AN EXPLORATION OF THE REASONS WHY 10 WOMEN FROM CENTRAL VICTORIA CHOSE TO BIRTH AT HOME

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Abstract

Women in contemporary Australian society commonly do not choose home as a setting for giving birth. For example, in Victoria, out of a total of 61,102 births in 2001, 127 (0.2%) were planned home births. Home birth is a contentious issue in professional domains, particularly in relation to the issue of maternal and infant safety. However, research has concluded that there is no evidence to suggest that giving birth at home is any less safe than giving birth in hospital. The rural focus of the current study has identified that women residing in rural communities have fewer options for maternity care available to them than metropolitan women, and, increasingly, women living in rural areas are faced with having to leave their local communities to travel to regional hospitals to access maternity care services.

It is ironic that, although women are the consumers of maternity services, very little is known about what motivates their choices when accessing these services. In the absence of available evidence, this research seeks to understand the reasons why the women in this study have chosen to access the non-mainstream maternity care option of birthing their babies in their own homes.

The current research utilised a qualitative approach employing a micro-ethnographic methodology underpinned by feminist principles. A convenience sample of ten women residing in the area identified as Central Victoria and who planned to give birth at home volunteered to be participants. Triangulation of data collection methods was utilised involving participant observation and the compilation of field notes, in-depth semi-structured interview, and a focus group interview. Ongoing collaboration between the researcher and the participants was a major element in the analysis of the data generated. Four major themes emerged from the data as the reasons why this group of women elected to give birth at home: to incorporate beauty into their labour and birth; to honour the sacredness inherent in birth for mother and baby; to fulfil the need for partnership with the people involved in the labour and birth; and to provide an avenue for this group of women to bestow their knowledge concerning birth to posterity. These themes are in contrast to mainstream discourse concerning birth, which considers the medical aspects of birth to be paramount.

The current study, while consolidating what is understood about the choices women make when they elect to give birth at home, also presents new findings that explore the emotional context of birth identified by this group of women. This new knowledge concerning birth as an emotional experience prompts further exploration of the term 'safety' and the way it is entered into current

discourse concerning not only home birth but birth in any setting.

This study reintroduces language that has been gradually dislocated from professional dialogue into current discourse concerning birth, and emphasises the women's perspective of birth as, primarily, an emotional event in their lives. The use of terms such as beauty and sacredness reinforces the notion that labour and birth for this group of women was more than just a physical process to expel a foetus from the womb. The importance these women attributed to these emotional aspects of birth is evidenced by their desire to share and pass on their beliefs and experiences of the beauty and sacredness inherent in the event of giving birth. This desire by the women for their knowledge of birth to be respected and shared initiated the identification of the themes of partnership and posterity.

Understanding that emotions strongly motivate a woman's decisions in birth offers maternity care providers a new context in which to consider women's satisfaction with their birth experiences. Potentially, future surveys could ask women if they experienced beauty and sacredness in giving birth; or if their experience of birth is what they would like future generations of women giving birth to undergo.

The findings of the current research provide new understandings of why women in a rural location value the choice of home birth, and the context in which they make the choice to birth at home. This knowledge has the potential to contribute to the debate concerning the provision of birth options to women in rural areas, particularly the continuation of the structure of care these women accessed to achieve their births at home, as well as consideration of the creation of new models of maternity care to provide the option of home birth in rural communities.

Statement of Authorship

Except where explicit reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. No other person's work has been relied upon or used without due acknowledgement in the main text and bibliography of the thesis.

Lyn Kelson

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Dedication

I dedicate this work to my father, who, when he was alive, once told me I was too ambitious. I tend to agree with him now. However, like so many other things, I've left it too late to say.

This is for you, Dad.

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1. Introduction

This research seeks to understand the reasons why women resident in rural Central Victoria chose their homes as the place where they would give birth to their children.

Historically, a woman's home was considered the most appropriate venue for birth to take place, and much was made of birth as a social occasion, with rites and rituals to mark the event. Women would gather to give support to the labouring woman who would be attended by a woman experienced in birth. The birth attendant would use her acquired skills to assist the labouring woman during the birth and in the early days of mothering. Thus was born the role of the midwife: someone to be with a woman while she gave birth.

In contemporary society, the home is no longer accepted as the most appropriate venue for giving birth. The majority of births in Victoria in 2002 took place in a hospital; less than one percent occurred as planned home births. This transition—from birth in the domestic setting to birth in a hospital setting being the norm—has occurred over a span of 200 years, largely under the guidance and supervision of the medical profession with the intention of improving outcomes for both mother and baby.

The societal understanding of pregnancy and birth has also undergone significant change over this period, and has been influenced, to a large extent, by the medicalisation of childbirth that occurred simultaneously with the transfer of birth from the domestic setting to the hospital setting. In particular, advances in monitoring of maternal and foetal conditions during pregnancy and labour have led to an increase in the routine use of technological equipment in the process of childbirth, largely in the absence of evidence to substantiate its use (Tew, 2000; Wagner, 1996).

Debate surrounding improved outcomes in childbirth and the causal factors has been ongoing for many decades, and continues today. The change of birth venue from the domestic to the hospital setting, and the subsequent changes to the delivery of care are key topics within the current discourse concerning birth. The central focus of this debate has predominantly been the issue of physical safety in birth for both mother and infant, and the venue where this is best optimised. Evidence available to date does not demonstrate that one venue offers advantages over the other in regards to safety in birth, suggesting that both hospital birth and home birth should be offered as viable options for women when deciding where they will elect to give birth (Senate Community Affairs References Committee [SCARC], 1999).

However, the reality facing women when they seek to make choices concerning a birth venue does not reflect the available evidence. Medical dominance of maternity care in contemporary society significantly influences the options in childbirth that are made available to women. Medically founded systems have been developed to classify women into risk categories associated with their pregnancy and birth in order to recommend the most appropriate venue to give birth, as well as what type of practitioner is the most appropriate to provide care.

Typically, the medical fraternity considers that birth is best achieved in a hospital because of the medically defined understanding of labour and birth as inherently dangerous processes. The medically administrated options for care that are made available to women in childbirth, therefore, orientate women to give birth in hospitals.

Since the late 1980s, consultation with consumers of maternity services has identified factors that could improve maternity care. Particular consumer needs identified included increasing choice in childbirth, increasing the provision of continuity of care, and the redistribution of control over the event of childbirth to increase the involvement of the labouring women in decisions made relating to her giving birth (Health Department Victoria, 1990; National Health and Medical Research Council [NH&MRC],1998).

Providers of maternity care services have made efforts to incorporate these factors into the care options available through the introduction of various models of maternity care such as midwife care clinics; birthing centres; family birthing suites; and shared-care arrangements involving doctors, midwives, and obstetricians. However, these care options still direct women to give birth within a hospital setting and, thus, choice in birthing venue is not widely acknowledged or offered as as an option in childbirth.

Considerable disparity exists between the options for maternity care available to women who reside in metropolitan regions and those who reside in rural areas. Increasingly, rural women face having to travel considerable distances to access maternity care in larger regional hospitals where services have been centralised. Factors that influence the services available to pregnant women in rural areas include the ongoing rationalisation of heath care facilities that has seen some rural hospitals cease to offer maternity services. The recruitment and retention of appropriately qualified staff in rural areas is a significant factor in the provision of maternity services in rural communities. The maintenance of the skill levels of birth attendants in some rural hospitals—where only small numbers of births occur—has also been identified as a point of concern for the continuation of small rural birthing facilities (SCARC, 1999).

The safety of giving birth in small rural hospitals has also come under scrutiny because of the distance from and time taken to access emergency equipment and personnel. Many smaller rural hospitals have limited access to specialist doctors, such as anaesthetists and paediatricians, and facilities, including operating theatres and special care nursery. This has led to recommendations that women who are considered to have any risk in their pregnancy or labour commence labour at a hospital that can provide these services in case any complications develop. Obtaining these services generally requires that the pregnant woman leave her family and support structures in her hometown and travel to a larger regional centre for her care. This need to move away from home and family can seem extreme, particularly as the definitions of what constitute risk in pregnancy and birth are not standardised across maternity care practitioners or facilities. In addition, the indicators for risk classification have proven to be unreliable, as a pregnancy considered to be high risk may progress to a safe birth without complication, and a low-risk pregnancy may develop complications unexpectedly.

In this environment of medically administrated maternity care that focuses primarily on the medically defined safety of childbirth, there is a small minority of women who choose to move away from the societal norm of receiving maternity care in hospital and select their home as their preferred birthing venue. Research concerning what motivates women to make particular choices relating to the care they access in pregnancy and birth is not extensive, and there is a particular paucity in the knowledge that illuminates why women choose their home as the venue for giving birth. This research project seeks to address this knowledge deficit with particular emphasis on why women in a rural environment choose their home as the location where they will birth their children

A micro-ethnographic method has been chosen to conduct this current research, and feminist principles have underpinned the research process. Triangulation of data collection methods has been used, which included semi-structured individual interviews, participant observation and collation of field notes, and a focus group meeting. The sample size for this current research consisted of ten women who selected their home as their preferred place for giving birth, and who resided in the area identified as Central Victoria at the time they planned to birth at home.

A characteristic of this study is the ongoing collaboration with the participants during the analysis of the data, which has supported the feminist principles of the research. It is the intention of this research to add into the current discourse concerning contemporary birth practices the knowledge these women hold around their choices to birth their children in their own homes in a rural environment.

The literature review that follows will look at the history of birth place and birth attendants. It will describe the evolution of the care of women in pregnancy and birth into the system of contemporary maternity care available to women in rural Victoria. The existing knowledge concerning women's perspectives on maternity care will be reviewed with regard to the choices they make when accessing care in pregnancy and birth, particularly the option of choosing to give birth in their own homes.

2. Literature Review

> *However distressed the poor mother may be, she will always prefer her own habitations and the unbought, soothing cares of her own family during her hour of trial.*
>
> Granville (1819) (as cited in Oakley 1984: 219)

Over the past 200 years, maternity care has undergone significant upheaval. One of the most notable changes to have occurred during this time is the setting in which birth takes place. Traditionally, birth occurred in the domestic home of a pregnant woman; however, this occurs rarely in contemporary society. In Victoria, the first lying-in hospital where women could attend to give birth to their babies was established in Melbourne in 1856 (McCalman, 1999). Subsequently, public acceptance of the hospital setting for birth grew and numbers of home births gradually declined, and by 1950 virtually all women, except those in remote areas, birthed their babies in hospitals (McCalman, 1999). The hospital setting continues to be the predominant location for birth in contemporary society. Of births occurring in Victoria in 2002 only 0.3% were planned home births, 0.4% occurred as unplanned out of hospital births, 2.3% took place in a birth centre, and 97% of births took place in a hospital (Victorian Perinatal Data Collection Unit [VPDCU], 2002).

Another change to occur in maternity care over the last century has been the introduction of a variety of maternity models of care. The care of birthing women had traditionally been the domain of women midwives (Tew, 2000); however, over the past 100 years, the medical profession has dominated care increasingly. Medical dominance in the care of pregnant women has precipitated a societal shift in understanding of pregnancy from a normal life event to a medical condition requiring monitoring and treatment (Reiger, 2001; Tew 2000).

As a consequency of this shift in understanding, the predominant contemporary system of maternity care in Victoria is founded on the notion of pregnancy as an illness or altered state of health, and, as such, women are classified for their suitability to access the available models of care according to the presence of identified risk factors (Halliday, Ellis & Jones, 1999).

Consumer-led change was brought about in the late 1970s, when small numbers of women began to challenge the medical profession's authority to dictate to them the conditions under which they would give birth (McCalman, 1999; Oakley, 1984; Reiger, 2001; Tew, 2000). The raising of public awareness concerning dissatisfaction with maternity care through consumer groups resulted in the development of new models of care to try to accommodate the needs expressed by women who utilised maternity services (Reiger, 2001). In 1990, the Victorian government conducted the Ministerial Review of Birthing Services, which acknowledged the individual woman's right to make choices concerning the care offered to her during pregnancy and birth (Health Department Victoria, 1990).

There is a growing body of evidence that identifies the needs of women in childbirth, the factors that increased their satisfaction with allocated models of care, and where scope exists for improvements within the system (Brown & Lumley, 1996; Health Department Victoria, 1990; Reiger, 2001; Senate Community Affairs Reference Committee, 1999). However, there is little information available to identify why women choose a particular place/setting to give birth, or why they choose a non-mainstream model of care, or whether or not such choices are actually a reality for many women. To address this knowledge gap, this research project aims to gain a greater understanding of the choices women make in relation to the place they give birth by exploring and describing the reasons why ten women living in Central Victoria chose their homes as the venue to give birth.

2.1 An historical overview of birth location and attendants

Childbirth has long been recognised as a major event in the life of a woman and, as such, has been associated with rights and rituals that acknowledged the significance of this event (Kitzinger, 2000; Shaw, 1998; Tew, 2000). Central to many of these rituals was the presence of a trusted, caring, female attendant to assist and comfort the woman during the birth process through to the nurturing of her newborn child (Robertson, 1997; Tew). These attendants became skilled in providing care and support to women in childbirth and came to be known, over time, as midwives (Robertson). Usually, the women who performed this role came from within the family or the local community, and had experienced childbirth themselves. Childbirth, in this context, was the domain of women sharing a like experience (Tew).

Historically, the traditional place for birth to occur had been the home of the woman who was to give birth. In more recent times, the alternate setting of a lying-in home or hospital became available to women (Campbell & McFarlane, 1994; Tew, 2000). This shift from home to

hospital as a place to give birth brought with it a shift in carers. The midwife who had offered care and support to the birthing woman in her home was replaced in the hospital setting by a medical doctor, whose primary interest was in gaining understanding of the physiology involved in childbirth (Tew). The medical discourse that began with this change in birth setting began to focus on the event of childbirth from a purely physiological perspective, which held as its base premise that pregnancy was a pathological condition that required treatment (Cahill, 2001). In contrast to this medical ideology was the philosophy of the traditional midwife, who believed that a woman had the inherent biological power to birth her child with her own efforts (Tew).

The medical concept of childbirth as a pathological condition evolved with little resistance from women, as many of the women who initially utilised the lying-in hospitals were poor, undernourished, and often homeless, or were women who had experienced some difficulty in labour to which the midwives in the home setting could not respond (McCalman, 1999). In exchange for the care received in the hospital, women who experienced complicated or less than optimal pregnancies became the subjects from which the medical profession could learn the pathology of childbirth (Tew, 2000).

Over time, and as more and more women used the hospital setting, the medical profession became the established overseers of care during birth and consistently professed that care given under their supervision in a hospital setting improved safety associated with childbirth—so much so that by 1956, in England, the government of the time recommended that seventy percent of births occur in hospital. This figure was achieved in 1964 (Campbell & McFarlane, 1994:19). In Victoria, by the 1950s, virtually all births (with the exception of those occurring in remote areas) were taking place in hospitals (McCalman, 1999). Although this almost universal acceptance of change of birth setting occurred swiftly in England, the change was most rapid, and more complete, in countries such as New Zealand and Australia 'where a political revolution had ordained that social and economic betterment was to be achieved through systems of planning and control by experts, and betterment in maternal and infant welfare through a system of childbirth care planned and controlled by medical experts' (Tew, 2000:1).

2.2 The medicalisation of childbirth

The traditional view of childbirth is that pregnancy and birth are considered normal life events, which women have the innate ability to achieve without intervention (Wagner, 1994). However, the prevailing medical discourse around birth today places it as a crisis point in life: a pathological condition and a medical problem warranting medical treatment (Cahill, 2001;

Wagner). These two ideologies concerning birth are referred to, respectively, as the 'social' model of care, and the 'medical' model of care (Wagner).

As doctors increasingly provided care to pregnant women, the notion that women needed this supervision took root in the societal culture of birth (Cahill, 2001). Doctors, as professionals, held a position of authority and alleged to offer a service providing better-quality and safer outcomes for the woman and her child during childbirth (Cahill; Oakley, 1984; Tew, 2000). Society accepted this assertion, and increasingly women sought to have their babies under the supervision of doctors in the hospital setting (Tew).

The concept of medicalised pregnancy and birth is now commonly introduced during pre-natal care—a time originally intended to monitor and improve the health of the mother but, which has become, increasingly, the opportunity for observation of the growing foetus and the consequent inadvertent but unfortunate undermining of the mother's confidence in her inherent reproductive capabilities (Tew, 2000). Dominant medical discourse does not accept that any setting other than a hospital can provide safety for a woman in birth, and openly opposes home birth on the grounds of safety and considers that women who choose this birth option expose themselves to an unacceptable level of risk (SCARC, 1999).

The current practice of classifying women during pregnancy into risk categories based on the potential for complications to arise in pregnancy and birth further reinforces the perception that pregnancy without medical supervision carries risks and that birth needs to occur in hospital (Oakley, 1984; Tew, 2000; Wagner, 1994). The medicalisation of pregnancy and birth—particularly the amount and type of intervention encountered in childbirth—has impacted on the way women experience the process of giving birth.

2.3 Intervention in birth

The cultural perception of the superiority of the hospital care provided by doctors has been fostered by the increasing application of technology to obstetrics, such as mechanical interventions (e.g., forceps), X-ray of the foetus, pharmacological control of pain in labour, monitoring of the foetal heart rate, and, more recently, the use of ultrasound in pregnancy and surgical birth (Oakley, 1984; Tew, 2000; Wagner, 1994). Although many of these interventions are now considered mandatory and desired in pregnancy and childbirth, they have occurred, largely, in the absence of evidence to validate any claimed benefits to the woman or child (Tew; Wagner). As hospital has become the accepted place to give birth, many of the technologies

associated with the medical model of care have become routine, producing what has been identified by Wagner (1994:8) as 'the birth machine: a wide array of medical interventions, often of a technical nature, used before, during and following birth'. Tew (2000: 33) identifies the cascade of interventions associated with the medicalisation of birth as 'one intervention to compensate for and if possible put right the harmful consequences of the damage created by an earlier intervention'.

Collated statistics for Victoria in 2002 indicate that for every 100 women giving birth for the first time, only 8 achieve a birth without intervention of some type (Victorian Perinatal Data Collection Unit, 2002). This high incidence of intervention in birth has prompted several investigations into the appropriateness of such interventions. In 1999, the Senate Community Affairs References Committee (SCARC) released a national report entitled *Rocking the cradle: A report into childbirth procedures*. Specific foci of this report included inquiry into variation in birth practices between different Australian hospitals with respect to interventions, variation in intervention rates between public and private patients, and variations in clinical outcomes associated with intervention rates. The report stated that intervention rates were highest among those women with private health insurance, those birthing in a tertiary centre, and those who were attended by specialist obstetricians. Of particular concern to the SCARC investigation was the unacceptably high incidence of elective caesarean sections unsupported by any available evidence. Enkin, Kierse, Renfrew, and Neilson (2000:404) found that little improvement in birth outcome is seen when caesarean rates rise above a minimum level, and that no clear parameters exist for the indication for caesarean section birth.

In Victoria, in 2000, 23.4% of all births were by caesarean section, and 11.9% of these were performed as elective caesarean section births (Riley & Halliday, 2001:35). A noticeable difference in elective caesarean section rates in Victoria was evident between women cared for in the public sector and the private sector. Of the 20.6% of public patients having caesarean births, 9.7% of these were recorded as elective, whilst 30% of the private sector patients had caesarean section births, and 16.8% of these were classified as elective (Riley & Halliday:37).

An Australian study by Roberts, Tracey, and Peat (2000) examined intervention rates in private and public obstetric patients, with a similar percentage of women classified as low risk in each setting. The study concluded that private patients are significantly more likely to have interventions before birth, as well as experience an increase in the rate of instrumental birth, thus highlighting the cascade effect of obstetric intervention in the birth process.

Dominant discourse concerning the rate of intervention in birth commonly involves reference to women classified as low risk or high risk. The process of classifying women in pregnancy and birth will now be explored as it pertains to the options of care made available to women.

2.4 The 'risk approach' to classifying women

The act of classifying a woman into a category of potential risk serves to direct her to the model of care for which she is considered suitable—or to which she will be permitted access—and to whom will provide her care (Saxell, 2000). The World Health Organization (WHO) (1996:2) reports that the 'risk approach' has been, for decades, the dominant method used when deciding on the logistics of birth such as place, type, and caregiver. WHO further identifies that a disproportionately high number of women are classified 'at risk' as a result of this approach and have correspondingly higher levels of intervention at birth. Criticism of the risk approach to classifying pregnant women has arisen because this method fails to accurately predict those women who will experience complications in birth (Enkin, Keirse, Renfrew & Neilson, 2000). Pregnancies identified as high risk can progress to an uncomplicated birth, while many classified as low risk can develop complications (Saxell; WHO). In addition, the risk approach has been shown to encourage the pregnant woman to be a passive 'patient', with the focus of care placed more on the foetus, placing it in competition with the pregnant woman (Wagner, 1994).

The concept of risk has infiltrated current discourse concerning pregnancy and birth, shifting it from a natural life event to a hazardous process. The concept of fear associated with risk in pregnancy and birth has served to disempower women by creating doubt in their innate capacity to give birth without intervention (Gilliland & Pairman, 1995; Saxell, 2000; Thomas, 1998). The underlying premise for the classification of pregnant women into risk categories is the medical definition of normality during pregnancy and birth. Medical discourse has established strict criteria for what is considered 'normal' in pregnancy and birth before intervention to assist the process is undertaken (Wagner, 1994). WHO (1996: 4) defines normal birth as 'spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth the mother and infant are in good condition.'

Wagner (1994) recognises that normal birth, as currently defined by medicine dictates the environment, the attendants, and the procedures concerning birth, so that to know what birth is

like outside of these constraints is virtually impossible. Hence the entire modern literature concerning birth is based on a scientific perception of the process.

The terms 'normal' and 'low risk' are applied to determine the models of care women can access in pregnancy and birth. However, there are, as yet, no consistent and reliable definitions of these terms. WHO (1996) defines 'normal' in accordance with an obstetric perspective of birth. This definition primarily encompasses the physical stipulations of presentation and gestation in the absence of any complication, and normality is only declared in retrospect.

An alternate view of 'normal' is as a construct of social conditioning and, thus, varies according to culture and context (Page, 2000). Any understanding of 'normal' will change according to the society lived in and the cultural practices of that community. As a result, any definition of 'normal' must also be malleable to changes in perception that will occur over time (Hartley, 1997; Saxell, 2000). The definition of 'normal' as 'that most frequently occurring'—even if this is routine intervention such as artificial rupture of the membranes or episiotomy—has moved normal birth from an uninterrupted physiological process to a medically constructed event (Cornack, 2001). Normality defined as 'what is average'—such as a rate of cervical dilatation of 1 cm per hour, or the second stage of labour occurring within the confines of progress in 1 hour—has become an accepted measure for such classification in medical discourse (Cornack; Hartley; Page).

Taylor (2001) suggests that many aspects of birth such as breech presentation retain the label of normal, but are just not the usual. However, these births do not constitute deviation from the norm. The process of birth can be viewed as normal, regardless of the time taken to arrive at birthing, or the presentation of the baby (Cornack, 2001). Childbirth can also be viewed as a journey labelled neither normal nor abnormal, but as a unique and individual experience for each woman (Banks, 2001). Taylor aligns abnormal with the potential for pathology, rather than as a separately identified pathological episode. The Nurses Board of Victoria (1999) stipulates that midwives must be proficient in the detection of abnormal conditions in mother and child. However, the benchmark for normality, or deviation from it, has yet to be determined.

It is equally as difficult to identify an agreed upon or standardised tool for assessment of risk scoring, and the tools that do exist have yet to be validated for their efficiency (Saxell, 2000). The methods used to determine risk carry a large degree of variability and are associated with a poor capacity to identify accurately those women who will actually progress to have complications in birth. What is more, those women who *are* identified as having increased risk

of complication may progress throughout pregnancy to an uneventful birth (Saxell; WHO,1996).

Giving consideration to the notion that the choices made available to pregnant women concerning their carer and place of birth are determined by their risk status, it would seem appropriate that a universally accepted scoring system be implemented (Enkin et al., 2000; Saxell, 2000). In the context of poor consensus around the classification of women regarding their suitability for various models of maternity care, the available options for maternity care in rural Victoria will now be considered.

2.5 Options for maternity care in rural Victoria

In general, advances have been made since the 1970s in the range of options now available to women in childbirth (Reiger, 2001). Halliday, Ellis and Stone (1999:19) list eighteen different models of pregnancy care available in Victoria. The reality for women in rural Victoria, however, is that choices concerning childbirth are very limited, as is community knowledge concerning alternate models of maternity care (Owen, 1998). The services available to women birthing in rural areas are less diverse than those available in metropolitan areas because some birth options, such as birth centres, are currently only available at large hospitals (Halliday et al; SCARC, 1999).

The most accessed model of care during pregnancy in rural areas is care provided by a local general practitioner/obstetrician caring for the woman as a public patient, or care provided by a private obstetrician (Halliday et.al, 1999). The model of care identified as 'shifted care'[1] is provided by a general practitioner/obstetrician to a public patient and is predominant in areas where the public hospital does not provide any care in pregnancy to outpatients so women must obtain this care privately. The elevated use of this model of care in rural areas suggests that public health facilities do not offer pregnancy care, and that general practitioners are providing this care.

The choices available to women in rural areas have been commented on in the SCARC report into childbirth procedures (1999). This report stated that there were only two options for women

[1] When a public hospital does not provide any outpatient antenatal care, women attending as public patients are required to obtain this care privately. During the intrapartum period the woman's care is provided by the hospital medical and midwifery staff working on that day. This model was developed as a result of many public hospitals ceasing to offer antenatal clinics necessitating that women seek private antenatal care but receive care as a standard public patient during birth and the postpartum period (Halliday et al., 1999).

birthing in country regions: give birth at the local hospital with general practitioner and midwife services; or, in the absence of this facility, travel or be transported to a larger regional centre hospital.

One of the factors quoted in the SCARC report as contributing to the limited number of choices for women birthing in rural areas was the issue of small numbers of births occurring in rural health facilities. The report stated that half of the maternity units in Australia had fewer than 100 births each year, and the majority of these units were in country areas (SCARC, 1999). The Victorian Perinatal Data Collection Unit (VPDCU) has recorded birth numbers in Victorian country hospitals—other than those identified as country base hospitals—as having fallen from 18.7% of total births in 1986 to 12.6% of total births in 2000 (Riley & Halliday, 2001:69). Figures recorded in Victoria for 2002 indicate that 36% of obstetric hospitals had fewer than 100 births per year and accounted for only 2% of all births in that state (VPDCU, 2002). Because of the low level of births, it is difficult for staff working in these services to maintain sufficient skill levels. Rural midwives have expressed concern about this de-skilling of midwives, as well as about the retention problem of midwives in rural practice—where maternity clients are often cared for alongside medical, surgical, and geriatric clients (Australian College of Midwives, 1998). The acute shortage and the difficulty in recruiting and retaining midwives in the rural sector has been identified in the SCARC report on the inquiry into nursing (SCARC, 2002), which states that, as a result of this shortage, consumers are now exposed to non-midwifery care, in some instances: 'Women in rural and remote areas are more likely to have a higher rate of maternal and infant morbidity and mortality....women are also having to be transported many miles from their homes to seek care during the birth of their baby because of the lack of locally available midwifery care' (SCARC, 2002:182). The decreasing number of general practitioners and midwives providing maternity care in rural areas has also reduced care options for women living in these areas—necessitating travel to larger regional hospitals (SCARC, 1999).

Another factor affecting the range of options for care in pregnancy and birth available to women in rural areas concerns the financial viability of practising in rural localities where only small numbers of births may be attended. The total lack of availability of professional indemnity insurance for midwives, which is a requirement for practice, threatens the ongoing availability of private practice midwives—further reducing birthing options available to women (Rumble & Bryden-Brown, 2002; SCARC, 2002; Owen, 2002). The cost of medical indemnity insurance for doctors practising in the area of obstetrics has become uneconomical for those attending small numbers of births (Fraser, 2002). It is also becoming a problem to attempt to obtain such

insurance, as many companies providing this service are themselves in financially precarious situations, which threatens their ability to insure doctors—particularly those with high premiums such as obstetricians (White, Kerin, & Stock, 2002). In addition to the constraints imposed by insurance issues, doctors practising in rural areas also face difficulties associated with the demands of being on call for extended periods. All of these factors combine to have an impact on the recruitment and retention of obstetric doctors in rural areas (Fraser).

Issues surrounding recruitment, retention, and skill levels also contribute to the debate concerning the safety of giving birth in small rural hospitals. Concerns have been expressed around these services' unacceptable distance from support and back-up emergency services, the problems encountered in the continued upskilling of their staff, and the unavailability of—or limited access to—other health professionals such as anaesthetists or paediatricians (SCARC, 1999). For these reasons, rural women who are identified with risk factors during pregnancy are encouraged to give birth at a metropolitan or regional centre where specialist staff are available. However, to do this, women need to travel from their own communities and leave the support of families and known care providers (SCARC, 1999). This scenario further reduces the number of women birthing in rural hospitals; thereby compounding the problems associated with maintaining these smaller services.

Perhaps of most concern are the increasing pressures to rationalise health services in rural areas that have led to a reduction in the range of services offered, including maternity services. Rationalisation of services has also meant that even healthy women residing in country areas with no access to birthing services must travel to a larger central hospital for care, thus losing the benefits of birthing within their own communities (SCARC, 1999:72; Fraser, 2002). The closure of these smaller rural maternity services is in direct contrast to the recommendation by the National Health and Medical Research Council (NH&MRC, 1998:12) that 'the closure of small maternity services providing care for healthy women with normal pregnancies should be resisted unless clear and unequivocal advantages can be demonstrated.' The SCARC report (1999) also highlighted the need to maintain small rural obstetric services for rural women who desired care close to their homes. However, rural services continue to decline. Despite the closures, women continue to present in labour to services that are no longer equipped to provide that care, leading to sub-optimal birth outcomes (Stainsby, 1998; SCARC, 1999).One rural hospital to withdraw the provision of maternity services was Sunbury Private Hospital, which ceased to offer a maternity service from April 2002. The closure of this service left 200 women who had already booked to have their babies at this hospital with no option but to travel a considerable distance to the next closest hospital offering maternity care. The hospital

management cited staff shortages and low birth rates as factors in the decision to cease providing maternity services (Panayotou, 2002).

In the context of this current practice of directing women in country areas to birth in larger regional centres, the option of home birth as a viable or tenable option for rural women will now be considered.

2.6 Home birth as an option for maternity care

Home birth is not readily accepted by the medical establishment or the wider community as a viable option for women (Reiger, 2001). The Royal Australian College of Obstetricians and Gynaecologists opposes home birth on the grounds of safety, and considers that women choosing this option are exposing themselves and their babies to unacceptable risk (SCARC, 1999). The safety of home birth has been debated, primarily, by using crude mortality figures from planned and unplanned (out of hospital) home births as a combined figure (Olsen & Jewell, 2002: Campbell & McFarlane, 1994). This has led to an erroneous understanding about the issue of safety regarding home birth because the mortality rate for unplanned home birth is considerably higher than for planned home birth (Northern Region Perinatal Mortality Survey Coordinating Group, 1996). In Victoria, since 1999, perinatal data statistics collated on the number of out of hospital births have differentiated between planned home birth and unplanned out of hospital births. Mortality statistics, however, are not routinely collated and published. The report on maternal deaths in Australia 1994–1996 records one death associated with home birth; however it is not specified if this was a planned or unplanned home birth (NH&MRC, 2001:21).

Because the number of births occurring at home is now so low, the statistical value of comparing the safety of birth at home and birth in the hospital setting has been questioned (Dowswell, Thornton, Hewison, & Lilford 1996; Northern Region Perinatal mortality Survey Coordinating Group, 1996). International studies conclude that home birth can be as safe as hospital birth in women with low risk pregnancies (Remez, 1997). The extensive English report *Where to be born* (Campbell & McFarlane, 1994) concludes that there is no evidence to support the claim that hospital is the safest place for women to have normal births. Olsen and Jewell (2002) also conclude that there is no strong evidence to favour either planned hospital birth or planned home birth for low risk pregnant women.

In Australia, a report by SCARC (1999) agreed that research on the safety of home birth is inconclusive because of the small number of home births that occur. It concludes that no

evidence supports the view that planned home birth is a less safe option for most low-risk women provided they are motivated and are assisted by an experienced home birth practitioner who is backed up by a modern hospital system. However, the following qualification concerning home birth in rural areas is made in the same report: 'While supporting the continuation of the option of home birth for healthy women, home birth is considered undesirable, even for healthy women in rural areas because of the difficulty of obtaining rapid assistance in an emergency' (SCARC, 1999:75).

In view of the inconclusive nature of statistics concerning home birth mortality, increasing consideration has been given to morbidity and other outcomes such as breast-feeding rates. Parratt and Sprague (1999), in an investigation of outcomes other than mortality associated with home birth in Victoria, concluded that outcomes for mothers and babies in planned home birth were similar or better than those in births which occurred in birth centres (Parratt & Sprauge, 1999:341) In a 2002 study, Olsen and Jewell reported that fewer medical interventions occurred in the home birth study group, and that outcomes for babies were consistently higher for those in the home birth group than for the matched hospital group. Parratt and Johnston (2002) reported similar findings in their report on planned home birth in Victoria, which supported planned home birth as a safe birth option.

In summary, the options made available to birthing women in rural areas and the criteria under which such options are viable appear to be considerably restricted in rural Victoria. Home birth in rural areas is considered by medical factions to entail certain risks—despite research evidence that suggests birth outcomes in the home setting are equal to those in the hospital setting for low risk women. Women have consistently stated that they desire greater choice in childbirth; however, such choice appears limited for women in rural areas. The question of what women want or desire when accessing models of maternity care will now be addressed.

2.7 What do women want from a birthing service?

International and Australian research over the last two decades has begun to focus on women's views concerning maternity services. In 1990, the Victorian state government published a ministerial review of birthing services that included input from the women utilising the services. The main recommendations emerging from this report were that the focus of maternity care should become more woman-centred, that there should be an emphasis on continuity of carer, and that women should be provided with information concerning the options available to them during pregnancy and birth (Health Department Victoria, 1990).

In 1998, the NH&MRC published a research report that identified issues of consumer concern regarding options for maternity care. In this report, women consistently raise the following four issues concerning care in childbirth: (1) safety of birth; (2) control over the birth process; (3) access to and sharing of information; and (4) the desire for continuity of care (NH&MRC, 1998: 9). Homer, Brodie, and Leap (2001) also report that continuity of care and consistency of information, choice of care, choice of place of birth, and the right of women to maintain control over what happens to them at all times are factors that consistently arise as issues that increase the satisfaction women report about their maternity care experience. Continuity, control, and choice are considered to increase a woman's satisfaction with her birth experience (Hundley, Milne, Glazener, and Mollison, 1997).

These factors are multi-dimensional and, thus, are difficult to clarify with any single definition, as each woman will have her own understanding of these concepts (Weaver, 1998). Continuity of care and continuity of carer are often referred to as interchangeable terms when this is not the case (Edwards, 1998; Laslett, Brown & Lumley, 1997). Women value continuity of carer when this allows them to get to know their primary carer, which then enables a relationship of trust to develop (Edwards, 1998). Studies have demonstrated that the implementation of caregiver continuity delivers many benefits, including lower rates of intervention in birth, less use of analgesia, and increased satisfaction with birth (Hodnett, 2000; Enkin et al., 2000). Laslett et al. (1997) found in regard to carer continuity that women value respect, being treated as individuals, understanding of their personal experiences, explanation of procedures, and honest answers to their questions, as well as concern for their medical and emotional state.

Guilliland and Pairman (1995) identify that midwifery care in pregnancy and birth that incorporates factors such as respect for the normality of birth as a life event, continuity of care, independence, and woman-centred care works in partnership with the woman in the care of a midwife. Working in partnership with a woman during her pregnancy and birth and maintaining woman-centred care acknowledges the normality of birth as a life experience without diminishing the importance of the event for the woman from a personal, social, and cultural perspective (Parratt, 1996). The main outcome experienced by women who have had the opportunity of working in partnership with midwives is empowerment (Parratt, 1996). Brown and Lumley (1998) identify that the labouring woman's perception of caregivers during birth as helpful, and the extent to which women feel involved in decisions about their care are the most influential factors affecting women's satisfaction with care during birth. It is the ability to be actively involved in the process of making decisions concerning their care that women most

associate with having control of their labour, even though the options available to them may not be the most ideal (Weaver, 1998).

What a woman wants from a birthing service may, in part, illuminate the choices she makes concerning the model of maternity care she accesses and the venue she selects for her birth experience. The following section will investigate the existing knowledge available about the factors influencing the decision to birth at home.

2.8 Existing knowledge concerning the choice to birth at home

The choice of birthing at home has not been extensively researched either internationally or in Australia. This has resulted in paucity in the existing knowledge base concerning what motivates women to make this choice. The small sample size in most of the identified studies pertaining to home birth is reflective of the small number of women who choose home as their venue for giving birth.

Kitzinger (1978) conducted a study in England pertaining to women's reasons and preferences for home or hospital confinements. Data collection was by written responses to open-ended questions from a sample size of sixty-five participants. The four most common reasons given for wanting a home confinement were:

1. an objection to routine hospital practices and the impersonal atmosphere of hospital;
2. the desire for a natural birth, and the avoidance of obstetric intervention;
3. concern relating to the capacity to bond emotionally with the baby in the hospital environment and with the hospital practice of removing infants from their mothers for periods of time, particularly at night; and
4. the desire for birth to be presented as a normal part of living to other children in the family and to avoid separation from other young children.

This study also identified other commonly mentioned preferences in the home confinement: continuity of care and the desire for a personal relationship with the caregiver; wanting the husband to be fully involved and share in the process; the belief that breastfeeding is easier to establish at home; and the desire for the birth to be a gentle experience for the baby.

Another English study conducted by Chamberlain, Wraight, and Crowley (1997) surveyed women who planned a home birth in the UK in 1994. The research identified that a desire for less interference in their giving birth was cited by the greatest number of women as the motivating factor for choosing to birth at home. The convenience of home birth was also a common factor that influenced their choice to have a home birth. In response to one of the questions in the survey concerning what the women liked most about their home birth, frequently recorded responses included, 'feeling stress free', being in their own home, being in control, being with family, having freedom of choice, knowing the midwife, and not having to travel.

Viisainen (2001) investigated the reasons why twenty-one Finnish couples elected to give birth at home under a health system which is not supportive of this choice. Birth narratives recorded at interviews with the participants formed the data for the study. The research identified three predominant motivators for the decision to birth at home: a desire for a natural birth; a search for an alternative to hospital birth; and a search for personal control over decision-making about the birthing process.

Natural birth, the first motivator, was defined in various ways by the participants in the research, including birth not interfered with medically, and, also, birth that provided a gentle entry into life for the baby. The second motivator, seeking alternatives to hospital birth, predominantly related to women who had had a previous unpleasant experience of hospital birth. The factor of personal control in the birthing process, the third motivator, related to resistance to being dictated to concerning the birth experience. These couples wanted to do it in their own way, and make their own decisions concerning their birth experience.

Klasses (2001) researched home birth in North America using in-depth interviews with a particular focus on the relationship between religion and nature and the decision to birth at home. The study found that the women spoke of sacredness in relation to their home birth experience. However, this reference was not to a transcendent deity, but sacredness as it relates to the understandings the women had about what was natural about their birthing bodies. The decision of the women to birth at home permitted them to honour those elements of birth they considered sacred, but it also permitted them to incorporate elements of medical technology into their birth experience. It was reported that the women who chose to birth at home did not do so in isolation from medical technologies; rather, they incorporated aspects of medicine into their home birth as a component of the sacred event of giving birth. Klasses (2001:775) explains that 'these women claim that birth is a profound personal, spiritual, communal, and, for some, sexual

experience.' Their decision to birth at home allowed the women in the study to honour their beliefs about birth as a sacred act in a context other than the dominant medical discourse.

In Australia, Bastian (1992) conducted a survey of 552 women who planned to give birth at home. The questionnaire used in the study gave a list of eight possible factors that may have influenced the decision to birth at home as well as providing an opportunity for respondents to record other issues which were relevant to the decision to birth at home. The results demonstrated that the most consistently reported reason for choosing to give birth at home was the desire to give birth without medical intervention. Other reasons commonly recorded were the desire to give birth in—and for the baby to be born in—a natural, comfortable environment; and the belief that hospital is a place for illness or in the instance of high-risk pregnancy. Of the eight listed responses available, 95.8% of respondents indicated wanting a natural birth; 94% indicated not wanting to be separated from baby, partner, and family; and 88.6% indicated that wanting to maintain control was a major factor in their decision to birth at home.

In Western Australia, Morison, Hauck, Percival, and McMurray (1998a, 1999b) utilised phenomenological methodologies involving in-depth interviews to gather information about the lived experience of home birth from people who had had a home birth in the Perth metropolitan area. This study did not set out to compare home birth with hospital birth, nor was the focus of the study on reasons for the choice of home setting for birth. Themes about the experience of home birth were identified from transcripts of recorded interviews.

This study concludes that home birth involves active control of the process involved in preparing the social and the physical environment for birth in the home. An additional general theme identified from this study is the preparedness of people choosing home birth to assume responsibility for their own health and the birth of their baby. Recognition is also given to the magnitude of the birth experience and the 'naturalness' of birth.

Dodd and Reibel (2000) used written surveys to gather information concerning birth choices, including the option of home birth, in metropolitan Perth, Western Australia. The authors of this study identify recurring themes concerning respondents' decisions about where to birth. These themes are identified as comfort, security, control, and continuity of care. Respondents in this study who had chosen home birth cited continuity of care with a known carer as very important. Feeling comfortable in their own homes also added to their feeling of security during birth. The avoidance of unnecessary intervention, or fear of intervention, and the desire to participate in decision-making and maintain control were also cited as factors in the decision to birth at home.

Home birth for this group of women was also associated with being less disruptive to existing family and was perceived as a decision made in union between the parents. However, the tendency of home birth mothers to continue with normal domestic duties without immediate or ongoing support after birth was a point of concern for this study.

There have been no studies identified in this search of the literature which pertain to the decision to birth at home in a rural environment. This highlights the importance of the current research project which seeks to understand why women choose to birth at home in rural Victoria despite professional and social opinions that are unsupportive of this non-mainstream option for maternity care.

2.9 Conclusion

This concludes the review of the current literature concerning women's decisions to birth at home. The shift of birth venue from the home to the hospital has brought with it a shift in the way that care is delivered to women during pregnancy and birth. The most remarkable changes have been the medicalisation of childbirth, the introduction of technology into the birthing process, and the subsequent increase in the rate of interventions (now accepted as routine) in birth. The societal understanding of pregnancy and birth has changed as a direct response to the medicalisation of childbirth, so that birth is now considered a medical condition that carries inherent risks, requires the attention of doctors, and is best conducted in a hospital with emergency resources readily available. The models of maternity care that are currently available to women in Victoria are predominantly hospital-based and administered by medical personnel who direct women to give birth within a hospital. In rural Victoria, maternity services are considerably less diverse than those offered to metropolitan women, and many services have been centralised to larger regional hospitals which women have to travel considerable distance to access. According to current available evidence, the factors women attribute to increased satisfaction with their maternity care experience include having choice in birth carer and place, continuity of carer, and increased control over what happens to them in pregnancy and birth. Unfortunately, the current system of providing maternity care in rural Victoria is limited in the choices made available to women, continuity of carer is difficult to achieve if women are required to travel long distances to the maternity service, and control over the birth process is difficult to achieve if a relationship has not been established with the carer.

Home birth in rural areas is not readily accepted as a viable option for birth because of the time and distance to attain emergency services in the event of complications in labour and birth. In

spite of this, women in rural areas continue to elect to have their babies in their own homes. After considering the current discourse concerning home birth in contemporary society, it is evident that there is paucity in the knowledge around why women select the option of home birth. This knowledge gap is particularly evident in relation to home birth in rural areas, where there appear to be significantly decreased options for any choice in birth setting or model of maternity care and correspondingly significantly increased opposition to home birth as a viable birth option.

The current research project aims to address this paucity of knowledge concerning home birth in rural areas by seeking to understand the reasons why ten women who reside in Central Victoria chose to move outside of the mainstream model of maternity care available to them and give birth in their own homes.

3. Methodology

This chapter will describe the methodology used to conduct this research, explain the theoretical background of this methodology, and provide a rationale for its application. A description of the research method will then follow, detailing the recruitment of participants, eligibility criteria, sample selection, ethical considerations, data collection methods, and the analysis of data.

3.1 Research methodology

A qualitative approach has been utilised in my study. The focus of qualitative study is the discovery of the nature of phenomena as humanly experienced, and is grounded in the understanding that the significance of people's actions lies in their individual perspectives and associated meanings about the particular experience (Minichello, Fulton & Sullivan). My study utilises a qualitative approach to gain insights to the meanings participants associate with the choice of birthing at home.

A microethnographic methodology underpinned by feminist principles has been employed to conduct the research. A microethnographic approach is appropriate because of the narrow focus the research question has on an identified group who take part in a particular activity— in this study: women who live in Central Victoria who choose to give birth at home. A feminist approach is integral to this study because of the central role of the women who are the participants in this research, and because of the dominance of the patriarchal medical system that, for the most part, determines the maternity care available to women in contemporary society.

3.1.1 The origins of ethnography

Ethnography is a qualitative research method that has its origins in the tradition of cultural anthropology (Spradley, 1980). Traditionally, ethnography has been conducted by Western anthropologists to study the cultures of non-Western societies (Rice & Ezzy, 1999). Influential ethnographers in traditional anthropology include Malinowski, who wrote about life in the Trobriand Islands, and Mead who wrote of adolescents in Samoa in the early part of the twentieth century (Russell, 1999). In America in the 1930s, a group of researchers known as The Chicago School radically diverted from mainstream methods of research and applied ethnography to the study of subcultures within their own societies, including people living in slums and immigrant communities (Russell).

Researchers continued this trend of using ethnographic principles to conduct research on sections of their own culture (Rice & Ezzy). Examples of this over time included Whyte, who researched street youth gangs in Boston in the 1950s, and Goffman who studied the social world of mental institutions during the 1960s (Russell).

Ethnography is now widely accepted as an appropriate method to conduct research in the field of health, both within a culture and across cultures (Rice & Ezzy, 1999). The field of nursing has embraced ethnographic methods of research with the term 'ethno nursing', which was coined by prominent American ethnographer Madeleine Leininger to describe the use of ethnography in nursing (Holloway & Wheeler, 2002). Australian researcher Olga Kanitsaki has utilised ethnographic methods to study multicultural care service issues—notably, Greek community concepts of hospitalisation—and has provided new perspectives on aspects of nursing from a transcultural outlook (Roberts & Taylor, 2002).

While classical anthropological ethnography aims to contribute to an understanding of a group's social action, ethnography as applied in the health sciences is used to improve cultural appropriateness of professional practice (de Laine, 1997). Ethnographic research in nursing and midwifery is applied as a way of examining pertinent behaviours and perceptions with the aim of improving care and clinical practice (Holloway & Wheeler, 2002). The specific application of ethnographic study to the field of midwifery has been discussed by Donovan (1999:133), who cites authors Kirkham (1987) and Hunt and Symonds (1995) as researchers who have used ethnography to bring new understanding and clinical practice change to midwifery.

Ethnography is essentially the art and science of describing a culture (Fetterman, 1989; Rice & Ezzy, 1999). Culture has been described by Fetterman (1989) as the ideas, beliefs, and knowledge that characterise a particular group of people. Handwerker (2001) identifies culture as the knowledge people use to live their lives and the way in which they do so, while Spradley (1979) refers to culture as the acquired knowledge that people use to interpret experience and generate social behaviour. The ability of culture to generate social behaviour, and to determine what is considered a variation from acceptable social behaviour within a group, makes it a powerful influence in society. It gives people a way of seeing the world, presents rules to live by, and provides a structure to determine what is good, true and believable about the specific reality they occupy (Spradley, 1979).

When undertaking the study of a culture, the researcher seeks to gain an understanding of the knowledge that people of a particular group have; how they use this knowledge to conceptually

organise their lives; and what meanings they ascribe to this construct. Donovan (1999:132) states that 'ethnography aims to discover what is happening, how it is happening and ascribe some meaning to, or interpretation of this as it is relevant to the group being studied.' Spradley (1980) classifies culture according to three broad divisions of human behaviour shared by a particular group: the things they do, the things they know, and the things they make and use. Alternate terms for these three classifications are cultural behaviour, cultural knowledge, and cultural artefacts (Spradley). Ethnography seeks to understand how people think, believe, and behave (LeCompt & Schensul, 1999). This typically involves the researcher taking the role as the primary research instrument, using a multitude of methods to gather data that will increase the understanding of the issues that are the focus of the research (Walsh, 1999).

Ethnography has the potential to uncover the hidden cultural contexts of childbirth, motherhood, and the life of women (Donovan, 1999). The task of gaining an understanding of why women choose to birth at home necessarily involves an examination of the culture of this group of women, in order to learn from them why they do what they do and the meanings that they place on these actions. My study seeks to understand the way these women conceptualise their world and how this influences their choices about where they give birth. The decision these women make to birth at home is their cultural behaviour, the meanings that they ascribe to this action is their cultural knowledge, and their homes and the things in them are their cultural artefacts. The research question 'Why do women in Central Victoria choose to birth at home?' is answered by identifying and understanding the cultural considerations that influence these women's decisions. Therefore, ethnography is an appropriate method by which to research this question.

3.1.2 Micro-ethnography

When the focus of an ethnographic study becomes so narrow as to concentrate on a subculture, or a part of a social cultural system, the term micro-ethnography is applied (Creswell, 1998; de Laine, 1997). Fetterman (1989) describes the close-up study of a small social unit or an identifiable activity within the social unit as a micro-study.

Women who choose to birth at home in preference to birthing within a hospital setting, which is the accepted cultural norm in contemporary Australian society, are a distinct subcultural group within the larger cultural group of birthing women. The decision to birth at home—opposing the dominant contemporary cultural behaviour—is a complex process involving extensive motivation and planning to deal with issues of responsibility (Clement, 1998). This planned action is often condemned by the broader society these women inhabit and is also often opposed

on the basis of safety. Edgar and Sedgwick (2002) describe a minority group that opposes the dominant culture in an articulate and reflective manner—as these women do—as a counterculture. Therefore, this research, which focuses specifically on the counterculture of home birthing women and seeks to explore and describe the identifiable activity of choosing home as the venue for birth, is consistent with the criteria for a microethnographic study.

In an attempt to provide an avenue for participants to express the knowledge they hold regarding their reasons for choosing to give birth in their own homes, a feminist approach has been applied to the conduct of the research. The following section expands on the theory of feminist research and the importance of its application to this research project.

Feminist ethnography

The aims of feminist ethnographic study are to record the lives and activities of women in order to understand the experiences of women from their own perspective and to understand women's behaviour in the context of contemporary society (Reinharz, 1992). Further, feminist ethnography aims to enhance the position of women through making known what has been unknown about their lives and how they live them (Brunskell, 1999). Feminist ethnography is defined by the desire to make women's reality visible and their voices audible and, thus, provide an avenue for expressing from the perspective of women what has previously been unseen and unheard (Reinharz). Feminist research requires that women are central to the production of knowledge that will improve their situation, and that the research process be transparent and cooperative, rather than distanced and objective as is the case in research with a positivist perspective that associates superiority or authority with the researcher (Barnes, 1999; de Laine, 1997).

An underlying philosophy of feminist research is that the researcher is committed to working towards the transformation of the condition of the lives of women and facilitating social change through the production of new knowledge (Brunskell, 1999). An additional characteristic of feminist research is the search to identify women who are subordinated by male power relationships within society and to create knowledge that can effect change in their lives (Brunskell). DeLaine (1997) sums up the base premise of feminist research as: knowledge for its own sake is insufficient; rather, research must empower women and eliminate oppression.

This aspect of feminist ethnography is paramount in the characteristic relationship that is developed between the researcher and the participants in feminist research. In feminist research, the participants are not viewed as passive components of the process but more as sharing an

equal position with the researcher (Holloway & Wheeler, 2002). The researcher and the participants view the research project as a joint enterprise that is developed through a sharing of information between the researcher and the researched. The development of rapport between the researcher and participants is encouraged to the point where 'particular friendships' are formed that encourage the reciprocal sharing of information (le Compte & Schensul, 1999). Holloway and Wheeler (2002) suggest that if the researcher is of the same gender as the participants and shares experiences with them, then trust is promoted and the willingness of participants to communicate their feelings and ideas is enhanced.

A feminist approach is seen as particularly appropriate for this research because of the central role of the women participants. Because of the limited research into women's perspectives around choice of birth setting, the current study has the potential to generate knowledge that, as yet, has not had an avenue for expression. Although some recent research has been conducted into women's views relating to maternity care—such as Laslett, Brown and Lumley's (1997) research regarding women's views of different models of antenatal care in Victoria—the majority of research concerning home birth has been written from a medical perspective, and the predominant factor investigated is the safety of home birth as a medical construct. The perspective of women in home birth research has been given minimal attention, and, as such, knowledge concerning this issue remains obscured. To make the knowledge of women who choose to birth at home visible from their own perspective fulfils one of the criteria for research to be considered feminist. The women in my study are central to the knowledge that is generated. Their knowledge is accessed through the use of co-operative and collaborative methods of data collection including semi-structured interviews with individual women who have chosen to birth at home and a focus group interview with these same women. Reinharz (1992) comments that semi-structured interview allows the ideas, thoughts, and memories of women to be heard in their own words rather than as they are translated by the researcher.

As has been discussed in the review of the literature, the predominant providers of maternity care are medical doctors who, mostly, advocate hospital as the appropriate place for birth to occur (Senate Community Affairs References Committee, 1999). As a result, the accepted standard within contemporary society is that the majority of women will give birth within hospitals. Thus, the label of counterculture is appropriate for this group of women who exercise non-conformity by choosing to give birth in their own homes—firstly, because of their minority status and, secondly, because they often face disapproval or criticism for exercising this choice (Callaghan, 1996). Identification with this counterculture also exposes these women to

stigmatisation because their choice to birth at home is considered socially and culturally unacceptable (Short, Sharman & Speedy, 1993).

As elaborated in the previous chapter, it is the domain of medicine in contemporary society to determine the health status of a pregnant woman, and thus dictate the model of maternity care she accesses. The majority of maternity care options available to women are administered by and delivered from a hospital facility (Halliday, Ellis & Stone, 1999). The provision of maternity services through established hospital facilities entails pregnant women being assigned with the 'patient role', which carries with it the expectations of compliance and passivity in order to be made well by medical care (Short, Sharman, & Speedy, 1993).

Current changes within the structure of health care provision are further limiting the options for both place of birth and the types of practitioners who are permitted to attend care (Lecky-Thompson, 1996). The capacity of midwives to continue to provide a service accommodating women who choose to birth at home is increasingly threatened by their inability to obtain the necessary insurance required to practice (Owen, 2002). The literature reveals that women in rural areas already have a reduced number of options available for birth when compared to their metropolitan counterparts (Human Services Victoria, 1999), and additional restrictions on the number of practitioners permitted to provide maternity care will decrease their options further.

The application of feminist principles to my research is appropriate and necessary in order to give this marginalised group of women a voice to express their knowledge concerning their choice to birth at home in a social environment which does not support or encourage this choice.

An important factor pertinent to the feminist principles of my research and relating to the authenticity of ethnographic study is the setting in which the research takes place. The concept of naturalism will now be addressed.

3.1.3 Naturalistic perspective in ethnography

The term naturalism is applied to research that aims to study the social world in its natural state undisturbed by the researcher, and that is carried out in ways that are sensitive to and respectful of the nature of the setting (Hammersly & Atkinson, 2001). Naturalism requires that the researcher find a means of understanding particular behaviour through accessing the meanings that guide that behaviour (Hammersly & Atkinson). It is characteristic of ethnographic study that it be conducted in the natural setting of the group involved in the research, as opposed to an artificially constructed environment (LeCompt & Schensul, 1999). Donovan (1999:134)

recognises the importance of the natural environment to ethnographic research by stating that 'the behaviour of people can only be understood within the context in which it takes place.'

Ethnography is particularly focused on researching the group or culture in their own normal cultural context, as this is the means by which to gain the most comprehensive understanding of the influences on participant behaviour (Critical Appraisal Skills Programme [CASP] & Health Care Libraries Unit [HCLU], 1999). The nature of data collection is affected by this requirement because the researcher must allow the participants to behave in as natural manner as possible in order to minimise data distortion by the research process (CASP & HCLU, 1999). Research conducted from a naturalistic perspective aims to record the participants' thoughts and actions in their own words, rather than in terms defined by the researcher, thus giving emphasis to the meanings and views of the participants rather than the researcher's interpretations.

This project has a naturalistic perspective. Where possible, the research was conducted in the normal environment of the women choosing to birth at home; that is, the researcher, when invited, entered the homes of the participants and, for a period of time, shared their lives. The experiences of sharing birth stories in the home, of being present on occasions in the place where participants have given birth, and of being shown and introduced to participants' artefacts in the environment in which their context can be appreciated has contributed to the naturalistic perspective of my study. Allowing the women to speak in their own voice concerning their choice to birth at home and not directing their responses and conversations by using jargon also contributed to the naturalistic perspective of my study.

This close association with the participants in their own environment during the course of my research required that I take the impact of my presence into account when assessing the data generated. This process, termed 'reflexivity', will be considered in the following section.

3.1.4 Reflexivity in ethnography

Reflexivity is recognised in ethnographic research as the notion that research cannot be conducted in the field without the researcher's presence having an impact on the culture under investigation. Hammersley and Atkinson (2001) identify that reflexivity occurs in all social research because it involves participating in the social world, in whatever role, and reflecting on the effects of that participation. The acceptance that the researcher will undertake a degree of introspection and self-analysis in relation to the type and nature of data accessed in the field is encompassed in the term reflexivity (Donovan, 1999).

While reflexivity requires the researcher to be aware of any biases, values, and experiences brought to the research process (Creswell, 1998), hermeneutic theory states that an understanding of something is only gained through comparing it to something that we already know (Draper, 1997). With this concept in mind, my own known understanding of my own experiences could influence the understanding that I—as researcher—gain concerning why the participants choose to birth at home. As a woman who has chosen to give birth at home twice and also as a midwife who attends women who choose to birth at home, the concept of reflexivity takes on added importance. In my role as researcher, it was essential to have an ongoing awareness of these factors during interactions with the participants to prevent the unintentional distortion of the data collected due to an over-identification with the concepts or situations being discussed.

My experience as a woman who has chosen to have a home birth could have had the potential to create situations where participants take for granted an implicit understanding of aspects of their own experience of home birth. Such a scenario could have allowed inaccurate assumptions to be made relating to the researcher's identification with the participants as a woman who has chosen home birth. To reduce or eliminate this potential, it was intended to give the women repeated opportunities to validate the data generated.

Reflexivity is also important when considering the data that participants may divulge because they are aware of the researcher's professional status as a midwife. Holloway and Wheeler (2002) give recognition to the inequity of power that may influence relationships when the participants view the researcher as a professional with specialist skills. In this way, the researcher's professional status as a midwife could create the potential for participants to see me as possessing particular authoritative knowledge concerning childbirth. The participants could also consider the researcher to be in a similar role to that which midwives hold within the contemporary hierarchical structure of hospitalised birth and, thus, construct their responses and actions according to this stereotype (Donovan 1999).

Because of the reasearcher's familiarity with the cultural group being researched, vigilance was necessary to ensure that each woman's experience was recorded in their own words and as they themselves perceived it, rather than as the researcher's interpretations (Holloway & Wheeler, 2002). In the current study, the participants had ongoing opportunities to ensure the validity of the data through participant verification of interview transcripts and by their involvement in the analysis of the data during the focus group. This ongoing collaborative approach to my research also assisted in the construction of emic and etic perspectives, which are important in

ethnographic study. The next section will focus on the relevance of these two perspectives in ethnographic study.

3.1.5 Emic and etic perspectives

An important principle of an ethnographic study is that it aims to learn about the culture of the group being researched from the participants'stance. This is achieved through a process of learning from the people and being taught by the participants rather than studying them (Polit & Hungler, 1997; Rice & Ezzy, 1999). The ethnographer seeks to understand the culture of the group from within (Edgar & Sedgwick, 2002). Perspectives of knowledge gained in ethnographic study can be categorised as emic or etic.

The attempt to gain the perspective of the culture from the inside is known as an emic perspective (Brewer, 2000; Roberts & Taylor, 2002). Creswell (1998) identifies an emic perspective as the recorded view of the participant, while an etic perspective is the perspective or personal view of the researcher. An emic perspective is the construct of the participants' worldview, while the etic perspective is that which the researcher applies to the data through their own theoretical and scientific conceptual framework (Holloway & Wheeler, 2002). The researcher moves between these two perspectives in an attempt to balance their involvement in the cultural group they are studying and the scientific construct that emerges about the beliefs and practices within that culture.

The ability of the researcher to maintain a balance between an emic (insider's) perspective and an etic (outsider's) perspective is necessary for the production of sound ethnographic knowledge. The risk of over-identifying with the group under study, or 'going native' and losing the ability to look analytically at the cultural group and report an etic perspective presents a challenge for researchers closely involved with the group that is studied (Minichello, Fulton, & Sullivan, 1999). This issue was of particular relevance in the current research because of the researcher's familiarity with the culture. Holloway and Wheeler (2002) identify the danger for the researcher associated with a familiar group or culture of losing awareness of their role as researcher and, instead, relying on assumptions that do not necessarily have a basis in reality. The current study reduced the potential for this to occur by involving participants in the ongoing research process through returning collected data to them for verification of its authenticity, and their ongoing participation in the analysis of the data. Discussing the progress of the research with other academic researchers was another mechanism employed to preserve emic and etic perspectives in the research.

3.2 Data collection methods

Brewer (2000) identifies that to gain understanding of the social meanings and activities of a particular group, the researcher must have close association (if not full participation) with that group. A combination of data collection methods–including participant observation field notes, in-depth interviewing, and the use of personal documents and discourse analysis of natural speech—enhanced the ability of the researcher to achieve this. This multiple method approach to data collection is termed triangulation of data collection methods (Brewer). Minichiello, Fulton, and Sullivan (1999) describe triangulation as the process where the same issue is investigated in a variety of ways to produce evidence of different types to support findings. Triangulation of data collection methods allows for validity of findings to be tested through the comparison of data collected from various techniques to see if they corroborate one another (Walsh, 1999). In seeking to understand why women in Central Victoria chose to birth at home, my research employed a triangulation of data collection methods involving participant observation and compilation of field notes, semi-structured in-depth ethnographic interviews and focus group interview. The data collection methods used for the current study will now be discussed individually in detail commencing with participant observation.

3.2.1 Participant observation

The data collection method of participant observation involves the immersion of the researcher into the culture under investigation or fieldwork, in order to get as close as possible to the people to learn how they respond to situations, how they organise their lives, and what is meaningful to them from their own perspective (Rice & Ezzy, 1999). Participant observation allows the researcher to take part in the daily lives of participants in their natural setting, talk with them, and observe them in order to discover how they interpret their activities and apply meanings to these (Brewer, 2000). Increasingly, societies are becoming more and more private, and there are some phenomena that do not permit participant observation readily (Russell, 1999). Home birth is one such area that does not allow for participant observation in the purist sense of the term. In the current study, my role as participant observer was as a complete participant, which Spradley (1980) describes as the circumstance when the researcher studies a situation in which they are already ordinary participants. Brewer terms the utilisation of an existing role to study a familiar setting as 'observant participation'.

As a woman living in Central Victoria who chose to give birth at home on two occasions, I considered that I was already an ordinary member of the cultural group that is the focus of the

study. In my professional role as a midwife who attends women who choose to birth at home, I experienced an added dimension of affiliation with the cultural group involved in my research.

The data collection procedures of ethnographic interviews conducted in the participants' homes, and facilitation of the focus group interview involved participant observation in a more conventional sense. These interactions provided the opportunity for immersion into the cultural lives of the participants in their natural setting where fieldwork and the subsequent recording of field notes occurred.

Russell (1999) comments that there are differences in the investigative focus when interviews conducted in the field are classified as fieldwork. These differences are that interview data are not observational, that an interviewer is not centrally interested in the field itself as an interactional setting, and that the nature of participation in an interview entails qualitatively different kinds of research relations. Russell claims that to view interviews in the field as participant observations risks losing the context of meaning and purpose that human behaviour has when it is integrated into normal daily life. Hammersley and Atkinson (1995) acknowledge that the perspectives gained in interviews do not give direct access to the cognitive and attitudinal base that prompts a person's behaviour in a 'natural' setting, but that interviews are capable of illuminating that behaviour.

For the purposes of this research, the interaction between the researcher and the participant at the time of interview was not singularly for the purpose of interview; rather, emphasis was also placed on the time in the home setting as an interactional setting. At the individual interview appointment, the researcher spent time with the participant discussing issues associated with home birth generally and, more specifically, the participant's own home birth plan or experience. The researcher observed each woman in the natural setting of her own home, and listened to her speak about her experiences of giving birth in this setting. These interviews in the field provided the opportunity for the participant to share aspects of her culture by showing artefacts—the things these women used or made. Artefacts included articles that were special or significant to these women because they related to their decision to birth at home. Examples of artefacts included the space and the place of the home or property itself, photographs pertaining to their giving birth, videos of the birth, and personal items which held significance relating to their decision to give birth at home. The periods of interaction that accompanied the individual interviews with the participants in their homes provided the cultural immersion to engage fieldwork and record field notes. The focus group interview, on the other hand, provided an opportunity to observe the cultural group as a collective and to participate as a member of the

cultural group of home birthing women while they interacted and discussed their reasons for, and experiences of, birthing at home.

3.2.2 In-depth semi-structured individual interview

The use of in-depth interview as a means of data collection will now be discussed. The term in-depth interview pertains to an unstructured conversational-style interaction with participants, during which information—generally of a detailed and highly person-centred nature—is gathered (Minichiello et al., 1999). The aim of ethnographic interview is to learn from the participants by asking questions. Therefore, hearing—and learning to understand—the participant's own language is intrinsically important because that is how the participants convey their reality (Spradley, 1979).

In-depth interviews aim to explore the richness and complexity of experiences from the participants' perspective through normal conversation, rather than in terms that are predetermined by the researcher (Rice & Ezzy, 1999). This conversational quality is an important feature of ethnographic interview in that it allows for greater acceptance of the participants' own terms and common language than is expected in other forms of interview (Hamersley & Atkinson, 1995). Interviews can be conducted using various structures, which range from a formal interview with predetermined questions, to a semi-structured format using a question guide highlighting main topics to be discussed, to a totally interviewee-guided conversation (Minichiello, Madison, Hayes, Courtney, & St John, 1999).

Reinharz (1992) recognises that semi-structured in-depth interview has become the principal means utilised by feminist researchers to promote the active involvement of participants in the construction of knowledge about their lives. A distinguishing feature of a semi-structured in-depth interview is that, generally, an interview guide is followed. This allows a focus to be given to the conversation and allows similar lines of enquiry to be made at numerous interviews, although the specific sequencing and wording of questions would not necessarily be used at each interview (Holloway & Wheeler, 2002).

In-depth interview questions are typically open-ended, and the interviewee determines the course of the interview. Rice and Ezzy (1999) identify that appropriate lines of investigation are often not known until the interview is underway, and it is through discussing issues with the participants that an area of interest or field for exploration will be revealed. It is through dialogue that appropriate questions and relevant answers emerge, and it is through the

interaction of interviewer and interviewee that co-constructed meanings are attributed to information gained during the interview (Minichiello et al., 1999; Rice & Ezzy, 1999).

Research using in-depth interview often involves frank and open discussion that requires a certain amount of trust and rapport between the interviewer and the interviewee for the expression of deep inner thoughts (Minichiello et al., 1999). The development of rapport is an important feature involved in in-depth interview because it emphasises the sharing of power between the researcher and the participants in the construction of knowledge (Reinharz, 1992). A number of these features are also relevant to the facilitation of focus group interview, which was another data collection method used in my research. The use of focus group interview will be discussed in the following section.

3.2.3 Focus group interview

A focus group is described by Holloway and Wheeler (2002) as a group of people, often with common experiences or characteristics, who are brought together for the purpose of eliciting ideas, thoughts, and perceptions about a specific topic or area of interest. Focus groups are characterised by the participants interacting in an in-depth interview through which the researcher discovers how people in the group think and feel about a particular issue (Holloway & Wheeler 2002).

Focus group interviews vary from individual interviews in that they stimulate ideas that are then explored from multiple viewpoints—or shared perceptions—of the issue being discussed, rather than from an individual's understanding of the issue alone. The dynamics of a group may reveal dimensions of the topic being discussed through introduction of anecdotes, joking behaviour, and shared reaction or identification with another group participant's statements (de Laine 1996). This aspect of focus group interviewing makes it a valuable tool with which to explore cultural values and beliefs of a group (Holloway & Wheeler, 2002). De Laine (1996) considers that the group brought together as a unit for the focus of research rather than the individual participants distinguishes focus groups as a tool to analyse the culture of an identified group.

The importance of group participants interacting and, thus, providing a broader sphere for discussion and altered context for the exploration of the topic being researched cannot be underestimated. This interaction can provide a supportive environment for the expression of ideas and feelings that may not be discussed easily for fear of being seen as deviant or straying from the norm (de Laine, 1996). St John (1999) considers that a benefit of focus groups can be the provision of a safe and respectful environment in which participants can express their views.

The creation of a safe environment for the exploration of the reasons why the participants in this study chose to birth in their own homes also supports the feminist principles which guide this research. The aspects of focus group interview discussed above make it a particularly suitable model in the investigation of why these rural women chose to birth at home—particularly in view of the small number of women who do choose this option in a rural setting and in the face of medical advice to the contrary.

The chosen methodology for my study and the data collection methods utilised are consistent with the aim of gaining an understanding into why these rural women chose their home as the venue to give birth. Gaining understanding of what motivates a cultural group to act in a certain way and the meanings they associate with such actions is best achieved through an ethnographic approach, and the narrow focus on the counterculture of women who choose to give birth at home is appropriate for the use of a micro-ethnographic methodology. The data collection methods of participant observation, in-depth interview, and focus group interview are consistent with the principles of feminist research, which require that women's voices be heard without distortion by the researcher, and that the women in the study are central to the generation of new knowledge. The following section details the manner in which the theory underlying the research methodologies has been applied to the conduct of my research.

3.3 Research methods

The following section details the procedures used to conduct the current study, including the recruitment of participants, the eligibility criteria for inclusion as a participant, sample selection, ethical considerations of the research, data collection procedures, and the analysis of the data.

3.3.1 The recruitment of participants

Women were recruited to be participants in this study through the placement of A4-sized, black-and-white printed flyers, which outlined the research project and called for volunteers to be involved (Appendix 3). Thirty flyers were placed across Central Victoria in local shop windows, cafes, maternal and child health centres, doctors' surgeries, community notice boards, and local hospital notice boards. A contact telephone number was included on the flyer to allow interested women to contact the researcher and discuss their possible involvement in the project. The women who rang the researcher were provided with a detailed verbal explanation of the research procedure, and were then asked two questions to determine if they met the inclusion criteria for the research (see section 3.3.2 below). These questions related to whether her home

birth was planned or unplanned and where the woman was living at the time of her planned home birth. Those women who were living in Central Victoria at the time of a planned birth were eligible for participation. If the caller was eligible, the researcher advised her that involvement in the research entailed her participation in an individual in-depth interview with the researcher—at the time and setting of the participant's choosing—about why she chose to birth at home.

Potential participants were advised that the researcher would audiotape the interview and have it transcribed later as data for analysis. A copy of the transcribed interview would be returned to participants to allow them to verify the contents or make changes, clarifications, or additions if desired. The potential participants were also made aware of the researcher's intention to compile field notes that would form a body of data relating to the interactions/time spent with the women.

It was explained that following the individual interview, participants would then be given the opportunity to participate in a focus group meeting with other study participants. The purpose of this focus group would be to provide the women with an opportunity to discuss further their decision to choose their homes as the venue where they would birth their babies.

The woman then either elected to volunteer to become a participant in the research or declined any further involvement.

If the woman elected to be a participant, a mutually agreed time and venue to conduct an individual interview was arranged during this phone conversation.

3.3.2 Eligibility criteria

The criteria set for women to be eligible to be a participant in the research were as follows:

1. The woman was a resident in the area identified as Central Victoria at the time she planned to have a home birth. The area identified as Central Victoria for the purpose of this research is inclusive of the towns and surrounding areas of Daylesford, Castlemaine, Kyneton, Macedon, and Blackwood. The hospitals servicing these areas are Hepburn Health Service in the Daylesford region, Kyneton District Health Service in the Kyneton area, and Mount Alexander Hospital in the Castlemaine area. Tertiary level hospitals are available at Ballarat, Bendigo, and in the Melbourne metropolitan region. A map outlining the research area is attached as Appendix 2.

2. The woman planned a home birth for a current pregnancy, or had planned to have a home birth within the preceding six years. The outcome of actually birthing at home was not a key factor in eligibility for participation in the study, but rather the intention or desire to birth at home and the experience of undertaking the associated planning that is involved in the decision to have a home birth. No restriction was associated with the number of pregnancies or births a woman had experienced or the setting where previous births had taken place.

3.3.3 Sample selection

The sample used in this research was a convenience sample consisting of the first ten women to contact the researcher who met the eligibility criteria and consented to be participants in the research. Statistics collated by the Victorian Perinatal Data Collection Unit show that the total number of women who gave birth in Victoria in 2002 was 63,069 (VPDCU, 2002). Twenty-six percent (16,276) of these births were to women who were resident in rural areas. Home birth statistics are not specific to the area the woman resides in at the time of birth, but collated statistics state that in Victoria in 2002, 162 women had a planned home birth (VPDCU, 2002).

The sample size of ten women is reflective of 6.2% of the total population of women who chose to birth at home in 2002. Taking into consideration the small number of women who choose to birth at home, and the fact that only 26% of all births in Victoria in 2002 were recorded in rural areas, the figure of ten participants for this study of women who chose to birth at home in a rural area was considered to be a representative sample size.

This sample size also produced sufficient data to establish that theoretical saturation had occurred from which key concepts and themes could be developed. Theoretical saturation is considered to have occurred in data collection when similar ideas or instances recur in the data despite diversity being sought by the researcher (Llewellyn, Sullivan, & Minichiello, 1999). The sample size of ten participants was also congruent with theory relating to focus group interviews that suggests that six to ten participants is the optimal number to produce the best data (Llewellyn, Sullivan, & Minichiello, 1999)

3.3.4 Ethical considerations

Approval for this research was sought and obtained from the Ethics Committee of the University of Ballarat before any attempt was made to recruit participants for this project.

All participants in this research were involved voluntarily and signed a written statement of informed consent (Appendix 4) after they had read and understood a plain language statement (Appendix 1) discussing the research. The women were made aware that they were free to withdraw from the research at any time without prejudice.

In the event that any participant became distressed at any time during the research process, consultation with a counsellor or practitioner of the woman's choice was available to facilitate follow-up care. To ensure participant confidentiality, all data collected in the course of the research—including tape recordings of interviews, printed transcripts, and computer disks containing data—has been stored in locked facilities in the researcher's home. The person contracted to transcribe the taped interviews was required to sign a confidentiality agreement prior to transcribing any data, and alphabetical codes were allocated to the participants' recorded interviews prior to transcription to maintain the privacy and confidentiality of the participants.

The participants were each given a full verbatim transcript of their individual interview to read and amend where necessary. This step was taken to ensure the information collected was an accurate record of what each woman wished to disclose about her decision to birth at home. Pseudonyms were used throughout the research for all persons named in the data to provide confidentiality.

3.4 Data collection methods

Data collection methods used in this research involved:

- individual semi-structured in-depth interview;
- focus group interview; and
- participant observation

This diversification of data collection techniques allowed for cross-referencing of findings from one source with another to add rigour and to support the validity of the findings. The inclusion of the women in each data collection method employed was reflective of the feminist framework underpinning this research project. The following sections give detailed explanations of how these data collection methods were utilised in the current study.

3.4.1 Individual in-depth semi-structured interview

Participants initially contacted the researcher via telephone after responding to the flyer calling for volunteers to participate in the research. At this initial point of contact, the women were given a detailed outline of what was involved in participation. If they chose to volunteer to be a participant in the study, a mutually-agreed time and venue for an in-depth interview was arranged. The researcher made it known to the participants in this initial phone conversation that she had given birth at home. Permission was sought from the participants for the researcher to bring her baby with her to interview appointments.

In the current study, nine of the ten participants elected to conduct the interview in their own home. One of the participants chose, for her convenience, to come to the researcher's home to be interviewed. Five of the women chose to be interviewed in the afternoon, and the remaining five women chose to be interviewed in the late evening.

A number of the participants had their young baby with them throughout the interview and attended to them during the interview. At a number of the interviews, the researcher had her home-birthed baby with her, which prompted general conversation about babies and birth and facilitated the establishment of rapport between participant and researcher. Much of the introductory conversation revolved around the participant and the researcher sharing stories about their home births.

The interviews were conducted in an informal manner, generally while sharing a hot drink and a snack. Before commencing the interview, each woman was given a written plain language statement detailing the research, and an accompanying written consent form for her to sign to confirm her informed consent to participate in the study. Specific permission was then sought from each participant to audiotape the interview. Each woman was advised that her complete interview would be transcribed verbatim, and that a copy of this document would be posted to her to read, and to amend if desired. She was advised that the amended copy, once returned to the researcher, would be the article used as data.

Semi-structured in-depth interview techniques were used that involved the use of an interview guide consisting of five broad topics for discussion. The women were each shown the same guiding questions prior to the commencement of the interview to provide them with a general starting point for the discussion, and to encourage openness and equality between the researcher and participant during the conversation.

The guiding statements/questions for all interviews were:

1. Please tell me about your decision to have your baby at home.
2. What things were/are important to you about having your baby at home?
3. How did you find out about home birth and has this influenced your decision to birth at home?
4. What expectations do you/did you have about home birth and do you feel they have been met?
5. What things would impact on any future decision to have a baby at home?

Once informed consent had been granted, permission to record the interview had been obtained, and the woman had viewed the guiding questions, a small hand-held tape recorder set to record was positioned between the researcher and the participant and the interview commenced.

The interviews were interviewee-directed, in that the conversation could include any subject matter the women chose to discuss in relation to her decision to give birth in her home. All interviews had the five topics from the interview guide introduced into the conversation, although not in identical sequence. The interviews took the form of a two-way dialogue or conversation between the interviewee and the researcher, rather than a more orthodox question and answer format. It was intended that, through this less formal approach, the women would speak in their ordinary language about what was important to them about their decision to birth at home.

Although it was not specified in this research that the participants should be alone at the time of the interview taking place, the majority of the women chose an area of their homes to be interviewed which was removed from the general activity of the family, and which provided seclusion from other family members for the duration of the interview. Some women structured the timing of the interview to ensure privacy and some uninterrupted time when the interview could be conducted, such as when older children were attending school and partners were at work, or late in the evenings when children had gone to bed.

During some interviews, there were instances where the woman's partner was present in the room for a short period of time, and occasionally the woman chose to refer remarks or

comments to her partner. It was not the intention of the researcher to conduct interviews with couples who had decided to birth at home, but, in the instances when a partner chose to contribute briefly to the conversation, this was not discouraged. For the greater part of the interviews, however, women spoke independently of their partners.

The timelength of the actual interviews was variable for each woman—one interview lasted a little more than one hour, while others were conducted over three hours. The majority of the interviews lasted approximately one-and-a-half to two hours. In some interviews, the women indicated that they had no more information to contribute about why they chose to birth at home, while other interviews were concluded by the researcher when it seemed appropriate, with a general question asking if there was anything more they wanted to say or felt was important about her decision to birth at home. At the conclusion of the interview the tape recorder was turned off.

The tape recordings of the individual interviews were then transported and hand-delivered by the researcher to the person contracted to transcribe them. On completion of the transcription, the researcher collected the original tape recordings and the transcribed data that had been stored on a floppy disk. The data was then entered onto the researcher's computer, and the audiotape and floppy disk were stored in a locked cupboard in the researcher's home.

Participants were each sent a copy of their transcribed interview through surface mail. An accompanying letter encouraged the women to read the transcript and verify its content, and reminded them that they were free to make any alterations or additions to the transcript they desired. A stamped, return-addressed envelope was included with the document to enable the women to return their amended transcripts to the researcher. A timeframe of three weeks was given for the women to return their transcripts to the researcher. The women returned their transcript to the researcher via the pre-paid envelope or in person. At no time during the research did any participant have access to any other participant's transcript of interview.

3.4.2 Participant observation and field note compilation

The time spent with the women in their own homes prior to and after the formal individual interviews has been classified in this research as participant observation. It entailed entering the world of the participant, observing her in her natural setting, and sharing her experience of a life event during that time. The researcher compiled field notes from the episodes of interaction with the participants in the time associated with the individual interviews and the focus group interview. The recording of field notes was done as soon as practicable after the interviews had

been conducted. These field notes were a record of the researcher's thoughts about the interactions with the participants, and included shared information about the choice to birth at home additional to that which was tape-recorded during the formal interviews. The field notes also included a record of non-verbal interactions between the researcher and the participants. The field notes were also a means of recording information shared by the participants through the women's artefacts, such as videos and photographic records of pregnancy and birth at home, collections of candles, or particular music they chose for their labour and birth. One woman chose to share written documents concerning her choice to birth at home and these were included in the field notes. The field notes also allowed the researcher to record details of the women's homes and places of significance to the women as they told of their decision to give birth in their own homes.

3.4.3 Initial data analysis

The researcher then immersed herself in the data obtained from the individual interviews and the compiled field notes. The transcript of each individual interview was analysed to identify points the participant identified as important in her decision to birth at home. The field notes were also reviewed for commonalities concerning what women had shared about their decision to have a home birth.

A list of prominent points about the decision to birth at home was made from each interview, and, at the completion of reading all of the interviews, the lists were compared for similarities. The data from both individual interviews and the field notes was categorised to compile a list of common reasons concerning why women said they chose to birth at home. This list of common categories derived from the individual interview data was used as the basis for collaborative analysis of the data through group discussion at the focus group meeting.

3.5 Focus group meeting

The purpose of the focus group was to gather members of the researched cultural group together as a collective to allow for discussion of the data collated from the individual interviews and participant observation in a group forum. The gathering together of participants to discuss the data was in keeping with the collaborative nature that was integral to the feminist framework utilised throughout this research.

The focus group participants were seven of the participants from the individual interviews plus the researcher, making a total of eight participants. The participants had been recruited when

they responded to an invitation in the letter accompanying each participant's individual interview transcription. Each woman could then indicate to the researcher if she wished to participate in the focus group when she returned her interview transcript.

The option was offered to either attend a meeting on a set date and time, or to try to co-ordinate times that were convenient to a number of the participants. None of the participants chose the option of nominating a date and time to co-ordinate a focus group meeting. Seven of the ten women invited to participate elected to attend the researcher's home at the set date and time. Unfortunately, the remaining three participants were unable to attend at this time— one of the participants had relocated to another country, and the meeting time was not suitable to the other two participants. It was not possible to co-ordinate a further meeting to include the two original participants who were unable to attend the focus group.

The venue for the focus group was the researcher's own home. This was chosen as the location for the focus group because it offered a private, central, informal venue. It also allowed the researcher to return the hospitality she had received when she had entered the participants' homes for the individual interviews. A two-hour time allocation between one p.m. and three p.m. was planned for the focus group interview to be conducted. Participants were invited to arrive at the researcher's home between eleven-thirty and twelve o'clock, and a light lunch was offered prior to the commencement of the formal group interview. The participants were advised that their infants were welcome to be present during the focus group meeting.

The women met together, shared lunch, and chatted informally prior to the commencement of the focus group interview. The focus group interview took place in the kitchen of the researcher's house with the participants seated around the large central table. The hand-held tape recorder was positioned in the middle of the table and set to record. Paper was provided for the participants if they wished to make notes. The researcher commenced the discussion by briefly outlining the statistics for the number of home births in the previous year, and identifying that birth at home is not a common choice in contemporary society. To guide the discussion, the researcher then introduced the list of common categories that had been identified from the data collected from the individual interviews. A printed copy of the list of the categories was given to each participant to read and annotate.

The women were then asked, collectively, why the factors that several of the participants had spoken about individually were important to the group members in their decision to birth at

home. The list provided the focus for the collaborative analysis of the data and the identification of larger themes that motivated the women's choices to birth at home.

The participants spoke freely about the identified categories and expanded on the meanings these categories had for them. The researcher contributed to the conversation as a participant but also as the mediator of the group. Nearing the completion of the time allocated for the focus group meeting, the researcher asked the participants if they were able to group the common categories into any order, or if they could identify any common thoughts running between any of the listed common categories. They were asked to mark their thoughts about this on the printed lists they had been given and return this to the researcher.

The researcher closed the meeting when the conversation became circular and the same points kept being raised, which indicated that theoretical saturation had been reached. The participants also expressed that they felt that the discussion regarding their choice to birth at home had been exhausted. Before concluding the focus group, the researcher asked the women to group any of the common categories on the list or to make written notes concerning these categories that they felt were pertinent. The researcher thanked the participants for their involvement and turned off the tape recorder. The women then chatted briefly over a cup of tea or coffee, and made their way home.

The researcher then collected all of the common category lists that the women had marked, as well as any other notes that the women had made on the paper provided during the focus group and the tape-recording of the meeting. Field notes of the meeting were recorded at the earliest convenience following completion of the focus group, detailing seating arrangements, interactions between group members, facial expressions and body language of participants, as well as the primary thoughts of the researcher about the focus group meeting and the prominent points that had emerged.

3.6 Data analysis

The initial analysis of the individual interview data was by content analysis applying coding of the interview transcript text (Ryan & Bernard, 2000). Content analysis seeks to view 'how things are said' and the underlying or symbolic meanings behind statements made by participants, and focuses on the manner in which language is used and the visual imagery this creates to establish meanings (Lupton, 2000). In the current study, this involved the researcher identifying commonalities in the individual interviews concerning why the women chose to

birth at home, as well as the identification of like comments recorded in the field notes. Lupton (2000:454) applies the term 'discourses' to identifiable patterns or themes which are used to represent people or things in texts, either in words or in images. In qualitative analysis, greater attention is often paid to the discourses which appear across a group of texts, rather than the frequency with which they occur (Lupton). Bulmer (1979) (cited in Ryan & Bernard, 2000:781) identifies a number of factors that may influence coding of data by researchers including literature reviews, professional definitions, researcher's values and prior experiences, as well as the researcher's general theoretical orientations and the nature of the phenomena under investigation. A flaw in this method of analysis is that it does not make visible the categories or points that may have been mentioned by only one participant, making what Silverman (2000) refers to as 'overlooked categories', which, as the name infers, is where some data is ignored or not taken into account in the overall analysis. In the current research, an attempt to reduce the possibility of the creation of overlooked categories was made through the ongoing collaboration of the participants in the analysis of the data allowing the women to identify if key influencing factors in their decision to birth at home have been unintentionally omitted.

Once concepts or categories have been identified, the task of the researcher is to bring clarity to their meanings and their relations with other categories. This is achieved through comparison of data from various categories to reveal similarities and differences, which then lead to the differentiation of categories into more clearly defined categories or possibly the development of sub-categories (Hamersley & Atkins, 2001). The current research used the focus group meeting as a vehicle for the collaborative analysis of the initial categories identified by the researcher that provided the clarity of their meanings as referred to by Hamersley & Atkins.

The field note data collated by the researcher was coded in the same manner as the interview transcript texts. The triangulation of data collection methods via the utilisation of the focus group meeting allowed for further rigour to be applied to the analysis of the data, particularly as this included the women participating in the data analysis and giving validity and authenticity to the finding so that it was an accurate portrayal of how the women in this cultural group perceived the data.

In summary, a micro-ethnographic approach underpinned by feminist philosophy and principles was utilised for the current research. Triangulation of data collection methods was applied incorporating ethnographic in-depth interviews, participant observation with compilation of field notes, and a focus group meeting. Analysis of the data generated was through classic content analysis of texts culminating in the identification of clearly defined major themes. A

collaborative approach between participants and researcher was utilised in the analysis of the data in accord with feminist principles of equality and partnership in the research process. The results chapter will now detail the findings of the analysis of the data.

4. Results Chapter

The philosophy guiding this research was based on feminist principles, which strive to make women's unrecorded knowledge accessible through providing a medium for their voices to be heard. This chapter presents an avenue for the women who participated in this study to express, in their own words, their knowledge concerning their reasons for choosing to birth their babies in their own homes. In keeping true to these research philosophies, the results have been produced through ongoing collaboration between the the participants and myself, the researcher. By presenting these results, I have attempted to let the voices of the women be heard to illuminate the reasons why they chose to birth their babies at home.

This chapter presents the results in a format reflective of the manner in which the data was generated; namely, in progressive segments corresponding to the ongoing consultation with the participants. It was an integral component of this research that the women involved collaborated with the researcher in the analysis of the data generated from the various collection methods. Thus, the results are presented in stages of analysis and transitional clarity to arrive at the eventual findings.

Section 4.1 presents an overview of the participants and relevant demographic information. Section 4.2 presents the preliminary categorisation of data obtained via individual interviews and participant observation. The data generated from and refined during the focus group interview then follows in section 4.3. This is presented as four major themes concerning why this group of women who live in Central Victoria chose their own homes as the venue where they would birth their babies. These themes are conveyed in a cultural context in accordance with ethnographic methodology.

4.1 Overview of the participants

Ten women volunteered to be participants in this research project. Eight of the ten women were born in Australia; all of the participants spoke English as their first language. The women's ages varied from mid-twenties to early forties, and the majority of the women were aged in their thirties. All of the women in the research were in a relationship with the father of the child they planned to birth at home. Seven participants had education to tertiary level. Four participants had nursing or midwifery backgrounds, and two of these had practiced midwifery in the home setting as attendants at home births.

4.1.1 Birth outcomes

Of the ten women in the study, all but one achieved a home birth. The remaining woman gave birth in a major metropolitan hospital due to medical circumstances. This woman was included in the research because her initial intention was to birth at home, and she had undertaken the planing and organisation to have a home birth. Therefore, it was felt that because she had intended home as her chosen place for birth she had valid insights to contribute to the study.

4.1.2 Birth histories

All of the women spoke retrospectively about their decision to birth at home. Eight women had given birth at home within a 12-month period prior to being interviewed, one woman had given birth at home four years prior to being interviewed, and one woman had given birth at home two years prior to being interviewed.

At the time of the home births under discussion, five women were experiencing their first birth, while the remaining five participants had previously given birth on one or more occasions. None of the women had experienced giving birth at home prior to the birth they discuss in this study. Of the women who had previously given birth, two had experienced giving birth in mainstream hospitals, and one woman had experienced birthing in a birthing centre. Two women had experiences of giving birth in both a birthing centre and a mainstream hospital.

4.1.3 Birth practitioner attendants

The majority of women in my study chose to be attended by midwives during their home birth. Two women employed doctors to provide care jointly with midwives. Of the nine women who did achieve a home birth, qualified midwives attended seven of the births. Three women had two midwives in attendance for labour and birth. One woman had two midwives and a medical practitioner present at her home birth. One woman chose to be cared for by a retired medical practitioner and two lay midwives. Three of the women had care provided by one midwife during labour and birth. One woman gave birth at home prior to the arrival of her contracted midwife and was attended by her partner at the time birth occurred (although the midwife did arrive shortly after the birth). The woman who birthed in hospital had the midwife she had contracted for her home birth present with her as she gave birth.

4.1.4 Participants proximity to hospital services

Four of the women in this study lived in rural towns with a hospital that provided maternity services with doctors available on call. The remaining six women resided in outlying regions from rural towns and had a minimum of fifteen kilometres to travel to a local hospital. The minimum travel time by road from any of the local hospitals in the region of the study to a major regional hospital providing advanced maternity and nursery services was forty minutes.

4.2 Preliminary classification of data

Data generated from the individual interviews and from the field notes were examined by the researcher for identifiable similarities in the content and also to allow recognition of any differences that may have been present. After immersion in the data it was possible to identify common categories to classify what the participants shared in their interviews concerning their decision to birth at home. The categories formulated from the individual interview data are presented in section 4.3.1, and those formulated from participant observation/field note data are presented in section 4.3.2.

4.3 Individual interview data categories

4.3.1 Birth is a natural process

The first category to be identified was the most consistently repeated concept amongst this group of women concerning their decision to birth at home. The women in my study all held the belief that birth was a natural process, and that they each possessed the innate capacity to fulfil the process of giving birth. The women's deep convictions concerning birth were reinforced by the recurring concept in the data that they all desired to avoid intervention in the process of giving birth. Their cultural belief was that birth was a normal event and that they could give birth 'naturally'—that is, without intervention. The cultural concepts that birth is a natural process and that intervention in birth should be avoided were often spoken about simultaneously, as the following excerpts from interview transcripts display:

> *I genuinely believe that it [birth] is a normal process, I believe that women were designed to give birth without trauma.... I don't think we have to have so much intervention.* [Simone]

> *I wanted to experience one of the most natural things, birth, as natural and drug free, intervention free as possible.* [Virginia]

I didn't want any intervention. I feel like birth is such an amazing process and it is a natural one. [Naomi]

Women in my study found it difficult to reconcile this belief in birth as a natural process with the medical approach to birth that is common in contemporary society. This discord is evidenced by the recurrent reference to hospital as a wrong venue for birth as the following excerpts illustrate.

I feel you go to hospital if you're sick, not because you're giving birth. [Virginia].

I associate hospitals with disease, the sick and ill, and giving birth is just like the opposite, and it just didn't feel right to go in such a place to give birth. [Margaret]

I also stayed away from the hospital thing as much as I possibly could because it just felt so wrong in terms of babies and births. [Simone]

The whole idea of having a hospital birth felt really sterile to me and also disempowering in terms of a medical process rather than a natural process" [Naomi]

The majority of the participants recognised the role medicine has in pregnancy and birth where complications arise by qualifying the term 'natural' as pertaining to pregnancy and birth without complications.

4.3.2 The desire for safety

The second category to be identified related to the women's need to feel safe in the experience of giving birth and how this influenced the decision to birth at home. Safety in their experience of birthing was an important consideration for this group of women and it was a prominent focus in discussion during interviews. The participants' strong belief in the naturalness and the normality of birth influenced the context in which they constructed their conversations concerning safety and their choice to birth at home. The women discussed the topic of safety in a manner that revealed this factor as having four aspects: (1) physical safety; (2) emotional safety; (3) safety from the threat of intervention; and (4) safety in the relationship with their carers. While not all participants discussed all these components, most did address the issue of safety in one or more of these contexts.

The desire for physical safety in birth

The women in my research valued feeling physically safe in their experience of home birth, and considered that their decision to birth at home had not compromised the physical safety of themselves or their baby. All participants had an alternative plan for transfer to a hospital in the

event of any complications in their labour and birth and had ensured ambulance cover in case of an emergency. The participants who discussed safety from this perspective incorporated their understanding of physical risk when deciding on their birth venue.

> *It was going to be safe. I had all of the facilities there for in case there was an emergency, so I think the safety element was there.* [Maude]
>
> *I felt totally safe all the time and they [carers] did all the appropriate tests and checks.* [Anne]
>
> *Of course you have to consider possible complications, and perhaps if I was high risk I wouldn't have taken that option [home birth]...I really thought that I was low risk.* [Naomi]

Margaret considered available research findings concerning safety and birth venue when making her decision to birth at home.

> *All the studies for home birth when it comes to risks and outcomes they're much better with home births so why would you risk going to hospital?* [Margaret]

Safety from the threat of intervention

As revealed earlier, the participants in this study held a strong belief in birth as a normal process the female body is designed to achieve, and this belief was reiterated in their desire to give birth without medical intervention. One of the facets relating to safety and the decision to birth at home discussed by nine of the ten women was that birthing at home helped to make them feel safe from the threat of unwanted intervention in their birth.

Margaret, Naomi, and Edith each stated that their decision to have a home birth was influenced by the desire to avoid intervention in their labour and birth:

> *Just knowing that with home birth the risk of having drugs or interventions is so much smaller I think, because I didn't want it [intervention] so that's another reason to choose home birth.* [Margaret]
>
> *The possibility of intervention at home was far less than if I was in a hospital circumstance and I didn't want any intervention.* [Naomi]
>
> *I didn't want to have any of the drugs for pain control; I wanted the baby to be born naturally. I was happier in a situation where I didn't have that choice even if it was just a bit more difficult.* [Edith]

Anne was particularly reluctant to experience a hospital environment while giving birth because of what she perceived as routine interventions and chose home birth to avoid this:

My fear and a mistrust of traditional [mainstream] midwives and doctor's practice and their interpretation of "active birth" which equates to active interfering, such a poking and prodding, vaginal examinations, episiotomies, officious, efficient, heartless, no real connection with the woman, partner or baby.

The discussions concerning the decision to birth at home and intervention in birth relayed the notion that these women felt safer birthing at home where the potential for medical intervention in their personal experience of birth was minimised.

Emotional safety

Participants discussed, from an emotional perspective, how their decision to remain in their own environment to give birth had enhanced feelings of safety during this time. It was evident that some of the women placed a heavy emphasis on the emotional experience of giving birth and desired to feel safe in that emotional experience.

Virginia spoke of the safety her own space afforded her in birth:

I think just having my house as a space made me feel really safe... for me to be brave was to have to go to hospital but staying at home was being safe. Maybe it's the safety and secure feeling in a space that you have created rather than when you are pulled out of that space and you're put in someone else's space, which I see as sort of public.

Anne also commented how her own environment contributed to her feelings of safety from an emotional perspective:

I was in my own environment, if I had not been I would have been much more scared. In a hospital delivery room [I would be] much more scared. Just the smells, the unknown, not knowing the people...worrying about interference.

For Simone, birthing at home provided a venue where she could let down her emotional defences safely:

I wanted the privilege of being able to be just me without having to relate to people who didn't know me or didn't really care. Home birth provided security because I'm very much a homebody and to me it [birth] was exposing a part of myself that I'm not terribly comfortable exposing like that, not on a physical sense but on an emotional sense.

Maude also valued the emotional safety that her decision to birth at home offered:

You can do your own thing and feel that you don't have to explain it to anybody, and feel comfortable doing whatever you want to do within the security of your own four walls.

Safety in the relationship with their carers

In some ways, safety in the relationship with carers encompassed the other three components, because the participants' relationship with their chosen carers influenced the way they perceived their physical safety, emotional safety, and the boundaries of normality in birth beyond which intervention would be necessary. The importance of this aspect to perceptions of safety when considering their decision to birth at home was reflected in the frequency that this issue arose in interviews. Eight participants made comments concerning safety in the context of the relationship with their carers. The development of a trusting relationship with their carers was the most influential factor in enhancing the participant's perception of safety in their home birth experience:

> *I felt really safe and very comforted by my midwife's presence. We had spoken about my expectations...having trust in the midwife by building up a relationship for many months meant a greater sense of control in the process of labour.* [Edith]

> *I wanted to feel safe with my practitioner....I needed to know I had someone I had confidence in.* [Gemma]

> *Getting to know my midwife before hand was important so that you're not meeting them on the day, you trust them, you get on with it and you're really guided and you trust them when they say to you it's safe to do this if you're not sure.* [Anne]

The potential to establish a relationship with their chosen carer was identified as a major consideration by the majority of the participants when deciding to birth at home. The association between carer trust and their perception of safety was a significant factor in the decision for these women to give birth in their own homes.

4.3.3 The desire to participate in decision-making

The third category identified in the data related the women's desire to be involved in decision-making concerning their labour and birth. It was characteristic of the participants to be active rather than passive contributors in this decision-making process. The women in my study identified three key areas of decision-making in which they particularly wanted to assume greater involvement: labour and birth interventions; choice of carers; and choice of who could be present at the birth.

The following quotes illustrate how some of the women regarded having greater control over the proceedings as having influenced their choice of home as a venue for birth.

I'd definitely put having control of the process as a primary factor in the decision to have a home birth. I wanted to be in control of this process. I wanted to have a happy, safe and beautiful birth on my own terms. [Edith]

I have the power in my own space. I find when you go to a specialists rooms or doctors or hospital you lose power. They start talking over you and making decisions and you doubt yourself. I think I just liked the idea that it was my place, my domain that I was in charge of. I felt more powerful here than at a hospital. [Nancy]

I felt being at home I would be more in control of making those decisions such as episiotomy and pain control and not be pressured into doing something I didn't really want. [Naomi]

One of the issues relating to self-determination that arose consistently in the data was the opportunity home birth provided for the participants to elect who would share in their birth experience:

I think you get to state what you really want; what you want to happen or who you want to be there. [Virginia]

I think that my first priority would be that I had the power to choose what I wanted and didn't want. Like being able to choose who is with me, I wanted to choose the environment I give birth in. I wanted to be able to choose what intervention I wanted or didn't want. [Margaret]

The power to choose the professional birth attendants was important to the majority of women in my study, and this was articulated as a motivational factor to birth at home:

Another aspect of the home birth that I liked was that it meant engaging a midwife, the continuity of care. [Edith]

I think it is <u>really</u> important to feel out who you want to be there... being able to choose..., people are different and you click with some people and you don't with others. I went to a few midwives and some of them might have been too masculine or too clinical or just not the energy that would make me feel at ease through the process and I didn't want to feel uncomfortable at all. [Virginia]

The inclusion in decision-making that the participants valued was closely associated with the relationship they had formed with their chosen carers. The establishment, over time, of a relationship of trust enhanced the women's feelings of being involved in decision-making, predominantly through the sharing of information and expectations. Edith was able to articulate this relationship:

I felt that my midwife knew when I needed encouragement because we had spoken about my expectations...having trust in the midwife by building up a relationship for many months meant a greater sense of control in the process of labour.

Simone spoke of having the same philosophy concerning birth as her chosen carer:

> *I was really looking for somebody [a carer] that I felt very at ease with...All I wanted was someone who had the same approach to it [birth] as I had and who saw it as a perfectly normal process and a perfectly straight forward process and who I felt was on my wavelength.*

Gemma identified how her relationship with her carers impacted on her confidence:

> *Choosing who you have at your birth, people who I have confidence in, and that have complete confidence in me, and continue to tell me right through my labouring process how well I am doing...that made it so much easier.*

Nancy and Margaret spoke of the friendship they formed with their midwives, thus reflecting the degree of trust and understanding present between them:

> *So then when it came to the actual second stage you've got both of them [midwives], friends, you listen to them. Because you know them and by then you trusted them.* [Nancy]

> *I think the midwives really took on the role of a girlfriend or sister or maybe your mother or someone like that...* [Margaret]

The ability to be involved in deciding who could share their birth experience was identified as important to these women. All of the participants expressed how the decision to birth at home permitted them to have partners and family members involved in the birth. For some participants, having their partners involved with the birth was viewed as one of the major advantages of home birth:

> *Having my partner being there and being involved, I was really keen to have him help deliver the baby, to maybe really start that connection, that was really important.* [Anne]

> *I think that at a home birth the partner can be more actively involved. First of all with helping to prepare for the birth and during birth as well. ... to take an active role at birth may help him to take an active role as a father too later on.* [Margaret].

> *I really only wanted John and myself to be there and one other person who could support us and assist us.* [Simone]

> *Being able to invite them [husband, mother and midwife] into a very intimate moment really while you birth, and a very special moment.* [Helen]

For the women who had other children, the capacity to decide on their children's involvement in the home birth was significant in their choice to birth at home. The following quotes are typical of the types of comments made in relation to siblings' involvement in home birth:

The kids were fully involved, and no mad rush to the hospital and everything all fell into place making it an experience for the kids as well, a positive experience for them. [Maude]

It was important that they [children] be here and I wanted the girls to see that birth was just normal you know, not a drama or some medical condition. [Nancy]

We didn't want to pack the other two up and off, they were old enough to be involved. I could be there with them and them with me to welcome the new baby. [Helen]

These comments reveal that the women in my study felt that their decision to birth at home enhanced their involvement in decision-making around the events concerning their labour and birth, choosing their carer, and determining who would share in their birth experience.

4.3.4 Participants valued their own environment and belongings

It was evident that the participants placed great significance on the environment that the birth took place in, and their decision to birth at home was influenced by this. Most frequently, the women associated home birth with the ability to prepare and create a particular environment in which they would give birth. The creation of the environment for birth often involved the use of candlelight, the use of oils, and playing music.

I wanted it [birth] to be nice, to be beautiful. That was really important for me that there was beauty and peace. We used essential oils and we had a nice environment and flowers and nice music. Clean environment, nice cups of herbal tea to drink. Nice colours around. [Gemma]

And preparing for that [home birth] was just lovely, getting all those things ready and getting Alex's room ready and having my basket of labour things and preparing music and candles and that sort of thing. I had the oils that I like and my rescue remedy and related stuff all ready and I had collected candles which I had on a tray. So we had just in the corner of the room a little tray of candles lit with the kids' picture next to them. [Helen]

Seven out of the ten participants also talked about the creation of a space they felt they could use in labour, such as a water pool, or their garden, or property.

I've got a room in this house that I live in that I practice yoga in and I don't do anything else in there other than meditating and practice yoga in there. It's a very sacred site, and Ruth was born in that room so to me it was sacred and that takes months and months and months of creating that energy. [Naomi].

I thought if it was daylight it would be lovely views and I would have a nice walk outside and the surroundings would be much nicer and much more relaxed and I could do whatever I liked. [Nancy]

For me it was important and natural to do the nesting thing throughout pregnancy, creating a sacred space. [Virginia]

Some of the women spoke about the significance of the comfort that being in their own environment provided when they gave birth.

I was very comfortable. Ruth was born at 9.30 pm and by midnight I was in bed with this new baby, but it was my bed, in my room, in my home. [Naomi]

I also wanted my things around me. I wanted to be in a place where I knew how I related in that place, so there was a sense of belonging...I love my environment and I wanted to be here for that process [birth]. [Simone]

Also the sense of familiarity with my surroundings I really enjoyed. It's a place that I love and one that has been built specifically for us by David, that means a lot to me. That's a happy thing. It's a space that I enjoy very much and I feel very comfortable in and I think you need to be reasonably relaxed during the birth process. [Edith]

Perhaps it's not control, but the desire to feel comfortable in familiar surroundings. [Virginia]

For some other women, their home environment provided an important continuity of normality in their lives as they gave birth:

The main thing I wanted and did get out of it [home birth] was normal. Normalise everything. I woke up in labour, had a baby, had a shower, got up and had a cup of coffee, normal. Just the continuation of normal life. There was no interruption to life. [Maude]

I really just wanted that normality, normal family life around, and [to] have familiar things. [Anne]

Seeing it as something that we could do with just the family around, that support, that was probably the main thing, just no fuss at all. That I didn't have to jump in a car and go somewhere and organize the kids. [Helen]

Three of the women recognised the birth they planned at home was going to be their final birth, and they commented how they felt that birthing in their own home allowed them to achieve their optimal birth experience. Simone's comment illustrates this point:

It was predominantly my experience through the first 2 births that made me pretty adamant to have a home birth for my last child. I had actually realised by that stage that it would be my last child and I wanted to experience the process of having exactly what I wanted for her and give it my best shot really.

4.3.5 Home provided freedom

Another issue that arose in six of the transcripts was that the participants considered that birthing at home provided them with greater freedom than alternative venues.

The notion of freedom generally related to the time constraints in labour and birth that the women associated with birth in a hospital:

> *I think one other reason [to choose to birth at home] is that I want to do it in my own time. Just because I was so rushed in hospital.* [Margaret]

> *I think my first baby would have been a slow dilation the same way as this baby was, a not too intrusive and difficult dilation, but because I was in hospital everyone said it's not happening fast enough.* [Gemma]

> *There are no schedules or timetables at home. The birthing process could take all night and no one would be rushing you along."*[Virginia]

Frequently, participants expressed how home birth provided the important freedom to move around the home without censure, rather than being confined to a designated space.

> *I think midwives are far more respectful of women at home because it is their space and its fine to go off wandering around the house and doing things.* [Anne]

> *I could lay in the lounge room if I wanted to or go into the toilet or have a long shower or I don't know I felt really comfortable to just be myself, to have the freedom to go wherever you want and take as long as you want.* [Virginia]

4.3.6 Local maternity services did not meet participants' needs

Six participants chose to birth at home after deciding the other available maternity services did not meet their needs. One of the prominent needs that these women identified as not being met by alternate maternity services was the establishment of rapport with care givers:

> *I remember one of the doctors speaking to me in a tone that was like a disapproving adult would speak to a child and I remember there and then making the decision that I wouldn't go back.* [Simone]

> *My decision was basically because my GP no longer does obstetrics and I don't have the same rapport with the other GPs.* [Maude]

> *I wouldn't take a dog to Hospital A. I don't care if you put that in bold letters. Not because of the midwives or the nursing staff, but publicly you don't have a lot of choices when it comes to doctors.* [Nancy]

For some of the other participants, the limited nature of the services available in the local area was a factor in their decision to birth at home. The following quotes illustrate this issue:

If there would have been a birth centre then that would have been an option for us, but since there was none available we thought well home birth is the way we want to go. [Margaret]

There was a shift in that they were offering you a service, and this is what they had to offer, and that was the limit of it. [Edith]

The identification of these broad categories completes the initial analysis of the individual interview data. Consideration will now be given to the categorisation of the field note data. The breakdown of field note data pertains more to the identification and investigation of the artefacts used by this cultural group in their planned home births. For this stage of data analysis, observations made during the visits to the participants' homes have been grouped into common categories.

4.4 Participant observation and field note data

4.4.1 Rural locality of homes

One of the most striking features about where the women lived was their geographic isolation. Six of the nine participants resided outside of rural townships in semi-isolated situations, either in secluded bush settings or on large acreage farmland with a considerable distance to neighbouring homes. It was not uncommon to travel down dirt roads to find the homes of these participants, which all had a feeling of seclusion and privacy related to the absence of immediate neighbours. The homes of the other three participants were in rural townships, and their homes also provided a sense of privacy and seclusion, partly through the presence of established gardens with large trees close to the house, or the position of the property on hilltops above surrounding homes. It was feature of this cultural group that their homes when viewed as artefacts had these elements of seclusion and privacy.

4.4.2 The artefacts used for home birth

Much of the field note data focused on the items that the participants had used or made for use in their home birth, or had created as a product of their home birth experience. One of the main sources of field notes were the verbal recollections of birth that participants shared with me during my visit to their homes. Three participants showed me the place in their home where they gave birth. Another source was the photographic record of the home birth, which was shared with me by four of the women, and, in one case, the videorecording of the participant's

home birth. These photographic records of home birth are an artefact of this cultural group themselves, but also contain evidence of other artefacts that the women in this study created.

The photographs that these participants shared with me were stored in albums created to commemorate the birth of their child, and contained images of the women in pregnancy, during labour and birth, and in the time immediately following the birth. Photos of family members with the new baby were also kept in these albums. Some participants had taken photos of items associated with their baby, such as hand-crafted rugs, their birth pool, and candles. Helen was particularly fond of a photo of herself with her baby taken just after giving birth, and she made particular mention of being on her couch on the blanket she had handmade for the event of giving birth. Nancy commented how nice it was to view herself giving birth in her own lounge room in the video of her home birth, and was particularly pleased to be able to see her children's reactions to her giving birth.

It was evident in the field note data that the majority of the participants purposefully prepared a place in their homes in which to give birth. The continuing discussion concerning the creation of a place to birth, and the artefacts that these participants used, will cover four dimensions: setting, light, smell, and sound.

Setting

The feature most frequently recounted by the participants in preparing the environment for home birth was the setting up of an area for a pool for use in labour. Seven women considered the availability of water to use in their labour as an important factor. This often meant selecting a room or space to erect a sizable pool or tub with access to a water source and a facility to drain the water away. Four of the women showed me the place where their pool had been and outlined the setting up of the facility. From this I concluded that a water pool is an artefact used in home birth.

A number of the women prepared their home environment in other ways. I recorded in field notes how Virginia prepared her home for the birth by having various pictures and images of pregnant women and women with infants on display, and how Gemma had a collection of crystals she felt had enhanced the birth environment. Naomi prepared her birth room using yoga and meditation. Helen had made a rug on which to give birth which held particular significance for her in her home birth. These items are artefacts women have used in preparing the setting for their home births.

Light

The preparation of the birthplace frequently involved the use of candles for lighting, and three of the participants specifically created collections of candles for their birth, and then created lasting records of these collections in photographs to signify their importance. I have included candles as artefacts used in home birth.

The use of colour in the birth place was another factor spoken about by participants. Some participants had decorated rooms in particular paint colours and had draped coloured fabric banners across the ceiling to alter and soften light. Natural light was a feature of Simone's recollection of her home birth. She recalled the birth occurred just on dusk in her lounge room, and she referred to the time of birth as one of the most romantic moments of her life. The ability to alter the available light by choosing to use candles, softening electric light, or natural light was a feature of how participants used light as a tool in their home birth.

Smell

The use of aromatherapy in preparing the environment for home birth was a feature that some of the women recounted in their telling of their home birth experience. This was often associated with the use of candles, either in oil burners or as fragrant candles. Scent was used as a tool for creating an environment of peace and to promote feelings of wellbeing. Lavender oil was a frequent choice of fragrance as was clary sage and rose. I have included fragrant oils as an artefact some participants used in their home birth.

Sound

A number of the women spoke of choosing the music played during their labour and birth as an important part of the preparation of the environment. Although there was no tangible evidence of music being important, such as in photographs, and women did not show me individual recordings of music, this was an important part of the preparation of a home birth nonetheless. The fact that some of the women could recall or associate particular selections of music that they had compiled (such as the Gregorian chanting chosen by Anne) or listened to during their home birth warrants the inclusion of music as part of the preparation of the environment in home birth. Virginia had a selection of musical instruments in her home that were played to her baby during pregnancy, and she considered music an important part of her birth plan.

It was also evident from field notes that some of the participants in this research used music as a tool to create the environment for birthing and, therefore, I have included music as an artefact of this group.

The categories described above were presented to the participants at the focus group meeting to identify—through discussion and collaborative analysis—the meanings the participants associated with this data. The analysis of this data identified four major themes concerning why women in this group chose to birth at home. These themes are identified and reported in the following section.

4.5 Focus Group Findings

By presenting the participants in this research with the data that had been generated from the individual interviews, I was able to validate these findings and add clarity to them. This was particularly relevant from a cultural perspective as participants were presented with the data as a cultural group, rather than individually, which gave a new perspective to the findings. In this setting, I was able to gain insights as to why the particular categories that the participants had identified individually held significance for these women in a cultural context.

When the women were asked why the factors identified in the common categories were important to them, the discussion focused on the needs that were met by these things of significance. Four major themes emerged: beauty, posterity, sacredness, and partnership. While each of these themes has individual merit, the synergistic effect of the themes was also recognised in the discussion.

4.5.1 Beauty

The first issue that was clearly articulated by the participants was that the decision to birth at home revolved around the cultural belief the participants held that birth was about beauty. The women identified that they believed natural birth to be a beautiful event, and that the decision to birth at home permitted them to accentuate the beauty they associated with the experience of giving birth. These women considered that home birth provided the ability to maintain the normality of birth—and, thus, its inherent beauty—as well as allowing them to accentuate their experience of beauty in birth through creating and embellishing their own environment with artefacts and selecting who would be present.

During the focus group, when I asked the participants collectively why it was important for them to give birth to their babies at home, Edith stated, 'Because it's about beauty. Hospitals aren't about beauty.' I rephrased the statement back to the group: 'So is it important to us that our births be beautiful?' The response was a unanimous and emphatic 'Yes!'.

Many of the actions the women undertook in planning and preparing for their home birth were identified during the focus group as being aimed, fundamentally, at providing a beautiful experience of birth. The creation of a beautiful physical and emotional environment where birth could occur was identified as important because it enhanced the beauty the women in this group associated with unadulterated birth. The act of being in their own space provided beauty for many of the women.

The most universal perspective of beauty among the participants was that normal or natural birth was inherently beautiful. As Virginia stated during the focus group discussion, 'Birth is beautiful. I love giving birth. I love this feeling and my ability to do it.'

For these women experiencing unadulterated birth or birth that did not involve medical intervention accentuated their interpretation of the beauty inherent in normal birth. These women considered that birthing at home minimised the potential for medical intervention in their birth, and thus preserved the beauty inherent in normal birth that they sought to experience.

Beauty in birth also encompassed the environment in which labour and birth occurred. The aspect of a beautiful environment held importance for these women on two levels: the significance of a beautiful environment as an influence on their own experience of labour and birth; and the significance of the environment as an influence of their baby's first experience of life outside of the womb. Naomi articulated this point: 'I wanted my baby to come out and feel comfortable in the world, being welcomed into the world. At home I can create that.'

The environmental aspect of beauty inspired the participants to embellish their homes with belongings to enhance what they believed as beauty. It was in this capacity that many of the artefacts described earlier in the results chapter were utilised by the participants. Examples of the use of artefacts to create a beautiful environment included the way the participants used candle lighting in their birth environment to provide dim, gentle lighting; the use of music during labour; and the use of aromatic oils.

The concept of beauty also involved a sense of comfort for the participants. This notion did not relate to the absence of pain, but to the security—both emotional and physical—that some women associated with their own space, their own familiar surroundings, and the company of family members and trusted carers and support people. Edith and Virginia both commented on way their own space enhanced their feelings of safety and security during their home birth:

I didn't know whether I was going to be wandering around the property huffing and puffing or whether I was going to be in the house or would I want to get in the dam or you know I didn't know. I didn't know how long it was going to take, but you're safe. [Edith]

The room I set up for birth tried to create a pool for my womb an external womb that I could be I, and for him [baby] to come into. That space that I felt safe in. Keep that secure feeling that everything is ok this is normal this is home and it is safe" [Virginia]

The importance of the ability to determine who would share in the birth event added to their experience of comfort and, thus, their expression of their birth as 'beautiful'. The following comment, from Virginia, is typical of many made throughout the discussion:

That is one thing about the home birth for me, being able to share the experience with my partner and for him to catch our baby and me feel totally comfortable about him being there.

Some members of the focus group also expressed the importance of having a beautiful birth experience because it was seen as a positive legacy to hand down to their child. The nodding and verbal aggreement that greeted the comment by Anne—'Sharing with your kids, you know your birth was beautiful'—reflected how the women wished their children to understand their birth.

The beauty of the home birth events had been captured and preserved by some of the participants in photographic and video images of the pregnancy, labour, and birth so that they could be shared with their child and others in the future. The sharing in the experience of a beautiful birth was also seen to be an important legacy for all the people chosen to be present for the event, particularly other children, partners, and, in some instances, parents. These women wanted to share the beauty they believed to be inherent in normal birth, and for other people to see birth in this same light. This facet of portraying beauty in birth was held as very important, particularly by women with daughters because they felt that they were introducing their daughters to an experience of birth that would encourage a belief in themselves and their own future ability to birth in a manner free of medical dominance. Gemma's comment during the focus group illustrates this point:

I think home birth for me with my daughters around the idea of giving them the belief in themselves and in their bodies ...the same concept that women are strong and able to do these things. We're not weak and not sick. I think that is a really important part of it.

A review of the components of a beautiful birth experience as perceived by this cultural group identifies that normal birth was viewed as inherently beautiful; that the environment in which

birth took place was significant to the experience of beauty for both the mother and the baby; and that the people who shared the birth experience contributed to the construct of beauty in childbirth. The attainment of a beautiful birth experience was seen as a positive legacy to pass onto the child being born, and to others who shared in the birth event. The sharing of the beauty of birth reciprocally enhanced the beauty experienced.

4.5.2 Posterity

The second theme identified was posterity. This related to the importance the participants placed on creating a birth history that affirmed their cultural belief in the naturalness of birth. The need for the creation of a positive birth history was viewed as twofold. Firstly, it was seen as an important factor for the child being born, so that their understanding of their entry into life would be gentle and positive; and, secondly, as a tool to ensure the continuation of the cultural belief in the naturalness of the birth process into the next generation. Participants could identify that this theme was fundamental to why they felt it was important to have siblings present for the birth and to have partners share in the event. In the case of one participant, it was important to share this perspective with her own parents who had a medicalised experience of birth. The creation of a positive birth history was associated with enhancing the inherent beauty of natural birth, avoiding intervention, and sharing the event with significant people.

The theme of posterity related to the desire these women expressed to create a particular history of birth. The term posterity identified the way that the women wanted to share their beliefs about the normality and naturalness of birth with others in the hope of influencing the way birth would be experienced in the future. It related to not only the physical act of giving birth without medical intervention but also to other facets of birth these women identified as important, such as knowing the beauty inherent in birth, recognising the sacred components of birth, and acknowledging the reintroduction of birth into the social sphere of daily life and the people who share that space.

The focus group discussion revealed a need expressed by the women about wanting to be educators to their children, to their partners, to their parents, and to their friends. They hoped to share a positive experience of birth with these people, to show them that birth could be normal, that women have the ability to give birth in a way that is beautiful and sacred and that does not need to be supervised and intervened by medicine and technology. They wished to teach that birth could be integrated into the experience of normal life—not removed and isolated and

occurring in a foreign situation and space. Edith clearly articulated this aspect during the focus group:

> *It's an integral part of your life. You tie it more closely to ones life. It is an extension of an experience within your life rather than it being something alien to your life. So your baby is introduced to your life. And it means a great deal to me that they live and are born in the same place. You know within a foot or two. That is significant.*

It was important to the women in this study that normal birth, and all that normal birth entailed, was recognised and respected and that it continued to be known in the future. The continuation of this knowledge was important because the women identified contemporary birth environments as valuing technology and discouraging women to believe in their innate capacity to give birth. The women discussed that it was important to impart knowledge that provided an alternative to birth within the medical model.

> *I think it is important in sense of teaching normality of birth that it is actually normal for women to give birth. It's not normal for men to intervene and its only recently that they have been doing that.* [Naomi]

Their decision to give birth in their own homes was motivated by their desire to let others experience birth as a beautiful, sacred act that could be honoured in an intimately prepared domestic setting, attended by chosen and skilled carers who shared an individualised understanding of birth with the woman to whom they gave care. The decision to birth at home allowed the women in this study to be a living example of the social model of birth, which recognised the psychological, social, and spiritual facets of birth in balance with its physical facets. Nancy's comment at the focus group sums up how she hoped to influence birth in the next generation:

> *That's what I liked about Sean's birth, I was also educating the two girls that they don't have to have them in hospital. Even the girlfriend I got to come along and sit with them...she said I had no idea you could birth like that. So I felt really good that I was able to show her that she didn't have to have medical [birth] next time and all that intervention. And the girls will grow up thinking this is totally normal again to have a baby."*

Another facet included in the posterity theme that the women expressed as very important was the individual birth history that they would be passing on to their children. Virginia's comment, quoted earlier, concerning sharing the beauty of birth with her child encapsulates the importance the women in this group placed on the creation of a positive birth history for their children. The wish to enrich the child's life through a positive affirmation of their beginning was seen as a strong motivator to birth at home in an environment where the women could maximise the

beauty they experienced in their giving birth. They did not want to pass on to their children birth histories that depicted pain and resentment about the experience of giving birth to them. It was important to be able to say that birth was a positive and valuable experience, and for that to be the foundation of their child's life and the beginning of the child/parent relationship. The following comment made by Gemma at the focus group succinctly stated the desire to create a positive birth history: 'You are giving strength to your kids by being able to say it's the best possible start that we can give them.'

The needs identified in the posterity theme were strong motivational factors that compelled these women to choose to birth at home. The ability to create the environment of birth and determine who would be present when the baby was born, as well as minimise the risk of intervention were all components of the decision to birth at home that fulfilled the need to pass on this cultural knowledge of birth to others.

4.5.3 Sacredness

The third theme to emerge concerning why the participants chose to birth at home was sacredness. Sacredness did not refer to a religious or spiritual construct but, rather, was identified by these women as a reflection of the magnitude of the life event of birth—both for themselves and for their babies. Participants acknowledged that giving birth was a major transitional event in their own life and in the life of their baby and wanted to be able to honour that major life event in the manner they gave birth and welcomed their new baby. Sacredness also encompassed the honour that these women attributed to the exclusively female ability to give birth. The creation of a new life and the conveyance of that life from the womb into the world were regarded as sacred acts. The recognition that giving birth had the potential to be an experience of self-discovery and to significantly affect their understanding of themselves and their capabilities also defined the sacredness of birth for women in this group.

Elements in the decision to birth at home that had bearing on the construct of sacredness for members in this group included the creation of a safe space for the unfurling of natural, unadulterated birth. The preservation of the normality of birth was important because intervention was considered to violate the sacredness of birth for both mother and baby. The creation of a beautiful environment for birth was important because it enhanced the experience of sacredness. The creation of the social and the physical environments were integral to the experience of sacredness as defined by members of the focus group.

There was strong recognition in this group of the innate power women possess to achieve birth, and this power and ability was revered. The eternal history of women giving birth and the acknowledgement that this is a special and revered role reserved exclusively for women was discussed. Naomi summarised this facet: 'It's a feeling of femininity. For so long, forever, it has been women giving birth.'

It was an important component of the concept of sacredness that birth was allowed to occur without intervention, and there was consensus amongst these women that to interfere in the natural process of birth violated the beauty and sacredness of the event. Achieving a natural birth was seen as the optimal way to honour the sacredness of birth as a womanly process and to experience the uncharted depth of power that women have when they give birth. The experience of giving birth by their own power was often referred to during the focus group and in individual interviews using terms such as empowerment, self-discovery, finding a sense of strength in themselves, and trusting themselves. Virginia's statement during the focus group encompassed much of the conversation concerning the sacredness associated with the innate power women display in giving birth: 'I trust that I can do it myself and I don't need to put all of my trust and power in someone else to do it for me.'

The way these women sought to experience this womanly facet of sacredness related largely to the emotional supports they had in place in their plan to birth at home. The creation of an emotionally safe environment where they felt able to be emotionally unguarded while they gave birth—without the fear that the process of birth would be taken over from them in an attempt to help them—was of key importance. This was particularly linked to being able to choose who would be present during the birth, the relationships of trust between the birth team members, and the shared respect for womens' innate ability to birth. Simone, Edith, Gemma, and Virginia all expressed their need for privacy and protection, commenting that even though they had planned to have a number of support people present, they eventually only wanted one or two people with them when they actually gave birth.

The physical environment of their own home also assisted some of the women to feel emotionally safe to experience a sacred dimension of birth. Naomi had extensively prepared her home using yoga and meditation to create a safe place for herself. Virginia spoke about using her birth pool to create her own 'womb' where she felt safe to welcome her baby.

> *The room I set up for birth tried to create a pool forme, my womb; an external womb that I could be in. And for him [baby] to come into. That space that I felt safe in. Keep that secure feeling that everything is ok this is normal this is home and it is safe.*

The decision to birth at home also permitted these women to personalise their experience of giving birth and to mark the transitional life event according to their own agendas, rather than the protocols and policies of a medical facility. Edith's comment during the focus group summed up the desire some of the women expressed to make their birth experience personal and meaningful in the context of sacredness:

> *I think you are aware that the whole experience is one of the most significant in your life so why wouldn't you want to ensure that...and to have that mediated by others agendas and other people's routines is an anathema to me.*

The element of securing an environment to optimise the sacredness of the birth event was seen as equally important for the new baby entering the world. It was important to the women that they were able to determine the physical and social environment their baby first encountered upon entering the world. The use of artefacts to beautify their homes was a component of how women sought to honour the sacredness they associated with birthing their babies. The women chose home birth to ensure that their baby was welcomed into an atmosphere of love, beauty, emotional warmth, and safety, and with the minimal clinical austerity possible. Naomi articulated how she hoped to welcome her baby, and how birthing at home helped her achieve this goal: 'I want my baby to come out and feel comfortable in the world, being welcomed into the world. To have warmth and touch. At home I can create that, but in the hospital you can't create that.'

Choosing to birth at home accommodated the need to create the social environment desired by the women because it facilitated their ability to elect who would be present at the birth, and to form relationships of trust and shared philosophies with those people to ensure the desired outcome.

It was through choosing to birth at home that women in this group felt they could justly honour the sacredness they attributed to the process of birth. Sacredness was associated with the feminine capacity to give birth and to be the bridge between the supported life of the unborn baby and the independent life of the baby once born. The event of birth was seen as a major transitional life experience for mother and for baby—a rite of passage with the capacity to have far reaching consequences for both parties. By choosing to birth at home, these women

considered they were able to experience a birth that encompassed and respected what they viewed as sacred elements of that event.

4.5.4 Partnership

The final theme to be identified at the focus group as fundamental in the decision to birth at home was the desire for partnership. The participants identified that they viewed birth as an event of significance in the life of a family and, as such, it was part of the entire fabric of their lives, not an event that occurred in isolation from the rest of their life activities. It was recognised by the participants that they desired to give birth in an environment that would sustain supportive, collaborative, interactive relationships with the people chosen to share the experience of birth. The need for partnership encompassed many participants in the birth, including carers, partners, family members, children, and support people. The participants recognised why the ability to be involved in decision-making was important when making the choice to birth at home because it fundamentally required that there be a collaborative partnership encompassing shared philosophies involving all the people the woman identified as important in her plan to birth at home.

During the focus group, the discussion concerning the choice to birth at home contained many references to the concept of the normality of birth, and the desire for life to continue normally around the event of birth. It was of importance to some of the women in this group that their life could incorporate giving birth without having to move completely outside their normal life practices. The women who had other children did not want to have to leave them in order to give birth; rather, they wanted to maintain the normality of their lives and households. They sought to incorporate their children into the birth event not only to show them the normality of birth but also to reassure them that their lives retained normality. The children in the household were considered in the process of planning for home birth to be participants—and partners—in the birth event.

The partnership between the women and their partners was another important aspect that the theme of partnership addressed around the decision to birth at home. In most instances, there was consensus between the woman and her partner on the decision to birth at home, although, in some instances, the partner may have been more reserved in the initial stages of planning home birth. The desire for both parents to be actively involved in the birth process was considered by many of the women to be a significant factor in the decision to choose home birth because this was where they felt joint involvement would be optimal. Maude stated during the focus group:

'Motherhood and fatherhood; they have as much involvement and entitlement to be a part of it as we do. It can be life changing for them too.'

This comment supported what many of the women had spoken about in their individual interviews concerning their desire for their partner's involvement in the birth, and how they saw this sharing as part of the transition into parenthood. The sharing of the birth event with their partners was a significant need that was met by the decision to home birth. The choice to birth at home ensured that the partnership of the couple was respected, as well as being a means for the couple to plan and work together to achieve the birth experience that they both desired.

The women also discussed partnership with their professional carers as an important consideration in the decision to birth at home. Many of the individual interviews contained discussions concerning the importance of the relationship that the women had formed with the carer they chose for their home birth. This importance was reiterated during the focus group in the theme of partnership. The women identified that through relationships with their carers they achieved shared understandings about what could be expected and accepted as normal for their birth events. The formation of a partnership that acknowledged shared philosophies was fundamentally important to the women achieving their optimal birth experience. It was important for these women to feel that their carers understood their personal expectations for birth, and that their carer understood their philosophies concerning the naturalness of birth and how they wanted other people to share in the event—particularly their husbands and other children. These women considered that by working with one carer throughout pregnancy, it would lead to shared understanding of what each wanted to achieve during the birth. The recognition of each woman as an individual was a key point that was particularly important in this relationship. The women felt that the decision to birth at home allowed them to choose a carer and form a partnership with that carer over time that recognised the individual nature of each woman and her unique needs during the birth.

The theme of partnership encompassed the sharing of hopes and dreams, experiences, responsibilities, and the future with the many people who were involved in the decision to birth at home. These women sought to birth at home with their families and friends in an environment of normality that integrated the birth of the baby into their daily lives. Inherent in the partnership theme was a shared cultural understanding about birth and its impact on the life of the family by all who shared in the event.

4.6 Summary

The results reveal that the decision to birth at home was motivated by a number of needs these women sought to meet in their experience of giving birth. A culturally significant belief amongst these women was that normal birth is not an inherently dangerous event for mother or child. This underlying belief permitted these women to experience birth removed from the confines of medically defined safety, which holds that birth is a potentially dangerous event. Safety was a key factor in participants' decision to birth at home; however, their construct of safety differed from that associated with current medical discourse. Safety, for the participants, comprised four components: physical safety, emotional safety, safety from the threat of intervention, and safety in the relationship with carers. Women valued the freedom that home birth provided to use their own space and the ability to create the environment both physically and socially within that space by using their own belongings and choosing who would be present for the birth The women expressed how their decision to home birth had facilitated increased involvement in decision-making concerning their labour and birth. The four themes—beauty, posterity, sacredness, and partnership—identified by the focus group discussion clarified why and how different aspects of the choice to birth at home held importance for this cultural group. These themes, which are deeply entrenched in the culture of this group of women, stem from the belief that birth is normal and natural, and represents a rite of passage in the life of a woman. The following chapter will look at how these results add to the existing body of knowledge concerning the choice to birth at home in a rural location.

5. Analysis and Discussion

The analysis and discussion contained in this chapter is reflective of the underlying feminist principles of this research. The collaborative relationship between the researcher and the participants throughout the research process culminated in the identification of the four major themes concerning why this group of women from Central Victoria chose to birth at home. This chapter aims to make the women's knowledge accessible to a wider audience presenting an account of what the members of this cultural group identified as their reasons for choosing to give birth in their own homes. The discussion will be presented in two distinct sections. The first section of the discussion will focus on the common categories that were identified, while the second section will focus on the four major themes of beauty, partnership, sacredness, and posterity that the women constructed.

It was evident early in the analysis of the data that this group of women considered birth to be a normal event and a natural physiological process which the female body was designed to achieve without medical assistance or intervention. This philosophy of birth aligns with what is described in contemporary literature as the social model of birth. Wagner (1996:32) cites Gaskin's definition of the social model of birth as 'a biological, anatomical, physiological and bio-chemical event integrated with mental and spiritual components.' To extend this concept, Wagner (1996) identifies that birth in the social model is neither medical nor a problem, pregnancy is not an illness, and that birth should be seen as a biosocial process that is part of everyday life. Further defining the concept of birth within the social model is the notion that birth involves society, and the management of birth influences societal understanding concerning reproduction, family relationships, women's position in society, and the socialisation of children.

Thus, the social model of birth affirms that birth has biological, psychological, and societal facets of equal importance. The women in this group consistently expressed the belief that birth is a natural and normal event in the life of a woman and it was this belief that, fundamentally, upheld the decisions of these women as they removed birth from the medical environment of a hospital and relocated it in their own homes. The interconnectedness of the reasons why this group of women chose to birth at home is revealed when they are considered within the social paradigm of birth, as the many facets of the experience of birth including social, psychological, and physical aspects are evident in their answers.

In an attempt to illustrate the process of collaborative analysis of the data, and the synergistic relationships that have been identified within the data and between the themes, I have developed a pictorial expression of the results and the process of analysis that highlights the contribution of the participants in the identification of meanings from the data. Figure 1 displays the steps involved in collection of data, beginning centrally with the research question, then moving outwards to the next circle where individual interviews and participant observation are represented. The outer circle represents the focus group meeting where the cultural group involved in the study came together collectively to discuss and analyse data.

Figure 2 displays the steps of data collection and analysis and the formation of themes, again beginning with the research question in the centre, moving outwards to the circle containing the common categories that were identified from interviews and participant observation. The themes identified at the focus group are depicted in the outermost circle. The arrows connecting the themes represent the synergistic effect of the themes. The correlation between the data collection stages and the ongoing development and analysis of data is evident when the two figures are viewed concurrently. A circular presentation was chosen for the figures, as this was symbolic of the interconnectedness of the data, and allowed a visual display of the links between the interview data/participant observation data to the themes without repetition. The overlay of the circles allows the reader to select data from the inner circles and correlate it to the themes in the outer circle, and makes the relationship between the common categories and the themes visible.

Figure 1 Research Process and data collection methods

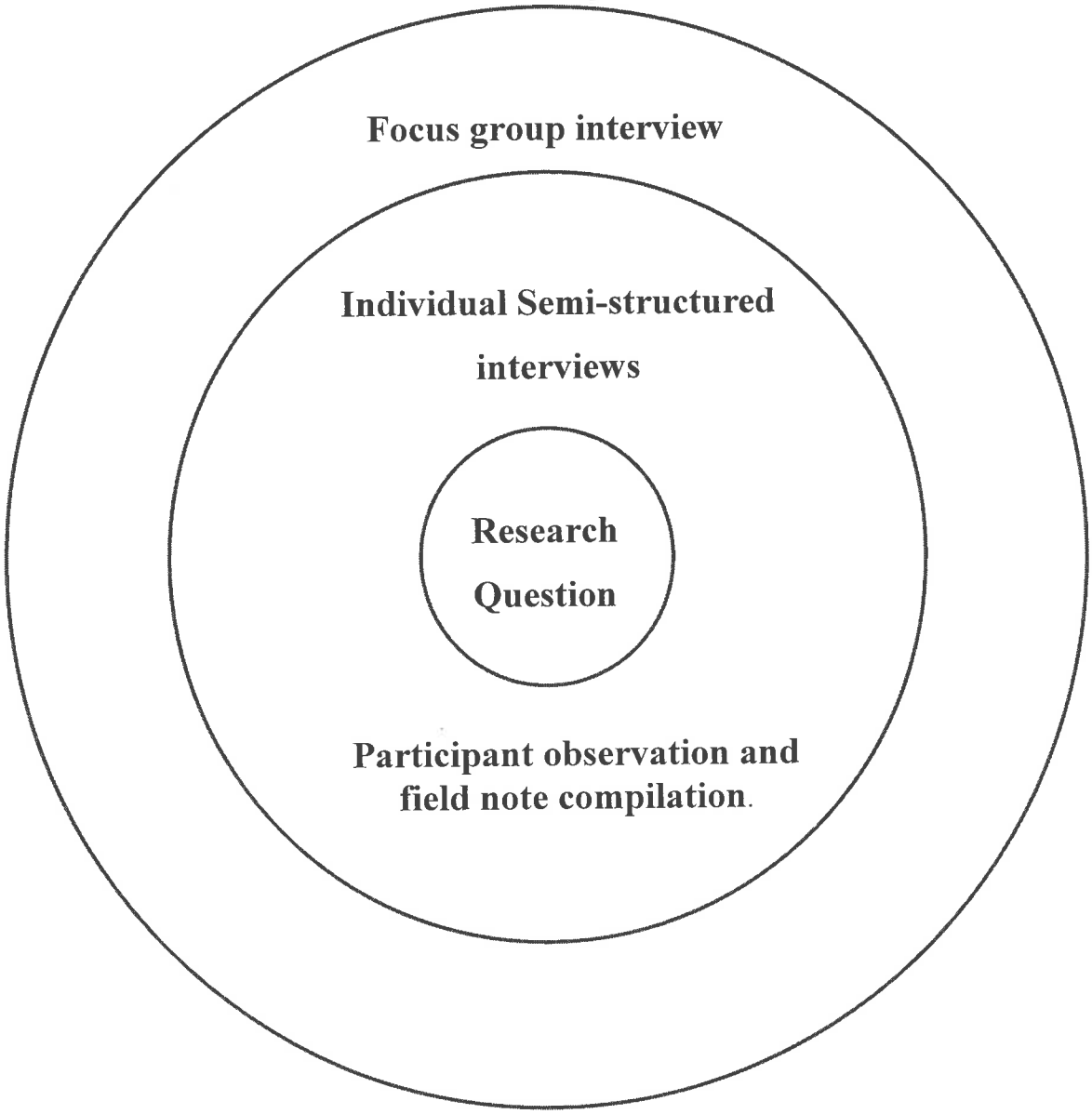
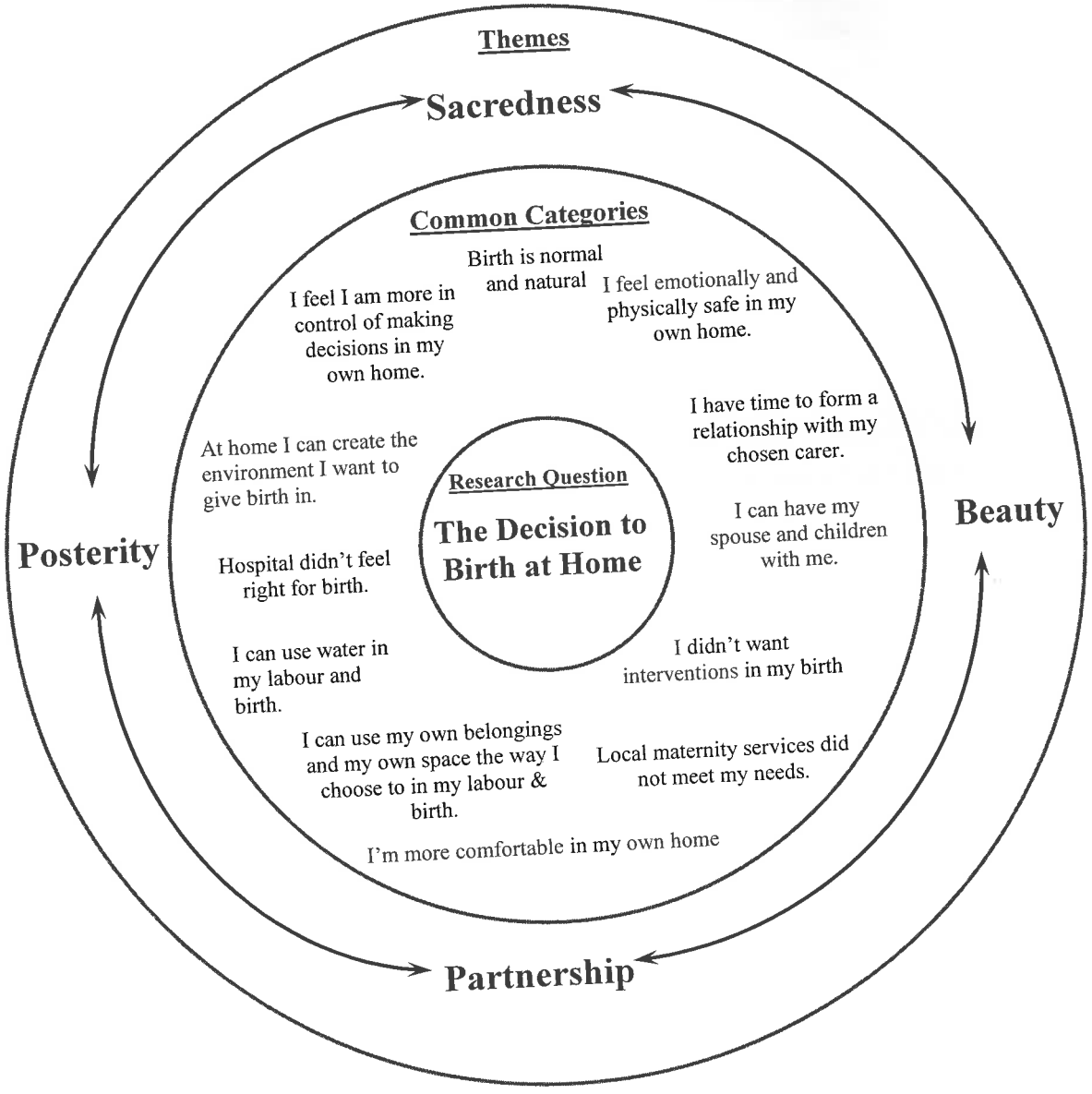


Figure 2. Development of themes from data collection sources



5.1 The decision to birth at home

The choice the women in this study made to birth at home is not a common decision in contemporary society—only 0.3% of the birthing population of Victoria in 2002 made this choice. Research has identified that more women than currently utilise this option would like the option of birthing at home (Senate community affairs reference committee, 1999); however, the reasons why women want this option have not been extensively researched.

Recent discourse concerning maternity service provision has focused on increasing women's choices in childbirth; however, choice in birthing venue has not been addressed in this debate. Although maternity service providers have attempted to introduce various models of maternity care to increase choice available in childbirth, limited choice extends to where birth will actually take place, and hospital is advised, consistently, as the desired venue regardless of the model of care utilised. The current medically orchestrated system of maternity care dictates that birth is best accomplished in a hospital and, as such, the majority of models of maternity care orientate women to give birth within that setting. This study has introduced new dialogue into the debate concerning birth venue by recognising that an alternative venue to hospital does exist, and that a small minority of women do choose to move outside of hospital to give birth at home. The question of why this particular group of women have chosen to do this has been the focus of this research.

5.2 Motivators for choice of birth venue

The SCARC report entitled *Rocking the cradle* (SCARC, 1999:2) states that 'Australian women value safety during birth for their babies and themselves above all other considerations. For this reason the vast majority choose to birth in hospitals.' This statement positions the issue of safety as the primary motivational factor determining where a woman will choose to give birth. However, the results of the current research reveals that the participants, while not disregarding safety, recognised other significant motivational factors when deciding to birth at home; namely, a desire for beauty, sacredness, and partnership in birth, and the desire to impart their knowledge of birth to posterity. These results reveal that the women in this study viewed birth from concomitant perspectives with no single perspective prevailing to the exclusion of others.

Safety was a major consideration for these women in their decision to birth at home, but their construct of safety was noticeably different from the medical construct that is considered in

current discourse. The medical construct of safety originates from the medical model of birth, while the participants of this research constructed their concept of safety from the social model of birth.

The understanding of birth as a natural process influenced the context in which these women placed the concept of birth safety and, thus, their decision to give birth at home. They did not consider birth to be an inherently unsafe act but, rather, a process that they possessed the innate capacity to achieve. Consequently, they did not approach birth with undue fear or perceive it as a threat to their own or their baby's physical safety. The results indicate that, for these women, the focus of safety did not rest solely on feeling safe from the physical risks potentially presented by birth, but also encompassed feeling safe to experience wholly the life event of giving birth. Safety was not only associated with the availability of birth technology and operating suites, but with birthing in a space that was known and familiar, with people who were known and trusted, and the security these elements provided to allow birth to occur without intervention. The elements described in the results that comprised safety in this context were feeling physically safe, feeling emotionally safe, feeling safe in the relationships with carers, and feeling safe from the threat of intervention in labour and birth.

These concomitant facets of safety have not yet entered the debate concerning safety and birth venue; however, it is evident that they were major considerations for this group of women. The fulfilment of the need to feel safe, as identified by the women in this group, was instrumental in the process of meeting the deeper desires for beauty, sacredness, partnership, and posterity that motivated their decision to birth at home.

Home birth in rural locations is discouraged by the majority of professional medical bodies on the grounds of safety, because of the potential dangers associated with the distance and, thus, time it would take to access facilities in the event of an emergency. In the discussions with the participants in this research this element did not arise as a major consideration in their decision to birth at home. Despite six participants living in secluded or remote locations outside of the rural townships, not one considered that this compromised their own or their baby's safety in birth. Again, the context of safety for these women meant that the focus of safety did not lie with the procurement of medical facilities, but with ensuring the creation of an environment to optimise the unfurling of the natural birth process.

The participants were not unheeding of the possibility that they may have needed to change venue in the event of complications arising in labour and birth and, in fact, had made alternate

plans which included ambulance membership and a booking at their chosen hospital should transfer to that setting be required. The issues of time and distance to these facilities did not create concern for the women because they expressed trust in the relationships with their carers to manage situations that would require transfer or an emergency should it arise.

5.3 Factors contributing to the decision to choose to birth at home

A number of points have been identified in the current study that contributed to this group of women making the decision to birth at home. These are displayed in the diagram in the second inner circle of Figure 2. These factors were identified from the individual interview data and from the field notes, and formed the basis of the common categories that were presented to the focus group.

A number of these factors have been commented on in previous studies concerning why women choose to birth at home. Several authors (Bastian, 1992; Chamberlain, Wraight & Cowley, 1997; Dodd & Reibel, 2000; Kitzinger, 1978; Morrison, Hauck, Percival & McMurray, 1998, 1999; Viisainen, 2001) have identified the desire to experience a natural birth and to avoid medical intervention in birth as major factors influencing the choice to home birth. The fact that this remains—over a span of twenty-five years research—a constant key factor in the decision to birth at home highlights that women who choose home birth perceive birth as a normal event in the life of a woman.

Research supports the notion that birth at home entails less medical intervention. Parratt and Johnston (2002), when researching outcomes for home birth in Victoria, identified that 91.6% of their study population achieved spontaneous cephalic births. Statistics from the Victorian Perinatal Data Collection Unit (VPDCA, 2002) pertaining to home birth also support the finding that home birth entails less intervention. These figures show that 98.8% of women who planned a home birth commenced labour without medical or surgical induction. A similar number (96.9%) used no pharmacological analgesia in labour. Two percent of births were assisted by the application of vacuum and no forceps-assisted deliveries were recorded in the home birth figures. The intact perineum rate was 85.5% in women who chose to birth at home. These statistics are in contrast to those reporting the course of a woman experiencing her first labour within the hospital system in Victoria, which indicate that only 8% of women proceed through labour and birth without any intervention (VPDCU, 2002:41).

Other recurring factors identified in past research associated with the choice to birth at home includes not wanting to be separated from baby, husband, and other children, and the desire for partner and family involvement in the birth (Bastian, 1992; Chamberlain, Wraight & Cowley, 1997; Dodd & Reibel, 2000; Kitzinger, 1978). These issues also arose frequently in the interviews and focus group discussion in my study population, consolidating the notion that the need for close family involvement in birth is a prominent factor influencing the decision to birth at home.

The findings of Morrison et al. (1998) that home birth encompasses preparation of the physical and social environment for birth are also consolidated by my study through the identification of the ways that many of the women in my study wished to personalise the birth environment through embellishing their own home with artefacts—such as their own belongings, music, candles, lighting, and the use of aromatic oils. The construction of a social environment for birth is also evident in the results of my study. Women specified it was important for them to nominate who would be present for the birth experience and the roles that those chosen people would be given, such as carers for siblings and support people. Included in this was the capacity for the woman to select her professional birth attendant.

Control, choice, and continuity are concepts that repeatedly arise in discourse concerning birth, and the context of these terms is noticeably different depending on the venue chosen for birth. While hospitalised birth offers choice within the constraints of the particular institutions, policies, and procedures, the context of choice in home birth pertains more to achieving aspects within the birth experience the woman may desire.

Discourse around the issue of control in the home birth venue associates this control with the ability to determine the birth environment and the power relationships of people within the home environment. This holds particular relevance to the sharing of power in decision-making, particularly as it influences intervention in birth, and the women accepting responsibility for their decisions (Kitsinger, 1978; Morrison et al., 1998; Viisainen, 2001). The concept of maintaining a position of control is raised by Bastian (1992) and Viisainen (2001) in relation to women who had experienced a birth where they felt they had no control—a situation most commonly associated with hospital birth experiences.

The current study also identifies that the women involved in the study sought similar characteristics regarding control of the birth environment, which was demonstrated by the women actively preparing their home for birth and embellishing the environment for birth. The

women's relationships with others and the sharing of power when they chose to birth at home was displayed in the comments relating to the equality they felt in relationships with others involved in the birth and the desire for inclusion in the decision-making process during pregnancy and birth. It was also evident in the way the women expressed the freedom they felt in their own homes to use their own known space and the facilities they had prepared, such as a birth pool, oil burners, and candles.

The context of control within the hospital setting is frequently related to women seeking greater involvement in the decisions pertaining to their care, and being able to make informed decisions about options offered to them through having adequate information made available to them (NH&MRC, 1998). Women consistently express the desire for greater control over their birth process; however, this is an ambiguous phrase as no clear definition of what it entails is available. The degree of control a woman is able to exert over her birth process within a hospital system is directly linked to the options that are offered to her within the constraints of that system. Thus, in hospital, a woman can only make decisions about what the hospital routine offers her, and requests outside these parameters are often denied. When women are denied choice, their perception of the degree of control they have diminishes. When they are left no option other than to conform to what someone else wants, control of the situation has been unwillingly relinquished. Choice and control are closely associated in the home birth discourse, as birthing at home entails a decision that ensures that many of the other choices a woman could face concerning her birth experience are already addressed and accommodated in her home birth plan.

The notion of choice within institutionalised birth is discussed by Brown and Lumley (1998) who found that 96% of women stated they did want to be given a say in what happened during labour and birth. They also reported that women expressed greater satisfaction with care when they believe they have played an active role in decision-making during labour and birth. Again, the results of the current study support the findings of previous research concerning the need women express to have choices available to them in birth. Comments made by some of the participants in this research, such as being able to choose where they will move around their home, the choice to use water in their labour and birth, the choice to select their carers and who would be present during birth—particularly other children and family members—support the finding that women like having choice in childbirth.

Another aspect of the current discussion concerning what women value in home birth and in hospital birth is continuity of carer. Dodd and Reibel (2000), Kitzinger (1978), and Morrison et

al. (1999) identified the importance women who chose to birth at home placed on the relationship they had with their chosen carer, how this influenced their decision to birth at home, and the way they experienced birth. The women in my study ardently identified the ability to choose a carer and have continuity with that carer—throughout their pregnancy, labour, birth, and the time after birth—as a major factor that contributed to their decision to birth at home. The relationships that the women spoke of forming with their carers were reminiscent of friendships or family relationships that had a professional component, and were highly valued by participants.

Many of the factors identified by this study as contributing to the choice of this group of women to birth at home do not, in themselves, constitute new knowledge around this subject. These factors, however, had not previously been identified in a group with the specific rural geographical attribute that this study particularly sought to investigate. It is apparent that the reasons given by women who live in rural areas concerning their decision to birth at home are not significantly different from those identified in previous research of women deciding to birth at home in urban areas. The recognisable uniformity in factors identified by the majority of such research is that women who choose to birth at home hold the belief that birth is a normal and natural event, rather than a medical event. This philosophy of birth removes it from the medical setting regardless of where the women live, be that rural or metropolitan.

The current study, while consolidating what is known about the decision to birth at home, has also extended the current body of knowledge. The women in this research have been able to clearly articulate the meanings they associate with the many points identified as contributing to their decision to birth at home—something that has not been done in previous studies. It was during the focus group discussion, where the collaborative analysis of the data took place, that the cultural significance of the decision to birth at home was considered and expressed. It was during the deliberations over not only what was important to women in their decision to birth at home, but why these factors were important, that meanings were apportioned to the data.

5.4 Discussion of themes

It is the *why* of this question that led these women to identify the themes of beauty, sacredness, partnership, and posterity as motivators for their decision to birth at home. The relationship between the factors that were identified as important and the meanings this group of women attributed to these will form the remainder of this discussion through the exploration of the four major themes. While there is considerable overlap in the factors that contribute to women

choosing home birth and the development of the themes, I consider that the four themes were distinctly identified. I believe that synergistic effects exist between the themes, and also between the factors contributing to women choosing home birth; that is, to experience beauty in birth enhances the sacredness of the event (and vice versa), and so to with the remaining themes of partnership and posterity.

These women told me that they chose to birth in their own homes to ensure that they experienced giving birth the way they wanted not on the terms of anyone else. They clearly desired to own their birth experience and to integrate that into their own lives. Gaining insight into the context of safety for this group of women was integral to understanding how they sought to meet their needs for beauty, sacredness, posterity, and partnership in their labour and giving birth.

The venue of their own home provided these women with the feelings of safety they needed to accomplish their labour and birth. This primarily related to not being threatened by medical time constraints and the procedures considered routine in hospital settings. Safety was also closely associated with who was present to support the women in labour, and how comfortable the women felt in their own space. As I have mentioned earlier, the philosophy of these women concerning birth was that they possessed the innate ability to labour and give birth without medical intervention. They did not hold undue or excessive fears about their physical safety while giving birth. This philosophy of birth allowed them to move away comfortably from the hospital setting into the home setting to give birth, where they were able to acknowledge and meet other needs in their experience of giving birth. These other needs were identified as beauty, sacredness, posterity, and partnership. Each of these themes will now be considered individually.

5.4.1 Beauty

> *"How we remember, what we remember and why we remember form the most personal map of our individuality"*
>
> Christina Baldwin

Beauty was not identified as a common category from the individual interview transcripts nor from field note data. However, in the setting of the focus group where collaborative data analysis occurred, the need for beauty in giving birth was highlighted as a major theme

underlying the decisions of these women to give birth in their own homes. In the light of the focus group identification of beauty as a motivator in the decision to birth at home, further analysis of the interview transcripts identified that the word beauty, or references to beauty and birth, had occurred frequently during the interviews. Words used by the women in association with beauty included safe, nice, happy, powerful, fantastic, romantic, and positive.

Women from this group identified beauty as a need they wanted met when they gave birth. While each woman had her own definition of what beauty meant for her, the women collectively expressed that birth possessed inherent beauty. These women wanted to experience the beauty they associated with unadulterated birth, which is why they did not want intervention in their birth. Through choosing to birth at home, they considered that the risk of medical intervention in their birth had been minimised, while also optimising the capacity to create beauty in their birth experience.

They wanted to be in a beautiful environment when they gave birth, which is why they chose the intimate private space of their home—prepared with music and light and smell. They wanted the beauty of sharing co-creation with the people most important to them, which is why they chose to birth at home, where they could determine who would be present for the birth. They wanted to welcome their baby into their own carefully created intimate and private space to provide a beautiful experience of birth for their baby. In summary, birthing at home was seen by these women to provide the optimum opportunity to create a beautiful experience of birth, which is what they sought when they decided their birth venue.

5.4.2 Sacredness

> *"For each of us as women, there is a deep place within, where hidden and growing our true spirit rises...within these deep places, each one holds an incredible reserve of creativity and power, of unexamined and unrecorded emotion and feeling".*
>
> Audre Lorde

The term sacredness was not identified from interview data or from participant observation data. However, the women in the focus group identified sacredness as a key reason why they chose to birth at home. Sacredness did not relate to religion or godliness, but was used in the context of reverence for a major life event. Amongst the women in my study, there was an acute awareness

of the notion that giving birth has a profound impact on a woman. Giving birth was seen as a major event in their lives and in the life of the baby, and they sought to honour the magnitude of that event in highly personal ways. The women in my study considered women's ability to carry a child and give birth to it as something very special. They particularly honoured the ability of women to birth their children, and viewed unnecessary interference in that process as a violation of the sacred capacity women have to give birth.

The women in my study wanted to recognise and experience sacredness in their experience of giving birth, so they chose to birth at home. They wanted to know their inherent sacredness as women when they gave birth by their own power, which was why it was so important that they did not experience medical intervention in their birth. They chose to birth at home where they considered the risk of medical intervention in their birth to be minimised, but also, importantly, where they could maximise their ability to give birth by their own power, in their own time. Their own space and the items they chose to use within that space were considered to empower them to give birth by their own strength, and, thus, experience and honour the sacredness they associated with their feminine capacity to give birth. They wanted to honour their role as a bridge between the supported unborn baby and the independent life of their baby once born, which is why they created their private safe space of their own homes and embellished it with their artefacts. That is why they wanted to use their own things, in their own ways, in their own homes. These women wanted to be able to share the sacredness of the mystery of creating new life with the people they cared most about, which is why they chose to birth at home where they could determine who would be present. They wanted to honour the creation and welcoming of a new baby into their lives by creating a beautiful birth experience for their baby. The recognition that they were creating the initial experience of life for their baby motivated many of the women to create a warm, loving, safe environment in their own homes where they could enhance the environment with their own artefacts. Choosing to birth at home permitted women in this group to honour the life experience of giving birth in their own individual manner as well as determining the birth environment for their baby being born, thus recognising the sacredness inherent in giving birth and in being born.

5.4.3 Posterity

"We're not just teachers, we're educational artists. We paint young minds".

Vina Barr

The theme of posterity was also a term that was not identified from the data prior to the focus group discussion. Joint analysis of the data identified posterity as a reason why women chose to birth at home. Women in the study identified that they chose to birth at home to educate others concerning birth. They wanted to share with other people that birth can be beautiful and sacred and can involve as many or as few people as desired. They wanted to create positive birth histories to share with every one associated with the birth event. Positive birth histories entailed a beautiful, sacred, shared experience of birth. All of the components that have previously been discussed—such as intervention-free birth, occurring in an intimately prepared private setting, surrounded by and shared with loved and chosen people—facilitated the creation of positive birth histories with which to educate others and impart to posterity. These women chose to birth at home so they could share their vision and experience of birth in the hope that the future of birth will continue to include their cultural perceptions of birth. Posterity also encompassed the history of birth that the child being born would inherit and the way this would impact on the parent–child relationship in the future. It was significant to these women that their babies learnt that their birth was a sacred and beautiful event, and that this positive beginning formed the foundation of their relationship with their parents and siblings. The identifiaction of this need to pass on birth knowledge to others and the creation of and a desire for a particular birth history has not previously been articulated in literature as a factor influencing birth choices women make.

5.4.4 Partnership

"The only thing to do is to hug one's friends tight and do one's job".

Edith Wharton

The theme of partnership that the women in this study identified related to their view concerning the context of birth within the entire fabric of their lives. The event of giving birth was considered by women in this group as part of the greater picture of their lives and, as such, they sought to integrate it into their normal lives, rather than isolate it from their day-to-day lives by birthing in a hospital. The event of birthing at home was seen as a time for establishing and strengthening partnerships with the many people who would be present for the birth and,

thereby, form a part of the fabric of each woman's life. Partnership was used in this context as a way of describing the bond of sharing in the experience of giving birth at home.

The partnerships formed that these women referred to in this theme involved their partners/ spouses, their children, their professional carers, their chosen support people, and their extended family. Each person who entered a partnership with the individual women had shared philosophies and understandings about what the experience of birth meant for that woman giving birth and, as such, had a role to perform in ensuring the desires of the woman and her family for birth were respected. The term 'partnership' implied that those chosen by a woman to share in the birth would enhance the experience through understanding what was beautiful about birth for the woman; how and why she sought sacredness in her birth; how she wanted future generations to understand birth as she experienced it; and how the sharing of birth impacted on these concepts.

The partnership between the women and their partners was important because the fulfilment of the other identified needs were linked closely to this. The women considered that to share birth with their partners added to the beauty and sacredness of birth, which also enhanced the birth history created. The shared understanding about this correlation and the desire to secure a birth experience that enhanced these aspects were fundamental components of the theme of partnership. Participants identified that having a shared understanding concerning their birth expectations with all of the people involved was essential if they were to achieve their optimal birth. It was through the formation of partnerships with their children that some woman felt they could share labouring and giving birth because they shared understandings about that experience. In addition, planning to have someone there to support other children in their involvement in home birth to create a positive birth history was encompassed in the partnership theme.

The partnership that women spoke about with their selected professional carers allowed women to feel safe in their plan to home birth, thus enhancing their capacity to experience sacredness and beauty and the creation of a positive birth history to share with others in the future. While partnership is acknowledged in discourse concerning birth, this group of women, again, created their own context for the term. Guilliland and Pairman relate partnership as a fundamental component of the midwife/woman relationship. Central to this relationship is the woman-centred focus of care, which identifies that the woman defines the relationships within her childbirth experience. For women in my study, the identification that partnership was essential between all the persons involved in the birth experience extended the importance of partnerships

beyond just the chosen professional carer. It also identified that partnerships did not occur in isolation, but that planned home birth involved a team of people working in partnership, incorporating shared philosophies to achieve an optimum birth experience as defined by each woman individually.

The women in this study identified that they chose to birth at home to accommodate their desire to experience beauty in giving birth, to acknowledge and experience the sacredness they associated with giving birth, to experience partnership with all who would share their life event of giving birth, and to impart their cultural understanding concerning these elements of birth to others who would carry this knowledge onto future generations of women giving birth. The rural locality of this study group and the proximity to medical facilities did not impact significantly on their decisions to birth at home.

5.5 Conclusions and implications

The four themes that have been identified in this study use language that is not frequently used in contemporary discourse concerning birth. The medical focus of birth in hospital has developed language that concentrates on the physical process of labour and birth—largely to the exclusion of the emotional process involved for a woman and her family. This research has identified that for this group of women the decision of birth venue was centred in the emotional experience of giving birth and the impact of this event on their lives and their families. The themes identified relate very clearly to a psychological dimension of birth that embraces the feelings associated with the event of giving birth and the social impact of this experience. Although the themes have physical dimensions, these are not paramount; rather, they constitute a part of the overall experience of giving birth.

The current body of knowledge pertaining to reasons why women choose a birth venue states that safety is the main consideration; however, this discourse only addresses a medical construct of safety. The current research has allowed women who choose to birth at home to express what they consider constitutes safety in birth and to express how their construct influences where they choose to give birth. This discussion has also highlighted the way the context of words changes significantly depending on the venue for birth—particularly, the terms safety, partnership, choice, continuity, and control, which have been shown to take on diverse meanings when birth occurs in the home setting.

Further, the current study validates home as a venue for birth, because it has identified aspects desired about home birth that cannot be replicated in a hospital setting, regardless of how home-like the hospital environment is made. The associations of safety and comfort and sacredness and beauty that this group of women identified as emerging from their decision to birth at home could only be achieved in their own home environments. It follows that the optimum, desired, birth history could only be achieved when birth occurred in the home setting. That is not to say that birth in alternative settings cannot involve beauty or sacredness or partnership, or create positive birth histories to pass onto future generations. However, the women in this group defined these themes in relation to their decision to experience home birth.

The prevailing medical debate concerning safety and home birth in rural settings that advises against the choice of home birth because it undesirable and unsafe does not appear to have influenced the decisions of the women in the study to birth at home. The context of safety for these women was such that the home setting provided the greatest sense of safety and security for them, despite their distance from medical facilities.

The identification of an alternative construct of safety relating to childbirth has the potential to broaden the debate concerning safety and birth venue through the inclusion of a consumer group perspective, which has been absent to date. The identification that the concept of safety has various components for women in this group leads to question how women giving birth in other venues construct their concept of safety. The impact of this knowledge on clinical practice is that birth experiences for women could be improved through an understanding of what makes women feel safe in childbirth and accommodating these needs.

A further implication of my study stems from the identification that birth had very significant emotional components for this group of women. The recognition in this study that birth has these deeply emotional components can be used to introduce this facet of birth into current discourse. This will help to balance the debate concerning birth practices, which has progressively become distanced from the emotional impact birth has on a woman. The potential to ask if a procedure or aspect of care adds to or detracts from the beauty and the sacredness of a birth experience; or how it will impact on the way birth is known in the future exists because of the articulation of the knowledge this group of women have shared in the current study.

Appendix 1 – Plain Language Statement

My name is Lynette Kelson. I am a mother of 3, and am currently pregnant with my 4th baby. I gave birth to my 3rd baby at home and plan to have a **home birth for my 4th baby also.**

I am a midwife undertaking research at the University of Ballarat to obtain a Master of Nursing qualification.

The focus of my research is to explore why women from Central Victoria choose to birth at home.

There is currently very little known about what motivates women to choose to have a home birth, particularly in today's society when the predominant setting for giving birth is in a hospital.

I wish to explore the reasons women give for choosing to have a home birth. In order to do this I require your assistance by being involved in an individual in-depth interview/s in which you can express in detail the reasons behind your choice to have a home birth.

This interview can be conducted in your own home or a place you nominate, and at a time that is convenient to you.

It is not anticipated that this interview will take longer than 2 hours. If greater time is required a subsequent meeting will be mutually agreed upon.

If you choose to be involved in individual interviews, I will tape record our conversation so that it can be transcribed to be used as data for the research. I will then send the transcript of the interview to you so that you can read it and make any additions/ clarifications to it that you wish, and then return it to me via post.

You will be asked to choose a pseudonym by which to be identified by for the duration of the research, and only yourself and I will know this name.

You will then be invited to participate in a group meeting of women who have experienced, or who plan to have a home birth. The purpose of this group meeting of women with a common bond of home birth is so as to allow sharing of a like experience among women.

This meeting will also allow me as a researcher to make notes about this group of women who choose to have a home birth.

If you become distressed at any time during your involvement in this research, a trained counsellor will be made available for you to further discuss the issues that are causing your distress.

You are free to withdraw from this research project at any time without prejudice.

Your consent to be a participant in this research can be given by signing the attached consent form, which implies that you have read and understand this document.

If you have any questions or would like to discuss this further with myself, please feel free to contact me on 5424 1366. I would be most happy to hear from you.

I wish to thank you in anticipation of your participation, and I look forward to meeting you in the near future.

Regards.
Lynette Kelson.

Appendix 2 – Map of Study Region

○ Hospitals providing birthing services in study region. Melbourne metropolitan hospitals not identified

Appendix 3 – Flyer

A request for participants to be involved in research about Home Birth.

Are you interested in home birth? Have you had, or would you like to have a home birth?

My name is Lyn Kelson.
I am a midwife undertaking study at University of Ballarat.

I am interested in exploring the reasons why women in Central Victoria choose to birth at home.

I would like to talk to women in this area who have had, or hope to have a home birth about the reasons behind their choices.

If you would like to be involved in increasing the current understanding of why women choose to birth at home, please contact me for more information.

Phone 5424 1366.

Appendix 4 – Informed Consent Form

UNIVERSITY OF BALLARAT
INFORMED CONSENT

4. Code number (if any) allocated to the participant .....

5. Consent (fill out below)

..... of .....

..... hereby
consent to participate as a subject in the above research study.

The research program in which I am being asked to participate has been explained fully to me, verbally and in writing, and any matters on which I have sought information have been answered to my satisfaction.

I understand that:

- all information I provide (including questionnaires) will be treated with the strictest confidence and data will be stored separately from any listing that includes my name and address
- aggregated results will be used for research purposes and may be reported in scientific and academic journals
- I am free to withdraw my consent at any time during the study in which event my participation in the research study will immediately cease and any information obtained from it will not be used.

SIGNATURE: ..... **DATE:** .....

To be filled out where participant is under age - where appropriate.
Please delete if minors are not involved in the Research Project.

Consent of minor:

I, ... of .....

..... hereby
consent to participate as a subject in the above research study.

SIGNATURE: ..... **DATE:** .....

Consent of Parent/Guardian:
I, ..., parent/guardian of ..... (minor's name)

of ..... (address)

hereby consent to ..... (minor's name) participation in the above research study.

SIGNATURE: ..... **DATE:** .....

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