervention, with no difference in neonatal outcomes. This clearly supports the proposition that women should be encouraged to birth in primary maternity units. Further the congruence the six New Zealand studies have with international studies, provide a sound theoretical underpinning, to support this research. As place of birth is a woman's choice, the next thing to look for in the literature is how informed choice and decision-making may be influenced by midwives.

[Informed choice and decision-making](#)

This research examines how midwives discuss birthplace options with women. How they support the woman's choices and how they inform them of evidence on place of birth is therefore an implicit part of this study. Given this, some understanding of underlying theories of informed decision-making and of information sources, is pertinent. Inclusion criteria for this second part of the review, were contemporary studies undertaken from 2006 – 2016 (research published to date [2019]). An exception to this was the O'Cathain, Nicholl, Thomas, and Kirkham (2002) randomised control trial, and qualitative counterpart (Stapleton, Kirkham, & Thomas, 2002), as they are of good quality and highly relevant to informed choice. Fourteen studies were selected because they explored informed choice in relation to place of birth decision-making and / or the midwives' role. One thesis and one discussion paper were included for potential to add to the understanding of informed choice in a New Zealand context (Davies, 2017; Tupara, 2008). Some of those not reviewed in detail in this part, are further explored in the next.

Sharing their experience of choice of birthplace, 70 women in remote rural Scotland participated in 12 qualitative focus groups (Pitchforth et al., 2009). The authors distinguished between active choosers and acceptors, with acceptors not perceived to have lack of personal agency, rather they made an intentional decision to trust the health professional. Conversely within this same study, many participants did not perceive they had a choice or believed their choice was restricted. The reasons for this included distance and accessibility for themselves and their social supports, and how information was presented by their doctor or midwife. It should be noted that women with a high level of risk were not excluded, so advice to birth in hospital would have been appropriate for these women (Pitchforth et al., 2009). This study informed the focus group discussions as I asked the midwives about the kind of women they looked after regarding different types of decision-makers, and if that influences how they talk to women about place of birth.

A qualitative study undertaken in New Zealand sought the experience of eight midwife-women pairs. Revealing a model of relational decision-making in midwifery practice (Noseworthy, Phibbs, & Benn, 2013), this research was of particular interest to my own because it was conducted in New Zealand. The authors contend this model is more fitting than existing theoretical models of (autonomous) decision-making, to describe the evolving process within the midwife-women relationship. The midwife–woman dyad notion of decision-making aligns to the concept of partnership, underpinning the NZ model care. Applied to the current study, it was useful to ask the midwives if they perceived the birthplace decision is reached mutually, over time, and within the woman’s own context. Noseworthy et al. found making an informed choice to be a dynamic process, influenced by factors such as the women’s reason for selecting her midwife in the first instance, uncertainty, vulnerability and relational trust. These were related to her familial, local, cultural and socio-political context (Noseworthy et al., 2013).

Although this study used the decision-making process around the delivery of the placenta, the findings were also applicable to the current study in several ways. At what point in the relationship is the place of birth decision made? For example, at the booking visit or after trust is established, or is it contingent upon other factors? Do the midwives think women

choose them based on similar ontological world views? If so, does this suggest the confounding variable of self-selection likely present in outcome studies, may equally apply to midwives who promote primary units and their motivation to support women to achieve a normal birth. This raised a topic to stimulate discussion in the focus groups, “how much is the birthplace decision-making about you the midwife, and how much is about the women?”

Another important New Zealand study was conducted by Tupara in 2008. In her discussion paper on decision theory, Tupara highlights the ethical and professional responsibilities that midwives have in influencing women’s decision-making. Similar to the Noseworthy et al. (2013) study, Tupara’s approach was holistic. She suggests strategies for practice such as individualising the decision experience to the woman’s cultural norms and values, including whanau (family), appealing to different modes of thinking, and narrative (stories). What strategies, if any, midwives may utilise to fulfil their requirement to share information, whilst tailoring this to the variable information needs of each woman, was therefore looked for in the current study.

Although likely differences exist between cultures, research indicates women in general perceive themselves to be the main decision-maker in place of birth choice (Coxon, Chisholm, Malouf, Rowe, & Hollowell, 2017; Grigg, Tracy, Daellenbach, Kensington, & Schmied, 2014; Patterson, Foureur, & Skinner, 2017), and the influence of others, such as partner, family, friends, and the midwife, have been shown to have variable impact on their decision (Coxon et al., 2017; Wood, Mignone, Heaman, Robinson, & Roger, 2015). One study found that although the midwife was more likely to influence the decision for women who chose to birth in a primary unit, some women were willing to change midwife if they did not feel supported in their choice of birthplace (Grigg et al., 2014).

As well as information directly from their midwives, women can take advantage of decision aids such as written leaflets and websites. However, there is some evidence that written leaflets make little impact on the decisions that are made apart from possibly supporting the status quo (O’Cathain et al., 2002; Stapleton et al., 2002). What is also becoming more apparent is that women’s requirements for information are extremely varied and that a one-

stop-shop approach will not suffice (Thompson & Wojcieszek, 2012). It may be that the midwives themselves are now no longer the main source of information and that women want to remain flexible about choices throughout pregnancy (Hinton, Dumelow, Rowe, & Hollowell, 2018). Consequently, I considered it was not only relevant to talk with the midwives in this study about what written information they provide and how they present it, but also the timing of both the discussion and the place of birth decision by the woman.

The concept of choice in maternity care is based on the weighing up of risk factors. Davies (2017) describes this in the context of fear and blame, as components of the current dominant culture of consumerism, now generalised in healthcare. Aligned to this, others have described a menu of choice for childbirth, in the pursuit of control and certainty (Sanders & Crozier, 2018) over that which is inherently uncertain. Given what Davies et al. elucidates as 'the tension between the rhetoric of choice and risk' (Davies, 2017), can women really be said to be free to make a birthplace choice? It is self-evident women do not enter pregnancy an 'empty vessel' without a world view or the influences of social norms (Sanders & Crozier, 2018). Using the example of caesarean section, researchers have proposed the notion of informed choice has obscured societal influences, this surgery now 'normalised' as a childbirth choice in western culture (Douche & Carryer, 2011; McAra-Cooper, Jones & Smythe, 2011). The impact of the socio-cultural context in which birthplace decision-making takes place, is further explored next from the perspectives of women and midwives.

Perspectives of women and midwives on place of birth

Making a decision about place of birth is influenced by factors that may result in a choice that is in conflict with evidence-based information. As much as midwives may wish to use best evidence in practice, decision making is a complex process which includes the midwives' professional and ethical responsibilities to share information. This is alongside the ambiguities arising from the sociocultural context in which this occurs. Inclusion criteria for this final part of the literature review was the most recent decade of published studies, the same period as the previous section, except for the Lavender and Chapple (2004) study, as

it is of good quality and relevant to the research design (appreciative inquiry). What is already known about the experience of decision-making in this context was sought.

Studies reporting place of birth decision-making comparing hospital to homebirth only, were excluded. Despite the likelihood of similarities between the choice to birth at home and in a primary unit, homebirth is beyond the scope of this study and research problem (intervention rates are also low for homebirth). Eight individual research articles, one thesis, three systematic reviews and one qualitative synthesis that reported on the views of women or midwives about their perspective on place of birth discussions and / or decisions, are included. Four of these mentioned in the last part, are more fully explored here.

All but five studies were undertaken in the UK and are of variable quality. Some of the more recent studies report national strategies and research investigating how the findings of the Birthplace in England study (2011) can be translated into practice. The relevance of these studies therefore was moderated by the different model of maternity care in the UK. Two parts of a study not undertaken in the UK however (Grigg et al., 2014; Grigg, Tracy, Schmied, Daellenbach, & Kensington, 2015a), provide a key piece of research related to this study due to the robust and rigorous critique in this review, and relevance to both the research and context (deemed transferable). Another two studies having direct bearing, took a positive approach, seeking 'what works', as this research intends (Hunter, 2017; Lavender & Chapple, 2004). One of these using an appreciative inquiry design, guiding the lens applied to this study (Lavender & Chapple, 2004), and only one study sought midwives' perspectives of their birthplace discussions with women (Henshall et al., 2018).

Womens' perspectives

Pre-existing values, beliefs and experience may influence women's preference for birthplace, so much so that not all women will be open to looking at all settings as options (Coxon et al., 2017). In the NZ arm of the mixed method Australasian Evaluating Maternity Units (EMU) study, from a cohort of 702 low risk women (outcomes reported in part 1), some said they

had always known where they would give birth, even before being pregnant (Grigg et al., 2014). Despite the disruption of the serious earthquakes in 2010 and 2011, a survey response rate of 82% and data from 8 focus groups enabled both breadth and depth of understanding factors that enable women to give birth in a primary maternity unit, rather than a tertiary hospital. Those from the tertiary hospital group chose this setting for the specialist facilities (95%) 'just in case' something went wrong. Over half of these women gave this as the only reason, while those from the primary maternity unit group gave multiple reasons such as closeness to home, home-like, relaxed, peaceful, the size and for water-birth. Grigg et al. contended that different ideologies about childbirth existed for those choosing to birth in the primary unit and those in the tertiary hospital. Both groups believed their choice of birthplace to be the right and the safe one (Grigg et al., 2014). In the current study therefore, I asked if the midwives experienced the women who booked with them coming with pre-existing values and beliefs, so that their birthplace decision is already made, or did they perceive they are changing their minds, and if so how?

The associated constructs of safety and risk have been widely investigated regarding birthplace decision-making. International studies report similar dichotomous values and beliefs held by women, which influence their birthplace decisions. Strikingly similar findings for example, were reported in a grounded theory study exploring first-time pregnant women's expectations and factors influencing their choice of birthplace in the UK (Borrelli, Walsh, & Spiby, 2017). Women believed their chosen place of birth to be the right and safe place. Those choosing obstetric units, did so for the medical backup where environmental factors such as the atmosphere and avoidance of intervention were influencing factors for women choosing the FMU (Borrelli et al., 2017). Women who choose hospital seem prepared to 'trade-off' the benefits of the primary unit in order to feel safe (Grigg et al., 2014; Pithchforth et al, 2009). This highlights the importance to women of feeling safe in her chosen place of birth, regardless of the setting (Grigg et al., 2015a). Given the evidence of the powerful impact the concepts of safety and risk have on place of birth decision-making, it was important to explore how midwives in the current study talk about risk with women.

In the Borrelli et al. (2017) study, trustworthiness and reflexivity were evident but there may have been bias as how women were sampled was not stipulated. Further, although saturation was reached, the research questions were also reported as themes, effectively 'a priori' rather than emerging from the data, in keeping with grounded theory design. Recruitment processes in the current study therefore needed to be justified and clearly defined, and congruence kept with design, to avoid this potential compromise to rigour.

The decision-making experience of choosing to birth in a midwife-led birth centre in Winnipeg Canada, was investigated through a feminist lens using interpretive phenomenology (Wood et al., 2016). Making decisions in the context of relationships, or relational decision-making (Noseworthy et al., 2013; Tuapara, 2008), played a significant role. A 'visceral' response to exposure to the primary unit environment was unique to this setting (Wood et al., 2016). Consistent with other studies were, sense of safety (Coxon et al., 2017; Grigg et al., 2014), avoiding intervention, environmental factors, exercising personal agency as primary decision-makers, and trusting their bodies to birth physiologically (Borelli et al., 2017; Grigg et al., 2015a; Patterson, Foureur & Skinner, 2017). Trust grew from being known to the midwife who was unhurried, women-centred, and had demonstrated competence so the woman felt safe (Wood et al., 2016). This reinforced exploring mutual decision-making in place of birth discussions in the current study and built on the question of safety with the closely related concepts of confidence and trust.

The role of confidence was examined in relation to women's birthplace decision-making in another part of the EMU study, focusing on the qualitative data (Grigg et al., 2015a). The authors found that confidence in the process, the midwife, the place itself, the system and self-confidence were all aspects that positively influenced women's choice to birth in a primary unit. Confidence in the midwife was consistently found to be important, regardless of setting (Grigg et al., 2015). It was therefore pertinent in this study, to explore how the midwives support a women's confidence to choose a primary maternity unit.

Confidence in the system (Grigg et al., 2015), is essentially related to potential transfer to hospital if needed and is dependent on local factors, such as ambulance transfer time. In the

Borelli et al. (2009) study, proximity was a main driver in place of birth decision-making regardless of setting with some options unavailable in different geographical regions restricting choice, as found in the Pitchforth's et al. (2009) study. In a study set in remote rural New Zealand (Patterson et al., 2017), key concerns were the potential for transfer and the distance to hospital to reach specialist care if needed. Transfer to hospital therefore, was thought likely to be an important aspect when exploring how midwives discuss risk in the focus groups of the current study. Furthermore, if the study is to be transferrable to other New Zealand settings, it was considered necessary to recruit midwives from a diversity of geographical locations. This included distance from the tertiary hospital to explore differences, and if the midwives share information that considers local geographical factors.

From the perspective of women, socio-cultural factors explain the continued high uptake of hospital birth as a culturally normative and acceptable practice (Coxon et al., 2014), and choosing to birth in a primary maternity unit may be considered a 'counter-cultural' decision (Grigg et al., 2014). The literature indicates that belief in the safety of a primary maternity unit, the environment itself, and having confidence to choose this setting are all factors that enable the choice of a primary maternity unit. How midwives perceive they influence these factors and the choice to birth in a primary maternity unit, is explored next.

Midwives' perspectives

In the United Kingdom key initiatives over the last two decades, such as the Changing Childbirth Report (Cumberlege, 1993), the BPE study (Birthplace in England Collaborative Group, 2011), and national guidelines recommending low tech birth places for low risk women (NICE, 2014), have all failed to make a significant difference in the number of women choosing to birth in primary units or at home. This has generated much research to explore how this could be addressed from the perspective of women, as discussed, but caution is also exercised in transferring the findings from midwives' perspectives, due to the difference in the model of care. Several studies have focused on midwives, but only one researcher has investigated the approach of midwives supporting women in primary units in a New Zealand context (Hunter, 2017). This study however, did not focus on informing birthplace choice.

Thus, a significant gap in the literature was identified and gives further impetus for my research, given the partnership relationship between women and midwives.

Studies exploring influences on place of birth decisions, indicate that the same socio-cultural factors compelling women to choose hospital, not surprisingly, also influence health professionals working in hospital settings. In a qualitative descriptive study, the themes: belief in the safety of hospital birth, maintaining the status quo, the non-decision, alternatives are foreign, and a fatalist approach with intervention seen as the norm, influenced consideration of all other factors (Houghton, Bedwell, Forsey, Baker, & Lavender, 2008). They were not only describing women's views. As well as the 50 women and their partners recruited at 12 weeks' gestation, 12 midwives, 15 GPs and nine obstetricians participated in questionnaires, non-participant observation and in-depth interviews. Data triangulation provided 'multiple lines of sight' adding both breadth and depth in this rigorous study (Houghton et al., 2008). Partners and health professionals, despite high level policy support for choice of place of birth in the UK, were affected by the same discourses of risk and safety as women (Coxon et al., 2014; Houghton et al., 2008). So what factors contribute to the midwives' belief in the safety of birth in a primary maternity unit, was sought in the current study.

In a hermeneutic phenomenological study, Hunter (2017) aimed to discover 'what works' by interpreting how midwives and obstetricians support intrapartum care in primary maternity units. She found that the midwives had a normal birth philosophy and drew strength from their experience, mentoring in this setting, and collegial relationships. Hunter concluded that "confidence as conviction", was the balance that existed to enable, safeguard and sustain the midwives to support women to birth in a primary unit.

Confidence was also an overarching theme in the EMU study. The confidence identified to enable women to choose a primary maternity unit (Grigg et al. 2015a), is also likely to be a factor for midwives. To examine the factors affecting the readiness of community midwives to provide women with birthplace choice, data from the BPE organisational (ethnographic) case studies were analysed (McCourt, Rayment, Rance, & Sandall, 2012). The researchers found a higher level of confidence and support was expressed by midwives who worked in midwife-led units, with a lack of exposure to primary settings thought to affect the confidence

of midwives to support this choice (McCourt et al., 2012). These findings suggest that as well as confidence, familiarity or exposure to the primary unit may be an influential factor for midwives, as it is for women. This highlighted for me that all midwives in the current study could be familiar with the primary unit which may have been a limitation. To reduce this potential, while still meeting the criteria of a higher caseload, midwives more recently graduated were also sampled. It was important to not only explore how the midwives supported a woman to be confident to choose a primary unit, but also how their own confidence developed to promote this choice.

There have been studies reporting (research) interventions that encourage low risk women to plan to give birth in a midwife-led setting. For example, workshops were held in one London trust, aiming to increase knowledge of the BPE study (Rogers, Villar, & Harman, 2015). Unfortunately, there was a lack of rigour in the researchers report, for example the numbers of participants were not given. The authors, who had aimed for 30% of women choosing these settings, reported a 10% rise from a baseline of 15% (Rogers et al., 2015). This increase was discrepant with that reported during the period given (2010-2014). This demonstrates the importance of accurate and unbiased reporting if findings are to be credible. It may be in the current study for example, that the evidence although compelling, is not the main reason driving midwives to encourage the choice of a primary maternity unit.

Eleven studies were critiqued in a systematic review by Henshall, Taylor, and Kenyon (2016) to establish what is known about midwives' perspectives of discussions with women about their options for where to give birth. The discrepancy in numbers in the Rogers et al. (2015) study, was noted in this review. Although initially considered highly relevant to the focus of the current study, upon review four of the six studies that related to midwives' perspectives of place of birth discussions, pertained to homebirth only. The one New Zealand study reviewed that did include the option of a primary maternity unit, did not actually meet the review criteria as this was not the focus of the study. Five studies in this review included midwives' perspectives of interventions to support birthplace choice, none of which proved effective (despite claims to the contrary), and all were of poor quality. Themes generated included: the role of professional norms, inadequate knowledge and confidence of midwives,

a variation in what midwives told women, and the influence of colleagues (Henshall et al., 2016).

It is unlikely these themes, like other studies reviewed, would resonate with the midwives sampled in the current study, as all the participants are known to support women to birth in a primary maternity unit. This makes comparison difficult. The only study included in the review that was found to have low risk of bias, used an appreciative inquiry (AI) design (Lavender & Chapple, 2004). AI reframes the research from a focus on the problem, to the solution, aiming to discover from those doing the work, what is or could be effective. Choice of birth setting, models and philosophy of care factors were discussed by 126 midwives (six were students) working in maternity services in England (Lavender & Chapple, 2004). The current study aligns to this focus, justifying the AI lens to explore what midwives think works to support women to choose to birth in a primary maternity unit. The midwives in the Lavender and Chapple et al. study described having higher morale working within a culture that supported normal birth and evidence-based practice. Those who worked in midwife-led units were proud to offer choice of birth setting, although this was sometimes hindered by a lack of (staffing) resources (Lavender & Chapple, 2004). High morale, pride and motivation to support normal birth was therefore looked for in my research.

The interactive style of focus groups in the Lavender and Chapple (2004) study facilitated the emergence of in-depth data and was therefore also the chosen method in my study. A limitation of the study was non-verbatim transcripts to protect midwives, who were appointed to the sample by their manager, from feeling vulnerable (Lavender & Chapple, 2004). This was not considered necessary in the current study as the midwives all participated voluntarily, and were discussing their own, self-employed practice rather than that of an employee.

One final study reviewed, aimed to improve the content of midwives' discussions with low risk women about their options for place of birth (Henshall et al., 2018). This research was less relevant than initially thought as FMU was not an option (included one AMU only), so much of the discussion was around homebirth. The content included decision aides,

developed from research co-produced by women and midwives. As these were informed by evidence and (NICE, 2014) guidelines however, they bear some relevance to the current study. Leaflets were stratified for multiparous and nulliparous women to reflect the different potential outcomes, and a standardised script was developed for midwives. Information about intervention, safety and transfer rates in the different settings, was intended to promote informed choice. Although midwives found the interventions useful, some felt that due to the prescriptive nature, it impeded their autonomy. This may have been because all the midwives involved in developing the tool worked in the same place, so it may not have suited the midwives in the study who worked elsewhere (Henshall et al., 2018). Because of this, I sampled midwives who supported women in all the primary units in the region. This study also provided detail for my own regarding what evidence was shared including safety, intervention and transfer, and if differences for parity, such as higher transfer rates for nulliparous women, were acknowledged.

Summary

Outcome studies demonstrate the safety of birth in a primary maternity unit. Since their publication however, it would appear they have made little impact on women's choice of place of birth despite most women, except for those reported in one study, perceiving they had a choice. Autonomy commonly considered central to the concept of both informed choice and the New Zealand model of midwifery care (Davies et al., 2017), is valued by women (Douche & Carryer, 2011), and midwives (Dixon et al., 2017) alike. It is at best challenged by risk aversity, with autonomy in birthplace decision-making in this context, most likely circumscribed in common with other western countries. Qualitative research further indicates that the evidence may not be well communicated to women by health professionals, but this has not been explored in a New Zealand context.

Although the literature suggests place of birth decisions are complex and influenced by a woman's own ideology, confidence and sociocultural context, it is not clear to what extent they are fixed or open to change. Women choosing to birth in primary maternity units give

several reasons influencing their choice but there is no evidence in a New Zealand context, of how birthplace discussions with their midwife may have informed this choice.

Having already examined the women's perspective there seems to be real value in studying the midwives' perspectives of their role in the birth place decision, especially in relation to primary maternity units. Two studies undertaken in the UK reported the views of both women and midwives, and one study and one systematic review located, sought the perspective of midwives only that were directly related to place of birth choice. Although choice of setting was not the focus, the only known research undertaken in New Zealand, also aligns to the findings of a UK study. Confidence, belief in normal birth, and the support of likeminded colleagues enabled midwives to support birth in out-of-hospital settings. Most of the studies reviewed however, indicate that discourses of safety and risk support the dominance of the obstetric model of childbirth, endorsing the status quo of hospital birth as the cultural norm.

There is a paucity of research seeking midwives experience of birthplace discussions that may promote the choice to birth in a primary maternity unit, a gap this study aims to address. My thinking was informed and focused by this review of the literature. What I was looking for in this study, the question and topics that formed the discussion guide for the focus groups, how it was conducted and how I ensured rigour, were therefore shaped by what is already known. This methodology will be discussed next in Chapter 3.

Chapter 3. Overall research design/Methodology

Review of the place of birth literature demonstrated what the outcomes are in different settings, justifying a care approach that encourages women to birth in out-of-hospital settings. The qualitative studies explained why most women choose to birth in hospital and went some way to explaining what might enable women to choose a primary unit. Qualitative research methods have also been used to investigate the barriers to health professionals supporting women to choose alternative to hospital settings. This inquiry explores how midwives support women to choose a primary unit, an identified gap in the literature. This chapter outlines how the research was conducted.

Research Approach

The study took a descriptive qualitative approach, informed by appreciative inquiry. Qualitative inquiry is appropriate for the aim or purpose of the research because it explores the way people engage with each other and their perceptions (Patton, 2002), identifying meaning relevant to the issue (Erickson, 2011). Both qualitative description and appreciative inquiry (AI) are derived from social constructivist epistemology (Lavender & Chapple, 2004), and are therefore compatible approaches. An example of the underlying assumption that meaning is socially constructed, are discourses (Braun & Clarke, 2006) of safety and risk described in this study. One study using both AI and a qualitative descriptive design demonstrated the compatibility of this approach and design (Sidebotham, Fenwick, Rath, & Gamble, 2015). Appreciative Inquiry is a strength-based approach to organisational change, initially coined by Cooperrider in 1986 (Cooperrider, Whitney & Stavros, 2008), as based on positive dialogue and appreciation (Trajkovski, Schmied, Vickers, & Jackson, 2013). The method consists of the four iterative phases of: discovery, dream, design and destiny (Carter, 2006; Lavender & Chapple, 2004; Trajkovski, Schmied, Vickers, & Jackson, 2012). It has become increasingly utilised in health research (Trajkovski, et al., 2012). The study therefore, was also approached by actively searching out 'the best' of what is already being achieved (Carter, 2006).

Given that this research is a small work, being undertaken as part of a Master's programme, using the full four-dimensional AI approach was not feasible. The 'discovery' phase that aims to uncover "what is already working" (Sidebotham, et al., 2015, p. 113) however, aligns to the focus of this study. Consequently, the term 'lens' was used to indicate the general approach of the study, the philosophy recognising the best in people and valuing what "gives life, health, vitality and excellence to living human systems" (Whitney & Trosten-Bloom, 2010, p 2). This approach further aligns to the affirmative research question and purpose and therefore underpins and informs the study.

A qualitative design was selected to enable description of the phenomena of how midwives discuss place of birth with women, in straight forward everyday language (Jiggins, Colorafi & Evans, 2016). This was chosen because it is hoped the findings may provide practical information for other midwives wanting to promote birth in their community birthing units. Interpretations are made in as far as all descriptions are filtered through individuals' perceptions, but the descriptive design stays close to the data without imposing theory, and close to the words and events described (Sandelowski, 2000). The design is without the theoretical underpinnings of other methodologies and may be considered the least abstract or conceptual (Sandelowski, 2010). It fits the purpose of describing what presents itself, as it is presented (Giorgi, 1992). The AI lens provides the philosophical underpinnings of the study without creating incongruence with the methodology, as might have occurred with other more theoretical designs.

Research Design

Method

Focus groups were selected for this study to discover the perspectives of midwives who support and encourage women to choose a primary unit by exploring their 'collective intelligence' (Richardson-tench, Taylor, Kermode, & Roberts, 2014). Focus groups have effectively generated data for a broad range of qualitative midwifery research approaches including AI (Lavender & Chapple, 2004; Sidebotham et al., 2015; Smythe, Payne, Wilson, & Wynward, 2009). Gathering like-minded participants can also encourage the free-flow of ideas through discussion (Morgan, 1998), not elicited through individual interviews. Further,

unlike in an interview, a focus group can enable the researcher to better identify what is commonplace from that which is not usual (Kitzinger, 1994), in this case in the midwives' practice. It was envisaged the midwives would "stimulate each other to think more deeply" about the topic (van Teijlingen & Pitchforth, 2007, p. 78).

Setting

Birthplace options in the region of the study setting include home, four primary units and a tertiary maternity hospital. Two primary units are semi-rural on the outskirts of the city (north and south-west), one located in the city, and a fourth is south of the city in a rural neighbouring town. Although the latter two are located within hospitals, they operate independently as freestanding (stand-alone) units as these hospitals do not offer maternity services. Women living in the eastern suburbs of this region no longer have a primary unit within their community, several of the participants have a caseload in this area. Place of birth discussions take place where midwives choose to provide antenatal care (often termed their 'clinics'), either in a primary unit, a consulting room, or in the woman's home. The focus groups took place in the education room of one of the semi-rural primary units. The participants were asked to allow two hours, with lunch provided and petrol vouchers for those traveling from rural locations. The groups took between 55 and 70 minutes.

Recruitment of participants

Thirteen LMC midwives, 'known across the region to support a high proportion of their caseload' to birth in a primary unit, were purposefully sampled for their capacity to generate data and comparative possibilities (Barbour, 2011). To elicit both similarities and differences in their experiences, they were sampled from four different practice locations (urban, two semi-rural, and rural) for each group. To further achieve this, where possible they were sampled from several different practices within each location which led to planning the sample size of 13. After initially being invited to participate by an LMC midwife, all agreed to take part in the study and be contacted by the researcher. Three focus groups were planned with tentative dates emailed to the midwives who were asked to indicate their potential availability for each date. Allocation to the groups was based primarily on their availability, then a mix of the practices and practice locations described. The date of their focus group

was confirmed so the midwives could arrange cover for the two hours. It was also acknowledged that if they had been up for a birth the night before or still with a woman in labour, they could attend another group on one of the alternate dates. Once recruited, the midwives were keen to contribute so when they did have to postpone for the reasons anticipated, a later focus group date also needed to be offered, and the three groups extended to four. This resulted in all but one midwife participating in a focus group.

What constituted a 'higher caseload', was a minimum of ten women birthing in this setting per annum. This relatively low criteria were to enable midwives more recently graduated (one to two years), to participate. It was also anticipated that because of the proximity to the hospital, those from the central city may have a comparatively lower proportion of their caseload birth in primary units, but this was not the case according to the demographic data collected, see Table 2. Why I deemed 10 a 'higher caseload', was relative to the caseload of a number of LMC midwives in the region, with no women choosing to birth in a primary unit. Although not expected to be representative, a broader range of data was anticipated by different midwifery group practices', practice locations and the demographic diversity of the participants. The participant views however, were found to be remarkably homogenous. Further, although the findings were not intended to represent their individual views (Stokes & Bergin, 2006), or be generalisable, given this diversity I considered what these midwives believed 'works', may resonate for others. Alongside the Research Context discussed in Chapter 1, and a description of the setting outlined above, consideration can be given by the reader, as to whether the findings can inform practice in other settings (transferability).

Table 2. Participant demographics

Name of Midwife	Age	Ethnicity	Number of years qualified	Area of practice (women's domicile)	Size of caseload per annum	Number of primary unit births per annum	Focus group
Mila	20-29	Pacific Island (PI)	1-2	Urban	>60	30-39	1
Kate	30-39	NZ Euro	11-15	Rural, remote rural	>60	30-39	1
Isla	30-39	NZ Euro	6-10	Rural, semi-rural	50-59	30-39	1
Naomi	30-39	NZ Euro	6-10	Rural, semi-rural	40-49	20-29	1
Hana	50-59	Māori, NZ Euro, PI	>15	Urban	>60	20-29	2
Megan	30-39	NZ Euro	1-2	Rural, semi-rural	30-39	10-19	2
Ava	40-49	NZ Euro	6-10	Rural, semi-rural Remote rural	50-59	30-39	2
Clare	60 +	NZ Euro	>15	Rural, semi-rural	<30	10-19	3
Sophie	40-49	Other Euro	3-5	Urban, rural & semi-rural	40-49	10-19	3
Di	60 +	NZ Euro	>15	Urban, semi-rural	>60	20-29	3
Jacinda	50-59	Other Euro	>15	Rural, semi-rural	>60	>40	4
Maggie	60 +	NZ Euro	>15	Rural, semi-rural, remote rural	50-59	20-29	4

The groups

To prepare for moderating the groups, I familiarised myself with seminal authors description of the method (Kitzinger, 1994; Kreuger, 1998; Morgan, 1998). Self-awareness dictated I consider how I might impact data collection, moderating not participating (Kreuger, 1998) would be my challenge. Two digital devices audio-recorded the discussion. An opening question: “You all have a high primary unit caseload, why do you think that is?”, and prompts were included in a discussion guide (Appendix A), denoting the broad areas of focus that this study was looking for. These were based on the approach and research question and informed by the literature. Prompt questions included:

- How do you inform women about place of birth, what information do you provide; and what is the timing of the birthplace discussion and decision?
- Do you encourage or persuade women to birth in a primary unit, how proactive are you?
- How much about the birthplace decision is about you the midwife and how much is about the woman or midwife-woman dyad or others?
- Who really makes the place of birth decision, do you have different types of women or women from different cultures, and do you adjust your approach?
- What contributes to your confidence and what do you do (if anything), to support a woman’s confidence to choose a primary unit?
- How do you talk about risk and safety, transfer and intervention?

Few prompts were required, as the midwives’ conversations led to these topics in one way or another through discussion, and “what do others think?” was asked to establish consensus or divergence if not volunteered. Points of view I wanted more understanding of or had not considered, that also related to the research question, were further explored by the cue “that’s really interesting, can you tell me more about that?”

Notes were taken during the groups. These included non-verbal behaviour, laughter and increased levels of animation about an area being discussed, of which there was much. Overall the groups exhibited great enthusiasm toward a topic (place of birth) they clearly felt passionately about. Enthusiasm from participants is commonly reported in AI studies (Trajkovski et al., 2012). By encouraging each other’s contributions and making supportive

comments, the midwives may be considered 'co-moderators' (Barbour, 2011), of the focus groups. There is of course the possibility that they felt pressured by group consensus (Kreuger, 1998), however an impression common to all groups, was a sense that they were proud of their contribution to women's decision-making and their high primary unit caseload. Field notes taken immediately after each group recorded this first impression, among others, and potential themes.

Analysis

Thematic analysis, similar to the qualitative descriptive approach, is not bound by commitment to theoretical underpinnings. It can be applied with a range of methods and across a range of paradigms, including social constructionist epistemology (Clarke & Braun, 2017). Further, it has been used as a method or tool to analyse focus group data for qualitative descriptive (Carpenter, 2018; Davis & Homer, 2016), and AI research (Sidebotham et al., 2015; Smythe et al., 2009). It was therefore selected as the method or tool for analysis to identify and interpret patterns of meaning (Braun & Clarke, 2006) from the focus group transcriptions. The data generated from the four focus group recordings were transcribed and analysed, with the field notes alongside (taken during the discussion and immediately after). An external transcriber was not used as I considered this task would enable me to become immersed in the data (Riessman, 1993 in Braun & Clarke, 2006). Although this was the case, the undertaking was much greater than anticipated. One of the groups alone generating over 8000 words.

Each transcript was colour coded to ensure the findings would not be centric to one focus group (Davis & Homer, 2016). Sections of the texts were highlighted as they related to the broad areas of focus to form codes or patterns of meaning (Clarke & Braun, 2017). As these areas of focus were informed by current theory gleaned from the literature, the reasoning behind what sections of text were selected, was deductive, that is what is already known. This process involved multiple readings going back and forth across the transcripts and identified codes (Braun & Clarke et al., 2006). Themes were developed from this iterative process.

The first set of themes I developed were effectively *a priori* resulting from that which had been 'looked for', as outlined in the focus group discussion guide, rather than emerging from

the data. This was also more akin to content analysis, commonly used in qualitative descriptive designs (Sandelowski, 2000). Despite needing to stay 'close' to the data, the themes lacked the meaning that was sought, from the chosen (thematic analysis) method. Patterns do not live in or magically emerge from the data however, they are still actively selected by the researcher (Braun & Clarke, 2006).

Going back to re analyse the data more inductively involved a systematic approach of entering the data from the original transcripts into NVivo software then initially identifying sub-themes, as I again read back and forth across the data. Subthemes that formed patterns of meaning were colour coded consistently within each transcript, and then developed into themes by grouping under "what are they actually talking about here?" These were further refined through identifying relationships between themes and subthemes, aided by a concept map (Guest, MacQueen, & Namey, 2014). What resulted from these two analyses was both deductive (theory driven), and inductively derived (data driven) themes (Braun & Clarke, 2006). Description of these including consensus and divergence, is described as the end product (Giorgi, 1992). Figure 1 provides a visual representation to summarise the research design.

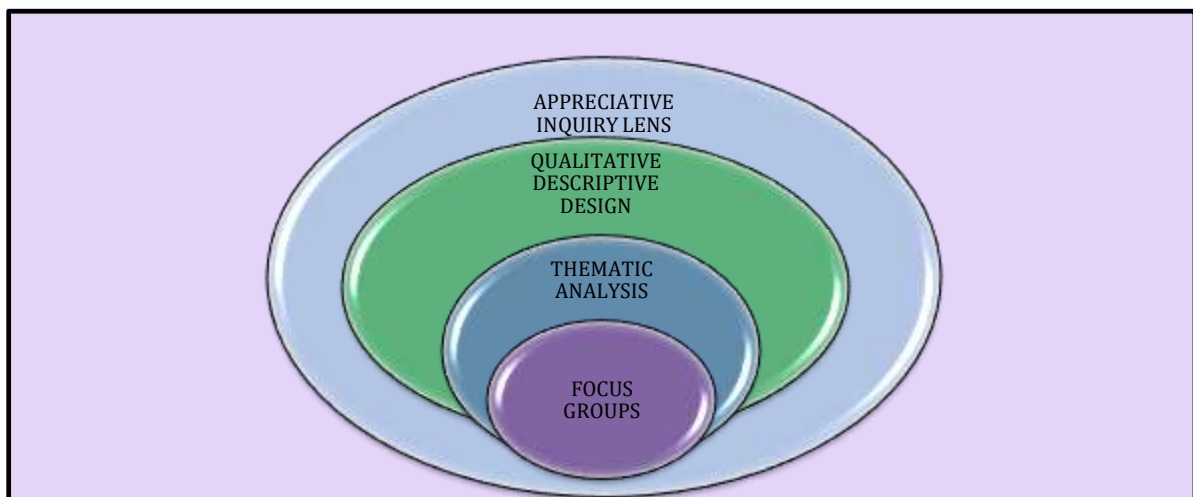


Figure 1. Research Design

Treaty of Waitangi considerations and obligations

The Treaty of Waitangi (Te Tiriti o Waitangi) is New Zealand's founding document. In relation to health care, it provides an overarching framework for Māori and non-Māori to exercise control over their health and wellbeing. The implication for research requires Māori are both involved in the process, and it is of benefit to Māori (Jahnke & Taiapa, 1999). To more specifically guide researchers, Te Ara Tika is a culturally ethical framework. In accordance with this framework, this study falls within a mainstream approach. Based on this mainstream approach, the following questions are addressed next. In what way does this research impact on Māori? Will they be included in the project? Is this appropriate and respectful, and do I need to consult with Māori for this project? (The Pūtaiora Writing Group, 2010, p. 9).

The NZ study of planned place of birth concluded that primary units might be of particular importance to indigenous women (Hunter et al., 2011). Women choosing to birth in primary units in New Zealand, per ethnic population, are more likely to be Māori (MOH, 2017). This is pertinent given the government's commitment to improved access and equitable healthcare for Māori (MOH, 2016). As this study takes an approach that focuses on how birth in primary units may be supported and encouraged, the impact for Māori may therefore be considered positive.

Tūranga Kaupapa are guidelines developed by Nga Maia, an organisation that represent Māori midwives and consumers, and have been adopted by NZCOM and the MCNZ. Māori worldview is encapsulated in whakapapa (genealogy). Māori values reflect the broader holistic (Hua Ora) context of Tikanga Whenua, maintaining the continuous spiritual relationship with land, life and nourishment, family and genealogy (NZCOM, 2015).

A Māori midwife participating in the study clarified she was reflecting on the influence of youth and whanau (family) on her clientele who may or may not have been Māori, rather than culture. Another midwife also referenced a high Māori (and Pacifica) caseload, but no analysis was intended beyond the holistic approach taken by all midwives, professionally

guided by Tūranga Kaupapa, as I am. This was because as a researcher however, I lacked the cultural competencies to do so (Came, 2013), and culture was not the focus of the study. I considered it was appropriate, as it is in any research undertaken in New Zealand in keeping with The Treaty of Waitangi, to ensure participation. This was achieved by respectfully recruiting, respectfully conducting the focus groups, and incorporating this perspective into the subtheme 'tailoring the information and culture'. I did not consult with Māori for this project, but am aware that mainstream ethics committees, through which this research sought approval, are also informed by Te Ara Tika (The Pūtaiora Writing Group, 2010).

Ethical implications

Ethical approval was gained from the Victoria University Human Ethics Committee (Appendix B). The following ethical principles were applied:

- Voluntary participation: To address any perceived power imbalance due to the researcher's current employment as Charge Midwife Manager of a primary unit, an LMC (self-employed) midwife assisted with recruitment. Under no obligation to participate in the focus groups, LMC midwives were provided with a plain language statement and invitation to participate (Appendix C). Information included exactly what the research is about, what they would be participating in, what was expected of them, the intention to protect their privacy and the risk to this. Details of those who wanted to participate in a focus group were passed onto the researcher.
- Anonymity: Although the focus group members knew each other and may recognise others in the groups' contributions, all reports from the discussions have ensured that no member is able to be identified by the reader. For example, responses to 'Which primary unit do you support women in?' upon reflection, should not have been asked when collecting the demographic data (Appendix D). This was removed from Table 1 as this information would increase the likelihood of identifying individual midwives to others practicing in the region, potentially compromising their anonymity.
- Informed consent: Written consent was obtained from the participants. They were able to withdraw from the study at any stage prior to data gathering. Due to the collective nature of a focus group discussion individual data was not able to be deleted

after this stage. This was made explicit in the information sheet (Appendix B) and consent form (Appendix E).

- Confidentiality: At no time will the researcher discuss participant responses other than with the research supervisors. Audiotapes and transcripts will be destroyed 5 years after the research has been completed. Data is kept in a password protected computer.
- Focus group guidance and confidentiality: Beginning with a general introduction of the topic, the ground rules were presented. These included only one person speaking at a time, respect for all perspectives and confidentiality. A particular aspect of focus group discussion is that although the researcher can ensure confidentiality on her behalf and can gain agreement of the focus group to maintain confidentiality on their part, the researcher cannot guarantee that no focus group member will ever divulge either membership or content of the discussion (van Teijlingen & Pitchforth, 2007). This was explained in the information sheet so that the participants could monitor the nature of their contributions.
- Conflict of interest: The researcher declares no known conflict of interest.

Strategy for rigour

In quantitative research the concept of rigour is expressed in the positivist terms of validity, reliability and objectivity (Guba & Lincoln, 1989). Guba and Lincoln present a more fitting alternative for qualitative research. They introduced *four* terms to parallel these measures of rigour for qualitative methods which were applied to this research. Trustworthiness, the term they used to express rigour (Guba & Lincoln, 1989), directly relates to that of the researcher (Patton, 2002). The audit trail including raw data (transcripts and field notes), and an ongoing record of decisions made and issues, were recorded in a large diary and discussed at regular intervals throughout with my supervisor. This will be kept providing transparency (Robson, 2011), ensuring findings are both *confirmable and dependable* (Guba & Lincoln, 1989). *Credibility* was achieved by staying close to the data and reporting rich description including both consensus and divergence to produce plausible results (Tracy, 2010). The results displayed visually on a concept map enabled my supervisor to help identify non-logical groupings. Generalisability is not an expectation of qualitative research as it is specific to the

context in which it is undertaken (Morse, 2015), however a thick description of the phenomena and context (including demographic data), will enable readers to determine *transferability*. That is if the findings are applicable in their own context (Guba & Lincoln, 1989).

Reflexivity is another aspect of rigour directly related to the researcher and thus, trustworthiness (Morse, 2015). This study was approached with a genuine naivety as the researcher has only practiced in brief as an LMC midwife and is not privy to LMCs place of birth discussions. Acknowledging however, the influence the researchers' beliefs, and experience (of promoting the primary unit to women, midwives and managers), will have had to the construction of meanings (Giorgi, 1992). This is my bias declared, not bracketed (Morse, 2015), but reflected upon throughout the descriptive qualitative research process. Re-analysing the data that initially reflected my preconceived ideas, is an example of reflexivity, albeit with the help of my supervisor.

Summary

This research was designed to answer the question "How do midwives with a high primary unit caseload, discuss place of birth with the women they care for?" The straightforward approach of qualitative description, focused by an AI conceptual lens, and the commonly chosen methods of focus groups with thematic analysis, were selected for this inquiry. In this chapter the rationale for this selection is given. An explanation of the underlying assumptions, how the 12 midwives were sampled and recruited and the study setting, precede descriptions of how these methods were implemented. Scrupulous attention to quality criteria (Tracy, 2010), and documenting decision points in a diary built a 'track record' (Patton, 2002). These can attest to the conduct of the steps taken to apply this methodology, and the ethical and quality measures described in the research.

Chapter 4. Findings

Overview

From the thematic analysis of the four focus groups, five themes emerged. These themes were derived from 26 subthemes which are shown in the oval shapes of the concept map (Figure 2). The subthemes are closely linked, and the themes shown in the rectangle boxes also relate to one another and connect to a central theme. For three (purple boxes), deductive reasoning was used, while two (green boxes), applied an inductive approach, allowing new theory to emerge.

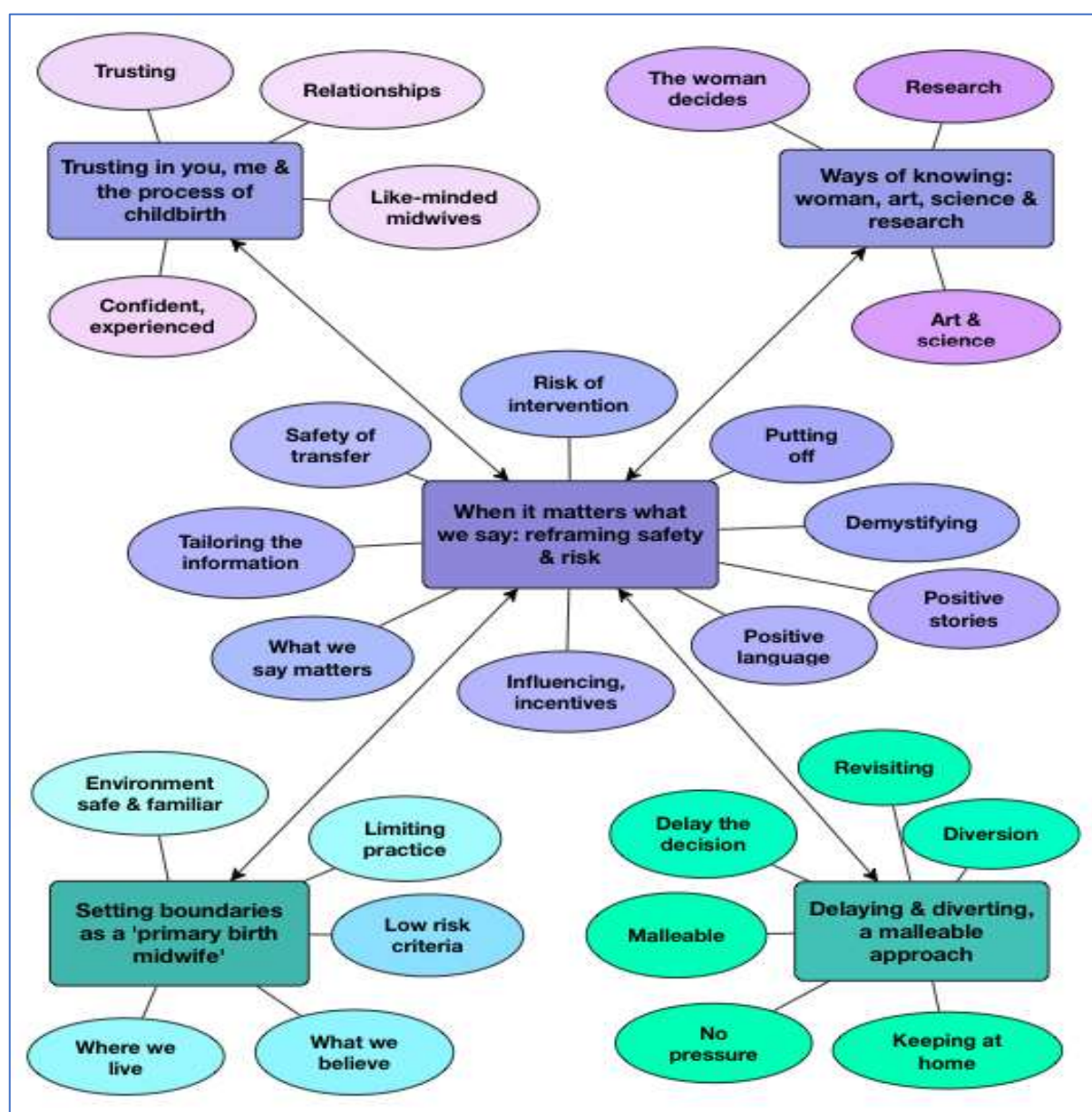


Figure 2. Concept map illustrating findings

In discussing place of birth, midwives with a high primary maternity unit caseload acknowledged that some women will come with their minds made up, but for others it mattered what they said. By re-framing safety and risk, they drew from midwifery theory, trusting relationships and trust in the normal process of childbirth, to counter the social-cultural norm of hospital birth. Applying an appreciative inquiry lens to explore what is already working, a malleable approach was seen. The midwives delayed the decision about birth place to provide more time for a woman to feel comfortable with a choice of a primary unit. They set boundaries around their practice, defining themselves as primary birth midwives to enable a high primary unit caseload. How these midwives discussed place of birth is described in this chapter, illustrated by excerpts from the participants.

Themes

Each of the five themes are introduced with an overview. This is followed by a description of the subthemes that collated, unify the broader theme. The subthemes are illustrated by excerpts from the participants, demonstrating prevalence (Braun & Clarke, 2006), and shedding light on their conception. Throughout the narrative, how these themes link to one another begins to be seen. One theme in particular was central, as pivotal to birthplace decision-making. Consequently '*When it matters what we say: reframing safety and risk*', is interrelated to the others. The order the themes are discussed in, numbered below, is simply because of the flow of ideas within the content, to relay the story to the reader. Themes one, two, and four may be recognisable as they align to existing theory (deductive). Themes three and five were data driven (inductive), and therefore present something new.

Table 3. Themes

1. <i>Ways of knowing: woman, art, science and research</i>
2. <i>Trusting in you me and the process of childbirth</i>
3. <i>Setting boundaries as a 'primary birth midwife'</i>
4. <i>When it matters what we say: reframing safety and risk</i>
5. <i>Delaying and diverting, a malleable approach</i>

1. Ways of knowing: women, art, science and research

The midwives in this study made use of the theory underpinning their profession to encourage women to choose to birth in a primary maternity unit. Research was used as a tool to reinforce what they inherently believed, that outcomes are better for low risk women who choose to birth in a primary unit. The phrase 'art and science of midwifery' is coined to imply that intuition, among other ways of knowing, is intermingled with what is known in science. Excerpts given for this theme, reveal this in practice, such as evoking emotion about childbirth physiology. They embraced their professional responsibility to share evidence-based information with women about place of birth, but in keeping with the model of partnership it is ultimately the women who inform them about this choice.

Using Research

The midwives used research to justify the emphasis they placed on the benefits of the primary unit and the risk of intervention in hospital. Outcomes were discussed by most. Three had created their own research-based resources, one used an app of evidence-based guidelines, while others recounted speaking more generally to women about the evidence. They gleaned evidence to share from this evolving body of knowledge to affirm what one midwife said she always knew. Another attributed her high primary unit caseload to this, albeit a little tongue and cheek.

...cause we encourage them, because we give them all the right research... Research articles, getting them to look at that, I have them there, I photocopy them. (Di Fg3)

Because it is weighting it, where the research is, you know in the early days we didn't, well the first inkling we had of it was a study... and that was you know, amazing for midwives because here were some stats that supported what we knew but didn't have proof of... now there's heaps. (Maggie Fg4)

We have folders but it's changing to electronics or we email a lot more now, we have a lot more research articles that focus on different areas... books... but um but all of it just talks about active birth and all those outcomes. (Sophie Fg3)

To increase relevance to women in a 'hit home' approach some used local statistics, one midwife generalising the findings of an international study directly to the local context.

...we talk about research in terms of outcomes for mum and baby being the safest option and then we talk about statistics of caesarean sections at [the woman's hospital]... and I think a lot of people are quiet confronted with that. (Mila Fg 1)

I talk about evidence, the outcomes here [semi-rural PMU], there's better outcomes. I do talk about if a primip walks through the doors of [the women's hospital], having their first baby, it's almost a 50% chance of having an intervention, that really hits home. (Ava Fg 2)

... the UK study that they did... the Birthplace study, I've got a little graph, a little chart [shows on her mobile phone]... they see risk of caesarean... (Jacinda Fg 4)

Art & science

The midwives articulated an awareness that a woman needed to feel safe, comfortable and able to relax in her chosen place of birth, despite the evidence indicating improved outcomes for out-of-hospital birth. The environment otherwise, could hinder her progress in labour. This references to the science around oxytocin and catecholamine release. Paradoxically, unlike the primary unit environment, the hospital environment is not typically associated with comfort, comfort in this context is a euphemism for sense of safety and used interchangeably by the participants.

If your comfort is not to birth in a place like this... I say to them I want you to birth where you feel most comfortable and safe so if that is [the women's hospital], even if everything in me is saying this is ridiculous, we should not be in here, you're never going to labour well at [semi-rural PMU]. (Isla Fg 1)

... if they're scared stiff of where they are, they're not going to labour well, whether that be at home or a primary unit, that maybe part of the reason for failure to progress actually and go well once they've transferred over... even if they didn't acknowledge that or recognise it but it's there. (Di Fg 3)

... I always say to women the best place for you to labour is where you feel relaxed, cause things will move along. (Maggie Fg 4)

Two midwives encapsulated that which might be termed the art and science of midwifery. This included Intuition, and as discussed by another, highlights a fine line midwives sometimes walk, in promoting normalcy whilst being ever alert to that which is not.

I talk about physiological and explaining how baby does its thing, for them to fall in love with how their body does things naturally and normally, they're always amazed with how baby does all its twists and its turns to come out, making them fall in love with their own physiology of birth, it's natural and normal and that's exciting. (Megan Fg 2)

But sometimes it's hard to know, you have this sort of horrible inkling, that even though she palps as an LOA, I'm not sure she's behaving like an LOA, this is really good labour but it doesn't seem to be moving along. I don't know sometimes it's very subtle things..., that sense of intuition and stuff... and it's a very delicate balance, you know cause you can see the abnormal in lots of things or potential for it, but it goes the other way to, you can see something and think oh it'll be alright... I see, with doing expert opinions that we don't always get it right. (Maggie Fg 4)

The woman decides

Whilst acknowledging, we do not always get it right, the midwives voiced frustration that it is health professionals who bear the responsibility to inform women's choice of birthplace and are not always doing so. In a subsequent pregnancy for example, a woman may not have been aware of the choice to birth in a primary unit, therefore had not made an informed choice to birth in hospital for her previous birth(s).

Because if you don't talk about primary units then the woman can't make that decision... I think that sometimes those conversations aren't happening... cause it's a bit sad if women say oh, I didn't know I could birth here. (Sophie Fg 3)

... they say I didn't realise I could have a baby here, or my first here [semi-rural PMU]. (Claire Fg 3)

...it would be interesting to know how they inform choice. (Hana Fg 2)

Viewing their role in the decision-making as one of information sharing to enable choice to be fully informed, alongside the research, one also provided an informed choice leaflet. The midwives were cautious to clarify that place of birth is the woman's decision, and one she can change anytime.

...and at that point a woman will come here in labour and be progressing well and actually decide herself she doesn't want to leave, she's happy here, she's feels comfortable... but if at any point the woman wants to change her mind and go into town then that's an option. (Isla Fg 1)

... the midwives are always part of that, but at the end of the day it's her decision where she needs to be. (Sophie Fg 3)

Our role is just to give these families the information they need to make their own decisions and that's what it's all about. (Jacinda Fg 4)

Those consumer leaflets, 'Choosing Where You Birth'... some I pay for, ...I give them at booking. (Di Fg 3)

2. Trusting in you, me & the process of childbirth

Information sharing is the tenet on which the partnership model of midwifery care in NZ is based (Guilliland & Pairman, 1995). A trusting relationship developed with the woman over time in a model of partnership, was a factor thought to contribute to their high primary unit caseload. Although not undervaluing the importance of a woman's social context in her birthplace decision-making, the initial influence of partner, family and friends was described as a potential barrier to overcome. The support of like-minded midwives was viewed as necessary to sustain their own confidence, gained from a solid grounding in the primary setting. Training, experience and confidence were conveyed to women to elicit trust. The participants belief in the primary setting to protect and promote normal birth, was enabled by a trust in the normal process of childbirth and projected to women to trust in their body's ability to birth without intervention.

Relationships

The place of birth decision is made by the woman as discussed, and in the context of partnership, if not articulated then described. Although the midwives in this study were driving the choice of a primary unit, some acknowledged the need for balance in this.

...it's the whole partnership model isn't it. They listen to you, you listen to them, and a decision made at some point, and that can change. That said... [rather] than saying it's a joint thing, at some point there might be that balance but at some point, its more midwife driven and should become more women decision-making. (Di Fg 3)

I respect any decision that they make, so I'd like to think it's between us. (Jacinda Fg 4)

You both bring parts to the decision, she doesn't have all the information but you're not making the decision. (Sophie Fg 3)

The midwife-woman relationship was considered advantageous to the birthplace decision, as trust grew once they got to know their midwife. Unlike the other participants, for one midwife it was important this occurred prior to any place of birth discussions.

I don't talk about it at all until their third trimester until they've got their relationship with me... when I do the birth plan and by then I've built their trust and they want me to be with them and yeah. (Kate Fg 1)

I think it's good to sort of give time to get to know each other and build up a rapport and gain some trust, I think that does help. (Ava Fg 2)

I think a benefit is that you build up the relationship, because I definitely, I think once they meet you regularly and they really get to know you and they see your confidence I feel that gives them confidence as well. (Sophie Fg 3)

They discussed the decision as one made not only in the context of the midwife-woman partnership, but within relationships with partner, family and friends. Some believed that where a woman initially wanted to birth, may be negatively impacted by their significant others, as might be expected given hospital birth is a social norm.

...like grandparents make it a huge ordeal to begin with... and parents, so no matter what they say, you're going to birth in [the city]. (Kate Fg 1)

I think they make their decisions on their whanau and their peers. If they're younger... well their peers are the main people in their lives. (Hana Fg 2)

...we deal primarily with the women and sometimes it's the men that have the anxieties and the worries. (Maggie Fg 4)

Like-minded midwives

Midwives also make decisions in the context of collegial relationships, other midwives who share their philosophy and support women to birth in the primary unit. Bouncing ideas off their colleagues, either practice partners or the core midwives in the unit, reinforced their confidence to encourage women to birth there. Trust was gained for one in the rural setting by training together in emergency skills.

...and the perspective of your colleagues as well, you've got to have that... my team member that I have to work with all the time, she's like the same as me, we just bounce off each other, it brings confidence. (Kate Fg 1)

I trusted that, at [closed urban community PMU] and [semi-rural PMU] they would give me the right advice and encourage me to stay there rather than encourage me to transfer for not a good reason... you always had someone to bounce back. You see that is the point, I feel the confidence from them, they feel confident. (Sophie Fg 3)

Well you need that support don't you, that reassurance of that support. (Naomi Fg 1)

Trusting in the other midwife who would assist during the labour and birth was so important that if they lacked confidence in them, they would call in their back-up for support. Most of the midwives who worked in the primary units however, were thought to share a similar philosophy.

...sometimes if I'm not 100% confident in them, then our practice always has a yep, you'll call us in and we'll be there. (Mila Fg 1)

Certainly, I think the staff at [semi-rural PMU] and [other semi-rural PMU], they're all midwives that want to support primary birth, you know it makes a difference, they want to see normal, the women who choose to work there. (Di Fg 3)

...you do feel part of the team in a primary unit in a different way, they come in and you know, you talk to them, as a new grad that was so important. (Sophie Fg 3)

Confident, experienced

Like-minded midwives were viewed as not only necessary to sustain these participants confidence, but alongside exposure and experience in the primary setting, were credited for inspiring it in the first instance. Megan highlighted the importance of confidence in promoting the choice of a primary unit, as she works toward gaining it.

I think my primary belief in primary birth came from being a new grad and having... who'd been a primary birth midwife what 30 plus years, she mentored me through my first year of practice... so I was grounded in primary birth from the get go... imagine if you did that for every new grad... I think our primary birth rates would go through the roof. (Isla Fg 1)

It does make a big difference to confidence. (Sophie Fg 3)

I guess I'm just one step away from feeling like I can really encourage them [women]... as a newish midwife... I need to gain in confidence of not having that red bell on the wall... so the more I do it the more confident I get definitely. (Megan Fg 2)

Their confidence, experience and for some, training, was purposefully portrayed to women. Believing that trusting the midwife who is confident in the primary unit, knows how and will act if needed, would reassure women they would be safe and well supported to birth in the primary unit.

I think a lot of it's my confidence for them to make a good choice about where they birth, and I'm clearly confident at the primary unit. (Maggie Fg 4)

... what if something happens and that's where I talk a lot about the trust in me as the care provider... I talk about our training... (Mila Fg 1)

... you're confident, you trust the process, you're experienced..., yeah definitely talk about training, that builds their confidence... you're well trained... if I didn't feel confident in you birthing your baby being here we wouldn't be here... they trust you. (Naomi Fg 1)

Yeah and that we will act. (Megan Fg 2)

Trusting

Trusting in the midwife to detect and act on the abnormal, was balanced by the belief that a normal birth can be expected. Trusting in the process and themselves to achieve it, was encouraged, and reinforced by highlighting that which is normal.

I push that you're normal there's nothing wrong, you know we're not anticipating for something to go wrong because everything's normal already. (Naomi Fg 1)

... building up the confidence of the woman in herself um, that pregnancy's normal and birthing's normal... I think I summerise it and I say, I expect the normal, but I'm on the lookout for the abnormal. (Maggie Fg 4)

... cause a lot of women want to stay out here [semi-rural PMU] because they actually believe in themselves. (Isla Fg 1)

...you haven't told your body to make your baby's eyelashes, but it did, you haven't said to your body okay now you need to make your baby's fingernails, so now you're not going to doubt your body's ability to birth. (Mila Fg 1)

3. Setting boundaries as a 'primary birth midwife'

Trust in the process, as described, revealed a strong normal birth philosophy and appeared to be underlying the midwives identifying themselves as a 'primary birth midwife'. Limiting their practice, such as not providing epidural care, enabled them to achieve a high primary maternity unit caseload. They supported women with risk factors during labour and birth in hospital and promoted the primary unit to those who met 'low risk criteria'. Some expressed a connection to their community, with a sense of belonging to their local unit. The importance to labour progress, and the perceived positive impact to birthplace decision-making of comfort and familiarity with the primary unit environment, was mirrored by their own comfort and preference to practice in this setting.

What we believe

A clear belief in normal birth is articulated and expressed by one midwife as the reason she can achieve a high primary unit caseload. It was the midwives focus and motivation for promoting the primary unit, with a lack of belief in normal birth assumed to be a barrier to other midwives having a high primary unit caseload.

I think a huge amount is about us... we have a high primary birth rate because we believe in primary birth. (Isla Fg 1)

Well I absolutely believe that birth's normal... I absolutely believe that most people should be able to have a normal birth. (Clare Fg 3)

I believe as midwives we are doing our best to actually promote the primary units... there's certainly some midwives that do believe that birth is normal, then there's other midwives who believe that it's complicated. (Hana Fg 2)

For me it just starts from the beginning in my [online] findyourmidwife profile just says that's our focus, my focus, so we're supporting you know safe, but healthy physiological normal birth. (Sophie Fg 3)

Limiting practice

With the exception of two, the midwives in this study limited their practice by 'opting off' holding the certificate required by the local DHB to provide epidural care in hospital. Expressed as a philosophical decision, two midwives spoke of the association with the cascade of intervention. They were transparent about this "right from the get go" (Hana Fg 2), differentiating their role from that of their colleagues in the hospital "because I'm a primary birth midwife" (Mila Fg 1). Women were therefore making an informed choice to book with them or choose another midwife.

I say I don't have an epidural certificate cause I'm not in the hospital enough... I just explain... how that can impact on normal labour and birth... I say you can but then I'm not the right midwife for you... we're experts in primary birth... and we can go into to [the women's hospital]... and that they're amazing at what they do but what they do is deal with emergencies and women that have complications. (Sophie Fg 3)

...the first conversation with me is always that I don't hold an epidural certificate. (Isla Fg 1)

That you're not that midwife... but I think that me and my practice because we're not epidural certified we talk about that at the start... we birth at these places so that's where we're we gonna go. (Mila Fg 1)

I bring it back to normal physiology, like epidural changes the whole dynamic... I say that before I book them... because I'm not epidural certified. (Megan Fg 2)

Should a woman require an epidural for any reason, they may stay in a support role, or leave if they had been with her, working for many hours. Di and Hana do have an epidural certificate but in keeping with their philosophy, did not offer one for pain relief but would continue care if an epidural was clinically indicated.

...you get the odd one at booking that says I want an epidural, and I say well I may not be the midwife for you then... like my philosophy is to support you through without having an epidural, cause I believe that anyone having a normal labour can get through without an epidural with good support. (Di Fg 3)

If they ring and say that they want to go to [the women's hospital] and they want an epidural, the same, I usually say I'm probably not the midwife for you, because I do have an epidural cert but I'll only offer you, or you can have an epidural if it's medically indicated. (Hana Fg 2)

...you're transferring into town and sitting with a woman with an epidural and somebody goes into labour, then you're not very fresh for that person. (Clare Fg 3)

Unlike most participants, Maggie did not suggest a woman find another midwife if she stated a clear preference for epidural in the beginning, "we can work with that" (Maggie Fg4), given information sharing was yet to happen throughout the pregnancy.

I think even when you book with women... they'll say well look I'm not the midwife for you, but that didn't worry me too much... (Maggie Fg 4)

Where we live

Beyond epidural, some limited their promotion of primary units to the one in their own community, while others offered more than one unit. In context, those who offered more than one primary maternity unit (and home), were centrally located in the city, although traveling out of the city to the semi-rural units was not necessarily practical for the woman or the midwife.

Because of where we live. (Naomi Fg 1)
...it's definitely about being our community. (Isla Fg 1)

...but I'm lucky because I'm so local [to the woman's home and semi-rural PM]. (Megan Fg 2)

.... it's a bit different for me because I'm more urban and I have a clinic in a separate area to a birthing unit... you know likely you're [a woman is] not gonna want to go across, right across town to the opposite place. (Mila Fg 1)

...we promote our practice as a local [community] practice... we all live in the area. (Ava Fg 2)

Two of the three midwives who had supported women in an urban [community] primary unit, now closed, continued to provide care to women in this community where they themselves live. Reporting that the loss for these women now having to opt for a primary unit that

although was not much further to travel to, was no longer within their own community, had resulted in some choosing hospital or home.

It's just the geographic around it that's changed so um I'm still looking after a lot of my returns. They were very very fond, they had three generations birthing there... and they've lost that, so it was like oh my god, where do I go. (Hana Fg 2)

...cause a lot of my clientele are very poor, and they used to bus there, I'm finding a lot more now birth at [the women's hospital], and then go home straight after birth. (Di Fg 3)

I'm sure most of your women used to birth at [closed urban community PMU] didn't they, cause that was like your home and now you haven't got a home. (Sophie FG3)

The term 'niche' used to describe their caseload however, not only referred to different community settings, but to those based in the city, attracting different types of women. Unlike the other participants who book women with risk factors within their community who would need to birth in hospital, one midwife did not. This midwife also promotes homebirth and has an entire caseload planning to birth out of hospital.

I do think we're lucky, cause we've all got our own little wee niche, and a lot of them will want to birth in their local unit. (Hana Fg 2)

60% of my case-load are Māori or Pacifica. (Mila Fg 1)

They're few and far between but I think there's probably more [women fearful of birth and midwives due to media]. (Di Fg 3)

I don't think I get many like that... I have probably 100% planning to birth at home or in a primary unit. (Sophie Fg 3)

No you probably don't because of your like niche, if you know what I mean... whereas I'm probably middle of the road sort of thing. (Di Fg 3)

Environment safe & familiar

The midwives practising in rural and semi-rural communities, held their antenatal clinics in their local primary unit. Regardless of where they held their clinics, there was consensus among the participants that exposure to this environment and the staff, enabled a comfort and familiarity that would increase the likelihood women would choose to birth there. This was recognised as important to the progress of labour, as previously discussed. For those in the city who had antenatal clinics elsewhere, this meant doing a tour or one-off appointment

in the unit the woman was considering or planning to birth in. A virtual tour online was not thought to be a substitute for gaining a 'feeling' of comfort.

Because I do antenatal clinics here, so this place becomes a safe and familiar environment for the woman throughout their 40 weeks of antenatal care. (Isla Fg1)

I'll try and do that labour birth talk at that unit and so because a lot of them will have looked online and be like oh yeah we've looked around but it's not quite the same... it comes down to that familiarity. (Mila Fg 1)

They say, even if they've been undecided, I just feel really comfortable here, I think I will come here. (Clare Fg 1)

I have just started doing a clinic at [urban PMU] as well so in the last four weeks, usually if they've finished work by that time, I can do a tour with them and that usually cements it. (Hana Fg 2)

Just as comfort and familiarity with the primary unit was thought to influence women's decision-making, so too was the midwives' own sense of comfort to practise within this environment. This was revealed to be another factor, alongside those discussed such as research, confidence, and their belief in normal birth, enabling them to promote birth in primary units.

I think if I was a woman pregnant and I looked at a midwife who had so much trust and belief in this primary birthing unit then it would sway me... We've got rid of the bed and we've got the couch and we go into it and people go to me oh wow this is really calming... a relaxed... non-clinical feel, that's made a massive difference. (Isla Fg 1)

I've always, that is my comfort, I've always felt really comfortable in that environment and less so at [the women's hospital]. (Ava Fg 2)

I hate that red bell... it's gonna be mad, everyone's gonna come in. (Hana Fg2)

... try for the primary units for my own sake as much as theirs because don't want to be in there, you know it's nice to catch up, but I'd much rather stay out, why add to their busy busy board. (Di Fg3)

Because I'm hardly ever there [the women's hospital] I forget all the charts, I forget all the forms I'm supposed to do. (Sophie Fg3)

That's primary birth midwives for you. (Di Fg 3)

Low risk criteria

On the odd occasion, a woman may come to them wanting to birth at a primary unit, not having met the criteria. The midwives were clear about risk factors precluding them from supporting the choice to birth in this setting. As well as the woman, this was also about

keeping themselves safe as midwives. Raised body mass index (BMI) between 35-40 however, was one example among several risk factors they believed should not preclude a woman from birthing in a primary unit.

Talk about contra-indications of why you couldn't birth in a primary unit, we definitely have those discussions. (Naomi Fg1)

...we've got a client... she's got no Wharton's jelly around her cord so we're like arrr, and it's gotta be that your health care provider has to be comfortable in that position as well, cause it's never gonna work if it's not. (Mila Fg1)

...and all those guidelines are in place, you know, gives us a pretty clear indication of who's really not able to birth in a primary unit. (Clare Fg3)

For me it's about keeping me safe as well... safety is the primary key for everybody involved, you've gotta make sure you're safe too. (Jacinda Fg4)

...some of my clientele, like Māori and Pacific Island that BMI is a killer, I mean some of my women have a BMI of 39, maybe over, they still birth well... but I still can't birth them in the PMU. (Hana Fg2)

4. When it matters what we say: reframing safety & risk

The concept of safety and risk permeated midwives' discussions on place of birth. Excerpts demonstrate the participants understanding that for some women, regardless of a lack of risk factors, the primary unit would not feel safe. Acknowledging that some women sought them out because they wanted to birth in a primary unit, for those open to considering alternative to hospital settings, and some who initially wanted to birth in hospital, the midwives believed they were changing women's minds or at least contributing to their choice of a primary unit.

Transfer, the predominant risk discussed in association with the primary setting, was informed by local factors, demystifying urgency and assurance of the safety of the system. Beyond transfer, to further address women's fear of 'what if' something goes wrong, and counter the 'horror stories', positive language and stories, tailored to her social context and culture were utilised.

The risk of intervention associated with the tertiary setting, was clearly articulated and supported by research as described. Statistics were used to put low risk women off choosing the hospital, such as the caesarean section rate. One midwife described a careful balance in this, in case she needed to go to hospital, others also conveyed the expertise of their hospital colleagues, in complex care. For some, letting women know they did fit criteria to be in hospital was as close as they could come to revealing their dilemma, that it may be better for low risk women if they didn't have the choice of hospital. Despite this, or perhaps because of it, they employed other strategies or incentives, such as highlighting the need to transfer after birth in hospital, parking, and the quality of the food, among other ways they believed could influence the choice to birth in an out-of-hospital setting.

What we say matters

Women may seek out the midwives who participated in this study, for the same reason they were purposively sampled, because they support women to birth in primary units. They may have cared for family or friends, had them as their midwife for a previous birth(s), or simply want to have a local midwife or birth in their local unit. Some maybe fearful of childbirth, which may be deep-seated or come from others or media, as previously discussed. Some come with their mind made up to birth in hospital, and some “hang in the balance and what we say matters” (Di Fg 3)

For me I think sometimes it's the clientele that choose me, they choose me because they know that I go to a primary unit... they search me out because of that. I find that, most of the referrals are word of mouth, so I've looked after family and friends. (Hana Fg 2)

I think it's that deep seated fear when it's that medicalised perspective, maybe that's what we can't change, until they see the other side of it. (Naomi Fg1)

Fear and anxiety are often the reason they don't want to birth here. (Megan Fg2)

It's that information pre-pregnancy... you know I'm four weeks pregnant and I'm birthing at [the women's hospital]. (Kate Fg 1)

Probably because of what we say, it is because of what we say to the women, isn't it... what if I told you that staying away from [the women's hospital] is the safest thing. (Jacinda Fg 4)

I don't know whether we're doing it, they're changing their minds, what we say probably contributes to that. (Maggie Fg 4)

Risk of intervention

Provided women had an absence of risk factors, hospital was seen as a place to avoid. Many excerpts from the transcripts relate to the value the midwives attributed to the primary unit environment, such as those given for the subthemes Art and science, and Environment safe and familiar. Ultimately however, choosing a primary maternity unit meant not being in the hospital environment was the best way to avoid intervention. Di sharing that in her experience, most women wanted to birth vaginally and avoid intervention, regardless of planned place of birth.

...if they want to avoid intervention, you go somewhere there isn't any. It's a big call isn't it, to transfer for an epidural you know, if you haven't got one available down the hall, they don't really ask. You know women want to avoid, most women when you do the birth plan, say they want to get through it without intervention and drugs, I would say 95%. (Di Fg 3)

...well I really don't want to have a caesarean section, well the best thing you can do actually, is not even go in there [the Women's Hospital]. (Ava Fg 2)

I always talk about that cascade of intervention always happens at [the women's hospital]... just shown what you're likelihood of an episiotomy an epidural and what a caesarean is... even the research shows that staying away from [the women's hospital] is the safest option... It's where we sit on that risk fence isn't it I think, no disrespect to obstetricians, they do an awesome job but they just feel they need to be doing something. (Jacinda Fg4)

...they've been the risk, you know, it's iatrogenic... at a tertiary institution because intervention ends up happening... It is very difficult, well as the stats show it's very difficult when you're in a tertiary institution to keep it normal. (Maggie Fg 4)

Safety of transfer

As intervention was for hospital, transfer was the predominant risk talked about in relation to the primary units. Some using local statistics, transfer was discussed transparently with women to allay concerns. Reassurances they provided included that transfer is usually for non-urgent reasons, and that they did err on the side of caution and consider the distance. Further women could be confident in the system for ambulance transfer and help waiting at the hospital.

Cause they imagine it's always gonna be that huge emergency... we just tend to err on the side of caution, we know we've got a bit further to go so there's less leniency... I just find that's what they're worried about. (Megan Fg2)

Yeah, and once you remove that... we've got the wee indicators... it's not a drop and run and oh my god. (Kate Fg1)

...we've got the statistics... I go through those, these are the main reasons for transferring in, like the biggest percentage is delayed progress... You've got to consider the distance... so that's always in the back of my mind as well. (Ava Fg2)

...the ambulance transfer, they all want to know about that, how long it's going to take... 15% I quote, and then I say of those, probably only 10% is for fetal distress... you know you think damn, I didn't need to transfer but better that than damn, I should have transferred, that's what I always talk about. (Di Fg3)

...so, I can get an ambulance there within half an hour, seems to allay a lot of concerns, yeah. (Hana Fg2)

...I think that helps them aim for that primary unit or home birth... then they know that if they need to they can transfer, and they can have all the help they need. (Sophie Fg3)

Demystifying

Further to demystifying transfer, talking about emergency treatment and showing women the emergency equipment at the primary unit, was also an aspect of information sharing used to allay fear, along with the comfort and familiarity afforded by this setting, as discussed.

I tell them that 83% of women that start off at [semi-rural PMU], birth at [semi-rural PMU], and usually the reason we need to transfer is nothing acute... I reassure them that we've got the drugs for post-partum haemorrhage. (Jacinda Fg4)

... go through the resuscitaire is really important, turn it [on], just say that we do it for every single birth and just show them what it is so they like to see that so they don't get panicked... cause that's a massive thing for them, is what do we do if baby's, they're not concerned about themselves as such. (Kate Fg3)

When I show them the room, we talk about the resuscitaire... some baby's need a little bit of help and that's okay... just kind of make it real but not scary. (Megan Fg2)

Positive stories

Aware that information comes from sources other than health professionals, such as media and other people always willing to share a 'horror story', a number of the midwives referred women to a publication containing positive birth stories, advising them that soon they too would have a positive story to share. Exploring a previous birth experience or that of a friend, some offered an alternative perspective.

I remind my women to share their great stories... I get really frustrated... when I get on an airplane I don't expect the person sitting beside me to warn me of all the airplanes that crash during flight, so why would I disempower a women about to have a baby by

saying you could have a caesarean... empower women, tell them amazing stories... also what's that really cool magazine... that has all those amazing birth stories. (Isla Fg1)

They get this information from all these different areas. I always talk about that as well, how people love to share their horror stories and that's why I think 'Tummy Talk' works cause it's positive... and I always say when you have a good story you can share your positive story. (Sophie Fg3)

I really explore that last experience, it's a big factor... what she might be able to do this time that might make a different outcome... also picking up on where their friends birthed or their relatives... um were they normal when they embarked on labour and you know, we know statistically that actually what happened for your friend happens in tertiary units. (Maggie Fg4)

Positive language

Positive language was also used, even for ambulance transfer, with an enduring optimism toward promoting birth in the primary unit. Believing as the research indicates, that just by planning to birth in a primary unit, a woman was more likely to achieve a vaginal birth. Implying a different 'norm' or expectation to that of hospital and highlighting the value of having the choice of a primary unit, were other positive cues used to inform the birthplace decision.

I just talk to them as if that's what I expect them to do [birth in a primary unit]. I say I won't put my house on it but I'd put money on it that you'll have a much different experience this time, you won't be pushing for two hours, you know, that sort of thing. (Di Fg3)

Actually, a transfer, posterior babies love transfers... and can wriggle round... and you get to [the women's hospital] and they're fully and pushing... that ambulance ride was amazing. If you were already in [the women's hospital], there'd be epidural, and oxytocin and the cascade begins. (Kate Fg1)

I think there's so much stuff about things going wrong, not being safe... I think to balance it I say if complications arise then I'm really sorry but that choice may be taken away from you so I do put it in that way so they're like oh no, I hope nothing goes wrong so I have to go to [the women's hospital], putting it that way so turning it round... you have a choice but unfortunately if something arises. (Sophie Fg3)

Tailoring the information & culture

Language tailored to the woman's own socio-cultural context, along with positive stories and picking up on where friends or family birthed or a previous birth experience, as discussed, revealed application of decision-making theory to enable the information to be usable and relevant to women.

I can't say for your friend but statistically da da da, so making it very personal sometimes helps to. So, what their language understanding and beliefs and everything else, so women that think it's safer to birth at [the women's hospital], you might be talking a lot more about that aspect of it. I mean I think the guts of it's the same, but you do use different language, different terminology you know, more in depth with some and not others and pick up on their interest or lack of... at the same time you're trying to share the same knowledge (Maggie Fg4)

Māori or Pacifica... they'll either be one way or the other... I'm like mmm maybe this isn't normal, they're like yeah it's fine..., or they're the complete opposite they're like the doctor knows best... I'll do what I'm told... we have to do a lot of discussion around that. (Mila Fg1)

I don't concentrate on stats so much, some of my clientele, like you can tell it doesn't mean anything to them, like I just had a young pacific island woman this morning and she'd been to clinic cause she's a V-back and wants a normal birth, she's had 2 caesareans now... she said he was rattling off all these numbers you know, and they don't mean anything to her. They want to know oh my sister birthed here, my aunty birthed here, so it's tangible, they can see it happened. (Hana Fg2)

But I don't want to presume so I do kind of offer them everything... yeah, I'd like to read these research articles... cause you can tell, they're like oh yeah I'd love to have a book to read or they're like, really, you're gonna make me do homework. (Sophie Fg3)

Quite often it's the opposite sort of women that says she wants it... like someone that's maybe got a PhD that says oh don't worry about it. (Clare Fg3)

Balancing putting off

As well as research applied to the local context, such as the caesarean section rate, which is balanced by conveying the safety of transfer to hospital, the local system requirement to transfer from hospital after birth, was also thought to put some women off choosing this setting. The tertiary hospital is burgeoning because most women choose to birth there. To manage this, following a project to promote primary units, the local policy is transfer to wherever a bed is available for postnatal care. This is not a choice, the only way to guarantee not having to move, or the primary unit of their choice, is to birth there.

... a 100% if you birth at [the women's hospital]... you're gonna transfer with your baby and yourself back out to a primary unit, so you're worried about a transfer in labour but what about a transfer post-partum with your new baby, middle of the night..., and the other thing... they're not guaranteed a bed now, at [semi-rural PMU]. (Isla Fg1)

... and the thing that changes everybody's mind is when I say that after two hours you have to get into the car with your tiny little baby and who wants to do that when you've just had a baby... I think that is a really big motivator. (Sophie Fg3)

I do, and they know that, they say well I won't get a bed there [urban PMU] if I don't birth there so that's very real. (Hana Fg2)

The midwives voiced their frustration with the system of choice for low risk women. Choice of hospital was considered counterintuitive to the protection and promotion of normal birth. Two spoke of a booking system of the past, when women could only book to birth in hospital if they had risk factors. Some explicitly informed women that although it was their choice, they did not fit the criteria to be in a hospital because of their lack of risk factors.

We talk about low risk women and then if there's need in terms of indications for us to be at the tertiary unit, yup, cool, we'll talk about that, otherwise if everything's normal we've got all these units. Like [the women's hospital] is for people who are unwell, have complications or have babies that are unwell, you don't fit any of those criteria. (Mila Fg1)

I agree, I say to my clients, without pushing them in one direction... those rooms are for unwell women, that's why you need to leave promptly after your normal birth there, a lot of them get put off by that as well. (Naomi Fg1)

It's not, well it shouldn't be a right to go into a hospital if there's no complication. (Ava Fg2)

I wish in a way there'd be a directive from, like the old [closed urban PMU] booking committee. (Hana Fg 2)

Influencing, incentives

Choice however, dictated the necessity to promote birth in a primary unit, which is after all the woman's decision. As carefully as they qualified this, they also reflected cautiously about their terminology in relation to their level of encouragement, aware that some incentives they were citing to influence her decision, such as the parking and food, may be considered extraneous to place of birth decision-making. Believing what they said could influence the decision for some women, discussed under the subtheme 'What we say matters', they set out to stimulate her prerogative to change her mind.

That's probably my first seed planted, putting the booking form in, just seeing the feelers of what they're feeling. (Isla Fg1)

I think changing their minds actually... and it's not because we're coercing them, it's because they realise themselves... (Naomi Fg1)

Yeah, I think changing their minds, yeah definitely. (Kate Fg1)

...kind of work on it, not work on it but I leave it open... I can point them in the right direction... I feel as though talking women into it, I don't want to feel like that... I definitely encourage. (Megan Fg2)

And it's interesting isn't it, I guess words like persuading, so I do consciously try and persuade or share or encourage because that's so much more likely to get a normal birth for her. (Maggie Fg4)

Sometimes it's like selling insurance. There are times, like I do use coercion with the parking... I know I'm naughty, but I do sell it [urban PMU] by the food. (Hana Fg2)

5. Delaying & diverting, a malleable approach

In order to allow time for a relationship to develop, exposure to the primary unit environment, and information sharing that may lead to a woman feeling safe and comfortable with the primary unit or dissuaded from hospital, these midwives were prepared to delay the birthplace decision right up until labour. They described being cautious to avoid undue pressure to choose a primary unit, revisiting the birthplace discussion throughout pregnancy. Regardless of planned place of birth, after keeping them at home as long as possible, they gave examples of initial assessments in the primary unit resulting in a woman changing her mind. Delaying the decision, in addition to complications arising during pregnancy or labour that may necessitate a change to the planned birthplace, would seem to indicate a remarkably flexible approach taken by these midwives, to supporting women in their chosen (or clinically indicated) place of birth, "all I need to know is where I'm driving to" (Hana Fg2).

Delaying the decision

A surprising finding, for women who were unsure, or those who initially wanted to birth in hospital, the midwives advocated delaying the birthplace decision until labour. Reassuring women they were booked at both the hospital and the primary unit. By keeping their options open, the midwives had more time to develop a relationship of trust and share information to build her confidence in herself and the primary unit environment, as described under previous subthemes.

I always reassure them um... that I book them everywhere and they don't have to decide till the day they're in labour. (Di Fg3)

I love keeping it open till the last minute... and find out what their fears are... cause often it's just about information sharing... even like last night, we were still having that conversation in labour at her place about where she was going to birth. (Megan Fg2)

... some make the decision pre-labour but for some it's on the day. (Jacinda Fg4)

I just keep saying, don't make a decision now... we can put a booking in for you at both places and you can decide at the time, whatever feels most comfortable, you know just feeding in feeding in... so only you can know that, and you may not know it till you're in labour. (Maggie Fg4)

Revisiting

Consequently, the choice to birth in a primary unit for some women, may be a continuum as the midwives' revisit the place of birth discussion, 'feeding in' throughout the pregnancy.

So, I usually think at booking, usually after the anatomy scan, again at 32 weeks... and probably just every time I see them after that... you know it's part of that filtering it in through the whole thing. (Di Fg3)

... and then each visit you're not, not necessarily every visit but you re-visit it in some form... revisiting that place of birth through the pregnancy as she becomes more and more confident in herself with her pregnancy and what's happening. (Maggie Fg4)

...kind of leave it at that then and revisit it later. (Ava Fg2)

No pressure

Another aspect of revisiting and delaying the place of birth decision, is removing the pressure to decide. One midwife sharing feedback that had raised her awareness of generating a perception of pressure, in promoting the primary unit.

But I think taking the pressure off the decision, the timing, like some are clear cut, but the ones that are not sure, I think they're more likely to make a decision to birth here if you take the pressure off, like I'm not trying to push you... letting them know if they're not sure, there's no pressure. (Megan Fg2)

Well I would hate to think that anyone felt pressurised to being at [semi-rural PMU] or forced into being at [semi-rural PMU], I have had a couple of women in the past who have said, who felt that we were pushed that way. (Jacinda Fg4)

... so don't worry about it, it will sort itself out and you'll know. (Maggie Fg4)

Keeping them at home

The 'time honoured' skill of encouraging women to stay home as long as possible was employed to avoid unnecessary intervention, such as epidural for pain relief. The midwives gave examples of how this could avoid a transfer to hospital or hospital altogether.

Anticipating that labour will progress in the comfort of her own home so she can gain confidence in herself and the process. Further, that cervical dilatation may reach the point where the primary unit is the better option due to its proximity to the woman's home.

So often the crux of it that I think that helped was that if they were confident enough to spend as much of their time in early labour at home... and they were confident cause they were progressing, and they were doing okay, and they were hanging in there and it was horrible, but it was OK (Maggie Fg 4).

...we do lots of home assessments in labour... so, you know you might plan to birth at [the women's hospital]... and then you're doing really well... I've done this much at home, like why would I go to a hospital you know, over a birthing unit... so you know they've already got that confidence in themselves. (Mila Fg 1).

So, I go to someone at home and they're 8cm, so I say it's a waste of time you going to [the women's hospital]. (Di Fg 3).

Diversion

Although birthing in the car on route to hospital maybe considered a risk, relative to the distance a woman lives from hospital, an initial labour assessment in the primary unit was not advice exclusive to the rural community. Applied to all for the comfort the environment itself was thought to afford, and the confidence gained in herself and the process by progressing in labour, previously discussed. This alongside the discomfort of travelling in a car, may mean a stop off in the primary unit on the way to hospital could result in a woman changing her mind in labour.

...those early assessments, you need to do an early assessment at home or in the unit [closed urban-community PMU], it's always good. (Hana Fg2)

*So even if they were planning a hospital birth? [Moderator Fg3]
Yeah, a labour assessment, yeah. (Hana Fg3)*

...if they choose to come here and be assessed in early labour... firstly, cause our women are quite rural, rather than driving all the way into town we'd often come here and do a labour assessment. I don't think I've ever had a woman that's chosen to birth in town, come here [semi-rural PMU] that at any point in the labour has said we need to go to town. (Isla Fg1)

Actually, the other tool that I use... and most of us do it in our practice, is we meet at the [semi-rural PMU] unit first to do that initial assessment and that makes a huge difference. (Ava Fg2)

I think they just get here and they realise that actually... I dunno, they get into that birthing room and I'm relaxed, that they feel safe, they don't want to get in the car. (Naomi Fg1)

Malleable

The findings cumulatively demonstrate a marked commitment from these midwives, to promoting birth in the primary unit, from throughout pregnancy right up until labour. Despite this and their impassioned belief the primary unit is more likely to result in a normal birth for her, at the end of the day being with the woman is what matters most. A change in the planned place of birth can occur anytime, sometimes due to a complication and sometimes not, but a decision to be equally supported regardless.

I don't mind where you birth, I'll follow you no matter what where ever you go. (Kate Fg1)

...you know I always tell them you know on the day that you go into labour if something in you is saying somethings not quite right or if there's something in me, if I'm seeing something maybe that's not right, then we're not locked in anywhere, we book you in everywhere for a reason. (Mila Fg1)

And they get it, sometimes when they're in labour when it changes, you know we can't change that... [or] they may say, I've changed my mind, I want to go to [the women's hospital] or um I want an epidural, so we just work from there... then we go. (Ava Fg2)

...it's not making them feel like they are stuck in this decision, that they've made this decision, and this is it... (Megan Fg2)

Because it is a working malleable, like in your situation last night, you might have a birth plan, but it might not necessarily stick to that. It goes on decision points doesn't it, like she was fully dilated, lets we go to [semi-rural PMU]. (Hana Fg2)

Summary

While some women will want to birth in the primary unit, the midwives in this study negotiated the paradox of promoting this setting to women who believe it is safer to birth in hospital, despite wanting to avoid intervention and have a normal birth. They understood the need for a woman to feel safe, regardless of her chosen place of birth. By providing evidence-informed choice, within a model of partnership, they believe that some are less inclined to choose hospital and gain the trust and the confidence necessary to choose to birth in the primary unit. 'Reframing safety and risk' is a central theme, with four others demonstrating the participant's application of existing midwifery theory and other ways they have adapted, to counterbalance this dominant discourse. In the next chapter I bring these ideas together; I will show the relationship between the themes and provide my perspective on the contribution this work makes.

Chapter 5. Discussion

Overview

In chapter 4, five themes were presented. In this chapter I will show how these findings can be placed within the body of knowledge on birthplace. The qualitative descriptive design effectively enabled description of how midwives with a high primary unit caseload, discuss place of birth. The appreciative inquiry lens illuminated what these midwives think works to encourage women to choose this setting, and there are two key areas of contribution.

Firstly, the three themes derived from deductive reasoning that relate to existing theory around ways of knowing, trusting relationships, and safety and risk, support current research, particularly that undertaken in Aotearoa New Zealand. Conflict between the medical and social models of childbirth are consistent findings. The second key contribution brings to the fore the notion of paradox in practice.

The two inductively derived themes around setting boundaries and a malleable approach, propose that the midwives manage their practice within the complex maternity landscape described by current theory, and that with considerable skill, manage to integrate contradiction and uncertainty. One can see this, for example, in how they work two paradigms of practice, both a medical and a social model of care. Another example is their need to set tight boundaries around their practice to enable them to support women to birth in the primary setting, whilst on the other hand remaining entirely malleable, ironically for the same reason.

Reflections on the research process ensure the recommendations for practice are viewed in the context of the study's limitations. More research is needed to understand how midwives embody paradox in practice, how this can be taught or mentored, and how the maternity system might facilitate more midwives to be confident managing it.

Dancing between worlds

The medical model of childbirth, based on techno-rational theory, assumes that birth can only be normal in retrospect. Aimed at controlling the outcome, risk is managed by surveillance, technology and intervention (Scamell & Alaszewski, 2012; Skinner & Maude, 2016). The paradox here is that risks by nature are uncertain, and that these measures themselves create risk. The social model of childbirth contends that those likely to have a normal birth can be predicted. This may be the case for most, based on the evidence of outcome studies confirming that the majority of women who plan to birth in a primary unit do so, but some will need transfer to hospital.

Modern western society wants control and certainty over outcomes, but in reality, “the only thing that we can be certain of, is that nothing is certain” (Skinner & Maude, 2016, p. 39). Nevertheless, risk management is now imbedded in maternity care. Midwifery, based on sociocultural theory, has had to incorporate it into practice. Midwives must manage risk, and at the same time promote normal childbirth, neither of which we can be certain. Moreover, this is complicated by fear and anxiety about the risk of something going wrong, the biproduct of this approach for both women (Coxon et al., 2014; Fisher, Huack & Fenwick, 2006), and midwives (Dahlen & Caplice, 2014; Scamell & Alaszewski, 2012). Within this context, medical knowledge holds the dominant and authoritative form (Grigg et al., 2014). Regardless of our ideology, in the aftermath of a serious event, this tends to be the source that people revert to (Skinner, 1999). It is unsurprising that within this risk averse consumer driven culture, most women in western countries choose to birth in hospital and may not be well informed of alternative to hospital settings, by some health professionals.

Midwives supporting women to birth in primary units have been described as having a greater sense of having to “carry the can” (Hunter, 2003, p. 239). Although concerns were not raised about a greater level of responsibility or blame should something go wrong, as found in the aforementioned studies, the midwives in this study did practise within the guidelines set by the local DHB in order to keep themselves (as well as the women) safe. They voiced frustration with what they considered were overly restrictive ‘low risk’ guidelines. Moderately raised Body Mass Index (BMI) for example (35 - 40), could preclude the option of a primary unit for

some women (Knox, Crowther, McAra-Couper, Gilkison, 2018). The “ever narrowing window of normality” (Scamell & Alaszewski, 2012, p. 207) has been attributed to risk categorisation and management where normality could only be defined by midwives in a study, as the absence of imagined unwanted features, despite their low probability. As such, in keeping with the medical model of childbirth, normality could only be said to exist in retrospect (Scamell & Alaszewski, 2012).

The inadequacies of techno-rational theory applied in childbirth have been exposed in research (MacKenzie Bryers & van Teijlingen, 2010). Skinner and Maude (2016), propose a new theoretical model represented by a three-legged birthing stool that addresses the theoretical gap of complexity and uncertainty, and fits within the social model underpinning midwifery (Skinner & Maude, 2016). In the current study, remaining flexible by delaying the birthplace decision to allow time for the women to develop ‘trusting’ within the midwife-woman relationship, reveals tolerance of uncertainty. Further complexity, accentuated by Skinner and Maude’s (2016) description of midwives as relationship and ‘paradigm brokers’, was born out in the stories shared by the midwives in the current study.

The central theme *‘When what we say matters: reframing safety and risk’*, demonstrated some of the ways the midwives attempted to assimilate the social model of childbirth into birthplace decision-making with women who wanted to birth in hospital ‘just in case’. Aligned to the findings of the NZ arm of the Evaluating Maternity Units (EMU) study, they described women coming to them with their minds made up to birth in hospital (Grigg et al., 2014), while others wanted, or as believed by the midwives in the current study, could be persuaded by factors such as the attributes of the primary unit environment. This too is supported by a finding of the EMU study where the decision to birth in a primary unit was significantly more likely to be influenced by a midwife for women who chose this setting, rather than those who chose hospital (Grigg et al., 2014).

A sense of safety was thought to be pivotal to birth place choice, as has been found in other qualitative research (Borrelli et al., 2017; Coxon et al, 2017; Grigg et al., 2014; Pithchforth et al, 2009). Interestingly comfort was voiced as a euphemism for safety and was used interchangeably by the participants. This was thought to be afforded by familiarity with, or

exposure to the primary unit environment for some women (Borrelli et al., 2017; Grigg et al., 2014; Wood et al., 2016), and midwives (Hunter, 2017; Lavender & Chapple, 2004; McCourt et al., 2012). These studies report factors that enable or support birthing in a primary unit, but not birthplace discussions women have with their midwife. Also common to all however, and articulated by the midwives in the current study, is a strongly held belief in normal birth and the woman's ability to do so under her own steam. Although this may seem fundamental to midwifery and a social model of childbirth, it is likely more easily enacted in out of hospital settings (Davis & Homer, 2016; Miller & Skinner, 2012; Smythe et al., 2009).

Promoting trust in your body's ability to grow and birth a baby naturally is contradicted by the requirement of midwives to offer an increasing number of options for antenatal testing and surveillance to screen for risk factors, many of which have become routine. Dahlen (2014) poses the following analogy "has modern maternity care morphed into a super trawler of risk, scooping up with its well-meaning 'net' the bycatch (healthy, young, childbearing women)" (Dahlen, 2014, p. 66). Even the conversation itself, regardless of the unlikelihood of a risk factor occurring, can serve to heighten fears (Scamell, 2011; Van Wagner, 2016). Like the informants in Van Wagner's (2016) study of 'risk talk', the midwives in this study used positive language, whilst assimilating with contemporary maternity care, for example *"I think there's so much stuff about things going wrong, not being safe that I then say, you know the anatomy scan was perfect, there's nothing wrong with baby, and everything's okay with you"* (Sophie, Fg 3). Positive stories were used as a measure to counteract the 'horror stories', shared indiscriminately with pregnant women. As well as tailoring the information to the women's sociocultural context, Tupara (2008) also advocated this use of language and decision theory in a discussion paper, akin to her research.

Another finding in common with New Zealand research is the impact of the geographical location of primary units (Patterson & Skinner, 2015). The distance to hospital also influencing birthplace decision-making in this study. The midwives were mindful of the distance and relayed the need for women to be reassured about the time the ambulance would take, and the safety of the system. Confidence in the system was identified in the EMU study, to be a factor facilitating the choice of a primary unit (Grigg et al., 2015a). Reframing safety and risk, the midwives were transparent about avoiding the risk of unnecessary intervention in

hospital, such as the high caesarean section rate, balanced by conveying the safety of the system of transfer from the primary unit, should intervention be required.

Transfer was also discussed transparently in most aspects, with the reasons, urgency and outcomes they shared, aligning to research findings (Grigg, Tracy, Tracy, Schmied, & Monk, 2015b). This was to demystify 'what if' and how emergencies are portrayed in the media, "*I think because they watch that 'One born every minute' and they're like lights on and it's all tension and all that kind of stuff*" (Naomi, Fg 1). The negative influence of media, like the horror stories shared with pregnant women, reflect society's inclination to dramatically depict birth (Sanders & Crozier, 2018), and grossly overestimate risk (Van Wagner, 2016). Closely related to the theme '*Trusting in you, me and the process of childbirth*', they reassured women of their skill, experience and the equipment to manage emergencies in the primary unit. Several also spoke of the high level of skill of the doctors and midwives in the hospital to manage complex care, should they need to transfer. The rate of transfer may have been underestimated for first time mothers, given the differences between nulliparous and multiparous women were not clarified.

The midwives voiced that the support of their practice partners and the core midwives who work in the primary unit, was important to their own confidence. They trusted not only the skill of their colleagues to manage emergencies, but also to share similar beliefs about supporting normal birth. Like-minded midwives have been reported to be important to supporting birth in out-of-hospital settings in other studies (Hunter, 2017; Lavender & Chapple, 2004). There was consensus in how the midwives discussed place of birth except for two of the participants with diverging views, in only two of the 26 subthemes. This, and the content of their discussions suggest they share a similar ideology, identifying with a social model of childbirth. This was theorised in the EMU study to apply to women who chose to birth in primary units (Grigg et al., 2014). Also like the women who chose this setting in another part of the EMU study, these midwives were clearly confident in the process of childbirth, the system, and the primary unit itself (Grigg et al., 2015a).

This contrasts with how the midwives discussed women who chose to birth in hospital, articulating a 'medicalised' perspective. Women choosing hospital birth have been found to

identify with a medical model of childbirth (Chadwick & Foster, 2014; Coxon et al., 2014; Grigg, et al., 2014). Whether or not this is also a factor for some midwives, as found in other studies (Henshall et al., 2016; Houghton et al., 2008; Scamell & Alaszewski, 2012), cannot be speculated. This is due to the homogenous sample of midwives (all had a high primary unit caseload), intended to ascertain 'what works' rather than the barriers. A lack of an informed choice regarding the option of a primary unit by some health professionals however, was a concern voiced by midwives in this study, as it has been in others (Pitchforth et al., 2008; Houghton et al., 2008). Relationships with women, whanau and other health professionals, represented another potential conflict for the midwives to negotiate in their practice, as they endeavor to encourage women to choose an out-of-hospital setting.

The midwives acknowledged that women are informed by sources other than their midwife. This included media and the internet, as identified in the literature (Hinton et al., 2018; Thompson & Wojcieszek, 2012). '*Woman, art, science and research*', a theme that encompassed the midwives '*Ways of knowing*', further demonstrated contradiction for the midwives. This is because science and research support their belief that an out-of-of hospital birth leads to better outcomes for women. Women on the other hand, who inform midwives about their beliefs and preferences, are strongly influenced by socio-cultural factors resulting in most choosing to birth in hospital. Some studies have reported women opting for intervention from a 'menu' of childbirth choice (Douche & Carryer, 2011; Saunders & Crozier, 2018; Scamell & Alaszewski, 2012), while others suggest most women want to avoid intervention (Patterson et al., 2017), as voiced by a midwife in the current study. The midwives used the evidence from both research and local facility outcomes as a tool in a 'hit home' approach, some providing their own resources. Supplying and referring women to literature or evidence based on their expectations or fears about childbirth, has been reported in another New Zealand study (Davis & Walker, 2010).

Information sharing was enriched by that area of midwifery knowledge that concerns itself with combining art and science. Among others, a good example of this was "*I talk about physiological... explaining how baby does its thing for them to fall in love with how their body does things naturally and normally, they're always amazed with how baby does all its twists and its turns to come out., and that's exciting*" (Megan, Fg 2). Such information sharing that

constructs childbirth as a normal physiological process and the maternal body as 'competent' was described by Davis and Walker (2010). They suggested this was particularly important in rural areas, so women had the confidence to birth in a geographical area distant from the hospital. Information sharing between the woman and the midwife reflects the foundation upon which the New Zealand model of partnership is based (Guilliland & Pairman, 1995).

In the current study, a trusting relationship based on partnership was thought to be particularly advantageous to promote the choice of a primary unit, *"(rather) than saying it's a joint thing, at some point there might be that balance but at some point, its more midwife driven and should become more women decision-making"* (Di, Fg 3). This excerpt implies an evolving relational rather than autonomous model of decision-making, commonly advocated in defining informed choice, including for maternity care (NZCOM, 2016). Relational decision-making was described by midwife-women pairs in a study where the participants believed decisions were made within the midwife-women dyad (Noseworthy et al., 2013). The midwives in the current study believed their established relationship enabled informed decision-making that could lead to the choice of a primary unit. Unlike the Noseworthy et al. study, they qualified this without exception with the women decides. The different focus however, that of delivery of the placenta, likely accounts for this as the decision related to a clinical intervention (giving an ecobolic or not), performed by the midwife (Noseworthy et al., 2013).

The midwives experience of encouraging women to birth in a primary unit, fits with New Zealand research. Specifically, having to shift between paradigms, in an evolving process of (birthplace) decision-making, tailored to the woman's socio-cultural context. This supports the application of childbirth risk (Skinner & Maude, 2016), decision-making (Noseworthy et al., 2013; Tupara, 2008), model of care (Davies, 2017; Guilliland & Pairman, 1995), and place of birth (Davis & Walker, 2010; Grigg et al., 2014., Hunter, 2017; Miller & Skinner, 2012; Patterson et al., 2017) theory, proposed by scholars within the context of the unique continuity model of maternity care (Grigg & Tracy, 2013).

In the next section that compares the two inductively derived themes, this study offers something new. As well as the New Zealand model of maternity care included in the research

context in Chapter 1, how self-employed midwives working within this model of care might fashion their own practice, was also briefly described. There is however, a lack of research to reveal these possibilities. Although how midwives manage their practice was not looked for, other than the potential of a shared philosophy, the themes unexpectedly provide some insight as the way the midwives commonly moulded theirs, emerged as one of the ways to support women to choose to birth in a primary unit.

Paradox in practice

The themes of '*Setting boundaries as a 'primary birth midwife'*', and '*Delaying and diverting: a malleable approach*', seem on the surface to be conflicting ideas. I did not recognise these ideas together within any existing theory. They were selected inductively from the data, as they presented as an area of interest in relation to the research question (Braun & Clerk, 2016). Some of the subthemes that formed the whole (theme), were nothing new, keeping women at home for as long as possible, and a strong philosophical belief in normal birth are two examples. Collectively however, with the more surprising subthemes of 'limiting practice' and 'delaying the decision', they formed something new. Comparing these two themes demonstrates a paradox in practice. This was the way these midwives managed their practice in order to achieve a high primary unit caseload.

As a surprising finding, setting boundaries was not something I had not looked for in the literature review. The iterative process intended by qualitative research (Barbour, 2011), subsequently led to a return to the literature to further inform this discussion. A practice dilemma that related to setting boundaries around epidural care, revealed in the current study, was located. The study titled "Should I stay, or should I go?" used the same qualitative study design and methods to describe midwives' views of continuing care when a woman chooses an epidural or handing over care to their hospital counterparts (Carpenter, 2018). This was a small study comparing the views of two LMC group practices. Both were sampled from urban practices, effectively controlling for geographical reasons for not providing

epidural care (Carpenter, 2018), given by some of the rural and semi-rural midwives in the current study (being available to the women in their community).

A consistent finding in both studies, was that the decision not to provide epidural care was predominantly based on philosophical reasons (Carpenter, 2018). Not providing epidural care represented one of the ways the midwives in the current study defined their boundaries as 'primary birth midwives'. The midwives were clear about their belief that they could support a woman to get through labour without an epidural. From the very beginning they articulated this to ensure women made an informed choice on booking. Except for one midwife, all stated that they would recommend the woman choose another midwife if she had pre-planned an epidural. This also indicated for the woman what the midwife's philosophy is, while for the midwife it increases the likelihood the women they do book, may choose the primary unit. Consequently, from the perspectives of the midwives, the primary unit represents a protective boundary from intervention for the low risk women in their caseload.

In the two studies that also took a positive approach, discussed in the last section, 'like-minded' participants shared a belief in protecting normal birth. Lavender and Chapples' (2004) appreciative inquiry and Hunters' (2017) phenomenological study, also demonstrated striking similarities in the strength the (core) midwife participants drew from working and mentoring in the environment (Hunter, 2017; Lavender & Chapple, 2004). Further, a paradox of practising within this setting was described in allowing normal labour to unfold while leaping ahead to safeguard from that which is not (Hunter, 2017). Here Hunter et al. refers to the unpredictability of childbirth itself. "Confidence as conviction" she concluded, was the balance that existed to enable and sustain midwives to support women to birth in a primary unit (Hunter, 2017). Developing confidence each time she supported a woman in this setting, one of the newer graduates in the current study believed, enabled her to promote the primary unit. The congruence of these findings, irrespective of the different focus, support the dependability of the current research.

The midwives overtly favoured the primary unit as their work place / space and 'comfort zone'. They not only identified with a social model of childbirth, but more specifically identified with their ('our') local community unit, referring to each other's as 'your home',

and 'your niche'. Alongside their lived experience of normal birth in this setting, it was my impression that this, rather than the evidence, may have been a main driver for most of the midwives to promote this setting. This may be part of the reason for their unanimously held belief that familiarity and exposure to the 'feel' of the primary unit could positively influence the woman's choice to birth there. This is supported by Woods et al. study that reported women had a visceral response to the Birth Centre, influencing their place of birth decision (Woods et al., 2016). For both the woman and the midwife, the importance of place and space, discussed in Chapter 1., has permeated this study. In relation to the theme *Setting boundaries as a 'primary birth midwife'*, if the primary unit is a boundary from intervention, such as epidurals, accordingly, it is a boundary around normal birth. From a midwifery perspective, this is portrayed by Davies et al. in her extensive philosophical study. She explained this connectedness to the built environment as a sense of ownership and belonging, being protective of their environment as the place to safeguard and be guardians of normal birth (Davies, 2017).

Other studies investigating the sustainability of (LMC) midwifery practice have also referred to midwives setting boundaries, but these were in relation to their availability and work-life balance (Donald et al., 2014). This was a factor thought necessary to avoid burnout (Young, Smythe, McAra-Couper, 2015), rather than defining a specific setting for practice. LMC midwives working with women in hospital settings have been reported to set boundaries from the 'obstetric gaze', creating a calm, women-centered protective space within the birthing room (Davis & Walker, 2010). Like the midwives in this study, the boundary may also be seen as separating the two dichotomous models of childbirth for women, but in which they the midwife will inevitably have to operate on both sides of, albeit to a lesser degree in an out-of-hospital birth setting.

Being 'with women', throughout the process of childbirth within the model of partnership, has been found to sustain midwives (Dixon et al., 2017; McAra-Couper et al., 2014). In contrast to setting boundaries around place of birth, the midwives were entirely flexible about the woman's birthplace decision, even during labour. In the theme, *'Delaying and diverting: a malleable approach'*, we see the midwives would go where ever the woman went "all I need to know is where I'm driving to" (Di, Fg?). This unlimited approach, although aligned

to the tenet of the partnership model, would seem to contradict their self-defining boundary as a 'a primary birth midwife'.

Findings in recent studies have led authors to raise questions about an evolving interpretation of the New Zealand continuity model of care. This is in relation to the current resourcing (staffing and funding) constraints (Carpenter, 2018), and sustainability (Davies, 2017). The issue is being addressed with the Ministry of Health via a new 'Co-design model', proposed by the NZ College of Midwives (NZCOM, 2017). In this context it may be that some midwives are drawing a line in the sand between primary and secondary (complex) care in response to workforce pressures and an increasing number of women with complex health needs (Eddy, 2019; Dixon, 2019).

So, I will clarify here, that in the current study with the exception of one who also promoted homebirth, the midwives booked women in their community with risk factors who would birth in hospital. They also continued to provide midwifery care in hospital to those who developed complex needs in pregnancy or during labour, in consultation with obstetricians and in collaboration with their core midwifery colleagues. Maintaining continuity after consultation, has been reported in other studies (Farry, et al., 2019; Skinner & Foureur, 2010). Two of the midwives continued epidural care if it was 'clinically indicated', but all had removed epidural from the 'menu' of childbirth choice in pregnancy. If a woman had an epidural for whatever reason, they may stay in a support role, or go if they had 'been up for a really long time'.

The place of birth decision was delayed, buying time for a trusting relationship and familiarity with the primary unit environment to develop. Further, the place of birth discussion was revisited, affording more opportunity for information sharing such as research, and for safety and risk to be reframed. Some women would never change their mind from choosing hospital. For women comfortable with the choice of a primary unit, or those who developed the 'comfort' and confidence to choose this setting, the option can be subsequently lost. A complication can arise in pregnancy, or the unpredictability of childbirth itself can necessitate the need for transfer in labour, "you make a plan and that can change" (Di Fg3). The midwives

tolerated this unpredictability and how they articulated this to a woman, may in turn support her to tolerate uncertainty.

They visited women at home in early labour, and / or diverted labour assessments to the primary unit, regardless of planned place of birth. This also allowed her time to develop confidence in labour progress and her ability to do so naturally. Although a surprising finding, this is in keeping with a recommendation arising from a contemporary study that sought the information needs of women when choosing where to give birth “Women wanted the option to discuss and consider their birth preferences throughout their pregnancy, not at a fixed point.” (Hinton et al., 2018, p.1). Another study reporting on an intervention (decision aids), included revisiting place of birth discussions throughout pregnancy (Henshall, et al., 2018). This same suggestion arises from the current study and is included next in the recommendations for practice.

Recommendations for practice and future research

A malleable approach and supporting women to tolerate uncertainty by exploring ‘just in case’ reasoning, are recommendations for practice stemming from this study. The experience of what works to encourage women to birth in a primary unit was shared by midwives with a higher caseload choosing this setting. Familiarity with the environment is an enabler for midwives, as it is women. Seeking support from like-minded midwives, using the evidence as a tool, use of positive language and stories, and relation decision-making are other examples. Revisiting the place of birth discussion throughout pregnancy is recommended. For some women, delaying the birthplace decision even during early labour, the midwives believed may buy her time to gain the confidence to choose this setting.

For midwives throughout the country to support the choice of primary units, there must be modern primary facilities available. The Ministry of Health advises consumers they are more likely to have a normal birth and less likely to have intervention by choosing an out-of-hospital

birth setting (MOH, 2016). The geographical configuration of primary units however, mean this is not a viable option for all women. The updating of existing facilities and building new primary units is constrained by limited health resources. Partnerships are being forged with community organisations toward the high-level general health strategy for all New Zealanders of 'Care Closer to Home' (MOH, 2016). Whilst midwives celebrate advances in care that have markedly improved childbirth outcomes for women with complex medical or obstetric needs, this is an opportunity to reverse the centralisation and medicalisation of maternity services for healthy low risk women, that has also occurred over the last century. We must therefore continue to lobby and raise awareness with women, so they stand alongside midwives to ensure there are primary units that meet the needs of the communities they serve.

More midwives need the opportunity to become familiar with the primary unit environment, mentored by those already confident in this setting. Education and drills and skills training alongside one another in the community setting is also confidence building. Like the midwives in Lavender and Chapple's (2004) appreciative inquiry, the field notes from the current study recorded the midwives demonstrated high morale, pride and motivation to support normal birth in a primary unit, factors important to the sustainability of the profession. Midwives need to share their passion and inspiration, their language and positive stories, not only with the women they care for, but with other midwives and doctors. We need to talk about what it is that midwives do when informing and encouraging women's choice to birth in a primary unit.

More research is needed to understand how midwives embody paradox in practice. How do we support more midwives and women to tolerate uncertainty? How can this be taught or mentored, and how might the maternity system facilitate more midwives to support more women to birth in out-of-hospital settings? Further, how can the acclaimed continuity model of maternity care, evolve in such a way as to sustain this? (Davies, 2017).

Significance of the study & reflection of the research process

The appreciative inquiry (AI) lens effectively illuminated how the midwives with a high primary unit caseload, encourage the choice of this setting. A good example of fit with this approach that differs from others in acknowledging the power of positive language (Lavender & Chapple, 2004), are excerpts of the midwives use of positive language and positive stories that generated the sub-themes of the same name. The qualitative descriptive design enabled the findings to stay close to the midwives' words, so they could be described in such a way they might further inform and validate the promotion of primary units. This research adds weight and something new to other qualitative studies, that alongside the quantitative evidence, comprise the place of birth body of knowledge.

The research process described, was not linear as it has been laid out in chapter 3. Although this might be expected in that the iterative process of qualitative research requires repetition in a more back and forth manner, it transpired to be a far messier process than I had anticipated. Midwives postponed participation when unexpectedly up all night for a birth, and the volume of data eventually generated appeared huge. Thematic analysis became more complex once I let go of my pre-conceived ideas and the re-coded subthemes appeared to be all interconnected but not defined. By adding an extra focus group, and the use of a software programme for analysis, these issues were resolved. Figure 2, a concept map displayed at the beginning of Chapter 2 to give a visual presentation of the findings, aided logical groupings and redefining of the themes.

A limitation necessitated by the size of the study, may have been using only one dimension as a lens (the discovery phase), of the four-dimensional AI method. 'What might be' however, in keeping with the intention of realising this using the full method (Cooperrider et al., 2008, p. 5), can be envisaged for a greater number of women from the insights of the midwives in this study. Another limitation of the study is a drawback of the focus group method. The data generated may reflect more consensus than would exist if the participants were individually interviewed, as participants may be influenced by each other (Kreuger, 1998). The candid nature of their responses however, would suggest honesty. Incentives they gave to 'sell' the

primary unit for example, that they considered should be superfluous to place of birth decision-making such as the parking and the food. Seeking “what do others think?” and reporting diverging views, although limited in number, demonstrates credibility. Another drawback of the focus group method can be the dominance of one or two participants (Morgan, 1998). To ensure all voices were heard, excerpts from as many participants as was practicable, formed each subtheme. That is, the prevalence of responses across all the participants was sought, in the selection of these during thematic analysis (Braun & Clerk, 2016).

As well as this, and the recruitment strategy of sampling midwives from different practices that access the four different primary units in the region, the findings may ‘ring true’ with what works for other midwives in the region. Qualitative research is not generalisable by nature, and any potential resonance may be limited to the region. Some of these findings however, may also resonate and / or inform midwives outside of the study setting both within New Zealand, and beyond. This is suggested because of the widespread nature of consumerism and risk aversity. Brought to the fore by this study, it is this socio-cultural context that generates paradox in practice for midwives promoting an out-of-hospital birth setting.

As an insider-outsider (not an LMC), the findings ring true from my experience as a midwife, practising across the different settings in the region. Like the midwives in this study however, I am not neutral and am committed to promoting primary units. Although I was aware of this and reflected throughout the research process to minimise my influence, this bias cannot be ‘bracketed’ from my perception through which the data was sought, generated and thematically analysed (Braun & Clarke, 2006; Tracy, 2010). In keeping with the research design however, I have tried to stay as close or ‘true’ to the participants words as possible (Sandalowski, 2000), in reporting these findings. Bias may also be present in the approach itself, that is, from the assumption that meaning is socially constructed, I set out to discover ‘what works’, and purposively recruited participants I believed could provide this insight (Morse, 2015). Such is the nature of qualitative research that is ultimately up to the reader to decide on its trustworthiness (rigour).

Conclusion

Appreciative inquiry looks first to discover what is already being achieved. Encouraging low risk women to birth in a primary unit is an evidence-based practice. As Eddy, now Chief Executive of the New Zealand College of Midwives challenges, it is not enough to “simply nod and complete the booking form when women tell us they want to go to the base hospital” (Eddy, 2017, p. 12). Least we be complicit in maintaining the status quo of assumed hospital birth. Providing a “seemingly neutral menu” of (birthplace) choice (Van Wagner, 2016), does not constitute an informed choice either. The midwives in this study were anything but neutral. Whether explicitly informed by evidence such as the outcome studies, or from tacit knowledge of ‘what works’, or even swayed by their own comfort in the primary unit environment, much of this has been shown to be supported by research in this discussion chapter. Midwives are obligated by their professional standards to provide both informed choice and evidence informed care (NZCOM, 2015; NZCOM, 2016), but this is fraught with complexity in contemporary midwifery practice.

The social recalibrations needed to adjust the hospital birth norm, fueled by a disproportionate focus on, and misguided attempts to mitigate risk, are much broader issues than midwives alone can change. Shared by the midwives in this study however, they can reframe safety and risk, demystify ‘what if’ something goes wrong, draw from midwifery theory, trusting relationships and trust in the normal process of childbirth, to counter hospital ‘just in case’ reasoning. The unpredictability of childbearing itself, and the complexity of having to dance between worlds with opposing ideologies, could be seen in the focus group discussions and stories. The midwives never complained about or even mentioned the contradiction of deciding to place firm boundaries around their practice, while at the same time remaining entirely flexible. In fact, they were resolute about this. They just got on with it, defying the socio-cultural norm of hospital birth, committed to protecting and promoting normal birth by promoting an out-of-hospital birth setting, effectively managing paradox in practice.

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Appendices

Appendix A. Focus Group Discussion Guide



How do midwives with a high primary unit caseload, discuss place of birth with the women they care for?

FOCUS GROUP DISCUSSION GUIDE

GUIDANCE FOR MEMBERS

- The information shared in this meeting is confidential. You should not discuss the opinions and comments made by other focus group participants with anybody outside this room, but I can't guarantee this. We would like you and others to feel comfortable when sharing information.
- You do not need to agree with others, but you should listen respectfully as others share their views.
- We would like to hear a wide range of opinions: please speak up on whether you agree or disagree.
- There are no right or wrong answers, every person's experiences and opinions are important.
- The meeting is audio recorded, therefore please one person speaks at a time, and do not identify others by name.
- Please turn off your phones

I'm not here to ask you questions, just the one then it's your group discussion. I will not chip in except to bring it back to focus with prompts if need be.

GUIDANCE FOR FACILITATOR

One question and points (prompts) if not raised denote the six broad areas of focus that this study is looking for (based on the literature), if not raised by the participants, see below. Points of view I have not considered that emerge and relate to the research question, will also be explored.

Opening question

I've chosen you to participate in this focus group because you all have quite a high proportion of your clients who birth in the primary units. Why do you think this is?

Areas to check are covered:

- How do you inform women about place of birth, what information do you provide; and what is the timing of the birthplace discussion and decision?
- Do you encourage or persuade women to birth in a primary unit, how proactive are you?
- How much about the birthplace decision is about you the midwife and how much is about the woman or midwife-woman dyad or others?
- Who really makes the place of birth decision, do you have different types of women or women from different cultures, and do you adjust your approach?
- What contributes to your confidence and what do you do (if anything) to support a woman's confidence, to choose a primary unit?
- How do you talk about risk and safety, transfer and intervention?

Cues: That's really interesting, can you tell me more about that?

What do the others think?

Note: How they talk to each other, body language / non-verbal communication

Appendix B. Victoria University of Wellington Certificate of Ethics Approval



MEMORANDUM

TO	Bronwyn Torraine
FROM	Dr Judith Loveridge, Convenor, Human Ethics Committee
DATE	23 January 2019
PAGES	1
SUBJECT	Ethics Approval Number: 0000025699 Title: Midwives share their experience of informing women's choice to birth in a Primary Maternity Unit

Thank you for your application for ethical approval, which has now been considered by the Human Ethics Committee.

Your application has been approved from the above date and this approval is valid for three years. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards,



Judith Loveridge
Convenor, Victoria University of Wellington Human Ethics Committee

How do midwives with a high primary unit caseload, discuss place of birth with the women they care for?

INFORMATION SHEET FOR PARTICIPANTS FOR FOCUS GROUPS

You are invited to take part in this research. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request.

Who am I?

My name is Bronwyn Torrance and I am a master's student in a Master of Healthcare programme at Victoria University of Wellington. This research project is work towards my thesis.

What is the aim of the project?

The purpose of this qualitative descriptive project is to describe how midwives discuss place of birth with women during pregnancy. As the study aims to focus on the successes of an approach an appreciative inquiry lens is used in order to explore the midwife's perspectives of how they support and encourage the use of primary maternity units. Taking an appreciative enquiry approach has enabled a re-framing of the research problem (most low risk women choose to birth in hospital where intervention rates are high), into a more positive light to examine achievement rather than failure.

This research has been approved by the Victoria University of Wellington Human Ethics Committee, application reference number 0000025699.

How can you help?

You have been invited to participate because you are a midwife with a high number of women in your caseload who birth at the primary units. If you agree to take part, you will be part of a focus group at Lincoln Hospital. I will ask you and other participants' questions about why you think this is and how you encourage women to choose this setting. The focus

group will take about an hour. I will audio record the focus group with your permission and write it up later.

The information shared during the focus group is confidential. That means after the focus group, you may not communicate to anyone, including family members and close friends, any details about the focus group.

You can withdraw from the focus group at any time before the focus group begins. You can also withdraw while the focus group it is in progress. However, it will not be possible to withdraw the information you have provided up to that point as it will be part of a discussion with other participants.

What will happen to the information you give?

This research is confidential. This means that the researchers named below will be aware of your identity, but the research data will be combined, and your identity will not be revealed in any reports, presentations, or public documentation. However, you should be aware that in small projects your identity might be obvious to other midwives in your community.

Only my supervisors and I will read the notes or transcript of the focus group. The focus group transcripts, summaries and any recordings will be kept securely and destroyed on 23rd December 2019.

What will the project produce?

The information from my research will be used in my master's thesis and/or academic publications and conferences.

If you accept this invitation, what are your rights as a research participant?

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- choose not to answer any question;
- ask for the recorder to be turned off at any time during the focus group;
- withdraw from the focus group while it is taking part however it will not be possible to withdraw the information you have provided up to that point;
- ask any questions about the study at any time;

- be able to read any reports of this research by emailing the researcher to request a copy.

If you have any questions or problems, who can you contact?

If you have any questions, either now or in the future, please feel free to contact either me or my supervisor:

Student:

Name: Bronwyn Torrance

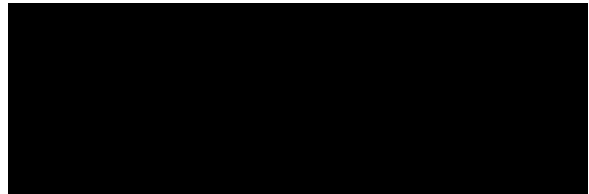


Supervisor:

Name: Dr Joan Skinner

Role: Honorary Research Associate

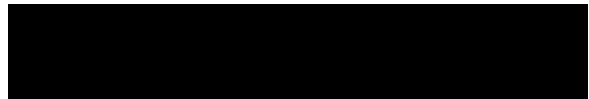
School: Graduate School of Nursing,
Midwifery and Health.



Name: Dr Robyn Maude

Role: Senior Lecturer, Midwifery
Programme Lead

School: Graduate School of Nursing,
Midwifery and Health



Human Ethics Committee information

If you have any concerns about the ethical conduct of the research, you may contact the Victoria University HEC Convenor: Dr Judith Loveridge

Appendix D. Demographic Data Form



How do midwives with a high primary unit caseload, discuss place of birth with the women they care for?

Demographic Data Form

Age	20-29 years 30-39 years 40-49 years 50-59 years 60 years +	Size of caseload per annum	<30 per annum 30-39 per annum 40-49 per annum 50-59 per annum >60 per annum
Ethnicity	Māori NZ European Other European Pacific Island Asian	Number of primary births per annum	<10 per annum 10-19 per annum 20-29 per annum 30-39 per annum >40 per annum
Number of years qualified	1-2 year 3-5 years 6-10 years 11-15 years >15 years	Primary maternity unit(s) you support women in	4 Options Removed
Area(s) of practise (women's domicile)	Urban Rural Semi-rural	Your name	(Will be changed to a pseudonym)

Appendix E. Consent to Participate In Focus Group



How do midwives with a high primary unit caseload, discuss place of birth with the women they care for?

CONSENT TO PARTICIPATE IN FOCUS GROUP

This consent form will be held for two years.

Researcher: Bronwyn Torrance, Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
- I agree to take part in an audio recorded focus group.

I understand that:

- I acknowledge that I am agreeing to keep the information shared during the focus group confidential. I am aware that after the focus group, I must not communicate to anyone, including family members and close friends, any details about the focus group.
- I can withdraw from the focus group while it is in progress however it will not be possible to withdraw the information I have provided up to that point as it will be part of a discussion with other participants
- The identifiable information I have provided will be destroyed on 23rd December 2019.
- Any information I provide will be kept confidential to the researcher and the supervisor,
- I understand that the results will be used for a master's thesis and academic publications and/or presented to conferences.
- My name will not be used in reports, nor will any information that would identify me.

- I would like a summary of the focus group: Yes No
- I would like to receive a copy of the final thesis and have added my email address: Yes No

Signature of participant: _____

Name of participant: _____

Date: _____

Contact details: _____