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## A phenomenological study of the homebirth experience : The couples perspective

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**A Phenomenological Study of the Homebirth Experience**  
**The Couples Perspective.**

**By**  
**Susanjane Morison**

A thesis submitted in partial fulfillment of the requirements for the  
Award of Master of Nursing at the School of Nursing, Edith Cowan  
University.

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## ABSTRACT

The purpose of this qualitative study was to describe the experience of parents who have had a homebirth in the past two years in Perth. Studies conducted to date have predominantly used quantitative research methods, investigating the safety of homebirth and comparing home to hospital birth without exploring a couples experiences.

A phenomenological approach was used as it seeks to understand human experience in context. The research design consisted of a field study, in which ten parent couples were interviewed and three homebirth videos observed. Data analysis was conducted according to the procedure outlined by Colaizzi (cited in Knaack, 1984, p. 110) which is to describe, interpret and extrapolate common themes and meanings. Of the ten couples interviewed four couples spoke of their first child's homebirth and the remaining six couples had three or four children who had been born at home. Research participants were attended to during their homebirth by one of five registered midwives.

The essence of these parents' experiences of homebirth was gained through identifying significant statements from transcripts and field notes then clustering these into themes. The four essential themes were Constructing the Environment, Assuming Control, Birthing, and Resolving Expectations.

The research findings provide health professionals and consumers with an insight into homebirth which challenges them to alter their practices and assumptions regarding this birth environment.



## DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education and that to the best of my knowledge and belief it does not contain any material published or written by another person except where due reference is made in the text.

Signature

A solid black rectangular box used to redact the signature.

Date: 16/8/96

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# **CHAPTER 1**

## **Introduction**

The experience of a couple having a homebirth, is a unique source of personal information, which has not yet, been adequately documented in published literature. In an attempt to address this situation, this study investigated the experience of homebirth from the perspective of parents who have birthed at home. Gaskin (1990) described how people tend to form their deepest attitudes about childbirth by listening to the stories of other parents. Homebirth experiences of parents which are retold as stories facilitate health professionals and consumers gaining an insight into this birth option.

### **Background**

Home was the original place to birth, although its acceptability as a birth environment has changed with time. Australia's homebirth trends are comparable to some other industrialised nations and provide an awareness of changing attitudes and practices in birthing. Babies have been born at home since the "Dreamtime" in Australian history. The number of homebirths dwindled after 1940 as hospital birth became the mode; however from 1970 onwards, homebirths began to increase in numbers to a peak of 1135 such births in 1985 (Spurre, 1988). Since then, the literature shows that in 1990, 0.5 % of overall births, in Australia, were planned homebirths (Child, 1990) that is one in two hundred births (Bastian, 1989). Many factors have influenced birthing practices including the availability of education, the status of women, the development of health care professions and advances in technology. The availability of child birth education to parents has enabled them to explore birth options (Towler and Bramall, 1986). Women's status in western culture has evolved with women becoming more assertive in declaring their rights (Ehrenreich and English, 1973).

Through out history, health professionals have acted as a major influence on birthing practices. Starting in the fourteenth century, there was a shift from midwife based care to the involvement of medical physicians in birthing (Towler and Bramall, 1986). Contributing to this shift in carers was the commencement of the witch hunts, where lay female healers such as midwives were violently persecuted and suppressed by the state, church and ruling class. At the same time a new male medical profession, educated at universities, was created under the protection and patronage of the ruling class (Ehrenreich and English, 1973). Physicians gradually assumed greater power and authority of people's health as faith in the traditional "old wives" and folk remedies became discredited. By the turn of the nineteenth century the exclusively male, medical profession was highly organised and competed with midwives in the care of childbearing women.

The evolution of medicine and midwifery as health professions contributed to changes in the setting of birth. In the 1930's improved medical education in obstetrics created a requirement for women to give birth in teaching hospitals. The hospital served the new profession of obstetrics by restricting competition from midwives, establishing the principle of medical control over clients and enabling the teaching of the new clinical expertise. In western industrialised countries obstetric societies were formed and the profession of midwifery was brought into the official care system and regulated, except in some parts of Canada and United States of America (U.S.A.) where it was outlawed (Wagner, 1994). Physicians on insurance boards decreed that while hospital births would be covered by insurance there would be no reimbursement for births at home (Flanagan, 1986). The shift in the place of birth, from home to hospital, commenced in the United Kingdom of Great Britain, (U.K.), U.S.A., Australia and Canada from the 1930's onwards. With the introduction of anaesthetics to obstetrics, women were promised pain free births in hospitals, while at home this

promise could not be met. The growth of obstetrics as a surgical speciality completed the move from home to hospital. During World War II in the U.S.A., U.K., Canada and Australia the trend towards hospital births was further encouraged by the increased availability of nurses in hospitals and the readiness of the mobile populations to travel to seek health professionals in hospitals (Flanagan, 1986).

Since the late 1960's advances in technology have impacted on practices and attitudes regarding birth in what was referred to as the "revolution in the technology of birth" (Towler and Bramall, 1986, p. 259). Industrial nations responded differently to the social changes and advances in technology at this time with health care systems varying in the delivery of obstetric care. For example, homebirths were incorporated into the Netherland's health care system, however, in the U.S.A. they were outlawed. Birth in many industrial countries was regarded as a sickness requiring the highest level of technological assistance. To birth where there was no modern technology available was considered dangerous and unsafe to mothers' and infants' health. By the 1970's in most industrial countries hospital births became the norm (Boland, 1989).

In hospitals, labour could be pharmacologically controlled and expediated. Hospital births sometimes involved electronic fetal monitoring, ultrasound and the use of machines to electronically deliver a predetermined dose of drugs intravenously to induce or enhance labour. These inventions provided independent objective data on the progress of labour and condition of the infant. However, they did not consider the birthing woman's viewpoint and moreover they restricted her movement. Currently hospital births involving high levels of technology are accompanied by a high degree of obstetric intervention. The evidence of this high degree of obstetric intervention is seen in the percentage of

caesarean births in countries such as the U.S.A. (22.1%), Canada (19.5%), France (13.8%) and England and Wales (13%) (Hingstman,1994) and Australia (17%) (Wagner, 1994). These levels are much higher than in the Netherlands (7.9%) (Hingstman,1994) where homebirths are included in the healthcare system.

In the 1970's an increasing number of the childbearing population requested a birth minus interventions and consumer discontent with hospital obstetric services grew (Towler & Bramall, 1986). In the U.S.A. and the U.K., consumers and professionals joined together to form national organisations that supported natural childbirth, working towards changing hospital practices and supporting non hospital births. Varney (1987) discusses how the natural evolution of consumer's discontent was to remember that childbirth had not always taken place in hospitals.

The late 1970's and the early 1980's in the U.S.A, Canada, U.K. and Australia saw the development of birth places other than hospitals which expanded the birth options available to mothers (Varney, 1987). At the present time birth place choices in these countries include hospital, birth centres and the parents' home. There are variations in birth centres; they are either independent or under the jurisdiction of a hospital. Women who attend birth centres need to meet the screening criteria established by their carers who are midwives and/or obstetricians. Homebirths differ to birth centres and hospitals in that the setting is not in the professional's territory but in the woman's.

In Perth, Western Australia there are seven registered midwives working independently, in private practice in the metropolitan area. Four of these midwives have undertaken an accreditation process, (through the Australian College of Midwives,) which recognises them as competent professionals. The services of a midwife in private practice (independent midwife) cannot be

claimed on Medicare (the national government health scheme) although some health insurance companies do reimburse a percentage of the cost. Half of the payment can be made in the antenatal period with the remainder given in the months following the birth. In addition some midwives work on a barter system to cover their fees.

A birth at home is set in an environment which is familiar to participants, and where the birthing woman is accustomed to feeling comfortable and in charge (Bortin, Alzgaray, Dowd and Kalman, 1994). This facilitates the involvement of family, friends and carers in the birth process. The same midwife remains with the mother throughout the pregnancy, birth and for a period after the birth, ensuring continuity of care. However, parents who choose a homebirth must overcome the attitudes of some people who see birth as a sickness requiring the safety of medicines and mechanisations in order to deliver a baby and who believe that to do otherwise is irresponsible (Brook, 1985).

As a student midwife I became interested in the persons home as an alternative birth environment. I worked with midwives from the U.K. and Malaysia who spoke of their practice as community midwives. While reading literature on homebirths I noticed the absence of experiential data from parents. When a friend was pregnant her husband challenged me to do a case study on expectant fathers. I proceeded to search for what research had been done in this area and found there was little documented, particularly regarding homebirth fathers.

### Significance

The significance of the current study is found in the sharing of homebirth parents' perspectives, to facilitate understanding of the experience amongst midwives in home / hospital and birth centre settings. It is not a comparison of homebirth experiences to hospital birth experiences. Home is a different

environment it is the setting of a unique experience which a couple share. Therefore, homebirth is focused on as a separate phenomenon.

Consumers of the Australian healthcare system have limited opportunities to give feedback to service providers. In offering a service, the providers ultimately become answerable to their consumers, particularly in the case of homebirth parents. Couples who choose to birth at home are not catered for in the public health care system and they seek their birth attendants privately. Exclusive to these parents is their experiential information which could make an important contribution to the database on homebirth. This knowledge may have the potential to encourage midwifery practices, in various settings, to be oriented to client needs.

The emphasis of this study is on the parents' experience of a homebirth which they have lived, sensed, felt and shared. How homebirth appears to the couple that have encountered this phenomenon has not been adequately researched and published. Research into homebirth has often concentrated on the safety and outcomes of the birth. A homebirth is more than the birth at a particular time, on a date, of an infant with a specific gender and weight. Birth is a physiological and social process by which a couple becomes a family. The meaning of a homebirth is derived from being a shared experience primarily between a couple. In expressing their experiences of a homebirth a couple can assist future parents who are seeking information on homebirths.

The father is not only present at the birth, he is participating and experiencing the birth and therefore his presence is not to be discounted but appreciated. In western culture mothers are encouraged to share their birth stories yet there are limited opportunities for fathers to speak freely of what they have experienced. Devito (1993) described how the emotionally expressive male may be judged by



some as ineffective, insecure and unmanly. This study provided an avenue for fathers to overcome this barrier and to inform people of what it means for them to experience a homebirth. Fathers are able to provide the male, parental, individualised viewpoint which is a perception that no one else can give. Paternal birth stories also need to be documented to educate other men on homebirth and the transition into parenthood.

The study is worthwhile for there is a lack of published research on homebirth couples' experience. The significance of the study is found in the seeking of experiential data on homebirth from both the mother's and father's perspective. Parents sharing their homebirths facilitate healthcare providers in providing appropriate care and supply a valuable source of information for other consumers of healthcare services.

### Purpose

The purpose of this study was to describe and interpret the experience of parents who have had homebirths.

### Objectives

The objectives were to:

1. examine parents' experiences of homebirth;
2. describe common elements, themes or patterns of the homebirth experience of parents;
3. interpret and analyse the meaning of the homebirth experience for parents;
4. use the information collected to contribute to the data base on homebirth.

## Research Questions

From the perspective of parents, what is the experience of homebirth ?

What contribution could the perspective of parents who have experienced a homebirth, make to professional and consumer knowledge?

## Definitions

Homebirth: a birth is conducted in the home environment of the birthing couple.

Parent: the biological mother or father of a child.

Midwife: a person who has completed a recognised education programme in midwifery and acquired the qualifications to be registered and/or legally licensed to practice midwifery. A midwife is able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to take care of the newborn (Australian College of Midwives, 1989).

Midwife in private practice (independent midwife): a midwife as previously defined who is not employed by a hospital and has entered a contractual arrangement with a client to care for them in pregnancy, birth and in the post partum period.

Environment: the aggregate of surrounding things, conditions or influences.

Antenatal: period of pregnancy prior to birth.

Stages of Labour: The first stage of labour is that of opening of the lower portion of the womb to enable the infant to be pushed out through the vagina. The second stage is that of expulsion of the infant. The third stage is that of expulsion of the placenta and membranes (Beischer, Mackay and Purcal, 1989).

Intrapartum: time period from the initiation of labour to the delivery of the afterbirth (placenta).

Transition: intrapartum phase in which the woman nears entry into and prepares for the bearing down phase of giving birth (second stage). A large

number of observations including behavioural changes have been identified as indicative of transition (Varney, 1987).

Post partum: time period from the delivery of the placenta and membranes to the return of the woman's reproductive tract to its non pregnant state (Varney, 1987).

Trimester: a period of three months (Beischer, Mackay and Purcal, 1989).

Birthplace Support Group: is a consumer group whose aim is to promote choices in childbirth, in the hospital delivery room, birthing suites and centres and at home.

### Organisation of thesis

The first chapter establishes the background and significance of the research study to nursing and details the purpose and objectives of the study. In chapter two relevant literature is discussed. The method of investigation is presented in chapter three, specifying the paradigm, design, sample, procedures and limitations of the study. Chapter four describes the study findings. A discussion of the findings, implications and recommendations is examined in chapter five.

## **CHAPTER 2**

### **Review of Literature**

The purpose of this literature review is to firstly provide a rationale for the study and secondly to place the study in context of what has been done.

Reviewing the literature on the subject for investigation can present a difficult problem in phenomenological inquiry, according to Oiler (1982) as it may bias the researcher's thinking and limit openness to meanings that are revealed.

Although a literature review is essential Van Manen (1990) described how the work of others may reveal the limits and possibilities of one's own interpretive achievements. With this possibility in mind a more substantial review was delayed until after analysis as suggested by Cobb and Hagemaster (1987).

### **Homebirth Systems**

In reviewing the literature it became obvious that the differences between countries healthcare systems was reflected in the research. There are distinct contrasts in the delivery of obstetric care between Australia, Canada and the U.S.A. compared to the Netherlands, United Kingdom and New Zealand. Each nation responded differently to the advances in childbirth technology and social changes that occurred between the 1950's and 1960's.

Traditionally the healthcare systems of Australia, Canada and the U.S.A. have not catered to the needs of the consumers seeking homebirths. Midwives in particular states of the U.S.A. and regions of Canada are outlawed from undertaking homebirths. With the social revolution of the 1960's a small but verbal segment of the childbearing population in the U.S.A. began to have their babies at home. If midwives were not readily available, lay women attended to one another and taught themselves midwifery (Flanagan, 1986). In Australia, midwives are legally able to attend homebirths, although there has never been a comprehensive support structure for homebirths. Hospital has been promoted as

the safest place to birth in the U.S.A. and Australia, consequently there is a predominance of studies from these countries investigating the safety of homebirth. Studies into the safety of homebirth will be discussed later in the literature review.

In the U. K., New Zealand and the Netherlands homebirth is legally incorporated in the national healthcare system. The National Health Service in the United Kingdom pays for the services of midwives who attend to homebirths. In the U.K. in 1991 a total of 7812 babies were born at home (just over 1 % of all births registered in the U.K.) (Floyd,1995). Government policy and professional organisations have influenced the trend towards hospital births. The Cranbrook Report in 1959 recommended a 70% hospital confinement rate while the Royal College of Obstetricians and Gynaecologists advocated 100% hospital births. The Peel Report in 1970 advocated a 100% hospital confinement rate on the grounds that hospital was the safest place to birth (Wagner,1994). Consumers' opinion or experience however was not sought until the 1991 Winterton Report, a government health report which sought evidence from women, midwives, medical staff and government officials regarding obstetric services (Leap, 1994). The Winterton Report called for a change in attitude towards childbirth. The government response to this was to form a task force headed by Baroness Cumberledge, one of the ministers for health. This body published a report entitled Changing Childbirth, which reiterated what the Winterton Report had stated and formed objectives with action plans for both the purchaser of services and provider of services. This report fostered midwifery care and facilitated homebirth services.

In New Zealand, it has only been recently that midwives have been legally able to attend to homebirths and have their services funded by the Department of Health. The Nurses Amendment Act of 1990 enabled midwives to work

autonomously and to be paid on contract by the Department of Health. Midwives are a separately registered healthcare profession from nurses and current regulations allow homebirth in areas where either a homebirth midwife is in practice or where a general practitioner is willing to attend. Abel and Kearns (1994) state that approximately 1 % of births in New Zealand are planned homebirths and this figure is slowly increasing.

In the Netherlands, obstetric care provides a contrast to the industrialised nations that border it. Its distinct features are that 31% of births are at home attended by a midwife or family physician, there is a relatively low rate of intervention and it has one of the lowest levels of perinatal mortality (9.6 per 1000 births) amongst developed countries (Hingstman, 1994). Since 1865 when the Act on the Practice of Medicine was established, midwives have been deemed competent to provide independent care during normal pregnancy and childbirth. The Ziekenfondsbesluit of 1941 (that is the Act of the Publicly Insured) regulated the competitive struggle between midwives and General Practitioners in the obstetric market (Hingstman and Boon, 1988). The Act stated that where there is a midwife available in a certain area mothers have to use her services to be eligible for full compensation for the cost of the delivery. According to Kerssens (1994, p.345):

Because pregnancy, labour and the postnatal period are considered normal physiological events women are encouraged to give birth at home instead of hospital. The choice between home and hospital delivery is free but without medical referral patients have to pay for hospital births.

Within the Netherlands health care system there is a screening system for high risk pregnancies. This is in the form of a list of indications and criteria on the basis of which midwives, general practitioners (G.P.s)'s and obstetricians decide whether the woman is to give birth at home or hospital. The screening list was devised in the 1950's as a consequence of health insurance funds fearing a rise in

the number of hospital births which would lead to a rise in costs. A clear list of complications requiring hospitalisation was established and in 1987 it was revised as a number of indications were no longer subject to referral to obstetricians (Hingstman and Boon, 1988). An essential feature of the Dutch system is the organised maternity home care funded by the government. A home care maternity nurse assists the birth attendant during the birth at home and cares for the family eight to ten days afterwards. Even the Dutch obstetric care system, which is orientated to homebirths, has experienced changes in the trends of birth setting.

Over the past thirty years in the Netherlands there has been a steady decrease in the number of homebirths from 72% in 1960 to 34.7 % in 1981 (Damistra-Wijmenga, 1984). Three factors contributed to the decline in homebirths: firstly changes in social relations and ideas about obstetric care, secondly a decline in the birth rate and thirdly mass media advocacy of the safety of hospital births (Damistra-Wijmenga, 1984).

In reviewing homebirth literature, consideration needs to be given to the differences in the delivery of obstetric care. According to Australian researcher Child:

There is little point in attempting to compare the local experience with that in the U.K. or Holland where much larger numbers are involved where medical and social criteria are used to determine suitability for home confinement and where medical and transport support services have been established (1990, p.637).

Research from the United Kingdom and Netherlands has concentrated on the delivery of the homebirth service such as Floyd's (1995) study on community midwives' views and experiences of homebirth and Kleiverda, Steen, Anderson, Treffers and Everaerd's (1991) study on place of delivery in the Netherlands. This type of literature would not be relevant to this study as it does not focus on

parents experiences. Available literature from various sources will be presented where it is found to be significant to this study.

The literature reviewed established the differences found between the delivery of obstetric care in various developed nations. Settings of research studies need to be acknowledged, as each country has it's own perspective on homebirth as influenced by its healthcare system.

### Safety of Homebirth

A source of controversy surrounding homebirth has been the issue of the safety of mother and infant (Schranm, Barnes and Bakewell, 1987). Literature and research findings reflect this view as there is a predominance of studies investigating the safety of a homebirth.

A significant and frequently cited American study into the safety of homebirth was undertaken by Mehl. In 1975, Mehl, a physician in the San Francisco Bay area, studied the statistical outcome of 1146 planned homebirths comparing these with 180 hospital births performed by one of the same group of physicians (cited in Stewart and Stewart, 1979, p. 72). The source of the data was the medical records from five home delivery services and hospitals. Variables investigated included age, parity of mothers and trimester in which prenatal care was begun. Characteristics of presentation, that is breech, transverse or vertex and type of delivery either vaginal, forcep, vantouse or caesarean were identified including complications (cited in Stewart and Stewart, 1979, p. 72). There was found to be no difference in perinatal mortality, although there was a higher rate of intervention in the hospital setting. Mehl's study was a retrospective survey which depended on the accuracy of medical records and parents reporting their experiences.



An inherent problem in statistics on homebirths is that sometimes they include the figures on accidental or unplanned births at home. This is a totally different experience to a planned homebirth and may give misleading data. For this reason, research on homebirths that accurately differentiates planned from unplanned homebirths is presented in this review.

Even in the Netherlands where a third of infants are born at home, the safety of this practice is questioned. Damistra-Wijmenga (1984) researched the safety of homebirths in a survey of 1692 women in the city of Groningen. Sample members were free to choose their type of obstetric care and place of birth. Three weeks post partum participants were interviewed, with their answers being used to complete a questionnaire; this was then analysed using computer processing methods. It was found that among women who had opted for home confinement significantly fewer complications occurred during pregnancy, birth or post partum than among those who had their births in a hospital. Morbidity was found to be lower among babies born at home.

Australia has a different health care system to the Netherlands, however, like the Netherlands it is concerned about the safety and viability of homebirths. A review of Australian studies into the safety of homebirth is appropriate, as this is where the present study is based and what has already been documented needs to be established. On a national level, investigations into homebirth were carried out by the National Health and Medical Research Council (N.H.M.R.C.) working party on homebirth and alternative birth centres (National Health and Medical Research Council, 1989). The working party attempted to overview the homebirth movement, develop principles for alternative birth practice and to look at criteria for the education of homebirth midwives. Conclusions drawn by the working party emphasised that literature reviewed did not substantiate concerns regarding the safety of homebirth and many obstetric services were not meeting

the needs of consumers. A need for better relationships between homebirth practitioner and hospital birth practitioners was identified. The working party stated that guidelines for safe practice were needed and that appropriate education for homebirth practitioners be available. Further reviews and research into the safety of homebirth have been undertaken at a state government level.

The most recent review of homebirth was by the 1990 Western Australian ministerial task force, which reviewed obstetric, neonatal and gynaecological services in Western Australia (Health Department of Western Australia, 1990). The task force was required to describe the services, assess the quality and efficiency of those services and to consider the needs of groups requiring special attention. It involved community and professional consultations and the gathering of quantitative data from such sources as the Health Department of Western Australia and the State Planning Authority. The safety and viability of homebirth was confirmed by this inquiry. Recommendations regarding homebirths also included guidelines for independent midwives practice and the review of fee structures. It was recommended that women undertaking a homebirth be booked into a hospital, and if they were transferred to hospital that their independent midwife continue to care for them. Research into homebirths in Western Australia has not been limited to state government agencies. At least two independent studies have been conducted and these studies are discussed within the context of this literature review.

Further West Australian research into safety of homebirth was undertaken by Woodcock, Read, Moore, Stanley and Bower (1990) in a comprehensive descriptive study in Western Australia between 1981 and 1987. It was found that the number of homebirths rose in that period and transfers to hospital occurred in 24.6% of planned homebirths, the main reason being failure to progress in labour. The perinatal mortality proportion of this sample group was 10.1 per

1000, slightly higher than the Western Australian perinatal mortality proportion for singleton births of 9.7 per 1000, although this is not statistically significant. The causes of perinatal mortality within the homebirth sample included lethal congenital malformations, infection caused by *Listeria monocytogenes*, neonatal infection and sudden infant death syndrome. The authors concluded that some causes of perinatal mortality are unavoidable wherever the infant is born.

In the south west of Australia, Howe (1988) conducted a retrospective quantitative study of 165 women who had homebirths. Howe (1988) utilised the registers of six independently practising midwives and concluded that women who choose a homebirth do so with a high degree of safety. Spurre (1988) argued that Howe's study (1988) could not statistically permit the conclusion that homebirths were safe, although Spurre also stated that there are risks in both homebirths and hospital births that can be accounted for as core risks of pregnancy and birth.

The literature reviewed confirmed that homebirth was a safe and viable option. Safety was measured as a physical outcome, not in terms of psychosocial outcomes such as personal development or experience. Now that the safety of homebirth has been recognised in literature, it is timely that this birth place be investigated in relation to parental experience.

### Comparative Studies of Birth Settings

In addition to safety a number of research studies have made significant findings from comparative studies of women who have had home or hospital births. Comparisons have been made regarding social networks, level of satisfaction and personal control between women who have birthed at home and hospital.

Mc Clain's (1987) study in San Francisco investigated the social network differences of 45 women choosing homebirth and 69 women choosing hospital births. Semi structured open ended interviews were conducted in the second or third trimester and again at four to six weeks post partum. Social networks of friends and family were more important to homebirth mothers than to the hospital mothers in their birth plans and experiences.

Differences between the two birth environments extended beyond the social network as studies from Canada reveal. A study in Toronto, by Fleming, Ruble, Anderson and Flett (1988), involved 17 homebirth parents and 44 hospital birth parents. The couples completed interviews and participated in questionnaires during the ninth month of pregnancy, third day post partum and one to three months post partum. It was found that women who gave birth at home were more satisfied with their birth experiences than mothers who had hospital births. Level of satisfaction was related to the number of interventions received and amount of contact with the baby. The study in Toronto linked parents' birth experiences to their level of control, particularly regarding interventions. This has been further examined in a review of Hodnett's (1989) study.

Hodnett (1989) continued investigations concerning the link between control and birth experiences. She compared personal control and the birth environment of 80 homebirth women and 80 hospital birth women. Pre and post natal interviews were conducted which revealed that the homebirth group had significantly higher levels of perceived control during childbirth, had greater affiliation with carers and had freedom of exploration and self expression. The research findings from Canadian and American homebirth studies are not isolated as Australian studies show.

Cunningham (1993) used mailed questionnaires to investigate the experiences of 395 Sydney mothers who gave birth at home, in a birth centre or in a hospital. Eighty five items were addressed on the questionnaire including an 11 item health locus of control scale and a 16 item women in society questionnaire. Cunningham (1993), found mothers birthing at home were found "to be older, more educated, more feminist" and were more willing to accept responsibility for maintaining their own health. Homebirth mothers were more knowledgeable on childbirth and more likely to be multiparous. Homebirth mothers expressed greater satisfaction with their midwives as compared to hospital mothers. What was most evident was that once women had chosen an approach to childbirth, they endeavoured to validate their experience in their own and other's eyes. A weakness in using questionnaires as Seaman (1987) described, is that they rely on self reports where recall can be selective and people may not be able or willing to express unconscious attitudes and beliefs.

Sample numbers in the comparative studies discussed were not of an equal number, frequently the homebirth population was smaller than the hospital sample which reflects birthing trends. Hospital birthing women and home birthing women form nonequivalent groups in that they differ vastly in ways other than environment, such as personality characteristics. Comparative studies between home and hospital births reinforced the significant differences between the birth settings. A number of studies have focused principally on the experience of a homebirth but only from the mother's perspective.

### Profile of Homebirth Mothers

Research on women who chose to have homebirths has also been undertaken to acquire a profile of their personal backgrounds and to gain an understanding of why they sought this birth setting.

A research study was conducted in Washtenaw County, U.S.A. by Schiff and La Ferla (1985) to explore the decision making process for birth location. Analysis of information from interviewing 20 women revealed that women planning homebirths emphasised the issue of control and the risks in a hospital setting. For these women, anxiety about the hospital contributed to their choice of a homebirth. Sources of anxiety included: loss of control, necessity of following rules, being rushed in labour and the presence of strangers.

Australian research has further investigated why women seek homebirths. The Victorian Ministerial Review of Birthing Services as cited in Child (1990) found that women chose homebirths because of the choice of primary caregiver, continuity of care and the advantages of a familiar setting. No further investigations were made to determine whether these outcomes were achieved. However the link between a person's background and their childbirth decisions has been researched in Australia.

An Australian study by Bastian (1993) investigated the personal beliefs and circumstances of 552 women who planned to give birth at home. Through the distribution of a questionnaire, data was collected which related to family details, beliefs and experiences of a homebirth. The survey found that homebirth mothers in Australia tended to come from diverse backgrounds and beliefs. They were also of higher than average educational and occupational status. The researcher concluded that choice of birth venue is made within the cultural framework that differs among individuals, communities and countries. No record was made of their experience of a homebirth, although a New Zealand qualitative study was found that focused on homebirth experience.

A New Zealand qualitative research study by anthropologists Abel and Kearns (1991) applied feminist methodology with the aim of exploring women's opinions

and experiences of a homebirth. The sample consisted of six women aged between 37 and 33 years (at the time of their labours) who had experienced a planned homebirth in Auckland during 1986 - 1991. Interviews were conducted in the women's home and involved semi structured taped discussions based around three themes: accessibility of homebirth, reasons for this choice and meaning of home as a place of birth. When the request for a homebirth was put to their G.P. half of the women were actively discouraged and they subsequently sought sympathetic practitioners. Three of the women spoke of homebirth as a package where their birth place decision meant that they had to accept responsibility for their health. The two main reasons these women chose homebirth was having a feeling of control at home and continuity of care and environment. All the women felt that giving birth at home was a positive, empowering and satisfying experience. Family members presence and assistance at the birth was seen as important in consolidating the sense of family. A limitation of the study was retrospective recall, the time interval was quite long considering that participants had to recall an experience that had occurred five years previously.

Research focusing on women who have had a homebirth has explored their decision making, rationale for birth choices and personal belief system. There are limited descriptions of the homebirth experience from the couple's perspective. Abel and Kearn's (1991) feminist study addresses gender relations from the feminine aspects of homebirth and highlights the absence of representation of the male aspect of homebirth. The male partner is often present at the birth, but in the research reviewed his perspective on homebirth is missing.

#### Fathers' perspectives of birth

None of the literature reviewed investigated fathers and homebirths thus there are gaps in the data base on homebirth. Research on the father's perspective of

birth only refers to the hospital birth environment. Qualitative and quantitative research has been undertaken regarding fathers feelings, involvement and roles at a hospital birth.

Comparative research studies have found that between mothers and fathers, social support and stress differ. In Seattle, Brown (1986) researched the influence of social support and stress on 313 expectant mothers' and fathers' health. Participants were gathered from the prenatal clinic of a large military base hospital and childbirth education classes in eight hospitals. The questionnaire involved a support behaviour inventory which had two subscales referring to satisfaction with partner support and satisfaction with other peoples' support. A health response scale was used to test participants concept of health. Brown developed a Stress Amount Checklist to measure stress, asking respondents to rate on a seven point scale the twelve situations listed. These scores were summed to produce a total score, reflecting the amount of stress experienced by the expectant parent, fathers having a lower mean stress score than mothers. Partner support was identified as a critical variable in understanding expectant parents' health. Further studies focusing on fathers in the antenatal period have confirmed these findings.

May (1982) interviewed 20 first time fathers in San Francisco over a two year period regarding level of involvement in pregnancy. The methodology utilised was a comparative analysis with semistructured interviews being conducted with fathers and their spouses. The study identified three phases in the development among first time fathers of their involvement in the pregnancy. The phases of announcement, moratorium and focusing phase, note the changes in the father's emotional and behavioural involvement in a first pregnancy and reflect the importance of a man's readiness.



In 1993, May conducted a qualitative research on the impact of activity restriction for preterm labour on 15 expectant fathers. Within two weeks of their partner's hospitalisation fathers were interviewed, then again after the birth and in a group interview. The study found high levels of distress amongst the 30 fathers, who reported feeling isolated, shocked, anxious, and stressed in relation to running the household and from the challenges of maintaining a relationship with their partner. None of the fathers reported any assistance from health professionals in dealing with their partners' activity restriction. Further investigations have been made by Chapman (1992) into the paternal intrapartum experience at hospital births

In the San Francisco Bay area, a grounded theory study was undertaken by Chapman (1992) on expectant fathers' roles during labour and birth. Twenty couples from five hospitals in the San Francisco Bay area participated in the study. Nine couples were observed throughout their hospital labour and seventeen couples were involved in semistructured interviews. The grounded theory method is interested in the generation of categories, properties and hypothesis rather than testing them (Polit and Hungler, 1989). Chapman achieved this in identifying three roles from the many behaviours described by the men, namely coach, team-mate and witness. Witness was the role adopted by the majority of participants. This study revealed diversity in the roles of fathers at the birth. Implications from this study for health care workers was to avoid stereotyping fathers and enforcing their beliefs on them. At the birth of his child a man takes on another role, that of being a father. This is demonstrated through attachment behaviour which has been researched and documented.

The paternal attachment behaviour of 48 fathers was conducted in a south eastern city in a pilot study in the U.S.A. by Bowen and Miller (1980). The sample consisted of forty eight fathers and their infants, who were observed for

15 minutes in the mother's delivery room approximately 12 to 72 hours after the birth. At each 30 second interval the behaviour occurring between father and infant was recorded on the observation sheet. Check marks were given a numerical value of one, thus each individual behaviour had a score ranging from zero to thirty. Observations found that fathers present at the birth demonstrated more social attachment behaviour. Experiencing a birth involves the demonstration of particular behaviours and expression of feelings, the latter has recently been investigated in a U.S.A. study in 1993.

A qualitative study on father's feelings about their childbirth experience was conducted by Nicholas (1993) involving 44 first time fathers who had attended one of two military base hospitals. Fathers were asked to write responses to three open ended questions about their feelings concerning labour, childbirth and their behaviours they believed to be most useful to their wives during labour and birth. Responses were analysed separately on fathers prepared by child birth classes and for fathers who did not attend classes. The findings indicated that for all fathers, regardless of antenatal preparation, the labour experience evoked generally positive responses in addition to a significant number of negative responses. Perceptions of the birth experience were primarily characterised by positive or very positive feelings, with fathers perceiving that they were most helpful to their partner during labour.

### Nightingale's Theory of Nursing

In reviewing the literature on homebirth, the relevance of Nightingale's approach to the environment encompassed parent's experiences of birthing at home. The birth environment is the key factor which distinguish homebirth parents experience as being the exception from the norm.

The core concept of Nightingale's writings is environment. She tended to emphasize the physical more than the psychosocial environment, this needs to be viewed in the context of her time and nursing experience. Environment is described as all external conditions and influences affecting the life and development of an organism and also capable of preventing, suppressing or contributing to a disease (Torres, 1985). Nightingale's view of nursing is congruent with that of homebirth midwifery. Nursing is seen as a noncurative process in which the patient is put in the best condition for nature to act.

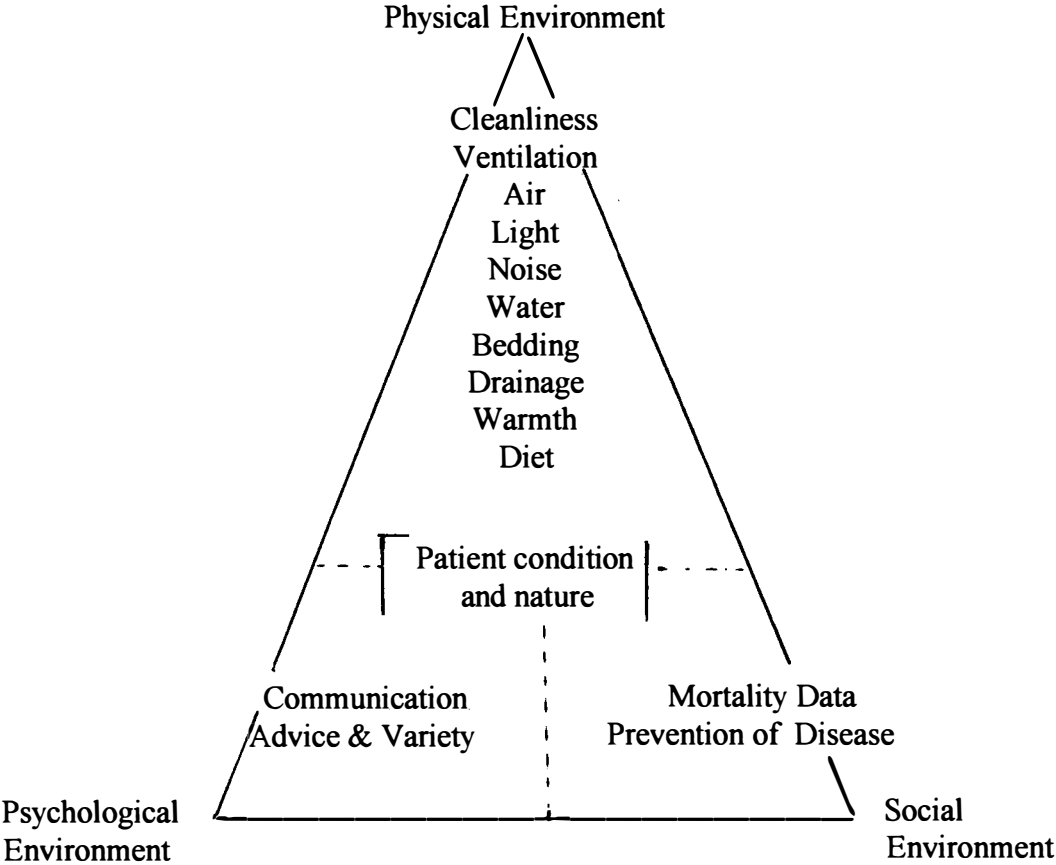


Figure 1: Nightingale's Theory of Nursing  
(Torres, 1985, 38)

Figure:1 offers a presentation of Nightingale's theory, the key factor is the centre of the triangle - patient condition and nature. The thrust of environment is on the patient and nature functioning in unity to enable the reparative process to

happen. Physical, social and psychological components of the environment are interrelated. Nightingale described that if people perceive a setting negatively it could cause physical stress thereby affecting the patient's emotional climate. Social environment was described as extending beyond the total community.

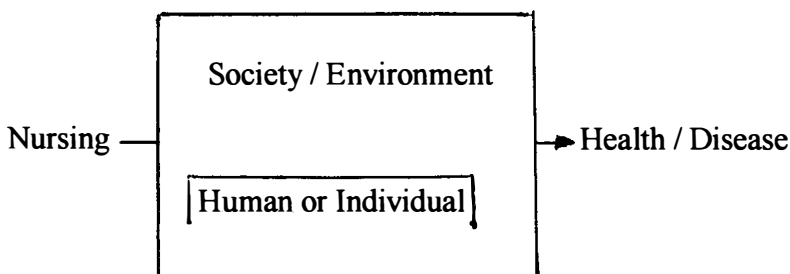


Figure 2: Nightingale's Theory and the four major concepts  
(Torres, 1985, 41)

Nightingale's theory states that the environment affects human condition with nursing having the role of affecting the environment so that health / disease becomes a reparative process. As Figure 2 shows each of the concepts impact on each other.

Florence Nightingale's theory focuses on the environment and how it affects people's health. Parents choose the environment in which they birth and this environment consists of physical, social and psychological aspects that influence their experiences of birth.

Summary of Literature

The literature review explored the themes of safety of homebirth, mothers who have had homebirths, the father's perspective of birth and Nightingale's theory. Research on the homebirth experience in Australia is limited, with the published literature reflecting the controversies of this birth place. There is a predominance of studies investigating the safety and viability of homebirth.

Homebirth literature is predominantly quantitative and focuses on measurable outcomes. However, birth is more than a statistical outcome: it is a rite of passage for a couple into parenthood and as such cannot be measured, although it can be described by those who have experienced it.

Furthermore, there has been a tendency in previous research to focus mainly on homebirth mothers even though fathers are often involved. The research on fathers refers only to hospital experiences and there is no qualitative data available on the paternal perspective of birth. Fathers presence at birth is expected although their experiences have not been adequately documented.

The concept of homebirth is inadequately documented in the light of the couples' shared experiences. In most studies, data on mothers was frequently obtained through comparison of hospital versus home mothers, thus, the phenomenon of homebirth has not been researched adequately as a separate entity. It is those who have experienced a homebirth and are willing to share experiences, who provide a unique insight into the experience in context. The present study gained descriptions from parents of their homebirth experience so as to attain the meaning of this phenomenon from their perspective.

## **CHAPTER 3**

### **Methodology**

#### **The Paradigm**

This study is situated within the interpretive paradigm. The purpose of the interpretive paradigm is to describe and interpret the meaning of peoples' experiences from their own account of those experiences. This paradigm maintains that meaning is contextually created as an intersubjective phenomenon; that is, meaning is constructed through human interaction. The interpretive paradigm applies qualitative and naturalistic approaches to inductively and holistically understand human experience in context specific settings (Patton, 1990).

The competing paradigm, referred to as logical positivism, maintains that meanings are dictated to people by the world, with behaviour being explained by objective facts (Firestone, 1987). Logical positivism uses quantitative and experimental methods to test hypothetical deductive generalisations (Patton, 1990). Salsberry (1989) reiterates that the positivist's natural scientific methods fail to adequately address experience, which is the intention of the current study.

An interpretive paradigm, utilising qualitative methods, is orientated to seeking parents' experience of a homebirth. The goal of qualitative research is to document and interpret the totality of the phenomenon being studied in particular contexts, from the individual's viewpoint or frame of reference (Lynch - Sauer, 1985). When describing a phenomenon from the emic perspective, that is the "actor's point of view" qualitative methods such as phenomenology are particularly useful.

Qualitative research such as phenomenological research is conducted in a naturalistic setting with no experimental controls being applied by the researcher on the phenomenon studied. Objective and subjective data are identified, studied and analysed in order to know and understand the internal and external worlds of people. These dimensions can provide an in-depth knowledge about an experience which could facilitate improvement in midwifery practice.

### Methodological Approach

The methodological approach to be utilised for this research study is phenomenology as it seeks to inductively and holistically understand human experience in context (Knaack, 1984; Patton, 1990). This research study is not a comparison of home versus hospital, but a description of a homebirth from ten couples who have encountered this experience, in order to better understand their perspective of the experience. The goal of phenomenological research is to see a phenomenon in its own right with its own structure.

Phenomenology is both a philosophy and a method of inquiry. The foundational writings of such philosophers as Edmund Husserl, Martin Heidegger and Maurice Merleau-Ponty have been associated with phenomenology. Historically, this approach has been interpreted in a number of ways. Mitchell and Cody (1994) describe how many of the varying interpretations of phenomenology are related with the differing perspectives of either Husserl or Heidegger.

Edmund Husserl (1895 - 1938) developed phenomenology as a rigorous science that was an alternative to the logical positivism paradigm. He described phenomenology as a method that allows us to contact phenomena as we live and experience them (Knack, 1984). Husserl's method involved the generation of essences of pure consciousness through holding presuppositions in abeyance. To

eliminate prejudgements and values, Husserl developed a procedure known as "epoche" or bracketing. Epoche involved suspending any belief about the reality of an object so that the thing itself, in itself, could be known (Cohen,1987). Customary ways of comprehending the world are temporarily suspended to allow other perspectives to emerge.

In contrast to Husserl's conviction that one can bracket one's beliefs about reality, was Heidegger's assumption that humans can never deny the basic actuality that they always exist in the world. Heidegger maintained that one's being in the world, one's historical facility and one's involvement with others, makes understanding of the world possible. Hermeneutical phenomenology, developed by Heidegger, is an interpretive approach that enables phenomena to show itself to people in an intelligible way. In the Heideggerian perspective, during research, one brackets or separates self, although a person can through intentional disclosure make explicit the presuppositions and values that guide his/her interpretations (Mitchell and Cody, 1992).

Phenomenologists hold diverse views on epistemological and ontological questions. Herbert Spiegelberg suggests that as there is no rigid, uniform view phenomenology could be described as a movement (Taylor, 1993). Spiegelberg identified six steps that are common to all interpretations or alterations of phenomenological philosophy. The six steps are as follows:

- (1) Investigating the particular phenomena through intuiting and analysing.
- (2) Investigating the general essences looking at the particulars to comprehend the general essences and their relationships;
- (3) Watching the modes of appearing;
- (4) Exploring the constitution of the phenomena in consciousness;
- (5) Suspending existing beliefs - bracketing;



(6) Interpreting the meanings which are not immediately manifest to our intuiting, analyzing and describing (Omery, 1983).

Phenomenological intuiting, in step one, is referred to as "anshauung" (German for 'looking at'). According to Oiler (1981, p.180) "it is looking at the experience with wide open eyes, with knowledge, facts, theories held at bay; looking at the experience with astonishment". The researcher concentrates on the experience becoming absorbed by the phenomenon without being possessed by it. A phenomenological study focuses on descriptions of what people experience and how it is that they experience what they experience.

Phenomenological analysing involves comparing and contrasting descriptions until recurring elements are noticed. Analysing identifies "the structure of the phenomena according to their ingredients and their configuration" (Spiegelberg, 1976, p. 671). In the phenomenological method the last procedure is describing what has been seen. The aim of this description is to communicate and direct the listener by giving distinctive guideposts to the phenomenon. Description is successful if it guides the listener to his own experience of the phenomenon.

Davis (cited in Anderson, 1991) and Oiler (1981) argue that phenomenology fits conceptually with the values of nurses, due to their reverence for clients' experiences and concern for quality of life. Nurses show reverence for clients' experiences by taking these into account when planning, implementing and evaluating patient care. The phenomenological approach effectively serves nursing's goal to understand experience. According to Lynch - Sauer (1985, p.106) "nursing as a science, has a goal to understand those individuals being cared for in order to know how to care for them." In researching the parents' experience of homebirth, insight can be gained by midwives into their practices which can contribute to midwifery knowledge.

## Design

The research design is a field study involving interviews and observation of videos of homebirths. People with experience of the phenomenon are the best source of information, therefore, this design was considered the most appropriate for uncovering the meaning homebirth held for them.

## Sample

The research study involved purposeful sampling. The targets of purposeful sampling in qualitative research are people who have experienced events, incidents and experiences, not number of people per se (Sandelowski, 1994, p.180). In qualitative research small numbers of participants are required, for this enables information rich cases to be attained (Rissmiller, 1991). Ten sets of parents who have lived the experience of homebirth in the past two years were the source of the data for this research study. Participants were sought from the Perth metropolitan area through advertising at midwives' clinics and in the Birthplace newsletter.

Sampling for participant observation was not random, but was event sampling whereby the researcher negotiated with Birthplace and one couple who had been interviewed to observe videos of three homebirths. One video of a homebirth belonged to a couple who were interviewed, while the remaining two birth videos were Birthplace resources. The Birthplace videos were of homebirths in Perth and are available to prospective expectant couples for viewing.

The criteria for inclusion in the study was that participants lived in the metropolitan area and had experienced a homebirth in the past two years. Homebirths were conducted by professionally registered midwives and the parents were living together during the pregnancy and birth. The primary

language of the researcher is english, therefore participants needed to be english speaking, to facilitate articulation of their experiences.

### Instruments

The main instrument in data collection in phenomenological studies is the interviewer. As a research tool, the interviewer's "... task is to facilitate the subjects' recall of experience, record the data and then to allow it to speak for itself" (Oiler, 1982, p. 179). As a midwife the researcher was able to use her knowledge and clinical experience to comprehend the interview.

As described by Drew (1989) the researcher investigates a phenomenon that matters to that individual, therefore, as a midwife some emotional investment is present, which can be a potential source of bias. To enable the researcher to see the phenomenon for what it is, assumptions and preconceptions of homebirth were held in abeyance through bracketing. The process of bracketing was achieved by writing memos, whereby personal feelings, beliefs and references are written, allowing the researcher to gain perspective and reflect on preliminary interpretations (See Appendix A for an example of the researcher's memo).

In order to reduce the researcher's idiosyncratic bias, as suggested by Oiler (1982) an unfamiliar setting and people were chosen. The researcher has experience in attending to hospital births in a country and a metropolitan public hospital. The participants were informed of this experience and the fact that the researcher is currently working in a paediatric medical ward and not in a maternity setting. Prior to interviews and observations the researcher exercised (swimming, walking, yoga) to facilitate concentration on the experience being discussed.

Interviews were conducted in research participants' homes, at a time convenient to them. Field notes were gathered from observations made during the interviews and observation of birth videos. All sensory input was recorded, including descriptions of the setting, persons, verbal and nonverbal communications and what was happening during data collection, for example, baby being breastfed while interview was conducted. These represent the participant observer's efforts to record information, to synthesize it and understand the data.

### Procedure

Advertisements for participants were placed in the Birthplace newsletter. A letter was sent to individual independent midwives informing them of the research study and requesting their involvement in the distribution of information leaflets about the study to clients (See Appendix B for information leaflet and informed consent form). Information leaflets were placed in prominent positions at independent midwifery centres. Two midwives gave the researcher names of clients who were interested in participating in the study. These clients were sent information leaflets and informed consent forms with a stamped, addressed envelope to be returned to the researcher.

The researcher received confirmation of people's willingness to participate in the study by mail or a telephone call. In the first telephone call with the participants their willingness to be involved in the study was confirmed and arrangements made for interviews. A date, place and time was negotiated with participants as to when an interview could be conducted. Couples were given the opportunity to adjust the interview time when necessary.

Once the informed consent form was completed the investigator conducted all interviews and observations. An interview was conducted, in the subject's home

for between sixty to ninety minutes. In this way the need for babysitters was alleviated and the couple's anxiety was reduced, as they were comfortable and familiar with the environment. Participants' homes had been the setting of the experience to be discussed, thus the researcher could visualise the experience. Interviews were conducted with participants sitting around a table with a tape recorder positioned nearby speakers.

Data collection was not begun until a sense of rapport was developed with participants. Rapport was established by the researcher introducing herself to participants, describing her reasons for conducting the research and being sensitive to parents' nonverbal and verbal communication.

Open ended questions were used to commence the open ended interview as this is consistent with phenomenological method. A question guide consisting of open questions and prompts (see Appendix C) was shown to participants prior to commencing the interview. The following question was asked of the informants:

*As parents, can you tell me about the experience of your homebirth?*

Participants were asked to describe all thoughts, feelings and behaviours they could recall of their experience. The central focus of the study was on the couples' experience, thus they were interviewed together, to allow participants to share and confirm their experiences. An audio tape recorder was used to record interviews.

Participants were shown how the tape recorder could be stopped and informed of their right to stop recording. Raw data was in the form of audio tape recordings, transcripts and observational notes on the ease of interaction, non verbal cues and impressions of the researcher.

The researcher contacted couples who participated in interviews and had mentioned that they recorded the birth on video. It was negotiated with one couple that the researcher be able to observe the birth video. Two birth videos used for educational purposes were loaned from Birthplace and observed. Detailed field notes were made of observations.

### Data Analysis

The goal of data analysis is faithful interpretation of the data. The taped interview was transcribed. Colaizzi's method (as cited in Knaack, 1984, p. 110) was used to analyze the transcripts of participants experiences. The steps by which data was processed included:

- (1) Reading through transcripts for a sense of the whole;
- (2) Extracting significant statements that pertain to phenomenon investigated;
- (3) Formulating meanings as they emerge from significant statements;
- (4) Repeating Step 3 for each transcript and organizing the formulated meanings into cluster themes;
- (5) Integrating the results of the analysis into an exhaustive description of the investigated topic;
- (6) Formulating the exhaustive description of the phenomenon into a statement of identification of its fundamental structure.

Data analysis occurred concurrently with data collection. New themes that emerged when analysing data were added to categories of themes already identified from previous transcripts. Data collection was ceased once there was enough data to build a comprehensive convincing theory and no new themes, for data saturation was achieved. As described by Sandelowski (1986) in data saturation, richness of data is derived from detailed description, not the number of times something is stated.

## Validity

In evaluating the validity of a qualitative research study its credibility, fittingness and auditability are examined. These naturalistic terms are equivalent to the quantitative criteria for evaluation of validity and reliability.

Credibility refers to how vivid and faithful the description of the phenomenon is to what was actually experienced (Beck, 1993). This was fulfilled by triangulation of the data and member check. Triangulation is described by Kimchi, Polivika, and Stevenson (1991,p. 364) as " the combination of two or more theories, data sources, methods or investigators in the study of a single phenomenon." Within methods, triangulation was applied in this study as a combination of two or more similar data collection (interview and observation) approaches were used. Observational data and interview data were coded and analysed separately then compared as a way of validating findings.

Member check is an approach whereby validity and credibility can be confirmed by participants of the study (Beck, 1992). Research participants were mailed a summary of the description of the phenomenon and were asked to comment on this by phone or mail. Seven out of ten people responded through verification interviews on the telephone. Any new relevant data gained from the participants was incorporated in the description of their experience.

Fittingness measures how well the propositions fit into a context (Beck, 1993). To achieve this criteria a detailed description of the study participants is given. As described by Sandelowski (1986) the descriptions and explanations of data contain atypical and typical elements of the data. Observations and interview responses were described in rich detail to capture the essence of these peoples' experiences in context.

Auditability is the ability of another investigator to follow the decision or audit trail (Sandelowski, 1986). Detailed descriptions are provided of how the researcher became interested in the subject, purpose of the study, data collection methods, setting and details on decisions regarding data analysis. The researcher's memo (see Appendix: A) and data display charts are convenient for auditing (see Appendix: D).

### Ethical Considerations

Permission was obtained from the Edith Cowan University Committee in the Conduct of Ethical Research and the Independent Midwifery Centres prior to commencing this research.

Involvement of all participants was strictly on a voluntary basis. Respondents were informed of their rights and how these would be protected both verbally and in a cover letter. A consent form ( Appendix C) was completed by all respondents after being informed as to how confidentiality and anonymity was to be protected. Participant involvement was renegotiated, with the respondents' right to withdraw being explained. In the event that during an interview the interviewee became distressed and required counselling, the agencies of Women's Health Care House and the Birthplace Support Group were available for referral. In this study these services were not required.

Data were protected through the use of a safe with a combination lock to hold raw data and the master list of participants, with only the researcher having access to this. In using a computer to process data, file names were only known to the researcher and only two disk copies were to be used. Audio tapes will be held in a safe until five years after the study is completed when they will be destroyed. This is in accordance with the National Health and Medical Research Council's



stipulations and Edith Cowan University's criteria that all research data be incinerated five years after completion of the research study.

### Limitations

Findings from this research study are not to be generalised as they are specific to the group of people studied and the sample group is not random but a purposive sample. There is the potential that in interviewing both parents at the same time, data may have been changed or omitted by them consciously or unconsciously, due to the presence of the other partner. A female interviewer may have affected the way in which respondents answered. Only male / female parent couples were considered in this study which excluded single mothers and female / female parent couples homebirth experiences.

## **CHAPTER 4**

### **Findings**

This chapter reports the findings of the research conducted in 1995. Findings will be presented under three sections. Firstly a brief description of the study participants is given, followed by an overview of the experience of having a homebirth. Finally, themes that emerged from the data which describe the essence of the meaning of parents' homebirth experiences are presented.

### **Participants**

The ten couples who were interviewed had experienced a homebirth in the Perth metropolitan area in the past two years. All participants were attended by an independent midwife and general practitioner during their pregnancy. Five different midwives were involved in the births.

Of the ten couples interviewed, four couples spoke of their first child's birth at home. The remaining six couples consisted of three families with two children, both of which had been homebirths and three families with four children of which three were homebirths. Two mothers had previously birthed in a hospital prior to their homebirth.

The socioeconomic level of these families varied. In each of the ten couples the chief wage earner of the household was the father, with their occupations ranging from skilled tradesman to professional. While some mothers worked full time prior to their pregnancy, at the time of the study their level of employment had shifted to part time or home based duties. The age of parents ranged from twenty years to forty years. Seven of the twenty mothers and fathers migrated to Western Australia; two were from Scotland and five from Northern England. The remaining thirteen participants were born in Australia.

### Having a homebirth

Homebirth is a personal experience of parents. Each birth described was unique to the couple interviewed. It entails more than the birth of a child at home. A homebirth requires preparation, such as the processing of expectations and developing supportive relationships within the community. All of the parents interviewed gave a description of their homebirth experience that incorporated the occurrence of positive and negative elements. The overriding tone of the parents' accounts was that homebirth was a positive experience.

A conscious decision was made by all the parents to have a homebirth, before conceiving or within the first three months of pregnancy. Prior to making their decisions, participants researched their birth options by considering peer's birth experiences, speaking to health professionals and seeking information from literature. The predominant reason for choosing a homebirth was the parents' desire for a natural birth without intervention. When couples opted for a homebirth, it was a unanimous decision. On announcing their decision parents received reactions ranging from strong opposition to positive support from family, friends and members of the public.

Couples carefully selected their midwife in private practice by a process of personal or phone interview in which questions were asked regarding the midwife's practice. A determining factor for parents when choosing their midwife was the presence of a sense of rapport, a feeling of empathy and understanding. A close emotional bond developed between all parents and their midwife.

Midwives involved in births gave their clients a list of G.P.s who were supportive of homebirths and had hospital admission rights. Parents selected one of these G.P.s and during the pregnancy mothers were cared for by both the

doctor and midwife. The collaborative service with the G.P. and midwife was a condition set by the midwives, who recognised that specific medical procedures such as an ultrasound could only be ordered by a doctor and that medical assistance may be required at the birth.

During the antenatal period parents physically and mentally prepared for the birth. Parents' mental preparation included gaining knowledge and discussing their desires, concerns and expectations for the birth with carers. These carers included their partner, family, friends and health professionals. The couples' families and friends provided emotional support by listening and talking about their birth beliefs. Physical preparation for the birth involved adapting the house, gathering equipment and mothers exercising to maintain fitness.

All homebirths occurred at least a couple of days after the expected date of confinement. Some mothers described how they took homeopathic remedies to initiate labour. If fathers were not at home when labour commenced they were paged or contacted at work, which they left to be with their wife. Once home, fathers supported mothers as they laboured, regulated the environment according to the mothers' needs and contacted support persons and the midwife.

Early in the labour, midwives liaised via the telephone with the birthing couples about the birth's progress and came to the house usually a few hours after they were first contacted. If the midwife could not be present another midwife from the same midwifery centre came to care for the parents until their midwife arrived.

Mothers employed different techniques to cope with contractions. All the women stated that they were mobile, spending most of the time walking and that lying down was found to be uncomfortable. Warm water in showers, baths and

tubs provided relief combined with massage by support persons. Couples found that familiarity with the birth setting assisted them to relax and be less anxious. Only three mothers required medications during the homebirth: an oxytocic intramuscular injection to control post partum bleeding.

The birth was variously described by parents as "wonderful", "amazing" and "miraculous". A sense of being on a "high" and feeling euphoric was experienced by all participants at the birth. The midwife included fathers and support persons in the birth by having them do such things as warming the baby's blanket and cutting the baby's cord. All mothers commenced breastfeeding immediately after the birth and continued breastfeeding at least until the baby was six months of age.

In the post partum period fathers were the key carers of the family and worked to maintain the running of the household. Fathers took time off from work to be with the family after the birth. The amount of leave varied from four days to six weeks. Some mothers found they did not rest long enough after the birth and that visitors were tiring. Support for the new parents in the form of cooking and cleaning was provided by family and friends.

During interviews most of the participants were open and expressive regarding their homebirth experience. At the end of interviews a number of parents spoke of how there were limited opportunities to speak of their births without being judged. Homebirth parents found, with some people, a censure existed which discouraged them from speaking of their homebirth. Despite having a case of influenza when interviewed one mother still contributed significant statements, as the opportunity to speak freely had been presented at the interview. Often the child whose birth was being discussed was present at the interview. A couple who were expecting their second child when the interview was held stated that

reflecting upon the previous homebirth helped them mentally prepare for the next homebirth.

In one interview the couple gave closed responses to questions, without elaborating further on prompting, hence, there are limited verbatim statements from them. Towards the end of many interviews, particularly when the tape recorder had stopped, participants spoke passionately about their experiences. It was interesting that in two interviews comments regarding hospital and hospital midwives were directed at the interviewer.

In reviewing field notes and transcripts from interviews, significant statements were identified. Further analysis of these statements resulted in themes emerging and cross case comparisons being made. Originally, twenty provisional themes were found and these were collapsed in a series of stages until the four essential themes remained. For example, the sub headings; safety of homebirth, natural birth and self expectations were collapsed to become Beliefs / values. This theme was renamed Formulating Expectations and became a sub theme of Resolving Expectations.

### **The Essence of the Homebirth Experience**

The essence of the parents' homebirth experience consists of Constructing the Environment, Assuming Control, Birthing, and Resolving Expectations. All couples who had a homebirth described the process of creating a conducive birth environment which included adapting the physical environment and establishing social support. Assuming Control was based on parents' belief that they could have greater control of the birth by exerting control and physically adjusting the birth environment. They also accepted responsibility for the birth. Birthing is a description by parents of the intrapartum process involving birth beliefs and interactions between themselves and their carers. Parents went through a

progression of formulating expectations, resolving these with the reality of the birth and then evaluating expectations.

Verbatim quotes are used to illustrate elements of the common experiences and themes. To maintain confidentiality a reference format is used. Following a transcript extract, a bracketed number along with M (for male) and F (for female) is allocated to each couple; for example (F 8) or (M 3). In a verbatim statement where a person refers to another by name, the title of that person will be typed with surrounding brackets, for example (baby) is used in lieu of the baby's real name.

### Constructing the Environment

Parents who chose to have homebirths described how they constructed an environment conducive to birth. Physical and social elements within the environment were organised to optimise conditions for birthing. Members of the public, peers, family and friends' attitudes towards homebirth were expressed during this time.

Once parents had decided where they were birthing, they then discussed and explored their intentions for the birth environment. They received ideas on how to create a positive birth environment by reading literature, attending antenatal classes and listening to peers' birth experiences. A father spoke of how he:

"... just listened, that was all, to the talks of what happened, different stories other peoples stories of what they've done. I used to learn that way. It made us more aware, we were more educated on what to expect."  
(M 1)

The couples considered the information gained from classes and peers, looked at their home environment and then applied this to create conducive conditions for their unique homebirth.

### Preparing the physical environment

Parents considered how the physical components of their home could be employed to facilitate the birth. One father expressed how he planned to create a birth environment according to the following premise:

"If you were a child being born, what would you like? And I figure, soft music because it's very tranquil. Low lighting, you know if you feel romantic or in a restaurant or somewhere when people want to be together that's low lighting"(M 5).

The aesthetic elements of the home lighting, sound and warmth were utilised to facilitate the birth. An atmosphere was formed with candles or natural light, favourite music being played and rooms being maintained at a comfortable temperature. Fathers worked to maintain a sense of harmony within the environment.

Items found around the house were used to support birthing. For example, one mother found hanging by her hands from the washing line effective in coping with contractions. Another mother birthed leaning on an ironing board. The shower, bath or birthing tub were used during labour as a distraction, to assist in relaxation and to keep body temperature comfortable.

Midwives requested that particular articles were present at the birth. These articles included towels, a hot water bottle and clothing for mother and infant. Physical resources specific to birth such as a birthing stool and birthing tub were simple in nature and not a focus of the birth. A mother described how the midwife:

"had everything in the kitchen out of the way... that's nice because you're not focused on all this gear ... all you've got is the midwife ... equipment is very low key. It just appears from nowhere" (F 7).



### Preparing the social environment

The social element of the homebirth environment was the support provided by family, friends, neighbours and health professionals. One mother refers to how she organised a support network for the birth:

"Organising, I think it was just things like support people like getting happening what we wanted to happen... The nursery and things like that, you know not a great deal of material stuff, it was just people" (F 10).

The majority of parents existed within a community where homebirth was viewed as an acceptable practice. Couples in such settings as antenatal classes, yoga classes, health food and homeopathy shops, interacted with people who had experienced a homebirth. In the words of one father:

"We live in a community where what we do is acceptable and not only acceptable but supported" (M 9).

Each couple had their own support networks and were in a geographical location of approximately twenty minutes driving distance between members. Support people provided emotional and physical support for parents who birthed at home.

Throughout the antenatal, intrapartum and postpartum period, social support was available and accessible. During the antenatal period, parents tended to surround themselves with people who were positive and accepting of their intentions, such as members of support groups and antenatal class members. A mother who had just moved from interstate to Perth described how her midwife assisted her in forming a support network:

"(midwife) put me in touch with a group of girls down here, a support group and most of them have had homebirths so that was really positive" (F 6).

Prior to the birth, parents selected people to be present at the birth, considering their personal characteristics and how they would influence the birth. Those present in the intrapartum period assisted in providing a beneficial birth setting. For example, someone provided food and beverages and another person cared for siblings. A father explained this process of selecting birth support persons:

"You know we'd select people who we thought were going to be practically appropriate. And it was just making sure that you had a sort of harmony. I mean we had someone who was looking after the drinks and running around fetching things" (M 7).

Familiar people with supportive and energetic personalities were in attendance, with everyone knowing each other. A mother remembered how the number of people present at her births was influenced by the degree of difficulty of the birth. For example the last birth was her fourth child, who was a breech waterbirth at home.

"I realised that I had that many people because it was a harder birth because it was breech. I needed more energy, more support" (F 9).

The environment was prepared and constructed for siblings to be present at the birth. Early in the pregnancy, parents informed their children of the impending birth. A person known to the child cared for them during the birth. In five cases, siblings participated in the birth of their brother / sister.

"The boys were good. We woke them about an hour or something and they just sat there and just giggled and got into it and it was lovely. (Baby's) head was coming around and he slipped back up again and they said 'he's gone back up again.' And (youngest sibling) said 'Oh you'll be another week I bet!'" (F10).

Children's attendance at the birth was described as an asset in that they did not escape the reality of birth and their lives were not disturbed. Siblings'

acceptance of birth is shown in this mother's statement:

"And when the baby's just out they're there and they're a part of it and they're very familiar with birth and very at ease with it. And other people, our friends have children they ask them details that adults aren't even interested ... that don't really have an interest in. And to them it's just normal." (F 9)

Family routines were maintained as much as possible during and after the birth.

In one family, the siblings had their breakfast soon after the birth .

A mother stated: " My Mum came along. She came about three in the morning." (F 5) This was the case in five families in which maternal or paternal grandparents were present and involved in the homebirth of their grandchildren. Some grandparents had come from interstate to be at the birth. Grandparents were invited by their children to be present for the birth and assisted in doing such things as boiling water and encouraging parents.

"I think once (baby) was born my Mum was sort of running in with hot towels and things for the baby. But otherwise she sort of kept her distance." (M 8)

"It was nice to see Mum here, she was included." (M 10)

Parents discussed the differences in birth practices between the generations. The grandmothers had birthed without their husbands being present in a hospital, whereas the expectant mothers birthed at home with their spouse, family and friends. One birthing woman stated in reference to her mother :

"I was so keen to show her after she had such horrific experiences of childbirth, I was very keen to show her that it can really be a very lovely experience." (F2)

Couples described how their parents' perception of childbirth was altered by witnessing their grandchild's homebirth and observed that a close bond existed

between grandparents and the grandchild, whose birth they had witnessed. A mother spoke of the significance of her father being at her baby's birth:

"My parents got to see her being born. And for my Dad especially that was a really exciting moment because I'm the youngest of five children and he's never seen any of us being born. He's never seen a baby being born before (baby). And in those days you know they'd drop off the wife, off you go Mr (his surname), we don't need you any more and then he comes back and the baby's clean and Mum's all clean and they've got no idea of what happened in between. Because it's not something they talked about then. So I think it's probably gave him a whole new light on Mum! And just women having babies in general. But he was just a hundred watt globe, wasn't he honey after she was born. And she's his special girl." (F 6)

Members of the support network assisted in the running of the household after the birth, working to meet such basic needs as providing food and clean clothing.

"we had a good support there as well which I think was important. (Mother's) mum came in every day and cooked and cleaned and what not. Because I had to go back to work after a couple of days, at the time." (M 4)

Families' and friends' support enabled parents to establish a bond with their new child, developing mothercrafting skills and gaining some much needed rest.

### Dealing with peoples' birth expectations

Family and friends' reactions to parents birth plans were either a source of support or contention, which the birthing couple worked to resolve. One mother stated:

"Half were supportive and half 'Oh God a homebirth! You know the cord will be wrapped around it's neck.' So the more conservative members were horrified and others thought what a great idea, good luck. But we had enough support" (F 8).

Future grandparents were found to be initially apprehensive, nervous and dubious regarding homebirth, though they accepted their expectant children's

plans. These comments reflect the relationship between parents and their families:

"But I think my parents just knew it was something that I was going to do and other things you've done you've always come out on top of it and so we'll trust your judgement " (M 5).

"I suppose they would have been a little bit apprehensive at first. They weren't actually in the area, so it wasn't a problem" (F 10).

"Well Mum was a bit dubious... not so much dubious she was a bit worried, you know like what if things go wrong. But she'd had all of hers in hospital, so it was not the done thing, I guess. But then she knew what I was like once I'd made a decision about something. So I explained to her then about the hospital back-up and everything so if there was any complications, don't worry you can go straight to hospital. And once she met (midwife) that put all her fears at rest" (F 6).

Birthing couples accepted people's apprehensions regarding homebirth, stating they initially had concerns and had resolved these.

The presentation of homebirth in the mass media and society was discussed by participants. Couples spoke of how societal norms favoured hospital births and the public was conditioned or programmed into viewing homebirth with scepticism and fear.

"You just get programmed by the idiot box and newspaper and friends. I think, there's something about the black humour of birth and people bring out the worst" (M 5).

"I can understand how they feel, that they're scared because they've allowed themselves to become conditioned by a medical society that says that you can't do this on your own" (F 7).

All participants experienced reactions from some acquaintances or members of the public in which they were labelled as being "nuts", insinuating that they were social deviants or mentally inept.

"I've got clients and friends that are doctors and they think I'm absolutely nuts" (M 2).

"My family were totally against it saying that we were nuts" (M 1).

"When we told her the kids had been born at home she just turned around and said 'My God are you bloody hippies or what ?'" (F 7).

"And I was working part-time at the supermarket and you'd have ladies coming through and they'd ask you 'how you were going' and say 'what hospital are you going to ?'

" Oh I'm not, I'm having it at home".

'Oh really!' and they all sort of take a step back and go, some people would sort of say 'that's really great'. But a lot of people would sort of say like 'you're crazy' " (F 5).

Anger and frustration was verbalised by some parents regarding people's inferences, as this quote reveals:

"I mean we're both intelligent adults, you know, we're not going to do something stupid to put myself at risk and our babies at risk ... I suppose after a while you get a bit ticked off with people because you think you know I'm not stupid" (F 4).

Parents' sense of humour and strong will assisted them in dealing with opposition. Once the couples had decided on a homebirth they did not seek people's opinions or advice, for as parents stated:

"we don't consult people anyway" (F 10).

"I guess we didn't give people much option to. This is how we're going to do it and I guess if they thought that it was a bloody stupid idea they didn't bother to say anything" (F 6).

These statements reflect homebirth parents' strength of conviction when facing opposition.

A homebirth involves parents constructing a unique environment consisting of physical and social factors that are conducive to facilitating the birth of their child. While preparing for their homebirth, couples dealt with people's reactions to home as the birthing environment.

### Assuming Control

The second major theme was Assuming Control. Participants discussed how they assumed that what was happening to them in pregnancy and birth was to an extent within their control. Dimensions of control described were control of the external environment and intrinsic control. Parents acknowledged that in exerting control, they took responsibility for their homebirth and acted autonomously.

### Parents' demonstration of control

Participants described how past, negative hospital experiences and interactions with health care professionals, which were unrelated to their pregnancy, challenged their perception of being in control. Past experiences contributed to parents seeking a birth setting which would enable them to exert control.

"... just losing control of your life while you're in hospital and having other people making decisions" (M 3).

"Not a place I wanted to be. I'd broken my leg a few years ago and in there having it pinned and plated and then I was back in again to get them out and I just hated the place" (F 5).

Parents actively sought healthcare professionals who would allow them to birth the way they wanted to, with a sharing of power and decision making. Three women spoke of how prior to choosing a homebirth, they sought a female doctor in general practice to attend to them in their birth. The three mothers identified several reasons for selecting a female G.P: that as a woman, the G.P. would sympathise with the female perspective of birthing and possibly have personal experience of birth herself and as a G.P. she would be less likely to intervene. On further investigation these parents found that their desire for a natural birth could not be achieved with the G.P. they had chosen.

" I chose a G.P. obstetrician because I thought they'd be more laid back. A female because I thought she'd understand. I went to see her and I was just horrified. I asked two questions about what she would allow and I came back depressed." (F 3).

"We'd gone to look at a couple before we decided on the homebirth and we were just looking for a woman doctor and we'd been to see that one from (suburb) hospital and I just walked out of the office after just going there. I said 'I don't like her, I'm not going back there again' .... She was really impersonal, really abrupt and I just said 'No I'm not going back in there again' (F 5).

As illustrated by these mothers, if parents found the healthcare professional's perception of control differed from theirs they terminated the contract. Through a process of careful selection parents found a homebirth attendant who was receptive to their ideas.

### Control of external environment

During the pregnancy and labour, participants described how they exerted control of the external environment. Birthing parents demonstrated this control, by physically adjusting the environment and by informing the people present what their needs were and how these needs could be achieved. Examples of external control are described by these parents' statements:

" And I went into the spare room. Just got everything for the birth and put it out there, without actually really consciously thinking you know I'd better get everything ready. I just did it" (F 3).

"At one stage when I was in labour with him. I said to (midwife) 'Oh, just go out, nothing's happening, I feel like I'm on show and I'm not performing!' It was so slow!" (F 2).

" And you knew that we wanted to see, but you wanted to be by yourself" (M 2).

"But then they respected that too. She said 'Fine, yeah it's horrible having someone hanging around, so I'll go and have something to eat.' She went home for a while" (F 2).



## Intrinsic Control

During observations and interviews a major issue discussed was parents' intrinsic control. This involved taking charge of one's own health, mentally and physically. The manner in which women dealt with contractions showed intrinsic control as they described:

"But in regards to pain and stuff I think... (mother) did it all mentally. You know, just saying to her, concentrate and because the time had lapsed and they'd come and go, they'd be low and you could relate to them, they'd come and you'd have to wake up and concentrate on breathing. It's all a mental thing" (M 5).

"No special breathing or anything, just relaxing and going with it. Going with the pain, not fighting it" (F 2).

"I was quiet within myself" (F 1).

"(Mother) was just going from... she was in the lounge, she was kneeling down in the lounge, she was in the shower for ages and she was mostly standing up or on the toilet for a while" (M 3).

Intrinsic control was witnessed on birth videos in the way the birthing women withdrew from communicating. They changed their breathing pattern and posture during contractions, with support persons physically assisting them. The degree of control a mother perceived she had in birthing altered during the course of the labour. Mothers described periods in which they felt as though they were "losing it", losing control of the situation. Transition in particular was an intense time:

"I just couldn't believe things got so bad. I remember begging (midwife) to take to take the damn thing out!! (laugh) But by then it was too late for any pethidine" (F 4).

"Yes so I was pretty close to transition. And I just gave him the car keys, I said we're going. We're going to hospital, you know! I can't believe this!!" (F 1).

The techniques these mothers employed to handle transition included talking to their midwife and physically changing their position.

### Differences in control between parents.

The core of control at the birth was the labouring woman. It was accepted that the birthing woman was the source of information on the birth being experienced and the reason people had come together. Birthing women identified the stages of labour revealing the extent of their childbirth education and how they were recognised to be a source of information.

Fathers acknowledged that the birthing woman was the focal point of the birth. Two fathers verbalised an acceptance that birth is women's domain and that they appreciated being present for the birth.

"Birthing is a very female thing to do ... it's hard for a male to look at birth and feel the same things that a woman would feel. It's nice to be included and do as much as you can from the male perspective, so it's a very strong female thing" (M 10).

"At the end of the day it's her procedure more than mine. ... it really is a woman's domain" (M 2).

The perception that birthing women had control fostered successful birthing. They had the assertiveness and self confidence to verbalise their expectations, which assisted them in birthing the way they wanted. This mother's statement exemplifies this:

"... being in the daytime and such a short labour I felt very much in control. I knew what I wanted and what position I wanted to be in and that really helped" (F 6).

The mother's assumption that she had the right and responsibility to control the birth enabled her to act in an assertive and autonomous manner.

During the labour the fathers' experienced a different extent of control from the mother. Half the fathers spoke of how during their partner's labour there were times when they felt useless or inept, for they were powerless to control the birth.

"You feel quite useless" (M 2).

"And if you ever want to get a man at his most vulnerable it's at that stage when he can't do anything and he sees his spouse lying there you know, either abusing him or begging him to stop the pain or whatever you know. And it's really humbling" (M 5).

### Recognition of rights and responsibilities.

Parents verbalised that in assuming control of the homebirth came responsibilities and an acceptance that some things cannot be controlled. As a mother stated:

"... like to the best of your ability get things going your way. Some things are out of your control ... but I think the biggie is the responsibility that you take on for what you're doing. You take that on 101 % type of thing" (F 10).

The homebirth was the parents' experience to own and be accountable for, as stated by one couple:

"If you had a homebirth I think you as a parent have to wear it. And that's the price you have to pay. You can't go around suing people or ..." (M 3).

"Blaming anyone. You say oh well we've done this and we'll accept what happens as on our shoulder. Where I think in the hospital system you give up your responsibility to someone else to an expert to a doctor whatever his name is. You know and if anything goes wrong it's his fault. We prefer the idea of you know ... with it staying with us" (F 3).

This statement reflects parents' ownership of the home birth and acceptance of responsibility for whatever happened. There was no reference to other people being culpable for what happened at their homebirth.

Ownership and control of the birth included parents considering how they would handle their worst case scenario, the possible death of a child. Before having a homebirth, they discussed all possible outcomes including negatives such as premature birth of the baby and the need to transfer to hospital. The following is an example of how a couple discussed their worst case scenario.

"I said look, (pause) worst case scenario, something happens and the baby dies, will you (mother) be upset, will you blame yourself. Or we could say (pause) look okay we did what we thought was right and it turned out wrong" (M 7).

There was an acceptance that death could occur in any birth environment.

All participants took responsibility for educating themselves regarding pregnancy, birth and health.

"I did a lot of reading and educating myself beforehand..." (F 7).

"...that's why we started to go to antenatal classes. It was to help overcome the fear you know, because fear doesn't help you relax at all .... This lady does these classes and we just went there. That was very, very good, we felt it was very constructive" (F 4).

"yeah, we went to a workshop, you know and they got all the dads together"  
(M 6).

"And we did a lot of reading and we did a lot of ... (mother) did a lot of yoga, I went along to antenatal yoga" (M 7).

Parents' motivation to learn was connected to their sense of responsibility and accountability for their child's homebirth.

"But if you go through the homebirth system you're compelled to learn more because you're going to be involved really ... " (M 3).

Participants discussed their use of homeopathy, aromatherapy, massage and yoga to maintain their health. The therapies listed were utilised on a continuous

basis not only in pregnancy and labour. One mother stated that: "homeopathy is taking health into your own hands it's taking it a step further" (F 10). Parents demonstrated self control and responsibility by educating themselves about alternative therapies and self administering them.

Parents were informed and assertive regarding their rights and were aware of the responsibilities this involved. A mother explained this sentiment as:

" we know our rights, we know what we want and we also know our responsibilities with those rights" (F 4).

Rights, as identified by parents, included the: right to information, the right to choice of birth environment and carer and the right to privacy and confidentiality. With these rights came such responsibilities as self preparation for birth and accountability for actions.

### Birthing

Birthing describes the rite of passage into parenthood and the development of relationships with partners and their carers. An integral feature that influenced birthing was the couples beliefs regarding birth.

### Birthing Beliefs

Birthing beliefs were the foundation on which parents and their carers based their actions. A significant belief held by parents and their attendants was that it was possible to give birth naturally at home. A father spoke of how important this concept was in a homebirth:

"There are a lot of women, a majority of women that struggle with the concept ...although (mother) is comfortable in her mind about homebirth and that's the biggest hurdle, I should imagine" (M 2).

A common point articulated by parents was that home as the birthing environment was not suitable for those who did not have confidence in their ability to birth at home.

".. if you're not feeling safe then again its pointless ..." (F 7).

"where you are comfortable is where you should have your baby" (F 3) .

"if it makes you feel safe then you do what you need to do" (F 1).

These statements reflect how participants viewed the birth environment as an individual choice and people seek and form the environment that works best for their baby's birth.

All parents viewed birth as being a natural process. A father spoke of the difference in birth beliefs between himself and his brothers:

"They tend to be focusing on the things that go wrong. Like it's some sort of medical condition rather than a natural process" (M 4).

The two different viewpoints on birthing were a source of disagreement between parents and some of their peers. Homebirth couples described birth as natural and that women's bodies were designed to birth without intervention and interference. A father stated:

" it's a natural thing and the body's designed to do it and if it's working well it should do" (M 10).

As birth was believed to be natural, it was not seen as being frightening.

"There's nothing to be scared about or anything which a lot of people immediately think of. Aren't you frightened? No. And I often tell people too, that a lot of women just think it's frightening and it's not" (F 2).

Parents expressed confidence in their birthing abilities.

"A lot of people are nervous about homebirths. They're not confident in themselves. Like (mother) has always been confident, which is probably

the biggest deciding factor. Like initially we wouldn't have worried either way, whatever way (mother) wanted to go, but because (mother) wanted to have a homebirth so I supported her that way" (M 10).

"I knew it was a anterior delivery not posterior everything felt right, so I felt really confident and really positive" (F 10).

Each couples' sense of confidence assisted them in birthing the way they wanted, for they had the assertiveness and self assurance to communicate their needs.

A mother spoke of how birth was to be experienced not just endured.

"I mean I know I could do it and there's no problem and I would survive it, but I don't just want to survive, I want to have a positive experience. A positive experience of childbirth that's what's for me " (F 9).

Childbirth for homebirth couples was more than giving birth it was an experience involving conscious and active involvement towards achieving personal expectations.

### The Birth.

The uniqueness of birthing at home came across strongly in interviews, with mothers and fathers describing how this environment facilitated childbirth.

"You're a lot freer at home, you're a lot more relaxed... the whole birth part is easier because you're not tensed up ... in an environment that you're more comfortable, that your hormones will work for you. But if you're in a place where you're nice and relaxed and comfortable and you know your surrounding and the people around you, it's in your favour to cope with the pain and labour" (F 2).

Parents felt relaxed, less tense and appreciated being in a familiar setting to which they were accustomed. Couples owned the environment in which the birth took place, therefore, they determined who was present at the birth and were able to maintain a semblance of their normal activities. One mother described the sense of relief being at home gave her:

"I was really happy for (Father) ... Just the fact that (Father) could move around his own home with confidence, like he wasn't interfering in anything, that to me was important" (F 4).

A father stated:

"That the best part about it I reckon. One of the best things. Just the fact that you're at home, when it's all over. You're here at home .."(M 6).

Each homebirth described by parents was unique to them, although some common experiences in birthing at home were identified. These common experiences were mothers' mobility in labour, mothers' determining birthing positions and parents having time alone with their newborn child.

All mothers were mobile for the first stage of labour. They were constantly moving and alternating movement from walking to swaying or rocking.

" Umm, I walk around as much as I can until I feel that, you know, it's not that you don't have this strength, but usually that's not pushing there's different stages, but all the first stage I'm mobile. Upright. Always upright, never lying down, always upright, leaning forward" (F 2).

"I spent most of the time walking around outside" (F 7).

" And then she'd go for a walk around the back yard. Hanging off the clothes line which was the best " (M 1).

It was observed in birth videos that women during contractions slowed down their movement as the contraction peaked and breathing patterns became deeper and rapid. Breathing then slowed, as the contraction subsided.

Birthing occurred with mothers being supported by their partner in positions that they had chosen. The couple had learnt of different stances in antenatal classes, books and videos. At the birth the couple adopted different birth positions until one was found that worked for them.

"And you were holding me because I'd birthed on all fours and then you were holding me up and I'd my head buried in your chest kind of " (F 6).



" like on my knees, like standing, you know like upright on my knees" (F 10).

" And with (baby) I was just kneeling on the floor leaning onto the bed, or leaning onto (Father's ) knee because he was sitting on the edge of the bed" (F 2).

Birth postures included squatting, standing and standing on all fours. Interestingly no mother lay on her back to birth, several mothers stated that lying flat in labour and birthing was most uncomfortable.

Articles utilised to assist mothers in birthing were simple and required fathers to physically brace mothers.

" That's right at the birth you had the baby sort of squatting and hanging over the ironing board. I was massaging your shoulders, holding onto the ironing board and (midwife) was taking care of the bottom half . And the baby just came out it was amazing" (M 3).

"..we used the birthing stool so I was sitting behind (Mother). So she was leaning back on me. It really felt for a man, the most active completely involved in your wife's birth, without I suppose physically delivering the baby yourself " (M 4).

It was observed on the three birth videos that the pushing, second stage of labour was managed by the midwife and birthing couple in a distinctly non traditional manner. No one was instructing the birthing woman when to push, the midwife spoke quietly in short sentences, words of encouragement.

" the baby was almost out and you felt like you know... The midwife said well just wait your body will do it. If you want to do it now you'll use your own energy up" (M 3).

"It got very, very strong. (Midwife) got here and I said 'Oh God I want to push!' And she was saying well go for your life. And I said 'thank God!'" (F 6)

Mothers were allowed "to listen to their bodies" (F 1) and push when they felt the urge. The midwife did not impose any time limit on the duration of active pushing by the birthing woman.

"My second stage was I think an hour and a half, something like that" (F 1).

"I've never had any tears or stitches from a homebirth and I've never had to hurry. And I think that's probably why" (F 2).

"It was a lot longer than we had expected. And (midwife) did say had I been in hospital with (baby) they would've been doing things, because I was pushing so long. It was about two and a half or three hours birthing. But she knew (baby) was okay so she was happy to go with it until such time when he got into distress, which he didn't" (F 7).

On the birth videos it was observed that the midwives listened to the foetal heart rate sporadically, using a doppler, a device which allows the foetal heart to be heard by all birth participants.

Parents described how the baby birthed and then was immediately placed in their hands or on the mother's stomach.

"And you know two seconds later (mother) had the baby and it's still attached to the cord still beating. And we just sort of left (mother) there for a while and then cut the cord and then that stopped and the afterbirth came out" (M 3).

"I actually help catch (son) which was nice" (M 10).

After the infant was born the midwife was observed to rub down the baby with a towel and no suction or medications were administered. The fathers cut the cord once it stopped pulsating.

"Great experience. And I liked cutting the cord. It's exciting. You don't expect it to be like a piece of rope" (M 1).

"It was nice this time (father) cut the cord once it stopped pulsating" (F 4).

After their child's birth, all couples spent time alone with their newborn. They were undisturbed by their carers and people present in the house protected their privacy.

" So then we cut the cord and everything and then just lay there for a while and then we all just hopped up and went into our shower. All three of us had a shower and she was about an hour old. And then we came out and dressed her and everything and there's our baby all dressed in these clothes we've been looking at all this time. Gave her a feed, off to bed and then we were at home, we just had our own environment" (M 6).

".. we had not set it in stone but a rule that we would have the child and there wouldn't be anyone around for a certain period" (M 5).

" Yeah we had that day all to ourselves, which was good. We all went back to bed " (F 5).

When parents were together with their new daughter or son, this time enabled them to become acquainted with each other, develop a rapport, a bond and to talk of the experience they had just shared.

After the birth there was a sense of achievement expressed by women. They spoke of learning to trust their bodies during labour:

"After a couple of days I think, it was really overwhelming that I did it! And I actually stayed at home and I didn't have any drugs..." (F 1).

"It's the ultimate to be able to trust your body" (F 9).

"You know a couple of days after he was born, I couldn't wait to my next one. You know thinking, well if it was this good this time around, I know I'll get it right in my third one. You know, I really feel that I've overcome the fear now. I know I can put that pain away which is great " (F 4).

The feelings parents experienced after the birth were expressed as elation, euphoria, relief, awe and amazement. This sense of euphoria was not diminished with subsequent births as this couple, who had just had their fourth child revealed:

"I guess the whole process of birth is the single most spectacular thing ever. ... I mean suddenly you've got a person you know,..."(M 2).

"... You know, when he was born I was really, I was high wasn't I? I thought I might wake up the neighbours. .. Oh, I've had a baby!! You know. It's really something very wonderful and you've got people around you that you know and that you love, and you know, nothing could be more wonderful sort of thing. It's just great" (F 2).

### Relationship between mother and father in birthing.

Fathers described how their role in labour and birth was unfamiliar. Not only was it a new experience but also a different relationship with their partner. As one father stated:

"Then when it comes to birth it really puts a shady patch between roles. You're not sure which role you should be doing. It's probably one of the only times in your life when you are roleless. And that gives you the ability to really connect with your partner and just as a man. He doesn't have a role to play. And so he can invent his own" (M 5).

This father's statement reveals the uncertainty that the birth of his child brings to a man and the presentation of an opportunity to possibly redefine roles and relationships within the partnership. Fathers' interactions were defined predominantly by their spouse and indirectly by the midwife.

"My job was to make sure everything was comfortable and right. I just let (mother) make the cue, I just went with whatever she wanted basically. And I mean after watching some other people's videos. That's when (mother) said to me. 'Look don't do this, don't go clattering about the kitchen" (M 3).

All mothers said they did not want a coach and the father was not to direct the birth. Mothers were the focal point of the birth, being the key source of information regarding the birth experience and core of control. During birthing, fathers were not allowed to leave their partner's presence. They were not necessarily in the same room as their birthing woman although they were available to her at all times. One mother set this ultimatum:

"I mean he's not allowed to leave my side, while I'm in labour" (F 2).

There was a connection between how mothers coped with labour and how their spouses interacted with them at birth, as this father stated:

"The births were great (mother's) a great birther and she's feeling nice and quietly just strong, it helps me handle that " (M 10).

Fathers described themselves as supporters and observers at the birth. As supporters they were involved in such actions as massaging, holding and encouraging their partner. Fathers as observers examined how the environment affected the birth and took actions to maintain harmony. This is illustrated by the fathers' descriptions of their involvement at the birth:

"...massaging back and thighs, holding her a little, encouraging her ... emotional, psychological, spiritual support ... it was just making sure you had a sense of harmony" (M 7).

"massage and holding her, washing, guiding, holding, whatever's necessary" (M 9).

"I'm just basically observing anyway from the whole thing and supporting where I can" (M 10).

Birthing demanded active involvement of both mother and father, this was facilitated by the couple's relationship. Parents articulated their admiration of each other's behaviour during the birth:

"And (Father) is the best support person, he's just wonderful. It's like we just connect and just do a job. It's been very, very fortunate and it has been like that everytime. Just falls in like this is what we do and we do it together like in harmony" (F 9).

### The relationship between client and carer

Based on their view of birthing, parents expected a particular type of working relationship with their healthcare professionals. The working relationship between clients and their carers incorporated a sharing of power and mutual

respect for each other. The primary carer in the homebirth was the independent midwife. A mother stated that at her child's homebirth:

"there's no power, there's no ego, it's just like we're doing it yeah!" (F 9).

Interactions at the birth were as a team, people working together for the birth. Midwives credited parents with having autonomy and only assisted them when needed.

Interactions between parents and their carers showed a mutual respect for each others skills and desires. It was birthing women who decided when the midwife was to be notified during labour and when examinations were to be done, which is demonstrated by one mothers statement:

"I went to second stage, she (midwife) said 'Oh we'll check and see how far you've dilated' and I said no I know I'm only three centimetres!' So she left it for a while but it seemed like ages to me. And then she couldn't feel the cervix. The head was coming down" (F 1).

Decision making during the birth was shared with clients and their homebirth attendants. Mothers decided when they wanted to be examined, where they were going to birth and in what position. Fathers, with their spouse's influence, decided how they wanted to participate. Parents allowed their midwife the power to decide if other health professionals were required or the need to transfer to hospital. This negotiating was based on parents' respect for the midwives judgement.

"But as far as we could tell, yeah okay, it's like as far as we could tell it was going to be a small risk therefore yes let's do it. And trusting (Midwife) to sort of say well okay it was going beyond a small risk now, off into the medical hospital " (M 7).

There was a personal as well as professional relationship between the midwife and expectant couple, a sense of rapport developing from meeting each other.

" The first time we went and saw her and as we walked away (mother) said she just made me feel so relaxed about it all and I feel really confident in her" (M 6).

Parents spoke of how the midwife transmitted a feeling of confidence, which created a sense of trust and safety within the relationship. This facilitated birthing and assisted in relieving anxiety as one father explained:

" Well I put a lot of faith in the midwife ... and I wasn't too concerned. I felt as long as she was there and she'd been doing it for years, I felt quite comfortable" (M 8).

Trust and confidence in the midwife was illustrated in a father's description of what he was thinking, when his wife was in labour at transition:

" at that time I was ready to bundle (mother) into the car and rush her off into hospital. (Midwife) was strong and firm with (mother) and I thought thank God she's here because that's when I would have lost the plot" ( M4).

This interaction demonstrated the respect and appreciation found between carer and client.

The continuity of care provided by the midwife fostered a close relationship. Clients referred to their midwife as a friend / family member with whom there was a bond that existed well after the professional contract had ceased. A father described this personal service:

"You really got to know... well you feel like you get to know her, don't you? I guess it was such an emotional thing too that it's nice to see the person you know you had the birth and then keep seeing them again " (M 3).

Significant to the relationship between independent midwife and a homebirth couple was the focus on the birthing woman and how parents can help themselves. The independent midwives' care, although concentrating on the

birthing woman also entails nurturing the couple to believe in their own ability.

A mother spoke of how:

"... midwives at home, they're very much at your service. They're there for your comfort. You know, I mean, I was going in and out of the shower like I don't know what this time, just going in and out, in and out. And (midwife) was having to monitor me all the time and it was no problem if she had to get down on her hands and knees or whatever, that's what she did. Anything to accommodate my comfort and you know, just gentle things. If I was sort of losing it or something she wouldn't have to say anything, she'd just sit there and just consciously just breathe a little bit louder and I could pick up on her breathing and that would set me in mine. Probably the biggest difference that I'd feel you know the focus was on me having the baby, not on what I can do for you, it's what you can do for yourself" (F 2).

Midwives assisted the birthing couple in reaching their own potential and developing the couple's birthing knowledge and skills. In the three birth videos it was observed that midwives acted as a resource in facilitating the birth, presenting alternatives, answering questions and alleviating concerns.

The midwives recognised that the parents owned the birth. It was the parents' experience and the midwives gave credit to parents for their birth. This was summarised by a mother who stated:

"well what they do is assist the couple in birthing their own baby ...they're not taking away from you" (F 6).

Birthing is the human aspect, the rite of passage into parenthood, which is based on a set of beliefs. In the intrapartum period relationships develop within the partnership and with the midwife. Parents described a sense of achievement and exhilaration after birthing their child at home.

### Resolving Expectations

The final theme of the findings is Resolving Expectations. A homebirth involves a transforming process whereby parents anticipate and resolve their



concerns and expectations regarding birth. Parents go through a process where they formulate their expectations of birth, experience the reality of birth and then evaluate whether expectations were achieved.

### Formulating expectations

At first some fathers were hesitant of having a homebirth, as one father stated: "I didn't feel comfortable with the concept initially" (M 2). These fathers identified three points of contention regarding homebirth: if it was the first birth there was an element of uncertainty; that hospital was viewed as the norm; and that concerns for the safety of mother and child were top priority. A third of the fathers spoke of how it took time to resolve these concerns and come to terms with the concept of a homebirth.

A common expectation of parents was that the birth was to be natural without interference or intervention. Their statements reflect this expectation:

"I wanted a birth free of interference" (F 3).

"I want it to be natural, what comes naturally you know and the natural process" (M 2).

The couples had read literature and / or attended antenatal classes which supported and substantiated the benefits of a natural birth. Birth was viewed as a natural process of life, not a disease to be frightened of. Parents questioned the medical system, demanding to know why treatment was required and asserted their expectations of birth.

"I started questioning the medical system and process and that was the first time I've ever done that...It was more from the natural part of the process to give the kid a natural start. I mean we questioned things like ultrasound. There are occasions when technology is a great help in some sort of stressful circumstances" (M 2).

The health carer who was prepared to listen to the parents' expectations and planned to meet these was chosen to attend to their care.

Safety was the priority of all homebirth parents interviewed, they dealt with this expectation by taking precautions and communicating fears. A booking was made into the nearest hospital, on the proviso that if they should need to transfer they were prepared. A father described this precaution:

"If anything was not right then you just went to hospital, we had some back-up. We weren't having a homebirth just for the sake of having a homebirth. The idea was to have a homebirth if possible. If everything went okay then we would. If it didn't then we'd go to hospital" (M 10).

The desire for a natural birth was maintained even if it meant transfer to a hospital. As one father stated:

"Before this we decided there was ...if we had to go to hospital there were to be no drugs" (M 1).

Parents had timed how long it would take to get to the hospital. Couples chose carers they had confidence in and felt they could trust.

At the birth there were self expectations in addition to expectations of others, as expressed by these mothers:

"We didn't have any expectations that anyone would do anything for us or let anything happen, other than we would do it" (F 9).

"The only expectation I had was of myself being able to give birth" (F 2).

These expectations confirmed the parents recognition of personal responsibility and control of the birth. Some expectations were discussed and others were assumed. All mothers informed fathers that they did not want to be advised or

coached and that it was assumed that the midwife and father would be present at the birth.

Parents spoke of the danger of having too many expectations as described by this participant who said:

"to have expectations to me would be setting myself up" (M 4).

Participants were flexible with their birth strategy, for as one father stated:

"No, I didn't have any expectations. Whatever happened happened, I wasn't too worried. Whatever happens, happens, basically we'll just go with it"(M1).

There were no formal birth plans for parents considered that this would lead them to be too worried about the plan rather than the birth.

"The whole thing we just played by ear. I mean you don't, if you plan it all out and it doesn't go to plan then you're too worried about the plan not the birth" (M 5).

There was an acceptance that expectations influenced experiences.

"If the expectation is problems that's what you're going to get. If the expectation is it's just going to happen that's what you get. And I think that a lot of our preparation was getting to that mental state" (M 7).

The primary expectation was "to have a baby at the end of it" (M 9).

### Reflecting on outcomes.

Three out of four of the women who were primiparous were surprised at how rapid their labour and birth was. They had prepared themselves for a long labour.

"I had my mind set against it because I'd heard countless stories where women were disappointed or their word is "devastated" when they think they're doing well ... and they're not. And I wasn't going to do that " (F 3).

"I don't know there was a lot of denial in my labour. You know whether I was in labour or not. And when she (midwife) asked what are the contractions like I said 'very mild.' But I think I was a lot further along than what I was saying you know I was expecting you know the worse so in a way it was a good coping sort of method" (F 1).

In regards to the expectation and the experience of pain this differed according to individuals:

"It certainly wasn't the worst I've experienced. It was similar to a tummy wog, but really not... I've had worse tummy wogs than that" (F 3).

"A bit more pain than I thought there'd be. I just couldn't believe my back hurt so much. But you forgot about all that straight away. I mean as soon as she's born it's like who cares about pain?" (F 5).

Previous experience of a homebirth impinged on parent's expectations of future births. Having experienced a homebirth, couples were assured and confident that they could birth at home again. A father recognised this when he compared his sons' homebirths:

"Yes by comparison (second son) was A/ a lot quicker and B/ I think (mother) felt more confident that she could do it the second time. Because the first time there's that unknown stuff" (M 7).

Parents had practical knowledge to guide their next homebirth, a father explained:

" we know what to expect in terms of what can happen and what support's appropriate and stuff " (M 9).

The six sets of parents with experience of homebirths described how in one mother's words: "each birth was different, the atmosphere, the circumstances" (F 10). Therefore parents were flexible with their expectations.

As fathers had limited ways of manipulating the birth and were observing rather than birthing, their expectation of being involved had to be adapted during

labour. The transition from expectation to the reality of birth was demonstrated in this transcript excerpt of a father who came home to find his wife labouring.

".. there's all this blood and ooze and everything running down her legs. And I'd just walked in and oh no! And I've not got a very good stomach, so I think, oh I've gotta lift my game here !! It's only going to get worse! (pause) I got the toilet roll, you know, to clean it all up" (M 1).

When expectations were resolved with experiences, anxiety was encountered by some fathers. Two fathers described the anxiety they felt during their partners' labour:

"I just sort of hovered around being anxious" (M 8).

"..so you know I already knew that she (baby) was distressed because of the meconium (baby's first bowel motion) and that was really quite frightening. I don't think (mother) had time to think about it but I did and I was quite ... Just thinking oh, please everything go right, you know because we'd still another good fifteen or twenty minutes probably till she actually came out. I mean that's a bloody long time when you know that baby's pushing down the chute and she could have the cord around her neck, you don't know why she's distressed and that was just a real ... You know you just, not feeling kind of useless. But you're sort of thinking God I hope everything's alright because you've got nothing here, just the midwife you know and you're depending on that one person. But she knew exactly what she was doing and she handled it really well" (M 6).

Fathers began to overcome this feeling of anxiety by observing their birthing woman, the environment she interacted in and looking to find what could be done to assist her. This process is summarised by this father's remark to his partner, regarding labour:

"But I knew you were in pain and that was hurting me you know. To watch you go through that and there's nothing I could do except try and do whatever you told me" (M 6).

### Evaluating expectations with outcomes.

All parents' experiences of homebirth exceeded their expectations. They all exclaimed that the birth was awesome and a miracle. A sense of euphoria and elation was described by both parents when they held their child for the first time. This extract from a transcript typifies the emotions one couple felt after the birth of their first child:

"....its just a wonderful experience...." (F 6).

"Just on an emotional high that night" (M 6).

"And (father) stayed up and (baby) got the hiccups and I didn't even know. He had a big emotional moment with her later" (F 6).

"Yeah, it hit me all at once actually like a big rush" (M 6).

All participants described how they fulfilled their birth expectations. Fathers were astonished that they surpassed their expectations. These fathers statements elaborate:

"And I remember we tried that exercise before the labour, I could hardly hold (mother) there for any length of time, but when it happened I just did it you know it was like this other world we all went into, especially (mother). But just the way I could hold her amazed me" (M 8).

"I mean I didn't have any expectations to be honest. Other than am I going to pass out or not, but I didn't so I suppose in that respect yeah!" (M 6).

Some parents described how they had not expected mother to be involved in the running of the household after the birth. Half the couples interviewed recounted how the mother resumed domestic duties too soon after the birth. Mothers spoke of attending to the household in less than twenty four hours after the birth and realised later that they should have rested.

"Being at home was really nice. You do tend to get up and do things perhaps sooner than you should. My mum said that to me, but you know

you soon pay for it, your body makes you lie down about three days later" (F 6).

One couple saw this as the only drawback of a homebirth:

"You can't put bub in a crib and walk off and go for a sleep for six hours" (M 4) .

"You don't tend to put your feet up as much although you know you should. You can't and that's a drawback"(F 4).

Some parents' tiredness was exacerbated by visitors coming unannounced at inopportune times, as a mother expressed:

"We found the homebirthers do get, like you have the people, like your friends and that coming to visit and it seems a lot easier for them to come and visit you at home than it is at hospital. It's good for them, but it's quite tiring" (F 1).

Three fathers in evaluating their homebirth experience identified the need for parents to learn more regarding post birth concerns like childcare and breastfeeding. Two fathers' statements particularly illustrate paternal wishes for education:

" An easy birth doesn't mean that it's all going to be easy, you know and ...that's something I realised. You could put a lot more work into learning about childcare and breastfeeding" (M 3).

" And the other thing they've really got to show is, how to bath babies" (M 1).

How people resolved their expectations affected their perception of the whole birth process. As individuals and a couple, participants worked to deal with their birth concerns and expectations. The resolution of expectations was a process whereby the expectations of parents were shaped and evolved into a unique experience.

### Verification Interviews

After the findings were documented follow up telephone interviews were conducted to clarify and validate data from the initial interview. Research participants were sent a one page synopsis of the findings to review. The researcher phoned parents to discuss and verify the findings, also providing an opportunity to further contribute to the study.

One couple had discussed the findings with friends who had experienced homebirths and reported that they had similar experiences as recorded in the findings. The most pervasive theme was parents assumption of control of their birth, they stressed how important it was to them to take on the responsibility of birth. One mother described how her thinking of how they would act in their worst homebirth scenario effected her expectations. Study participants confirmed that the findings did describe their experience and reiterated that having choices in birth was important and the assumption of control potent.



## **CHAPTER 5**

### **Discussion**

In this chapter, the experience of homebirth is discussed with reference to the literature under the four key themes of Constructing the Environment, Assuming Control, Birthing and Resolving Expectations. The relevance of the conceptual framework to the study findings will then be presented. Implications of the findings will be discussed with recommendations being established and the chapter will be concluded with suggestions for further research.

#### **Constructing the Environment**

The findings from this study describe how parents choosing a homebirth actively created a conducive physical and social birth environment. Information regarding what was a positive birth environment was collated by parents from several sources including peers, literature and healthcare professionals. The acquisition of this data and its synthesis, demonstrated parents' ability to consider the broad spectrum of options. The findings suggest that parents' decision to birth at home was not an impulsive decision but a carefully planned one. Moreover, parents had a holistic approach to constructing an appropriate birth setting by considering all aspects of the environment. Participants' education, religious beliefs, and life experiences may have led them to consider the environment in this holistic manner.

Tuan (1977) in his writing on space and place, describes how home as a place influences human experiences. Tuan considered home as an intimate place, a place where our fundamental needs are heeded and cared for, without fuss. A labouring woman would, therefore, seek a place where she knows she would be cared for - home in the case of research participants. The meaning of home as a place is made by the presence of the right people; this explains why particular people are chosen to be present at a homebirth. A house is described by Tuan as a

simple building that is significant as a place for such reasons as it provides shelter its hierarchy of space answers social needs, it is a field of care and a repository of memories and dreams. These reasons contribute to parents' decision to birth at a place significant to them -home. Hudson - Rodd (1994) issued a challenge for public health care workers to gain understanding of how place shapes human experiences. Midwives need to consider how a place (home, hospital, clinic, birth centre) affects their client's health.

### Preparing the Physical Environment.

It was interesting to note that when referring to the physical environment parents did not concentrate on objects needed for the birth. Instead they highlighted the way in which the aesthetic elements of light, ventilation and room temperature could be manipulated. These non-tangible features are probably in accordance with the couples' desire for a normal birth, free of intervention and artefacts.

Objects utilised in birthing were by modern standards primitive and simple. This may have been a reaction to the high technology employed in hospital births. The parents' emphasised birthing as a natural process and, therefore, desired familiar items. Articles commonly found around the house such as a washing line and ironing board were adapted to fit a purpose at the birth. Water therapy was significant with all participants referring to the benefits of the properties of water in birthing. The one article that some parents obtained for the birth was a birthing tub. Attwood and Lewis (1994) attested that many women found that water during labour relaxed, soothed, calmed and warmed them whilst at the same time increased their feeling of safety. Information on the therapeutic properties of water in labour as presented in the media may have made parents aware of this alternative.

Equipment related to birthing was placed inconspicuously in the home and not given undue attention, for example the midwife placed her equipment out of sight. The focus was on the birthing woman and the birth process. Parents had worked to individualise their very own birth setting. This could have been influenced by the desire for a personalised setting and not wanting the home to look like a hospital. Parent's feeling of empowerment to make choices facilitated them in birthing the way they wanted to.

The role and responsibility of maintaining the individualised birth environment was adopted by the fathers at the birth. The birth environment was maintained by the fathers who utilised effective communication skills, sensitivity to their spouses and physically adjusted the environment. This role is congruent with the traditional social mores of the man providing for the house: earning money to support the family and protecting the territory (Kitzinger, 1991). Conversely, Raphael - Leff (1991) proposes that we are seeing a new breed of young men who seem feminine and nurturant without losing their masculine capacities. Perhaps in maintaining a conducive birth environment, fathers were acting in a nurturing manner.

Edgar and Glezer (1992) argued that social changes, such as women returning to the workforce soon after childbirth and the development of the men's movements have encouraged father's nurturing instincts. According to Renouf (1990, p. 43)

There appears to be consensus among theorists and professionals that increased paternal participation in family life can have beneficial consequences for mother, father and child.

The implications of fathers increased participation in family life, as asserted by Grbich (1995) is that health, social work, educational and legal professionals need to recognise that male parents provide primary or shared care. She suggested that

attitudes, languages and documentation relating to antenatal and postnatal issues should reflect this.

### Preparing the Social Environment

Overall greater stress was placed on the social environment than the physical environment. Contributing to this, was that prior to pregnancy many parents had already established their basic needs of heating, water and electricity. To an extent the physical environment had its foundations set prior to the parents deciding to have a homebirth. At least one person in each couple was employed on a full-time basis, therefore, an income was available to pay for a homebirth and the articles it entailed. Abel and Kearn (1991), in their study of New Zealand women having homebirths, found sample members were more likely to be middle class women, for they fitted the criteria of being very assertive, articulate and in good health. These personal characteristics of assertiveness, being articulate and in good health were possessed by members of the present study.

This focus on the social environment denotes how a homebirth is more than a physiological process, these births occur within a social milieu. Social environment as defined by parents extended to include antenatal classmates, consumer groups and communities. Common interests were shared with parents and their support persons and they may have had similar lifestyles which, involved them meeting locally at health food stores and yoga classes for example.

Parents stated that it was imperative that their social environment pervade a positive and accepting atmosphere. People present at the birth were selected by parents for their positive personal characteristics. The crafting of a sympathetic birth setting by parents may have been a protective reaction to unsupportive comments about homebirth from media, literature and members of the public.

Work by Kiritz and Moos (1974) confirm that the social environment has important effects on physiological processes, such as birth. They found that in relationships where support, cohesion and affiliation existed, positive effects such as enhancing normal development and reducing recovery time from illness occurred. In creating an appropriate social environment for birth, parents in this study maximised these positive effects and enabled their children and grandparents to participate.

Children as participants in the homebirth were viewed as an asset who would learn from the experience. This inclusive attitude of parents differs from the common practice of not allowing children into hospital birthing units. Contributing to this attitude is the close bond with child and parent, the desire to maintain the family unit and the belief that birth is a normal event in the cycle of life. Birthing at home also eliminates the need for childcare and avoids restricted access to family members.

The present study's findings on children's presence at their sibling's homebirth is in agreeance with research by Mehl, Brendsel and Peterson (1977). They observed and interviewed twenty children who had been present at a birth, then compared them to twenty children who had not been present. Children present at the birth were found to view birth in a positive, happy manner and female children also felt capable of giving birth. The findings of Mehl, Brendsel and Peterson (1977) regarding less sibling rivalry was also reported by three couples in the present study.

The changes that have occurred in birthing trends were evident when five couples described their parents presence at the birth. The differences in birth experiences between the generations were discussed and provided grandparents with an opportunity to review their birthing experiences. For some grandfathers

the homebirth was the first time they had seen and participated in a birth. Grandparent's participation in the birth was facilitated by the close bond with the parents and the desire of parents to show grandparents that birth did not have to be the way they experienced it.

The significance of grandparents interaction at the homebirth was appreciated when on reviewing literature it was found there has been limited research into grandparents experience of the birth of grandchildren. Bright (1992) utilised grounded theory to research the interaction among parents, grandparents and firstborn infants in three families over fifteen months. Grandparents were found to be happy knowing the family would go on through the life of a grandchild. One grandmother in Bright's study expressed a sense of being blessed to witness the arrival of her grandchild. Perhaps it is this sense of continuity that potentiates the experiences parents and grandparents have at a homebirth. The interaction between grandparent and grandchild can have long term repercussions. Marris (1982) observed that unless children learn early that there are several unique nurturing people in their lives who love them, they cannot create the conditions for mature adult attachment. In a homebirth grandparents were found to commence this nurturing of their grandchild immediately at the birth.

#### Dealing with others' birth expectations

Members of the public's reactions to parents' birthplace decisions reflected how homebirth is often perceived as a controversial choice and that pregnancy and birth is viewed by some as public property on which to express their opinion. Unlike hospital birth environments, participants did not have media, medical or societal support for their choice. Despite this lack of support parents maintained their decision to birth at home. They were assisted by strong birth beliefs, self confidence and supportive friends/ family.

The strength of parents' convictions were demonstrated in their responses to negative reactions in which they were referred to as being "nuts". Comments were not taken personally and the other person's viewpoint did not stop parents from maintaining their stance on homebirth. Any anger and frustration regarding peoples' inferences and media bias were possibly exacerbated by the stress of imminently becoming a parent and the sense of responsibility with decision making.

Parents were assisted in making their choice by their education, communication skills and state of their relationship as a couple. Seven of the ten parents from this studies sample had migrated from the U.K. where there is an established homebirth system (Floyd, 1995). Having lived where homebirth is accepted into the health care scheme and being present when siblings were born, may have contributed to parents acceptance of this birth option.

### Assuming Control

Control is a word that can be easily misinterpreted depending on the manner in which it is perceived and the assumption on which a person bases their actions. Assuming control is the essence that describes assertive behaviour utilised by parents to control the birth environment, as physiologically birth can not be controlled.

### Parents Demonstration of Control

Participants' past experiences in vulnerable situations, particularly with healthcare professionals, contributed to their desire for control at the birth. The choice of homebirth was paid for privately or through their private health insurance this was discussed by parents as being a point of contention. Medicare covered the cost of maternity care in hospitals but not at home. Parents paid up to \$1600 for the privilege of staying in their own home to birth. The

implications of this payment extend to health insurance companies' policies for maternity payments, state and federal economic healthcare funding and family budgeting for an imminent birth. There are only a limited number of health insurance companies that will reimburse consumers for homebirth costs. With parents ability to plan pregnancies and choose insurance companies, it may be in the interest of both consumers and insurance companies to refund homebirths or lose customers and pay for more expensive birth options. State and federal government need to consider in the long term that for some homebirth may be a cheap way of delivering maternity care that promotes parents to be self reliant. With the development of contraceptives and allowance for maternity or paternity leave, parents are now able to plan a pregnancy to a limited extent for when it is economically viable.

### Control of the External Environment

Control could be identified in parents descriptions of adapting the external environment to achieve their needs. In owning the birth environment parents were uninhibited and were orientated to the location. People attending the birth were visitors, their presence had been requested by the parents and as visitors were under the parents' domain. For example, they needed to ask permission prior to making changes in the couples home. O'Connor (1995) conducted a five year national study of homebirths in Ireland which involved interviewing one hundred women. She suggests that contributing to parents' desire for control in a homebirth was the need for autonomy and to be in charge of their lives.

### Intrinsic Control

Intrinsic control refers to the central feature of homebirth parents, that they believe in their ability to take charge of their own health. Encouragement to assert control of health needs may have been assisted through parents' education, employment, family background, the consumer movement and being at home



where they are familiar and uninhibited. A trusting atmosphere was also created in having a rapport with a sensitive midwife. This rapport was a factor that contributed to assisting clients to verbalise their needs.

Mothers' descriptions of their experiences of contractions referred to "going with" the pain and not fighting it. In this manner birthing women revealed an acceptance of their labouring, working with their body and using natural alternatives. They viewed birth as a natural physiological process that a woman can achieve without pharmacological assistance. This is contrary to the view that pain in birth is unacceptable and efforts must be taken to stop this pain.

#### Differences in Control Between Parents

The subtle differences in perceptions of control may be related to gender differences in socialisation. Indirect control was possibly achieved by the father and midwife in that they influenced the mother's perception of the birth. In some cultures there is a social more that men are supposed to protect their women from harm (Kitzinger, 1991). This may be a cause of conflict and inner turmoil for men observing their women birthing as they are powerless to protect her from the pain and mental anguish of childbirth. Birth may be the first time that men experience this sense of powerlessness. At work and in the community parents may operate as capable, secure people who are in control. In contrast the birth process cannot be absolutely controlled.

In the present study mothers had the most control at the birth and were recognised as the reason birth participants had come together. No one can assume as much control of the homebirth as the mother for it is happening to her body and whatever she does directly influences the progress of the labour. Having control at birth has significant implications for mothers in the way they perceive the birth and feel about themselves. Humenick (1981) believed that

mothers having control at birth increased their self esteem and decreased post partum depression. In the present study, contributing to the mothers' perception of control was the factor that the birthing woman was seen as the "birth expert", who knows instinctively how to birth even though she may need encouragement and assistance.

### Recognition of Rights and Responsibilities

In choosing a homebirth, parents knew they had rights as consumers of a health care service and acted on the assumption that they have the right to control their health and make decisions regarding healthcare. Birth was a crucial crossroad to which parents applied personal skills and their support network to achieve what they saw as their rights. Recent societal movements namely consumerism, feminism and self help groups, have contributed to individuals believing in and asserting their rights. Study participants grew up with the attitudes of these human rights movements and during their lives may have acquired education and social skills that enabled them to assert their rights. L'Esperance (1979) described how women influenced by the women's liberation movement sought more from life experiences and defined themselves as autonomous individuals with some degree of control over their body.

Exercising these rights led study participants to take responsibility for their homebirth. Davies (1992) points out that responsibility is the crux of issues surrounding birth. She identified three forms of responsibility at birth: the relinquishing of personal power and responsibility by parents to their health professionals; the claiming of responsibility for the birth of their baby and lastly no responsibility for the birth is taken. In taking the initiative to birth at home, the couples in this study acknowledged that they owned, controlled and took responsibility for their birth.

Responsibility, as described in the study findings, entailed participants being accountable for their actions and not looking to others for culpability. This stance is the opposite of the trend in industrialised countries like the U.S.A. where if birth does not progress as expected by parents, the health professional may be seen as the cause of this, hence litigation follows (Flanagan, 1986). Parents' strong sense of responsibility may have been transferred from their positions of responsibility in the community, workforce and family.

Acting in a responsible manner involved taking precautions and gaining knowledge on childbirth. In discussing their worst case scenario, such as the death of the infant or premature birth, couples showed forethought and accountability. Contributing to this was family and peers' concerns for the mother and child's welfare and also parents' own anxiety. There was a realistic perception of the inherent dangers of childbirth by most of the study participants, as it was openly discussed and contingency plans made. Parents' motivation and education prompted them to seek information and ask questions regarding pregnancy and birth. In speaking of their experiences participants showed the extent of their knowledge and applied medical terms appropriately.

## Birthing

### Birthing Beliefs

Birthing beliefs were the foundation on which the experience of homebirth was found to be based in the current study. Parents strongly advocated that birth was a natural process that did not require medicalisation. The findings illustrated the conflict encountered by health professionals and consumers, with the medical model of childbirth versus the natural model of childbirth. Cunningham (1993) described the differences between these two models. Natural model followers emphasise the individual's rights to his / her own body with responsibility for health remaining one's own. In contrast the medical

model assumes that childbirth requires medical expertise and responsibility for an individual's health is placed with medical science.

Study participants were born into what has been described as the "childbirth technology revolution" (Towler and Bramall, 1986) and when it came to their giving birth, literature was available that questioned the overuse of technology. The quest for a homebirth may be a reactionary swing away from excessive medical intervention in childbirth. Recent publication and media attention on the West Australian Select Committee Report on Intervention in Childbirth (Turnbull, 1995) has provided statements from professionals and community interest groups which support parents seeking a natural birth. Parents spoke of how a respect for nature was nurtured in them by their family and friends and how this influenced their belief system.

The mental attitude of an expectant couple towards birth was acknowledged by study participants as being significant in determining a couple's suitability for a homebirth. Study participants were empowered to have a homebirth as they did not see birth as a frightening event, but as a normal positive process. The way in which family members, healthcare professionals and teachers speak of birth directly influences an individual's view of birth (Simkin, 1991). These are the agents of socialisation that have the potential to influence peoples attitudes regarding birthplace norms. It can be surmised that homebirth parents received positive input regarding birth and had the ability to critically look at the horrific birth stories of peers and media presentation of birth. A strong sense of self confidence from the parents pervaded interviews; this quality would have assisted them in birthing the way they wanted to.

A sense of self confidence and a supportive social environment encouraged parents in having a homebirth and enabled them to breastfeed for a prolonged

period. It was noted that all mothers in the study breastfed their infants. At the time of interview children ranging from twelve weeks to two years of age were being breastfed. This is higher than the norm in Perth where Percival (1990) found breastfeeding ceases in 31% of women after six to eight weeks of age.

### The Birth

In speaking of their homebirth experiences participants showed an appreciation of their birth environment. Pregnancy and birth have been recognised socially and by literature as a stressful period in peoples lives. The birth setting characteristics homebirth couples cherished were directly related to stress relief, minimisation of stress and maximisation of relaxation. Parents had the self awareness to be able to identify what relieved stress for them and employ this in their birthing experience. Furthermore study participants had a sense of belonging at home.

Self motivation and self reliance influenced the mothers' mobility during labour at home. As mothers had been educated regarding the physiology of birth and knew that lying supine would be counterproductive (Russell, 1982), this knowledge gave them the impetus to keep moving. Mothers had decided that they were not having any drugs and did not want birth interventions, therefore, they needed to find alternatives. Walking, rocking and swaying were used by mothers to distract their attention from contractions and enhance the progress of labour.

In birthing, women pushed when they had the urge, no time limits were emplaced on their progress and the baby was given immediately to the mother while the cord was still attached and pulsating. This is quite different to the obstetric active management of labour as espoused by Kieran O'Driscoll (cited by O'Connor, 1995, p. 13). Active management of labour is a model of consultant care that predetermines the time of birth, involves a programme of obstetric

intervention for monitoring and controlling the labour of first time mothers. Contrary to this, homebirth involved limited interventions, no time limits and enabled women to control when they pushed with positive safety results for mother and child. In this way parents practised what has been termed Active Birthing. Robertson (1994) described active birth as confidence in and acceptance of the natural process of labouring.

The manner in which women in the present study managed second stage was found to be supported by literature. Grant (1987) discussed the effect of different birthing positions on progress of labour, for example semi-sitting was found to potentiate contractions and make them more efficient than in the dorsal or lateral positions. Caldeyro-Bareia (1979) conducted a research study into the effects on the foetus of strong and prolonged bearing down efforts combined with breath holding in second stage. Foetal heart rate patterns, intrauterine and maternal blood pressures were recorded during various types of maternal bearing down efforts. The investigation indicated that prolonged bearing down efforts are dangerous to the foetus causing hypoxia, acidosis and delayed recovery of the heart rate. It was found that if a mother bears down physiologically, when she feels the urge and without closing her glottis or prolonged bearing down, foetal hypoxia can be avoided. Caldeyro - Bareia's (1979) findings reinforce the safety of management of second stage as described by mothers in the present study.

After the physiological and psychological marathon of birthing, mothers expressed a sense of achievement. The significance of this achievement is appreciated when considering that these women, unlike some of their peers, chose to manage without drugs or technological assistance to relieve pain or enhance labour. Mothers were inspired to birth in this manner from the desire to do what was best for themselves and their child. They had support from the social environment for their choice.

The social environment of the homebirth facilitated parents in their conscious effort to spend time with their newborn. After the birth the couple were drawn to look at the infant for prolonged periods, this pattern of interaction is similar to those described and observed in Klaus and Kennels' (1982) study. Their research found early bonding to be significant in parental attachment behaviour and the infant's development. They distinguished a sensitive period when attachment is more likely to occur, that is immediately after birth when the infant is quiet and alert. On observing parents' interaction at homebirth, Klaus and Kennel found a distinct pattern of interaction, including mothers being active participants who picked up their infant immediately after birth and commenced breast feeding within five to six minutes. This pattern of interaction was observed on the three homebirth videos used in the present study.

#### Relationship between Mothers and Fathers

The findings revealed that fathers felt unfamiliar and uncertain about the birth and their new role as a parent. The experience of impending fatherhood is frequently overlooked when a couple become pregnant. Mothers- to- be receive attention as they are physically showing their pregnancy status, meanwhile fathers who are often undergoing major mental upheavals and receive limited attention. Raphael- Leff (1991) explained that the dilemma of prospective fathers in western culture is that he is confronted by the same transitional fears, anxieties and envy as his traditional counterparts but has no rites to express these. Western fathers have to find their own means of finding social acknowledgement and achieving personal maturation in this transitional period. In relation to this transition a mother in the present study stated:

"While I believe in times gone by there would've been rituals, men would've known their roles, they would have known from feeling, but we're so disconnected from feeling that men don't know how to be." (F 9)

Social restrictions on male expressions of emotion and a tendency to focus on the pregnant partner's vulnerability and need for protection, present obstacles in achieving this task. The implication of this finding is that there is a greater need for health professionals and society to recognise the transition into fatherhood and to also provide support and opportunities for men to verbalise feelings.

In the current study mothers had requested that fathers not act as a coach at the homebirth. Fathers respect this wish by being supporters and observers but not coaching at the birth. Opposite to this paternal behaviour was that observed in Chapman (1991) study where fathers displayed the roles of a coach or a team-mate at the birth. Coaches were found to be in need of control of the labour and themselves.

An interdependence was observed in the manner mothers managed labour and fathers' behaviour at birth. For example, a father described how the quiet manner in which his partner laboured relieved his anxiety. The significance of the relationship between a birthing woman and her man extends beyond the birth into the following years of the marriage. Standley and Nicholson (1980) created an instrument for recording observations of labour which could be used in research and model building. They discuss how the interaction between husband and wife may have consequences for a woman's physiological response, comfort and long range repercussions for the character and quality of their relationship.

#### Relationship between Client and Carer

The working relationship with the midwife and parents is founded on the sharing of similar beliefs on birthing. Client and carer believe a person is capable of controlling their own health with the health professional acting as a resource.



Schiff and La Ferla (1985) in their study also found that parents who opted for a homebirth sought midwives who shared their views on childbirth.

The relationship between client and carer incorporated a mutual respect for each person and a strong rapport. Parents carefully selected their carer, considering their personal qualities and whether a rapport existed. Contributing to the nature of the interaction between client and carer was the self confidence of the couple that enabled them to assert their wishes and to use their bargaining power as consumers of a midwifery service they had privately paid for.

In interviewing parents it became evident that in the client and health professional relationships experienced by study participants, there were two distinct types of relationships based on two different health belief systems. One type of relationship or belief system was described by three mothers in relation to their female G.P.'s and the alternative relationship or belief system was described between mothers and their chosen carers. In the former relationship described in the findings, the mothers were expected to heed the health professional and be compliant. This is a form of patriarchy whereby the health professionals view themselves as the expert and attend to client's health without empowering patients to care for themselves. The conventional medical model (O'Connor, 1995) in which pregnancy may be viewed as a disease process, is the belief system on which this relationship is based.

An alternative relationship / belief system was described in the interaction with the midwife and parents, in that both believed birth was a normal process. In this relationship homebirth attendants discussed concerns, shared knowledge and negotiated when making decisions. The midwife's focus was on nurturing parents to become self reliant in attending to their health. The relationship between the

client and homebirth attendant was in accordance with a statement by Lao Tzu, a fifth century Taoist leader:

"Imagine that you are a midwife: you are assisting at someone else's birth. Do good without show or fuss. Facilitate what is happening rather than what you think ought to be happening . When the baby is born the mother will rightly say: ' We did it ourselves"  
(cited in Wagner, 1986,p.111).

These two diverse perspectives on health care have implications for individuals health and use of health care services. If people believe they are capable of controlling their health they may be prepared to take actions to maintain their health, which may decrease their seeking health care services and encourage them to assert their needs. However if a person believes a healthcare professional is the best person to attend to their health then they will refer to them for assistance and thus increase use of healthcare services.

In examining research participants' descriptions of the client / health professional relationship, it was possible to formulate pertinent recommendations for this interaction. It is recommended that health professionals, in presenting birth information, resist the temptation of giving only the information that they perceive the person needs. This is a patronising act that restricts consumers' accessibility to unbiased data and does not engender confidence in people to take responsibility for their own health. Health professionals themselves need to work towards breaking the patriarchal culture of control found within their professions. This can be achieved by changing peoples attitudes in regard to responsibility for health, encouraging health professionals to promote self care practices and addressing internal constraints that hinder clients from taking care of themselves

## Resolving Expectations

### Formulating Expectations.

Three of the fathers' initial hesitancy regarding having a homebirth illustrated that the decision was not made lightly and was a shared agreement between parents. Contributing to this was their concern for their family's welfare, the respect they had for their spouse and a need to contemplate birth options.

Participants' principal expectation of a natural birth may have been a reaction against the overuse of birth technology and current emphasis on nature from the "Green" movements and "New Age Health Culture" (Kay, 1982). Parents were literate, knowledgeable regarding childbirth and had the ability to examine information on birth carefully as evidenced in their questioning of the medical system. Couples had observed changing trends in birthing amongst family and friends. A strong yearning to do what was best for themselves and their child motivated them to birth naturally.

Safety was the primary expectation of parents interviewed. They took precautions to ensure safety and were not so against medical intervention as to endanger their family's welfare. Adding to parents concerns for safety was family and friend's anxiety, adverse media portrayal of homebirth and pressure from consumer groups and healthcare professionals .

Parents' expectations of self and self reliance permeated descriptions of their homebirth. It was an essential motivational factor in deciding to have a homebirth and the foundation for interactions at the birth. Participants owned the birth place and were aware of limitations beyond their control. Self expectations were supported by the parents' determination, assertiveness and a supportive relationship with participants at the birth. The implications for healthcare professionals is that they need to respect this self determination, to act as a

resource that will assist clients to be self reliant and to state when it is imperative that clients seek medical assistance.

Parents were pragmatic and realistic with their expectations of birth. They had made a concerted effort not to have extensive birth expectations. Study participants' reflection on birth outcomes and how they excelled beyond their expectations refutes the stereotype that people with expectations are bound for disappointment. The effect of limited expectations as described in the present study, was found to be similar to Green, Coupland and Kitzingers' (1990) study. In their study it was found that women who set specific expectations had higher birth satisfaction.

### Reflecting on Outcomes

On reviewing their experience, first time mothers found they were surprised as to how fast their labour had progressed. Contributing to this expectation was information presented in literature and classes, the uncertainty involved in birthing for the first time and peers' birth stories in which they recounted how disappointed they had been with their progress.

Past birth experiences were found to have limited influence on participant's birth expectations as the couples recognised that each birth is different and cannot be predicted. According to Boud, Keogh and Walker (1994) our perceptions of events are conditioned by our past experiences, which shape our response to the world around us and the knowledge of how this affects us is unknown. Study participants in the present study, who had previously birthed at home, therefore, may not know exactly how their past birth experiences influenced the present birth. Some fathers stated that they reviewed what they had done in past births while preparing for the imminent birth, for example, they knew what articles they needed at the birth. Stolte (1987) had similar findings

with mothers who had previous birth experiences. Mothers in Stolte's study stated that their overall expectations of labour and delivery were akin to the actual event as they based their expectations about current labour and birth on past experiences.

Some fathers spoke of experiencing anxiety initially when their birth expectations became a reality. Contributing to this anxiety was the notion that the couple had taken on the responsibility of birth, owned the birth environment and had limited opportunity to remove themselves from the birth. Stichler, Bowden and Reimer (1978) suggest that another cause for anxiety is the reality of being responsible for another life. Despite this fathers exceeded their own expectations, in that they did not faint and were able to physically support their partner.

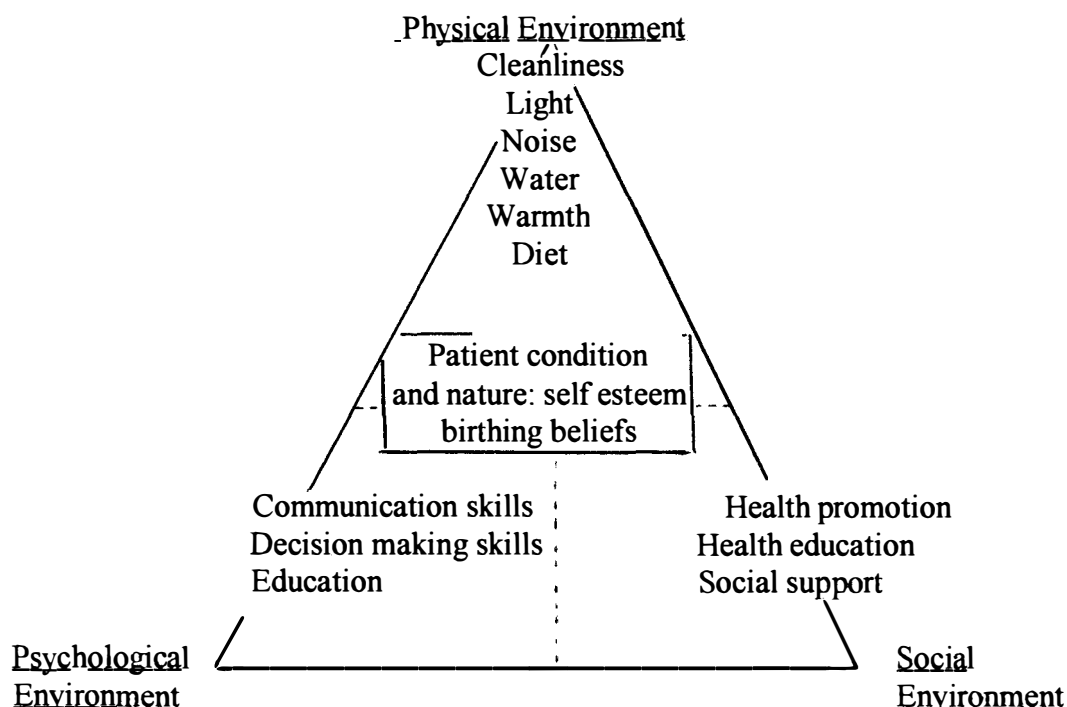
### Evaluating Expectations with Outcomes

It was unanimous amongst participants that their homebirth exceeded their expectations; in their words it was "awesome" and "miraculous". This contagious exuberance experienced after a homebirth, Klaus and Kennel (1982) define as "ekstasis". Parents achieved their birth expectations by taking responsibility for the birth and demonstrating control. The participants' flexibility enabled them to deal with any birth outcome. The extent of the self fulfilling prophecy on the couples' perception of their experience cannot be measured, but is a consideration that needs to be noted. Interlinked with parents' successful resolution of birth expectations is the relationship with their carer. Simkin (1991) in her study of the long term impact of the birth experience found that those women who felt highly satisfied with their births had felt in control of the birth. Control was experienced by the women in the current study and potentiated the feeling of achievement.

The study participants' found the major drawback of homebirth was that mothers recommenced their domestic duties too soon after birthing. The home environment assists birthing in that it facilitates parents to relax although after birth mothers found chores that needed to be maintained. The compulsion to attend to the house may have been exacerbated by, in the words of a mother, the "high" rush of energy women experience after birthing. There was also the desire to have an appropriate "nest" for the baby and entertaining visitors required preparation. Saunders (as cited in Abel and Kearn, 1991) suggested that the home is more of a work place for women than for men with both sharing a sense of home as sanctuary. O'Connor (1995) proposed that women resumed housework soon after birth in determination not to let birth interfere with their life and as a statement about how natural birth is to women. Implications for members of the social environment are that they need to encourage rest, ensure there is adequate support at home, visit in a considerate manner and perhaps employ home assistants.

#### Relationship of Study Findings to Theory.

Once the findings for this study emerged it was obvious that Nightingale's theory was relevant and it was therefore used to provide a second level of analysis of the findings. In this study the home environment is what differentiates parents' birth experiences from the norm of hospital births. Environment is the core concept of Nightingale's theory.



**Figure 3: Adaptation of Nightingale's Theory of Nursing**

Nightingale's writings form the first documented nursing theory, with some concepts appearing to be poorly defined when referring to more recent theories. However, Nightingale's theory is still relevant to today's nursing practice. As seen in Figure 3, her theory can be applied and adapted to the homebirth environment. From the study findings it was found that essential elements in the physical environment were those which parents emphasised as integral to creating a conducive birth setting. Patient condition and nature (see Figure 3) incorporates research participants' beliefs regarding health and birthing. These are supported and limited by the three environments, for example, a couple may believe birth to be natural and have the social support to birth at home but live where no midwife is available. It was found from the study that psychological environment identifies interpersonal skills and characteristics which facilitated having a homebirth. Social environment in the context of this study includes the responses parents received to their birth choice and how the couple are assisted in maintaining their health and preventing possible complications.

Nightingale defines environment in the context of her time, which may account for her stress on physical environment. According to Nightingale, environment is all external conditions and influences affecting life and development of the organism (de Graaf, Marriner-Tomey, Mossman and Slebodnik, 1983). Study participants in talking of the physical environment emphasised light, noise, water and room temperature. Opposite to Nightingales expounding of the virtues of sunlight was the parents actions during labour, to diminish light and movement towards dim soothing light. Observations of and statements from participants are in accord with Nightingale's comments on the problem of noise and its effect on patients. Nightingale exclaimed that "noise is the most cruel absence of care that can be inflicted on either sick or well" (Skeet, 1980, p. 39). She went on to warn that friends, visitors and those attending to the sick, must not attempt to cheer the sick by making light of their danger and by exaggerating their probabilities of recovery. It was observed in birth videos that there was minimal noise and limited speech particularly during contractions. In this manner birth participants adhered to Nightingale's viewpoint and assisted mothers to concentrate on the process of birthing.

Contrary to Florence Nightingale's emphasis on the physical environment, this study's research participants stressed the significance of a conducive social and psychological environment for as a mother stated:

"I think it was just things like support people like getting happening what we wanted to happen. The nursery and things like that, you know not a great deal of material stuff it was just people" (F10).

Nightingale recognised the need to consider all aspects of the environment. Nursing was described by her as helping people to live and to look upon the patient as a member of a family and a community member. In this way Nightingale gave credence to the existence of a social and psychological



environment. The positive findings regarding the presence of children at birth are supported by Nightingale who stated that: "A young child if unspoiled will adapt itself wonderfully to the ways of a sick person, if the time they spend together is not too long" (Skeet, 1980, p. 89).

While recognising that a birthing woman is not sick, the analogy can still be drawn. This theoretical principle was confirmed by parents whose children had an adult person to attend to them during the birth and allowed the children to wander freely in the house as their mother laboured. The social environment of today is quite different to that of Nightingale's time, in particular the expectation of fathers involvement at the birth.

During the birth fathers worked to maintain mothers' basic environmental needs of fresh air, dim light and a comfortable room temperature. In supporting and observing at the birth the father is nursing according to Nightingale's definition, although Nightingale assumed that only women would adopt the role of nurse. The father and midwife nursed the mother by assisting her to be in the best position for nature to act, that is for birth to occur naturally as parents had anticipated. Fathers received direction as to what was needed from their birthing women and midwives. The midwife acted as a role model for the parents for example by not talking while the mother experienced contractions. Nightingale's definition of nursing is somewhat limited in that it did not consider how midwife's nurture clients to be self reliant, negotiate with their clients or act as a health resource.

It could be misinterpreted that in referring to Nightingale's theory, pregnancy and birth is viewed as a sickness / disease. This is not so, for health was described by Nightingale as lack of disease, therefore, a woman who is pregnant

or birthing is healthy until a complication transpires. Nightingale further elaborates on how humans have vital natural powers for the reparative process (de Graaf, Marriner-Tomey, Mossman and Slebodnik, 1983). Powers that enable a human to face a challenge from the external environment were identified by Nightingale as adaptability and variability. Adaptability is the property of living things to attain a new state of equilibrium in a new situation. This was demonstrated when parents worked to resolve their expectations with the reality of birth. Adaptability is dependent on variability; also the person's biological, physiological and mental characteristics. Birth is a transitional period in which parents use their adaptability and variability to manage this new situation.

Florence Nightingale was the first nursing theorist to document that people have the ability to care for themselves. The works of such nursing theorists as Sister Callista Roy and Dorothea Orem (Chinn and Jacobs, 1983) further developed the self care movement. Findings from this research study raise questions as to whether health professionals have adopted practices that foster people's ability to care for themselves or are health professionals just verbalising this principle? In interviewing parents it was obvious that they wished to take control of their health and take on the responsibility of birth. The consumer movement and resulting proliferation of self help books on childbirth and child rearing encourage parents to be self caring (Armstrong, 1989). However, as this study's findings reveal, some health professionals are yet to be coaxed into encouraging and facilitating parents to be self caring in childbirth.

The need for a change within the nurse / midwifery paradigm was identified by this study. Parents assumption that they could control the birth challenges the culture of control within health professions. Traditions dating back to Nightingale's time are still tightly embraced by health professionals, for example the health professionals knowledge on childbirth is deemed more significant than

the birthing woman's inner wisdom. Impediments to nurse / midwives facilitating self care practices include organisational, cultural (nursing socialisation) and educational constraints. Until the profession reviews this paradigm and addresses constraints to their practice, midwives will not be in a position to empower parents to care for themselves.

### Conclusion

Homebirth was found to be a multidimensional experience of parents that extends beyond the physical setting of birth. The essence of a homebirth experience for the ten couples interviewed and observed in this study was described in four themes. The theme of Constructing the Environment described how parents optimised the physical and social elements of their environment to form a conducive birth place. Assuming Control was the second theme, in which parents spoke of exerting control of the external environment and taking responsibility for the birth. Birthing was the theme where parents elaborated on their birth beliefs, birthing and relationships. The final theme of Resolving Expectations concerned the process of parents forming expectations, experiencing the reality of birth and then evaluating whether expectations were met.

In conclusion homebirth is a couple actively creating a beneficial environment in which they take on the responsibility of birthing. As an experience, homebirths have long term repercussions for a couple as well as an individual parent. Mothers explained how they took charge of their birth and were the source of information on birth progress. Fathers described periods during the labour in which they felt unfamiliar and uncertain although they demonstrated the roles of supporter and observer at the birth. Homebirth was a joint decision parents made together, prepared themselves for and worked as a couple at birth to achieve their expectations. The study findings have implications for health care service provision, funding, accessibility and consumer use.

### Implications and Recommendations

In sharing their birth experiences, study participants, have contributed to the database on homebirth. The study findings bring an awareness of what it means for a couple to birth at home and from this recommendations can be drawn. In describing the homebirth experiences of ten couples the research furnishes a unique insight which has implications for women and their partners, their social environment, the people planning and providing healthcare services.

The implication for women is that not only do they have choices in birth they also have the opportunity control the birth process and take responsibility for it. Implications for prospective fathers is that they are able to minimise stress and effectively function as a spouse while progressing through the transition into fatherhood.

Study participants' descriptions led to the development of recommendations for prospective homebirth parents. The recommendations are for parents to educate themselves on the birth options available, to discuss these together and to assertively apply for their rights. It is imperative that parents ensure there is support available in the form of assistance with cooking, cleaning and childminding after the birth.

Homebirth was shown to occur within a social milieu, with parents receiving support or opposition from friends and family. The social environment plays an integral role in a couples' passage into parenthood and is a powerful influence.

Recommendations for members of the public include increasing mindfulness that there is more than one birth option (hospital birth). The shift into parenthood can be facilitated through people providing information, listening and assisting in

maintaining the household and family functioning. A significant role can be played by the mass media, educational institutions, healthcare professional bodies and families in providing balanced information on birth options.

The study found that the carer and client relationship influenced the clients control of their own health and this will be of great significance to the people designing healthcare services. Hence it is recommended that the continuity of the carer and impediments to patients taking care of themselves, be addressed in the planning of a maternity service. Organizers of a healthcare service need to provide accurate information on birth options and increase accessibility to alternative birth environments by ensuring availability of finance and appropriate carers .

Research findings have the potential to encourage midwives to reflect on their practices and possibly alter their care according to research participants statements. The relevance of the findings are not restricted to health professionals attending to homebirths. Those working in other birth settings can gain from heeding these participants/ consumers comments, as the client /carer relationships, rather than birth setting, was found to be a key issue.

The importance of interpersonal and communication skills in a health professionals relationship with their client was stressed in the four themes identified in the study. Parents as consumers of a privately funded healthcare service were prepared to shop around until they found an empathic carer. The implication for carers is that they are answerable to market trends. Access to their service is influenced by the need for a rapport with their client and is limited by the parent's economic standing.

The study findings have implications that may challenge midwives beliefs and practices. For example, study participants' assumption of control may threaten some health professionals' view of the client - carer relationship and definition of health. The description of homebirth experiences calls for midwives to acknowledge mothers as the central focus of the birth process and a source of information also control. A ramification of enabling mothers to have control in birthing is the need to find a balance between enabling parents to possess responsibility for the birth and the midwives ultimate accountability in preventing potential complications. The study illustrated how homebirth for a midwife extends beyond the physical catching of a baby, to incorporate the mental, spiritual and emotional care of a woman and her family.

Parents' accounts of their homebirth presented a reminder to midwives that birth needs to be considered holistically. The emphasis couples placed on their social environment suggests that midwives consider this in their practice. The reaction parents experienced from people on announcing their birthplace choice has implications for midwives. They are in a position to provide information and promote choice in birth settings and also to ensure media presentation is accurate and not misleading.

Fathers birth experiences can impinge on their memory of the event and interactions with their spouse and infant. The implication is that midwives are in a position of being able to influence fathers experience of birth and positively enhance their transition into fatherhood. This influence can be achieved through involving and informing fathers in the care of their pregnant partner and presenting opportunities to verbalise concerns and feelings.

It was found that parents and their midwife came to the birth with particular beliefs and expectations. Midwives therefore need to make explicit, to their clients, what their beliefs and expectations are in regard to birth.

### Summary of Recommendations

- \* To adopt a holistic approach to birth and to assist parents in creating a conducive birth environment.
- \* To act as a health resource by increasing accessibility to information on birth choices.
- \* To verbalise and document personal beliefs and expectations regarding birth in order to prevent potential misunderstandings and to facilitate the birth.
- \* To encourage the media and educational institutions to present realistic images of homebirth.
- \* To acknowledge fathers roles and needs during pregnancy and birth.
- \* To assist mothers to rest after birth and to discourage them from attending to household duties too soon.
- \* To ensure parents have a supportive social environment and to make available a directory of community resources.
- \* With consumers to lobby health insurance funds and members of state and federal government for funding for homebirth services.
- \* To educate parents and health professionals regarding parents' rights in childbirth such as right to privacy and right to choose. Education of patients rights also involves teaching people interpersonal skills to be assertive in applying their rights.

### Recommendations for Future Research

- \* To study fathers' experiences of birth as a separate phenomenon in the home, hospital and birth centres.
- \* To study grandparents experiences of being present at their grandchild's birth.
- \* To study couples experiences of birth in birth centres and hospitals.
- \* To look at outcomes - perspectives on parenting after having had a homebirth.



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## **Appendix A**

### **Researcher's memo**

The element of control was discussed or implied by parents during their interviews. This is a multifaceted concept, its presentation depends on the perspective of the speaker. My perception of control, particularly in the role of midwife, needs to be separated from that of the participants' perspective of control.

There is a distinct difference between control in a homebirth setting and in a hospital setting. In a hospital setting control is seen in the politics played between medical staff and midwives, within the medical team and the nursing team and this influences their interaction with patients/ clients. There are two perspectives of control. One is that the birth is controlled by learned professionals for the safety of the patients, with health professionals having the power. The opposite perspective of control is when carers and parents share information and negotiate control, where there is mutual respect and equal power. This is the control described in a homebirth.

Control in the hospital is exacerbated by administrative policies, inter professional relationships, self esteem and communication skills of the players (clients and carers).

In a homebirth control is influenced by the relationship between client and carer, their communication skills, self esteem and most significantly parent's ownership of the birthplace.

During this research the shift in control perspectives which start from admission to hospital was obvious. It appears to me that within a hospital setting health professionals sometimes tend not to show confidence in their patients' abilities to determine and achieve their needs. It is acknowledged that there are times when

a midwife must step in and take control to prevent harm. I admire the assertiveness, confidence and courage homebirth parents demonstrated, although I could see the potential for conflict with the midwife if their views differed.

**APPENDIX B**  
**Letter to prospective participants**


S. Morison



*Hello !*

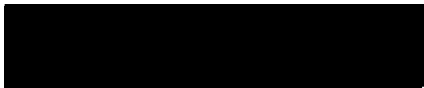
My name is Susanjane Morison. I am a Master's student at Edith Cowan University, School of Nursing. I am a midwife interested in the birth environment and in reading literature on homebirth I found that there is a lack of information on parents' experience of homebirth, particularly on the fathers' perspective.

This is the reason I would like to visit you and conduct an interview with yourself and your partner for 1 hour. It will be negotiated with you where and when this is suitable. The audio taped information will remain confidential as only I will have access to it and through the use of pseudo names you shall remain anonymous. Efforts to protect your identity include having any written information from the research kept in a locked safe and that no identifying information will appear in any research articles.

As you have had a homebirth in the last three years you fit the criteria for the sample I am seeking. You will be one of eight couples participating in this research study. You have the right to decide whether you wish to participate or not. If you decide to participate, you are free to withdraw participation at any time. Should you have any questions about the research study, please ask me, I can be contacted on phone number 

If you wish to participate in this study could you please complete the attached Informed Consent Form and return it in the stamp addressed envelope provided. Please keep this information sheet for future reference and contact me if you have any queries.

Thank you



**Consent Form**

I .....{print your given name}

have read and understood the information about the research study on parent's experiences of homebirths, being conducted by Susanjane Morison. The method of how my anonymity will be maintained, has been explained to me . I am assured that my identity will not be disclosed during the study or when the study is completed. I know that I can withdraw from the study at any time. All my questions have been answered to my satisfaction. I agree to participate in this study.

Signed participant: ..... Date .....

Signed participant: ..... Date .....

Signed researcher: ..... Date .....



## **APPENDIX C**

### **Interview Prompts**

- \* Can you tell me about your experience of a homebirth ?
- \* How did you find out about homebirths?
- \* What made you decide to have a homebirth?
- \* How did family and friends react when you told them you were having a homebirth?
- \* What were your expectations of a homebirth and were these met?

## **APPENDIX D**

### **Coded Transcript Sample**

#### **Interview transcript**

#### **RESEARCHER'S NOTES**

S: What kind of things did you do in the second stage of labour with (mother)?

F: I just massaged her shoulders just talked to her and you know, I mean I just went along with the flow I guess. I kept out until I was invited in really, and then I think you wanted me to comfort you. All I could do was massage her shoulders and just keep her, you know, make sure she was EQUIPMENT

held up and make sure that the ironing board did not fall over !

M: I just really wanted (father) there..

F: I had the fire stoked up in that room and this room you know, I mean there was fires to look after. My job was really to make sure that everything was comfortable and right. I just let (mother) make the cue. I just went with what ever she wanted basically and I mean, after watching some other people's birth videos, I mean, that's EDUCATION.

when (mother) said to me, look don't do this, don't

ACTIVE INVOLVEMENT.

FLEXIBLE, NO SET

EXPECTATIONS. 'M'

SOURCE OF CONTROL.

SUPPORTER

SIMPLE BIRTH

ADAPTED FROM

HOUSEHOLD ARTICLES

COUPLES INTER-  
RELATIONSHIP

MAINTAINING

ENVIRONMENT.

SUPPORTER.

SIGNIFICANCE OF HEAT.

'M' CONTROL, DIRECTOR.

CHILDBIRTH

SIGNIFICANCE OF NOISE.

go clattering about in the kitchen ..

M: Because you hear it on the video and I thought ABILITY TO CRITIQUE.  
rude husbands. EXPECTATION

### **Data Display Chart on the theme of Birthing**

Twenty themes from significant statements in interview transcripts were broken down into four themes which were further refined as shown below.

<b><u>Original themes:</u></b>		<b><u>Final themes:</u></b>
Preparation / Organisation	>	Constructing birth environment
Birthing Process	>	Birthing
Relationships	>	Assuming Control
Beliefs / Values	>	Resolving Expectations

In notation form the theme of birthing is presented in a manner that illustrates how it was collapsed to form the theme found in the findings chapter.

#### **Original theme: Birth process**

- \* Birth as a natural process, no intervention desired.
- \* Homebirth is not suitable for everyone.
- \* Use of alternative therapies
- \* Influence of home environment on labour / birth.
- \* Birth as a positive experience. Each birth was unique.
- \* Use of simple articles
- \* Relationship between midwife and couple
- \* Relationship between mother and father during labour / birth
- \* At birth had a period where just parents and baby were together.
- \* Mothers' sense of achievement after birth
- \* Mother getting up soon after birth.

Refer to next page for final themes

## **Final theme: Birthing**

### **Birthing Beliefs:**

- # Birth as a natural process
- # Homebirth not suitable for all
- # Confidence in birthing abilities

### **Birthing:**

- # Significance of home environment
- # Mothers' mobility in labour, determining their birth position and mothers' sense of achievement after birth.
- # Parents spending time alone with newborn

### **Relationship between mother and father:**

- # Fathers unfamiliar with their role in labour / birth. They described themselves as supporters and observers.
- # Mother being the focal point at the homebirth

### **Relationship between client and carer**

- # Parents choosing carers who complied with their beliefs / expectations
- # Sense of rapport with carer which enabled confidence and trust to develop
- # Carer's focus on nurturing couple to reach their potential and develop their birthing knowledge and skills.