Women’s Decision-Making And Factors Affecting Their Choice Of Place Of Delivery: Systematic Review And Qualitative Study

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ABSTRACT

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Abstract

The aim of the thesis is to explore pregnant women's decision-making and major influences on their preferences for a place of delivery. The study was prompted by the UK government's policy of a woman centred maternity service (Department of Health 1993b), and the observation that studies had concentrated on professionals' rather than women's views about the place of delivery. Two factors were considered to have potential influence in decision making, one being the individual woman's risk perception related to the process of childbirth, and the other, knowledge about available options for place of birth. First, a systematic review was conducted, looking at available studies on women's views about the place of delivery. Only 9 studies were found, suggesting a need for more studies. Secondly, a primary study was conducted using in-depth interviews with 20 women planning a hospital birth, and 13 planning a home birth to explore factors that led to their respective choices.

Results from the primary study indicate that women were not offered information about the availability of home birth. Consequently, 90% of those planning a hospital birth did not give thought to where they were going to have their babies, but assumed they were going to go to hospital. On the other hand, those planning a home birth found information privately and discussed the options with their husbands before making a decision. Additionally, results exposed differences in perception of safety concerning childbirth for subsequent deliveries according to planned place of delivery. Control of the birth process and environment was also found to be important for women planning a home birth. Risk perception and information about available options were found to influence decision-making about the place of birth, thus supporting the hypotheses of the thesis.
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Chapter 1: Introduction

The topic of place of birth is hotly debated, both in academic journals (Chamberlain 2000; Chamberlain, Wraight, and Crowley 1997; Cole and Macfarlane 1995; Draper 1997; Drife 1999; Drife 2000; Education and Debate 1996; Jowitt 1998; Macfarlane, McCandlish, and Campbell 2000; Settatree 1996; Springer and van Weel 1996; Young and Hey 2000), and in the press (Alibhai-Brown 1999; Newburn 1999; Rakshit 1997; Rogers 1998; Young 1999). However, the debate is about which venue is safer, and professionals, according to their preferences for home or hospital, lead the debate.

Many research studies on the subject of place of birth have also focused mainly on safety (Ackerman-Liebrich, Voegeli, Gunter-Witt et al 1996; Bastian 1998; Northern Regional Perinatal Mortality Survey Coordinating Group 1996; Wiegers, Keirse, van der Zee et al 1996; Woodcock, Reid, Moore et al 1994). Beyond the crucial issues of mortality and morbidity by place of birth which are at the centre of the debate about the place of birth, it is essential to investigate consumers views and preferences. What motivates prospective parents to reach particular decisions about where to have their babies? What is missing from the debate and available studies is a knowledge base of women’s own perceptions of the childbirth process, their views about the place of birth, and factors that they consider of significance when deciding about where to have their babies. Except for one identified study (McClain 1983) the literature has not yet touched on how women as consumers of childbirth services view risks and benefits of home or hospital birth, and whether risk-benefit analysis as might be applied by women may have any role to play in their preference or choice of either home or hospital. The lack of studies about women’s views is perplexing inasmuch as the United
Kingdom is a pluralistic society, with women from diverse cultures and beliefs, which determine their way of life, and therefore the kind of care they expect. Additionally, the UK government advocates a woman centred maternity service (Department of Health 1993b). One obvious question to ask in the light of the dominant debate about the place of birth is how it is possible to meet the Department of Health’s aim of a woman centred maternity service if the views of the women are not known. The only way to provide woman centred care is first to determine from the women what normal care is, according to their beliefs and individual circumstances.

It is with the above background that this thesis was undertaken. The thesis examines how much is known about women’s views of the process of childbirth, and goes on to investigate from women significant factors they consider when thinking about where to deliver their babies. First, a history of the traditional place of birth, which is the home, and factors which led to the change from home to hospital birth in the United Kingdom is reviewed. NHS policy about maternity care is discussed because policy determines how care is organised and therefore sets the standards for consumers about what to expect as normal care.

In other disciplines, such as psychology (Kahneman and Tversky 1984; Tversky and Kahneman 1974), economics and business (Schwing and Albers, Jr. 1980) where an element of risk is involved, decision-making is thought to be influenced by the individual’s perception of the risk. Since childbirth involves some risk, it is surprising that such an approach has not been employed to understand women’s preferences for different childbirth options. The thesis reviews risk-perception literature as used in the disciplines named above, and makes an effort to determine whether the principles could be applied in childbirth to explain the difference in preferences for home or hospital birth.
Two studies form the foundation of the thesis; one is a systematic literature review of women’s views about factors influencing their choice of place of birth, to demonstrate how much research is available, and therefore how much work still needs to be done in the area. Additionally, the review aims to highlight factors consistently found to influence women’s choice of place of birth. The second is a primary qualitative study of women’s perceptions of the process of childbirth, as well as their views about factors influencing their choice of place of delivery. It is important to conduct such a study because caring for women in a pluralistic society requires knowledge of the diverse factors influencing their preferences for care.

To set the scene, the thesis starts by reviewing the history of trends in place of birth. It is thought that this might help to determine the validity of the move, and suggest ways to redress the situation.

In most cultures, childbirth was traditionally seen as a normal physiological event, which occurred at the woman’s own home with the assistance of other women. However, this view gradually changed, and pregnancy and childbirth were increasingly viewed as pathological events. In Britain, birth took place at the family home until the end of the 19th century but by the end of the 20th century, barely 1% of all births in Britain took place in the woman's home (Tew 1990). The overriding reason for this shift in place of birth was a concern with safety. Pre-occupation with safety during childbirth was prompted by high levels of maternal mortality in the 1930s which resulted in professional and political organisations, followed by the women themselves, demanding hospital deliveries because they considered them to be safer than home births (Symonds and Hunt 1996). In 1970, the government accepted a recommendation of 100%
hospital delivery following a review of maternity services (Department of Health and Social Security 1970).

On the other hand, statistical evidence did not lend support to the premise that hospital birth was safer than home birth (Campbell and Macfarlane 1994; Russell 1982; Tew 1977; Tew 1978; Tew 1981; Tew 1985; Tew 1990). The scientific justification for the trend towards hospital deliveries was questioned, and consumer organisations such as the National Childbirth Trust (NCT) and the Association for Improvements in Maternity Services (AIMS) became actively involved in informing women about their maternity care rights. The Netherlands was held up as an example of a country with low perinatal mortality rates despite a high home birth rate (Lovell 1996).

In the midst of the confusion about home and hospital birth, the Expert Committee of the Department of Health was set up in 1992 to review policy on National Health Service (NHS) maternity care, particularly during childbirth, and to make recommendations (Department of Health 1993b). This was a sequel to the Government response to the Select Committee's report (House of Commons Health Committee 1992), which had suggested that the medical model of care that encouraged all women to deliver in hospital could no longer be justified on the grounds of safety. The expert committee's efforts culminated in the production of the policy document *Changing Childbirth* (Department of Health 1993b), which advocates maternity care that is appropriate, accessible, and effective. The document aims to make care during pregnancy and childbirth more woman-centred by setting targets for implementation and recommendations for good practice. The report stresses that:
"Women should be given unbiased information and an opportunity for choice in the type of maternity care they receive, including the option, previously denied to them, of having their babies at home or in small maternity units." page 1, para 4.

The following section will trace government policy relating to the place of birth, which contributed to the move from home to hospital birth.

Events leading to the move from home to hospital deliveries

A brief history of the trends in the place of birth since the Second World War shows a rapid decline of non-institutional births in the US from 44% in 1940 to less than 1% in 1970. Whilst the drop was slower in Britain, reducing from 50% in 1940 to less than 10% in 1970, it was slowest in the Netherlands, falling from 70% in 1963 to 32% in 1982, and gradually increasing to 35% in 1990 (Wagner 1994).

Factors leading to the shift from home to hospital deliveries in the United Kingdom is detailed by Campbell and Macfarlane (Campbell and Macfarlane 1987; Campbell and Macfarlane 1994). The historical account shows that the decline in the home birth rate was a result of successive government reports. A discussion of the reports thus follows, which exposes the origins of assumptions and misconceptions that have influenced thinking about the place of birth.

The Cranbrook report (1959)

The Cranbrook committee was appointed by the Minister of Health in 1956 to review the organisation of maternity services in England and Wales and to make recommendations. The chairman of the committee was Lord Cranbrook.
The committee issued a press notice informing the public of their terms of reference, and invited individuals and organisations to submit their views to them. In addition, some individuals and organisations such as the Association of Supervisors of Midwives, Medical Practitioners Union, Catholic Women's League, National Birthday Trust, British Dental Association, College of General Practitioners, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists were personally invited to give their views. The report of the committee was published in 1959 (Ministry of Health 1959).

The evidence about the place of confinement came from representatives from women's organisations, Regional Hospital Boards, and the Royal College of Obstetricians and Gynaecologists. The consensus of those who gave evidence was that there was an unsatisfied demand for hospital confinements. However, the Royal College of Obstetricians and Gynaecologists is singled out as having "emphasised that in their opinion hospital confinement offered maximum safety for the mother and the baby" (para 53). The report goes on to express that many of the witnesses were concerned about risk of infection to mother and baby, and considered that the risk might be higher in hospital than home confinement. Some of the witnesses felt that beds in general hospitals were provided for sick persons and should be used for that purpose rather than to meet the convenience and preferences of women, who could safely be delivered at home (para 54).

Many other reasons, presented in paragraph 55 of the report, were given in favour of home confinement. For instance, the report states that nearly all witnesses recognised that up to 20% of women preferred a home confinement, and many pointed out the important physical and psychological advantages when a normal confinement takes place at home. Such advantages include the fact that the relationship between the mother and baby developed better, breast-feeding
could be more readily maintained, risk of infection to the baby was reduced, family life is not disrupted, and less noise and activity at home promoted the mother's rest. Even the College of General Practitioners expressed the view that many women would prefer a home delivery if assured of its safety.

However, it would appear that the influential evidence was that from the Royal College of Obstetricians and Gynaecologists (RCOG), who testified that the hospital provided maximum safety over home birth. In their deliberations, the committee recommended that a sufficient number of beds should be provided to allow for 70% of deliveries to take place in hospital. According to Chamberlain et al (1997), the institutional delivery rate at that time was 54%, they go on to argue that this figure of 70% hospital deliveries was a repetition of an earlier recommendation by the Royal College of Obstetricians and Gynaecologists. In their report, the Royal College of Obstetricians and Gynaecologists had stated that from the figures of women wanting a hospital confinement at that time, it would seem wise to make provision to begin with for about 70% of all births to take place in institutions (Royal College of Obstetricians and Gynaecologists 1944). The rate of institutional deliveries at that time of the RCOG was 51%, and, therefore, 70% was about 20% more (Chamberlain, Wraight, and Crowley 1997). The report of the RCOG did not refer to any evidence supporting the need to increase institutional delivery rate to 70% and neither did the Cranbrook Committee when they reiterated the recommendation. On the other hand, the Cranbrook Committee disregarded the evidence highlighting the advantages of home deliveries. It would appear therefore that recommendations were made without any scientific evidence for any benefits, but rather from the views of medical practitioners.
The recommendations of the report underlined the need for more women to deliver in hospital, but still made provision for domiciliary maternity services to continue. There is a suggestion that the committee may have made an over-provision to employ the principle of “always asking for more than you need in order to get enough” (Chamberlain 1997:10). Another argument is that the Cranbrook Committee was following trends when it made its recommendations as public pressure for hospital births had grown, and more births were already classified as high risk (Lewis 1990).

The state of maternity service in the next ten years led to another review of maternity service by the Peel Committee.

**The Peel report (1970)**

The Peel committee was set up in 1967 as a sub-committee of the Standing Maternity and Midwifery Advisory Committee under the chairmanship of Sir John Peel. Sir John Peel was at that time the president of the Royal College of Obstetricians and Gynaecologists, which, as discussed above, had made recommendations to the Cranbrook committee that the hospital was a safer place to give birth than home. The task of the Peel committee was to consider the future of the domiciliary midwifery service and the question of bed needs for maternity patients, and to make recommendations. The committee made their recommendations in 1970 (Department of Health and Social Security 1970).

Medical Officers of Health, Chairmen of Local Medical Committees, the Central Midwives Board, and the Senior Administrative Medical Officers of Regional Hospital Boards (para 5) completed questionnaires for the committee. On the question of continuance of domiciliary midwifery service, 59 % of
Chairmen of Local Medical Committees wanted home confinements to continue. They, however, stressed the need for women to choose whether they wanted to have their babies at home, and for proper assessments to be made to ensure the woman's home is safe. In paragraph 9, the report states that "the majority view was, therefore, that domiciliary midwifery should continue."

In its interpretations of the Medical Officers' views, the Peel Committee states that:

"...notwithstanding the majority of responding Chairmen recording views in favour, or acknowledging a need for continuance, of domiciliary midwifery, no extremity of view is prevalent. General practitioners are clearly aware that the indications, both medical and social, for home confinement need to be much more stringently assessed than those for a hospital confinement, in which risks are minimised" (para 145).

There is no indication, from the summary of the chairmen's responses, that they considered hospital to have fewer risks than the home. On the contrary, the summary states:

"Some [chairmen] expressed the view that the present trend towards hospital confinement is largely the result of a misleading pressure on the public, encouraging them to believe that hospital confinement is always better. They felt that this was not necessarily true" (para 5).

It would appear from the chairmen's submissions that they were against the discontinuation of domiciliary midwifery. They felt that it was psychologically better for a woman to have her baby at home, that the birth of a child is a family matter, and should if possible take place in the shelter of the
home. They also put forward the fact that if the woman has other children at home, then it is better that she is not taken away from them for the period of confinement. Since the Chairmen of the Local Medical Committees did not express the view that hospital was safer than home, it could be argued that the Peel Committee were expressing their own views, possibly instilled by the recommendations of the Cranbrook committee, that hospital was safer than home.

When the Peel committee reviewed maternity policy, the home birth rate was 12.4%. The committee considered hospital confinement safer than the home for the mother and baby, and therefore concluded that the situation justified the earlier recommendation by the Cranbrook report to provide sufficient facilities for an increasing number of women to have hospital confinements. They went on to recommend a 100% hospital delivery, thus phasing out home birth completely. The committee felt that even without specific policy direction, the institutional birth rate was showing every sign of going towards total hospital delivery, and therefore the discussion of the advantages and disadvantages of home or hospital birth was academic (para 248).

The main argument for the recommendation of a universal hospital birth was the safety of mother and child. The conclusion that the hospital was safer than the home for delivery was reached without any supporting evidence. This assertion of safety in hospital became the focus of the debate on the place of birth, which is continuing up to now. There was no consideration for other factors that might influence women's preferences for home or hospital birth.
The Short report (1980)

The Short report was a name given to the House of Commons Social Services Committee report under the chairmanship of Mrs Renee Short. The committee took over and completed work begun by an earlier committee, to perform an inquiry into perinatal and neonatal mortality. The Social Services and Employment Sub-Committee, that was originally going to do the inquiry, was prompted to do so by increasing public concern that babies were unnecessarily dying or suffering permanent damage during late pregnancy and early infancy (House of Commons Social Services Committee 1980). The committee was also worried that the mortality rates in England and Wales were falling more slowly than in other developed countries. In addition, there were wide differences in mortality rates found in different socio-economic groups and different areas in England and Wales (para 1).

The investigation embraced a number of aspects of maternity care, including the question of place of birth. Evidence was received from mothers, Royal College of Midwives, and the Royal College of Obstetrics and Gynaecologists. Evidence from women, who are the consumers of the service, showed that they were in favour of delivering at home or in GP units (para 53-54). Women in the study were described as having strong views, and that it was not only the middle-class that had such strong views. On the other hand, the Royal College of Obstetricians and Gynaecologists argued that GP units did not meet the college's minimum standards for safety.

When the committee made their recommendations, women's views did not carry much weight. The committee felt that "...the understandable preferences of mothers in regard to place of delivery may not be compatible with the
requirements for the maximum lowering of perinatal and neonatal mortality" (para 64). The expert advisors, who were professors of Obstetrics, Paediatrics, and Clinical Epidemiology, influenced the committee's recommendations. It has been argued that these consultants were more interested in the protection of policies already agreed upon in their own profession, which outweighed their loyalty to the task of producing factual evidence (Sandall 1997; Tew 1998). Indeed the committee referred to the Peel Committee's recommendation for 100% hospital birth for increased safety of mother and baby, which was based on obstetricians' recommendations. For their part, the committee further recommended "increased concentration of births into larger, fully equipped and properly staffed consultant units" (Paragraph 55). The committee wanted home births to be phased out further. The Short committee is criticised for failing to consider statistical analyses already in print, which pointed out that mortality was higher in obstetric hospitals (Royal College of Physicians of London 1988; Sinclaire, Torrance, Boyle et al 1981).

Enquiries into maternity services did not end with the committees discussed so far. There were further investigations, led by dissatisfaction from the consumers and their representatives. A significant volte-face from complete hospital birth for all women was advanced by the publication of two Department of Health documents that recommended a woman centred maternity service (Department of Health 1993b; House of Commons Health Committee 1992). The two documents' main message is encapsulated in the following quotation:

"Women should receive clear, unbiased advice and be able to choose where they would like their baby to be born. Their right to make that choice should be respected and every practical effort made to achieve the outcome that the woman believes is best for her baby and herself" (Department of Health 1993b): 25.
The above quote represents the department of health’s change of emphasis from purely safety and professionals’ views about what is best for consumers of health care, to one in which consumers should be given information to empower them to make choices about their care. This position of the government regarding information-giving during childbirth can be traced back to the Winterton report (House of Commons Health Committee 1992) and the Cumberlege report (Department of Health 1993b; Department of Health 1993c).

The Winterton report (1992)

The Winterton report resulted from a review of maternity services that was conducted in 1991 led by Mr Nicholas Winterton. The committee was stimulated into conducting the inquiry by the general dissatisfaction with maternity services; and the realisation that women's needs were not being met (House of Commons Health Committee 1992). The committee had an advisory panel made up of an Independent Midwife, representative of the Royal College of Midwives, Consultant Obstetrician, Professor of Paediatrics, Professor of Obstetrics and Gynaecology, and a General Practitioner.

The committee starts the report by giving their view of childbirth.

"We set out on this inquiry with the belief that it is possible for the outcome of a pregnancy to be a healthy mother with a healthy, normal baby and yet for there to have been other things unsatisfactory in the delivery of the maternity care. Women want a life-enhancing start to their family life, laying the groundwork for caring and confident parenthood..." (para 3).

The Winterton committee believe that although avoidance of death is very important, it cannot be the only determinant of satisfactory maternity care.
Previous committees had made their recommendations on the basis of more safety for mother and baby (Department of Health and Social Security 1970; House of Commons Social Services Committee 1980). This committee was different from its predecessors because it was made up members of parliament of all parties, and it had an advisory panel named in the opening paragraph of the discussion of the report above, which helped to interpret the evidence.

The committee heard evidence and views from a wide spectrum of organisations and individuals representing the views of women. For example, they considered Mrs Marjorie Tew's analysis of statistical evidence, which led her to conclude that there was no causal connection between the fall in mortality rates in the 1950s and hospitalisation. Tew was challenged on her assertion that there was a negative correlation in the decrease in perinatal mortality rates and increases in the level of hospitalisation. However, her work is thought to have set in motion the search for the truth about the safety of home and hospital births (House of Commons Health Committee 1992).

The work of Campbell and Macfarlane, together with their critique of Tew's work was also considered. Campbell and Macfarlane, in their submission to the committee, expressed the view that there is no evidence in support of the claim that the safest policy was for all women to give birth in hospital. The Royal College of Midwives (RCM), the Association of Radical Midwives, Maternity Alliance, NCT, Association for Community-Based Maternity Care and the Association for Improvements in Maternity Services, echoed the view and gave evidence to the Winterton committee.

The review was carried out in just less than a year, and the committee's analysis of the evidence from individual women and organisations representing
them revealed the following elements, which greatly influenced the committee's recommendations:

- **Need for continuity of care**

  The Association for Improvements in Maternity Services (AIMS) drew out the importance women place in the continuity of the carer to the attention of the committee. It cited the Know Your Midwife Scheme, Effective care in Pregnancy and Childbirth, and a survey in Lothian Maternity Services which all attest to the importance women place upon continuity of carer (para 43). It was evident that women wanted continuity of care and carer at all stages of pregnancy and childbirth. The majority considered midwives as the group best placed and equipped to provide this.

- **Desire for women to have more choice**

  Maternity Alliance stated during its submissions that every woman should have the opportunity to choose the place of birth and person to care for her. This was in line with the government's position that women should, as far as practicable, be able to choose and have access to the type of care which they feel is best suited to their needs.

  The evidence the Committee received from both women and the organisations representing them was that the available choices were often more illusory than real. The Committee, therefore, concluded that there was widespread demand among women for greater choice in the type of maternity care they receive, and that the present structure of maternity services frustrates, rather than facilitates, those who wish to exercise their choice.

- **The right for women to have control over their own body at all stages of pregnancy and birth.**
The majority of those interviewed felt that women want to feel in control of themselves and what happens to them during childbirth, and that they are satisfied if they feel in control, and perceive themselves as partners in their care rather than passive recipients. The emphasis of the Winterton report is that women should have more choice and control in their care as captured in one of their conclusions:

"We conclude that there is a widespread demand among women for greater choice in the type of maternity care they receive, and that the present structure of the maternity services frustrates, rather than facilitates, those who wish to exercise this choice" (House of Commons Health Committee 1992) para 52.

The committee disputed the recommendation reached by the Maternity Services Advisory Committee, that birth in a consultant obstetric unit provided the best guarantee for a healthy baby, and therefore all births should be in hospital (Maternity Services Advisory Committee 1984). The Winterton committee felt that the recommendation had led to the situation of 98% of women in England giving birth in NHS hospitals, while there was no evidence to support the claim of more safety in hospital than at home. Such a policy, the committee felt, was misguided and regrettable. They concluded that:

"On the basis of what we have heard, this committee must draw the conclusion that the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety" Page xii para 33.

The Winterton Committee diverges from recommendations of previous committees which favoured hospital delivery (Department of Health and Social Security 1970; House of Commons Social Services Committee 1980; Maternity Services Advisory Committee 1984; Ministry of Health 1959). It is more
discerning of women's desire for continuity of care and carer throughout pregnancy and childbirth.

The government responded to the specific recommendations and conclusions of the Winterton report, and set about addressing wider issues in the organisation of maternity care. A report of the government's response was published (Department of Health 1992). A departmental task force was established, which set up a number of studies to address issues such as team midwifery (Wraight, Ball, Seccombe et al 1993) and midwifery-led and GP-led units (Department of Health 1993a). Of more relevance to the present discussion, the Expert Maternity Group was set up to review policy on NHS maternity care, particularly during childbirth, and to make recommendations. The work of the Expert Maternity Group, also known as the Cumberlege committee, will be discussed next.


The Cumberlege Report, commonly known as Changing Childbirth, (Department of Health 1993b) is a result of work done by the Expert Maternity Group that was established in October 1992 under the chairmanship of Lady Cumberlege, Parliament Under Secretary of State for Health. The members of the committee included women using NHS services, professionals providing the service such as a Midwife, General Practitioner, Obstetrician, Paediatrician, Midwifery professor as well as other members of the public such as a National Childbirth Trust representative, a journalist, and a management consultant. The report is considered a document for change, while the Winterton report (House of Commons Health Committee 1992) mapped the future of maternity services.
The Expert Maternity Group gathered evidence from a wide range of organisations, professional groups and individuals interested in maternity care. Women using the service gave oral evidence, while anaesthetists, general practitioners, midwives, obstetricians, paediatricians, other health professionals, and professional and other organisations gave written evidence. As an integral part of gathering evidence the group visited consultant maternity units, small maternity units, and midwifery schemes.

In addition to information provided by known organisations and groups, the committee wanted the views of others not linked to such groups. They therefore commissioned a study by the Market and Opinion Research Institute (MORI) of mothers who had given birth in England since April 1989. The survey found that most women felt they were given little choice about the place of birth. The majority reported that delivery in a consultant unit was the only option fully explained to them. Ninety-eight percent of women gave birth in an obstetric hospital, and 72% would have appreciated a choice. Of those wanting an alternative, 22% would have considered a home birth and 44% a midwife-led domino delivery.

A consensus conference was organised for the Department of Health by the Kings Fund Centre, a policy research group, to help explore the issues further. The conference panel produced a consensus statement, highlighting women's wishes for a safe and kind maternity service that offers continuity of care and carer, inspires confidence, responds to individual needs, and enables women to feel in control. The service must also make possible informed choice about the available options. The panel felt that professionals had no right to arbitrarily impose their views even when the women's views contradicted theirs.
Like its predecessor, the Winterton Committee, the Cumberlege committee was not just influenced by views of consultants about the most appropriate care for women. On the contrary, it gives more weight to the preferences of women, as they believe that "no-one cares more about achieving a safe and happy outcome to a pregnancy than the pregnant woman and her partner. Women want healthy babies and also to be healthy themselves after they have given birth. But this incorporates their desire to experience pregnancy, childbirth and the early days of parenthood as positive and fulfilling" (Page 9 para 2.1.2).

The Cumberlege report recommends that maternity care must be woman-centred, concentrating on meeting the needs of the women for whom the service is intended. It also endorses the importance of continuity of carer. Chapter 1 of the report starts by laying out important components of a woman centred service, which include the following:

Components of a woman centred service

- Every woman has unique needs. In addition to those arising from her medical history these will derive from her particular ethnic, cultural, social and family background. The services provided should recognise the special characteristics of the population they are designed to serve. They should also be attractive and accessible to all women, particularly those who may be least inclined to use them.

- Information about the local maternity services should be readily available within the community. The woman should be able to choose whether her first contact is with a midwife or her general practitioner, and should feel confident that she will receive accurate and unbiased information from the professional that she chooses.
• The woman and, if she wishes, her partner, should be encouraged to be closely involved in the planning of her care. It should be clear to her that her views and wishes, including her desire for a safe outcome, are important and respected. Antenatal care should be designed to ensure that professionals who are acceptable to her, and who have the appropriate skills and expertise required care for the woman in her circumstances. She should not feel that she has to choose from one profession and exclude all others. Women should be encouraged to use the service fully and to their advantage.

• The woman should feel secure in the knowledge that she can make her choice after full discussion of all the issues with the professionals involved in her care. She should feel confident that these professionals would respect her right to choose her care on that basis, and ensure that the services provided are of the best quality possible (Department of Health 1993b) pages 5-6.

The above components of good maternity care as set out by the Department of Health highlight the importance that must be placed in individualised care for each woman. The components also stress the importance of giving women information to afford them informed choices about their care.

The Expert Maternity Group is concerned that women are not given adequate information about the childbirth options available to them, which may result in them going for the only option which is promoted. Their main concern therefore could be seen to be 'how can women choose if they don't know what to choose from?' The government wants the woman to be the one to choose what she thinks is appropriate for her and her unborn baby.

The committee feels that the lack of agreement about whether a mother with an uncomplicated pregnancy is putting herself and her child at any greater risk by not having her baby in a hospital maternity unit suggests that there is no clear answer (Department of Health 1993b). The committee expresses the view that the professional cannot quantify the enriching experience felt by those who
have their babies where they choose, and therefore the professional's job should be to provide the woman with as much accurate and objective information as possible, while avoiding personal bias and preference.

Although the Cumberlege committee addressed the issue of the safest place to give birth, and referred to the reasons for and against hospital delivery, the committee has been criticised for failing to take a decisive stand and offer women their explicit support (Tew 1998).

As Chamberlain, Wraight, and Crowley (1997) have observed, the history of the place of birth has been driven by opinion rather than being led by evidence. Home birth used to be the only alternative; then other choices emerged often supported by pressure groups of doctors who used the argument of safety. Each side involved in the debate considers the other as obdurate and claim to represent what is best for the women.

Summary

National Health Service (NHS) policy with regard to the place of birth was considered important because successive committee recommendations resulted in a situation where home birth was nearly phased out. However, the recent policy aims to have a woman centred maternity service. The question for this thesis is whether the view given by successive committees, which painted home birth as unsafe and promoted the hospital as the safest place, could be seen to influence the situation today. The question of the safety of home versus hospital birth has been studied (Campbell and Macfarlane 1994; Tew 1977), and will therefore not be the focus in this study. The main theoretical underpinning for the thesis is that of risk perception, which will be discussed in the next chapter.
Chapter 2: Risk perception

Chapter overview

The previous chapter discussed successive government reports that led to the move from home to hospital deliveries for all women (Department of Health and Social Security 1970; House of Commons Social Services Committee 1980; Ministry of Health 1959). It then went on to illustrate how the department of health has revised its view on maternity care and is now recommending a woman centred maternity service (Department of Health 1993b; House of Commons Health Committee 1992). With the revised position, the emphasis is on information giving and choice during childbirth.

Chapter 2 discusses risk perception in general, and then tries to apply the principles to childbirth, which might explain the differences in women’s perceptions of the childbirth process and how they might lead to differences in choice of place of birth. The chapter starts by recalling the NHS policy on maternity care changes over the years, and how this might be a factor in the situation of place of birth today. A brief definition of the concepts of risk and perception, and how the concept of risk perception developed follows. Some approaches to the study of risk, such as behavioural decision theory, prospect theory, and the precaution adoption process, are also discussed. The chapter closes with a discussion of some risk perception studies, and assesses their relevance to childbirth.

Introduction and definitions

The National Health Service view on maternity care in general, and place of birth in particular, from the end of the 1950’s until 1970 considered the hospital
as a safe place for women to give birth, as it reduced the mortality and morbidity for both mother and baby, while the woman's home represented risk. This view is reflected in successive government committees that gradually recommended moving childbirth away from the woman's place to the hospital (Department of Health and Social Security 1970; House of Commons Social Services Committee 1980; Ministry of Health 1959).

The thesis proposes that the view introduced by successive government committees that the woman's place was unsafe might still influence how women view childbirth today. The thesis postulates that the difference between women who plan to have their babies at home and those planning a hospital delivery might be a result of how they perceive childbirth, and the risk they attach to delivering at home and vice versa. The concept of risk perception is explored, and an attempt made to identify any similarities with childbirth.

Risk is a term derived from the French word *risqué*, and was first used in England in the early nineteenth century (Moore 1983). According to the Concise Oxford dictionary, it means "a chance or possibility of danger, loss, injury, or other adverse consequences" (Thompson 1995). The term in the thesis is used to refer to the possibility of adverse consequences.

The word *perception* implies a potential gap between objective information about the world, and the representation of that world which each individual constructs for himself from direct sensory input, externally supplied information, and from their own inference processes and selective attention (Thomas and Otway 1980). Risk perception is therefore subjective, relating to the individual's evaluation of potential hazards and how they are likely to be affected.
From the health practitioner's perspective, risk assessment is the identification of causes of particular conditions/illnesses and the ability to make accurate predictions about the chances of people being affected (British Medical Association 1987; Douglas 1986; Hayes 1992; Lee 1981). Such risk assessment knowledge is also used to educate people and attempt to change their behaviour. For example, information about the relationship between smoking in pregnancy and risk of small-for-dates babies may be used to encourage pregnant women not to smoke. The expectation is that people's awareness of the dangers of their behaviour may help make them change or reduce their exposure to the risk. However, it has been observed that in real life people do not always react in such a rational manner to information about exposure to risk (Bagnall and Plant 1987; De Haes 1987; Regis 1988). Some authors argue that health education programs such as that of drugs and alcohol are actually counter productive (Bandy and President 1983; Kalb 1975; Kinder, Pape, and Walfish 1980; Schaps, Dibartolo, Moskowitz et al 1981).

According to the cultural theory, people select certain risks to take, and others to avoid, depending on their social or cultural circumstances (Douglas and Wildavsky 1982; Johnson and Covello 1987). Palmer (1996) argues that cultural theory provides a functional explanation for risk perception, and suggests that people fear what they do because it justifies and maintains their way of living. Ordinary people's perceptions of risk are often dismissed as failing to grasp the implications contained in the experts' objective information on the probability of given risks (Denscombe 1993), or as inadequate, muddled or mistaken (Offer 1989). Denscombe (1993) considers the dismissal of people's perceptions of risk as a dangerous trap to fall into. It has been suggested that to communicate successfully and be in a position to assist those in their care, health care workers
need to understand the basis of the beliefs of their patients (Sjöberg 1980). It is therefore important to understand what each individual perceives to be safe or risky. The point is that not only do lay people differ in their perception of risk compared to experts, but people exposed to the same extent of risk from a particular danger may well differ in terms of their reaction to that risk (Douglas and Wildavsky 1982; Johnson and Covello 1987). For some, the risk may be unpalatable and unacceptable, as they consider it to have a great probability of harm on them whilst for others it may be tolerable and worthwhile, because they may consider the risk to be quite small (Palmer 1996).

Much of the original work on perception of risk comes from psychology (Kahneman and Tversky 1984; Tversky and Kahneman 1974), economics and business (Schwing and Albers, Jr. 1980). In the health field, the concept is new (Kronenfeld and Glik 1991) and has been used in environmental hazards (Crawford 1987; Johnson and Covello 1987), safety (Slovic 1978; Slovic, Lichtenstein, and Fischhoff 1984), and AIDS (Abraham, Sheeran, Spears et al 1992; Dawson and Cynamon 1988; Richard and van der Plight 1991; Richard, van der Plight, and de Vries 1995). Most studies in risk perception have concentrated on the cognitive processes people employ in making decisions. As a result, there are several approaches to the study of decision-making process, such as, the behavioural decision theory, prospect theory, and the precaution adoption process.

Behavioural Decision Theory may be either normative or descriptive (Slovic, Fischhoff, and Lichtenstein 1977). The normative aspect prescribes courses of action believed to conform most closely to a rational decision-maker's point of view. The descriptive aspect, on the other hand, describes the values, beliefs, and the way in which they are incorporated in decision-making. Prospect theory, also known as judgement under uncertainty (Kahneman and Tversky
Prospect theory, posited by Kahneman and Tversky (1979), is a second approach to understanding decision-making. It posits that biases, rather than rational judgements, characterise decision-making. It has been used to demonstrate that people show systematic biases when making decisions by overestimating the probability of rare, serious events, and underestimating the probability of common, less serious events (Kahneman and Tversky 1979). According to prospect theory, most people perceive their chances of avoiding risk as being high (Weinstein 1982), and therefore are reluctant to take precautions, such as wearing seat belts. They also under weigh probable outcomes, in contrast to those that are certain (Slovic, Fischhoff, and Lichtenstein 1978).

The third approach to the study of decision-making is the precaution adoption process (Weinstein 1980; Weinstein 1988), which is divided into stages. In the first stage, people must recognise that a hazard exists; a failure to protect oneself is a reflection of ignorance of the threat rather than an underestimation of the threat. Next, additional hazard messages and hazard experience must convince them that the risk is significant, and that any precautions would be effective. In the third stage, the belief that the precautions would be personally effective is emphasised (Weinstein 1988). The second and third stages are often characterised by denials that one is personally at risk, and this happens especially in rarely encountered occurrences (Crawford 1987). After the necessary requirements, perceived risk is a function of the individual’s perceived severity of the consequences for one’s health and the efficacy and cost of preventive behaviour (van der Plight 1998).

The precaution adoption process attempts to merge a number of theoretical approaches within health education. The approaches are the health belief model (HBM), theory of reasoned action (TRA), and social learning theory (SLT).
HBM emphasises the value placed by an individual on a particular goal and the individual's estimate that the likelihood of a given action will achieve that goal (Becker, Heafner, Kasl et al. 1977; Janz and Becker 1984; Kronenfeld and Glik 1991; Maiman and Becker 1974; Rosenstock 1974). The HBM is widely used to explain preventive health behaviour by describing conscious decisions about the cost and benefits of specific actions, and attempts to distinguish factors assumed to influence the adoption of protective action (Janz and Becker 1984; Maiman and Becker 1974). Examples include beliefs and self-protection from HIV infection (Abraham, Sheeran, Spears et al. 1992), precautionary health behaviour as applied to issues such as polio vaccination, preventive dental care, hypertension-control and medical check-ups (van der Plight 1998). Precautionary behaviour is thought more likely if perceived severity of consequences and vulnerability are high. Kronfeld and Glik (1991) argue that the health belief model contains an explicit conceptualisation of risk beliefs, and that in a narrow perspective belief about susceptibility to a health danger is a risk perception. It has been argued that most studies of HBM are retrospective rather than prospective (van der Plight 1998), and that in retrospective studies it is often impossible to determine whether beliefs shape behaviour or whether people adapt their beliefs to be consistent with their behaviour (Calnan and Moss 1984).

A second theoretical approach incorporated within the precaution adoption process is the theory of reasoned action (TRA) (Ajzen and Fishbein 1980; Fishbein and Ajzen 1975). The TRA is based on an assumption of rationality of choice and systematic use of available information. According to the TRA, a person's intention to perform an act is the immediate determinant of the action. Behavioural intentions are seen as a function of two factors. The first factor is the individual's subjective attitude towards the behaviour, and the second is the social
normative factor. The individual's attitude towards the behaviour is a function of the belief that the behaviour will lead to a certain outcome, along with the importance placed upon that outcome by the individual. The social normative factor emphasises the influence of the social environment, and the person's immediate reference group upon behaviour (Kronenfeld and Glik 1991). Risk perception as a construct could be seen as part of the attitudes toward performing a health related behaviour in TRA (Kronenfeld and Glik 1991). Risk perception together with the normative beliefs predicts the intention to behave. The theory of reasoned action approach, therefore, attempts to explain behaviour, unlike the health belief model that contains explicit risk belief components (Kirscht 1989).

Social learning theory (SLT), also known as social cognitive theory (Bandura 1977) is the third component in the precaution adoption process. The SLT argues that expectancies and incentives determine behaviour. Three types of expectancies are isolated: those related to environmental cues; those about the consequences of one's own action; and those about one's competence to perform the behaviour needed to influence the outcomes (self-efficacy). Incentives, on the other hand help to regulate behaviour, but only if the consequences are interpreted and understood by the individual. In the health field, social learning theory emphasises the incentives to act in a given situation, and the balance of immediate incentives against the balance of more distant ones (Kirscht 1989). For example, the balance of the immediate gratification of smoking could be balanced against the distant gratification of longer life if one stops smoking.

The precaution adoption process (Weinstein 1980; Weinstein 1982; Weinstein 1988) combines the above approaches in an attempt to understand why people adopt or fail to adopt precautions. Weinstein (1980) argues that people demonstrate unrealistic optimism, whereby they believe that negative events are
less likely to happen to them than to others, while positive things are more likely
to happen to them than to others. Weinstein maintains that the greater the
perceived probability of the event and the more personal experience the individual
has with an event, the greater the tendency to believe that the person's own
chances are greater than average.

The theories discussed so far reveal a complex relationship between
perceptions of risk and actions taken to reduce them. Kronenfeld (1991) argues
that if risks are perceived, and actions are taken to reduce them, the relationship
between risk perception and risk reduction action should show an inverse
relationship. The next section will discuss some studies using the risk perception
construct, and how the results could give insights about risk perception in
childbirth.

Risk perception in applied research

When talking about the social and cultural construction of risk, Johnson
and Covello (1987) have said that decisions must be made about which risks are
important to an individual, and which risks they feel they can safely ignore. The
challenge is that there is often no consensus as risks considered by some
individuals to be tolerable and acceptable may be unacceptable to others. The
thesis proposes that the same is true in childbirth, what some women consider
risky, others may not regard as such. The process of childbirth has some inherent
risks and uncertainty. One never knows how the process is going to proceed until
it has ended. Choosing a place of birth may suggest that the individual concerned
has appraised information about risk and safety, and come to a conclusion about
what possible risks there are, and how best to deal with them. The individuals
therefore are thought to define risk, selectively choose what they consider risky,
and then choose the place they consider best placed to deal with their circumstances of labour and delivery. The process differs for different people as risk is not an objective reality but a social process (Douglas and Wildavsky 1982).

It has been argued that people use rules of thumb or heuristics by which they arrive at their assessments of risk (Kahneman, Slovic, and Tversky 1982). The heuristics involve simplifications of information by comparison of new risk information with other more familiar risks to assess the severity of the risk. The significance of the heuristics is that they involve consistent biases away from what is known to be objective facts about the extent of the specific risk. The result of this is that for different individuals, certain kinds of risk appear to be more likely to happen than they actually occur. They see other kinds of risk as less probable than would otherwise be predicted by the experts.

An example from the Lele tribe of Zaire (Douglas and Wildavsky 1982) illustrates how different social principles that guide behaviour may affect the judgement of what dangers should be feared most. The tribe is said to be susceptible to many diseases and illnesses, such as, gastro-enteritis, tuberculosis, leprosy, ulcers, barrenness, and pneumonia. However, it focuses on only three risks: being struck by lightning, barrenness, and bronchitis. When these events occur they attribute them to some moral transgression or defect rather than to a physical cause. Douglas and Wildavsky assert that whatever cause is blamed, society generates the type of accountability and focuses on particular dangers. They go on to suggest that people's concerns and fears about different types of risks could be seen more as ways of maintaining social solidarity than as reflecting health or environmental concerns. They suggest that such concerns must not be taken at face value, but there should be an analysis to determine what social norms, policies, or institutions are being attacked or defended. They assert
that each form of social life has its own typical risk portfolio. Common values lead to common fears and, by implication, to a common agreement not to fear other things.

In the United States and other industrialised societies, the issue of increasing concern with cancer risk from industrial pollution is seen as being partly the result of the rise in prominence of environmental groups. Such groups function as contemporary sects with a secular rather than a religious orientation (Cohen 1982). They use the risks as a means for holding the groups together, and for attacking the establishment groups that they oppose. Using the example of the proposed study, since hospital birth is now the norm, those who choose to deliver at home might be seen to be attacking modern obstetrics, and using the iatrogenic risks of the hospital as a means of group solidarity. For example, in one study, obstetricians referred to women who chose to have their babies outside the hospital as feminist-oriented or anti-establishment (Cohen 1982).

Another factor thought to play a role in risk perception is the way information is presented. For example, in a case study about a community whose water supply was contaminated by a carcinogen, trichloroethylene (TCE) (Fitchen, Heath, and Fessenden-Raden 1987), the local health officials made a broadcast through the local radio and printed a warning in the local newspapers that water should be boiled before drinking or cooking with it. The local officials' statement was that they were acting in a precautionary manner to protect the people, and hoped that the problem would soon be resolved and the nuisance of boiling water ended. Residents never actively sought information about the health risks, and never demonstrated any anger, accusation, or serious worry. At public meetings, questions and comments by the public indicated that the community's interest was not on the health risk itself, but the publicity surrounding it. For
example, they worried that the value of their properties might fall because of the publicity surrounding the contaminant.

The above case study shows an example of a high level of trust by the public for their officials, which resulted in the distortion of the perception of the risk they faced. However, in some cases the response may be quite different from the above. For example, in another case study, residents of a neighbourhood adjacent to the Love Canal chemical landfill in Niagara Falls, New York, were notified by their state health officials of the grave and imminent peril posed by exposure to its leaching contents (Fowlkes and Miller 1987). From the outset, the homeowners of the Love Canal were divided into two major and opposing factions of perception and response to the situation facing them. One third of the homeowners randomly sampled were of the opinion that chemical contamination from the landfill was probably limited in scope with little, if any, serious consequences for health. The other group felt that the chemical spill extended throughout and beyond the entire area that was eventually declared eligible for relocation. They also thought that serious health risks in all likelihood parallel the migration of the chemicals (Fowlkes and Miller 1987). The first group did not want to move because they had invested in the area and the other group had young children and were worried about the children’s health.

The two groups' perceptions of the same potential risk were vastly different owing to their different interests, and therefore different definitions of risk. They must be understood as equally and simultaneously subjective and rational in the context of the respective considerations and concerns that gave rise to each perspective (Fowlkes and Miller 1987). As Douglas and Wildavsky (1987) have observed, when choosing between risks, subjective values take
priority and it is a travesty of rational thought to pretend that value-free decisions are taken.

Risk perception in childbirth may similarly be influenced by the way information is presented by caregivers as well as by the interests and cultures of those concerned. For example, women looked after by obstetric consultants may tend to view childbirth as pathological and may be more likely to accept that they need interventions during labour. Those cared for by midwives, on the other hand, may tend to see childbirth as a natural process (Howell-White 1997). Additionally, it is also proposed that women are unlikely to consider the risk or safety of an option that is not explicitly made available to them.

In social psychology research, attention has been drawn to a number of key aspects of what was referred to as heuristics (Denscombe 1993; Slovic, Fischhoff, and Lichtenstein 1980; Thaler 1983), which reveal that perceptions of the extent of risk are crucially affected by a number of factors. The factors include fear of the severity of the damage that could result from the incident if it were to happen, called the *dread factor*. The dread factor strongly influences how people perceive the level of risk posed by a specific threat. For example, lay people regard potential global catastrophes such as nuclear accidents as more of a risk than do experts (Slovic, Fischhoff, and Lichtenstein 1980). This study hypothesises that in the same way, in childbirth, emergency caesarean section for conditions such as foetal distress might strongly influence people with regard to where they should have their baby. This might be especially true for women who have experienced the complication before, or know someone who experienced it.

The *vividness of the risk* also affects lay people's perceptions of level of risk, for instance, people are more likely to regard themselves as at risk where
they can easily imagine or recall a potential danger (Denscombe 1993). In childbirth, if a woman can recall a previous incident where she or someone close to her experienced problems requiring urgent medical attention, she might imagine the same risk when deciding about the place best suited to have a baby. This is referred to as *personal experience* of the potential danger, and makes the risk more foreboding (Denscombe 1993). The vividness of the potential risk may also be brought about by *exposure to information* about the particular risk (Thaler 1983) and how that information is presented (Combs and Slovic 1979; Fitchen, Heath, and Fessenden-Raden 1987).

Perceptions of risk are sometimes affected by a *sense of invulnerability*, where people have the attitude that it would not happen to them. As Douglas (1986: 29) has observed, "the best established results of risk research show that *individuals have a strong but unjustified sense of subjective immunity". In the precaution adoption process discussed earlier, the sense of invulnerability is called unrealistic optimism (Weinstein 1980). Slovic and colleagues (1978) have observed that when assessing a risk such as the chances of being involved in a car accident, people focus on the times they have driven cars safely as assurances that accidents will not happen to them. In this way, they reduce the level of perceived risk connected with a given event. If the situation is applied to childbirth, when deciding about where to have a baby, a woman might acknowledge potential problems that may require urgent medical attention at home. However, she might decide that since she has not had any problems before, it will therefore not happen this time. For example, it is thought that a woman who has previously had a successful hospital or home birth might be led by her experience to think that she will never experience any complications in childbirth, and therefore decide to have a home birth.
The thesis considers childbirth risk to have two dimensions. The first concerns the uncertainty of the process itself as problems could develop at any time. For example, a woman who did not have any problems at all during the first stage of labour may suddenly develop postpartum haemorrhage and collapse in shock during the third stage. It is possible that women who plan a hospital birth will be concerned about the uncertainty of the process. The other dimension could be risk due to technology, and modern medicine. For example, a woman who labours in hospital might be given an epidural for pain relief, which might then be followed by a caesarean section because she was not able to push when required to give birth. If the same woman had laboured at home, she may possibly have avoided the operation. Women who plan to have their children at home might be more concerned about the iatrogenic risks of the hospital. An important factor in the differences could be the perception of benefits (Starr 1969). If people perceive the benefits of their decision as great, their tolerance of risk is higher (Kahneman, Slovic, and Tversky 1982). It has been argued that factors such as personal relationships, control over events, and the importance of general happiness may also influence how one perceives risk (Crawford 1987). For example, a woman who desires to have a family experience of childbirth, where she is also in control, might worry less about the risk of childbirth.

Individual women's childbirth risk perceptions can only be understood in the light of their social, cultural, and religious norms, as well as their individual beliefs. Douglas and Wildavsky (1987) argue that there is no single correct conception of risk, and that there is no way to get everyone else to accept it. They take the view that people must decide which risks to fear most, which risks are worthy of attention and concern, which are worth taking, and which can be ignored. They also point out that the risks that are finally selected for attention
are not necessarily chosen because the scientific evidence is solid. On the contrary, the selected risks may have little relation to real danger, and be the least likely to affect people.

In the area of public health, the importance of cultural factors (Crawford 1987), and the role of communication (Nelkin 1989), and publicity (Kirscht 1989) have been emphasised in risk perception. Media presentations are thought capable of creating an image of risk about an event where none existed, often shaped by interest groups that have a stake in heightening perceptions of risk about certain issues (Kirscht 1989; Nelkin 1989). Chapter 1 of this thesis showed how successive government reports (Department of Health and Social Security 1970; House of Commons Social Services Committee 1980) created an image of risk about home births, by declaring it unsafe, and recommending more hospital deliveries. This resulted in women and women's groups fighting for more beds to be available in hospital for delivery.

Summary

The chapter reviewed a number of theories, which gave different views about risk perception and its role in decision-making. The aim of the thesis is to identify what theories could be employed to explain women's decision-making about where to have their babies. The thesis proposes that the following hypotheses derived from risk perception theories may apply in relation to childbirth:

The cultural theory suggests that people select what risks to take or avoid depending on their social and individual circumstances (Douglas and Wildavsky 1982; Johnson and Covello 1987). Each individual's decision-making could therefore only be understood against the backdrop of their characteristics, which
may influence their perceptions. Another factor identified by the cultural theory to influence decision-making is the way information is presented, which may influence how people react to it, and therefore how they make decisions (Douglas and Wildavsky 1987; Fowlkes and Miller 1987; Nelkin 1989). If the view of the cultural theory were applicable in childbirth, then women planning birth in different venues would make their childbirth choices according to reasons that are specific to their individual circumstances. For example, one woman might choose to go for a hospital birth because she does not want her other children to witness the birth, while on the other hand another might want a home birth because she wants her other children to witness the process. In the same way, while one woman might choose to have her children in hospital because of the proximity of doctors and emergency equipment, another might choose a home birth precisely to be away from doctors and equipment because she fears that she might be unnecessarily interfered with.

Secondly, as regards information giving and presentation, a woman who is given a choice of two hospitals is likely to choose one of the two rather than something else that was not offered to her, for example, she is unlikely to choose a home birth unless she has knowledge that it is open to her. Additionally, a woman who is told only about what is likely to go wrong with a birth and therefore what a good idea it is to be near a hospital might trust the judgement of the professionals and go along rather than consider what other alternatives are available. Conversely, a woman who is told about the good things about a home birth and nothing about the hospital is likely to go along with a home birth.

Prospect theory (Kahneman and Tversky 1979) posits that biases rather than rational judgements characterise decision-making. This implies that people might be easily influenced by events that are either favourable or unfavourable to
make decisions that are not necessarily objective. Decision-making in this case might be affected by a number of factors commonly referred to as heuristics (Denscombe 1993; Slovic, Fischhoff, and Lichtenstein 1980), such as, the dread factor, the vividness of the risk, and a sense of invulnerability.

The dread factor may manifest where a woman imagines having complications that require medical interventions during childbirth. For example, she might imagine giving birth to a severely asphyxiated baby, or suddenly collapsing during the second stage of labour and needing to go for an emergency caesarean section. If a woman has such a picture of childbirth, she is unlikely to want to be too far away from emergency equipment. The vividness of the risk is similar to the dread factor, because it is thinking in reference to a major complication, but in this case the individual can actually recall an incident where she or someone she knows had experienced a complication. For example, in childbirth, a woman may have previously had to go for an emergency caesarean section because the baby was severely distressed, or she might know someone who had experienced some kind of complication that required urgent medical intervention. Such experience would make the fear of the risk more ominous for the individual, and she might not want to take any risks by choosing a home birth.

The other side of the coin in the use of heuristics in decision-making is when the individual feels a sense of invulnerability, where although she may acknowledge that problems could occur, she somehow thinks it would not happen to her (Douglas 1986). The sense of invulnerability in childbirth could result because the individual concerned has previous experience of a birth, either at home or in hospital that went extremely well, and she takes that as some assurance that she will not experience any problems in childbirth, and therefore it is okay to have a baby at home.
The theory of reasoned action suggests that when making decisions, people show rationality of choice and systematic use of available information (Ajzen and Fishbein 1980; Fishbein and Ajzen 1975). The theory proposes that an individual’s attitude towards a behaviour (decision) is related to their belief that the behaviour will lead to a certain outcome, and the importance they place on the outcome (Kronenfeld and Glik 1991). The social environment and the person’s immediate reference group are thought to influence what choices the individual makes. The theory of reasoned action could apply in childbirth where women have access to information about what is available to them and they consciously make their decisions based on what outcomes they aspire to and what they know about the available options. For example, if women are told that they could have a home birth or a hospital birth, and what facilities are available with the two options, they could then match their needs with the options. For instance, they could be told that at home, they could have their families with them, but they could not have epidural analgesia or electronic foetal monitoring. On the other hand, they could be told that in the hospital, they have all the pain medications and emergency equipment, but they might experience shortage of staff if it is too busy, and there is a limit to how many family members could stay with them in the ward.

In an effort to explain women’s decision-making about the place of birth, the thesis reports two studies. The first is a systematic literature review of women’s views of factors affecting their choice of place of delivery, and the second is a primary qualitative study using in-depth interviews involving women planning a hospital birth, and those planning a home birth to determine from them factors that influence their choice. The report starts with the first study, which is reported in the next chapter.
Chapter 3: Systematic review of factors affecting the choice of place of delivery

Introduction

The previous two chapters discussed, in order of succession, first the NHS policy on maternity care, which, through recommendations of successive government health committees, encouraged the move from home to hospital deliveries (Department of Health and Social Security 1970; House of Commons Social Services Committee 1980; Ministry of Health 1959). The view that the woman’s place was unsafe gradually changed, and the latest policy is to empower women to make choices about their care by giving them information about all options available to them (Department of Health 1993b; House of Commons Health Committee 1992).

The second chapter discussed the concept of risk perception (Denscombe 1993; Douglas and Wildavsky 1982; Johnson and Covello 1987), and considered how it could be applicable in childbirth. The thesis investigated government policy on the one hand, and risk perception on the other, as possible influencing factors in women’s choice of the place of delivery by conducting two studies.

The present chapter discusses the first study of the thesis, a systematic review of the literature to identify factors affecting the choice of place of delivery. First, a general discussion of the rationale for systematic reviews, and comparison with the traditional literature review, also known as a narrative review, is presented. The objectives of the present review, methods employed in its conduct, and the results are then described. The chapter ends with a discussion of
the state of research on the topic of women's views regarding decision-making about the place of birth, and some recommendations.

Rationale for undertaking a systematic review

Systematic reviews of the literature are a scientific method used to summarise, evaluate, and communicate results and implications of studies in a particular subject. In the health field, systematic reviews are commonly employed to verify effectiveness, such as when there is uncertainty regarding potential benefits or harm of an intervention, when there are variations in practice, when a decision concerning the provision of a health technology is being proposed or when research is being planned or practised (NHS Centre for Reviews and Dissemination 1996). Systematic reviews are favoured in preference to traditional literature reviews, also called narrative reviews, because systematic reviews are a rigorous method of reviewing research evidence relating to questions of direct relevance to a chosen topic to promote the implementation of evidence-based practice. Systematic reviews summarise large bodies of evidence in a rigorous way, and help to explain differences between studies on the same question.

The review process itself is a form of research, with a pre-planned method and an assemblage of original studies, which serve as subjects for the study. The compound of primary studies that address the relevant question are combined by using scientific strategies that limit bias in their collection, critical appraisal and synthesis (Cook, Mulrow, and Haynes 1997). The strategies involve a comprehensive search of all potentially relevant articles, and the use of explicit, reproducible criteria in the selection of articles for review by giving the principles for inclusion and exclusion. Both published and unpublished studies are
considered. Primary research designs and study characteristics are evaluated, data are blended and results interpreted.

There are two types of systematic reviews, qualitative and quantitative (meta-analysis). In a qualitative systematic review, results of primary studies are summarised but not statistically combined, whereas a meta-analysis uses statistical methods to combine results of two or more studies. Systematic review results are used to develop evidence-based practice guidelines, which are appropriately tailored to local circumstances (Cook, Greengold, Ellrodt et al 1997). On the other hand, traditional literature reviews usually address a broad range of issues related to a given topic as opposed to dealing with a particular topic in-depth (Mulrow 1987). For example, a review about control of labour pain in a textbook (Mander 1997) would cover a number of aspects of pain control, such as, pharmacological and non-pharmacological methods. The traditional literature review therefore is useful for providing a broad perspective on a topic.

**Differences between systematic and narrative reviews**

Literature reviews, whether systematic or traditional, are retrospective observational research studies, and for that reason are liable to systematic and random error (Cook, Greengold, Ellrodt et al 1997). The quality and worth of the review is dependent upon the extent to which scientific review methods are employed to reduce error and bias. This is the main differentiating feature between traditional literature reviews and systematic reviews. The following table, adapted from Cook, Mulrow and Haynes (1997), presents a comparison of features of a traditional and a systematic review.
Table 1: Difference between Traditional and Systematic Reviews

<table>
<thead>
<tr>
<th>Feature</th>
<th>Traditional Review</th>
<th>Systematic Review</th>
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<tbody>
<tr>
<td>Question</td>
<td>Often broad in scope</td>
<td>Often a focused clinical question</td>
</tr>
<tr>
<td>Sources and search</td>
<td>Not usually specified, potentially biased</td>
<td>Comprehensive sources and explicit search strategy</td>
</tr>
<tr>
<td>Selection</td>
<td>Not usually specified, potentially biased</td>
<td>Criterion-based selection, uniformly applied</td>
</tr>
<tr>
<td>Appraisal</td>
<td>Variable</td>
<td>Rigorous critical appraisal</td>
</tr>
<tr>
<td>Synthesis</td>
<td>Often a qualitative summary</td>
<td>Often a quantitative summary, but can be qualitative</td>
</tr>
<tr>
<td>Inferences</td>
<td>Sometimes evidence-based</td>
<td>Usually evidence-based</td>
</tr>
</tbody>
</table>

Systematic reviews answer specific, frequently narrow clinical questions vigorously. For example, they can address various topics such as the following:

- Specific population and/or setting (Chamberlain, Melia, Moss et al 1997; Davies 1997; McQuay and Moore 1998; McQuay, Moore, Eccleston et al 1997; Richards, Deeks, Sheldon et al 1997; Seymour, Thomason, Chalmers et al 1997; Snowdown and Stewart-Brown 1997).

- Condition of interest (Ebrahim 1998; Johnson, Simnett, Sweetenham et al 1998)

- Exposure to a test or treatment (Crow, Gage, Hampson et al 1999; Faulkner, Kennedy, Baxter et al 1998; Murray, Cuckle, Taylor et al 1997; Petiticrew, Watt, and Sheldon 1997; Selley, Donovan, Faulkner et al 1997; Song and Glenny 1998)

If the question of the review is not clear, and there is no method section included, the review in question is likely to be a traditional rather than a systematic review (Bangert-Drowns 1995).

**Critique of Systematic reviews**

Systematic reviews help to summarise the otherwise overwhelming volume of literature on a subject and provide a précis that can be used for quick reference. Well-conducted reviews have the potential to delineate what is known and what is not known and therefore can be used to keep practitioners up to date. The method can be used to critically examine primary studies, and thus expose inconsistencies among diverse pieces of research. Reviews of several studies give a better evaluation of whether findings can be applied to specific subgroups of patients. In the absence of systematic reviews, researchers may miss promising leads or, in their quest to undertake research, may duplicate work already undertaken. Results of systematic reviews may also help practitioners generate clinical policies that optimise outcomes using available resources.

However, while systematic reviews can aid, they can never replace clinical reasoning. Clinical decisions are made about individual patients on the basis of analogy, experience, heuristics, and theory as well as research evidence (Cook, Mulrow, and Haynes 1997; McDonald 1996; Naylor 1995; Tanenbaum 1993). As Cook, Greengold et al (1997) have observed, although systematic reviews can lay the foundation for practice guidelines, they are not a panacea. The most fundamental limitation is that systematic reviews do not obviate the need for at least some critical appraisal of the original studies to understand the circumstances of the individual study results. Knowledge of the effectiveness of a treatment, as can be gained from results of such review, does not confer awareness
about how to use that treatment in caring for individual patients. On the other hand, evidence without critical appraisal and application can lead to bad practice (Naylor 1995). A conscientious practitioner is one who tries to understand the complexities of medical or midwifery decision-making and appreciates the way in which knowledge skills, values, and research evidence are integrated in each patient-clinician encounter. The key is to use the available knowledge and research evidence to provide individualised care.

Furthermore, systematic reviews, and therefore, the practice guidelines based on them may require modification as new evidence continually emerges. Multiple reviews may challenge guideline developers if they generate conflicting conclusions (Cook, Greengold, Ellrodt et al 1997), which would call for careful critical appraisal of each review (Oxman, Cook, and Guyatt 1994), by considering the focus of the individual review compared to the specific purpose of the guideline to be developed. Particular emphasis should also be paid to issues of clinical and statistical heterogeneity of the reviews (Jadad, Cook, and Browman 1997).

The present review was undertaken because although the topic of place of birth is often written about as discussed in the introductory chapter, women's views have not been made clear. It was therefore felt necessary to determine how much research has dealt with women's views, and to determine whether there were any gaps in knowledge about their views.

Methods

Before commencing the review, a check was made to determine whether a similar up-to-date review already existed, or had been commissioned or was in the process of being prepared. The verification was made in April 1999 in the
Cochrane Database of Systematic reviews (The Cochrane collaboration 1995), the Database of Abstracts or Reviews of Effectiveness (DARE) (NHS Centre for Reviews and Dissemination 1995) and the National Health Service National Research Register (NRR), (NHS Executive 1995). The databases were checked because they publish existing and commissioned research in the area. No such review was identified.

The literature search was performed in the Bath Information and Data Services (BIDS) database, using the Institute of Scientific Information (ISI) Science, ISI Social Science, EMBASE (Excerpta Medica Online) and MEDLINE (Index Medicus Online) databases. The MIDIRS midwifery database, PsychLit, and a new database, the ISI Web of Science were also searched. The Web of Science consists of three large, multidisciplinary databases of Science Citation Index, Social Sciences Citation Index, and Arts and Humanities Citation Index that may be searched individually or in any combination. All three were searched in combination. The Cochrane database, which is popular for systematic reviews of health care research was also searched, but only had a meta-analysis of the safety of home versus hospital birth, which was not relevant to the present review. The idea was to amplify the search as much as possible to avoid missing studies. The search was done for articles from the last twenty years, from 1980 or date first available until July 2000. Reference lists of all the relevant papers were also examined to identify any studies not reached via the electronic search. An Internet search was done via homebirth homepages to identify any unpublished studies.
The search strategy

The aim of the search is to provide as comprehensive a list as possible of both published and unpublished studies on the question of choice of place of delivery. The search strategy must be as unbiased as possible, to minimise the possibility of weakening the conclusions of the review through publication bias (Easterbrook, Berlin, Gopalan et al. 1991). There are some online databases such as Medline, EMBASE and the others, mentioned above, that are useful for locating medical literature. However, they do not record all publications from all journals (Dickersin, Scherer, and Lefebvre 1994), and, therefore, it is important to use several databases to maximise coverage of the search. It was decided in this review that to avoid missing potential papers, the search should begin by being very wide, and would include all studies about the place of delivery. It would then be trimmed down to include only those studies dealing specifically with women’s views of factors affecting choice of venue. The search strategy was divided into three stages.

First stage

The first stage was an introductory tour of the area to discover the different studies about the place of birth, the volume of literature available in the topic of interest, and the study designs employed. During the first stage, the main issues and controversies about the topic of place of birth were discovered that served as a guide to the specific questions to be addressed, and the outcomes to be measured.

The following table shows the search terms employed during the first stage:
Table 2: Search terms used

<table>
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<tr>
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<tbody>
<tr>
<td>Childbirth*</td>
<td>19,075</td>
<td>2349</td>
<td>592</td>
<td>22,016</td>
</tr>
<tr>
<td>Home childbirth*</td>
<td>722</td>
<td>2</td>
<td>0</td>
<td>724</td>
</tr>
<tr>
<td>Home birth*</td>
<td>183</td>
<td>180</td>
<td>24</td>
<td>387</td>
</tr>
<tr>
<td>Homebirth*</td>
<td>50</td>
<td>33</td>
<td>7</td>
<td>90</td>
</tr>
<tr>
<td>Hospital birth*</td>
<td>285</td>
<td>137</td>
<td>45</td>
<td>467</td>
</tr>
<tr>
<td>Place of birth*</td>
<td>348</td>
<td>0</td>
<td>310</td>
<td>658</td>
</tr>
<tr>
<td>Natural childbirth*</td>
<td>309</td>
<td>47</td>
<td>6</td>
<td>362</td>
</tr>
<tr>
<td>Home delivery</td>
<td>135</td>
<td>84</td>
<td>31</td>
<td>250</td>
</tr>
<tr>
<td>Hospital delivery</td>
<td>261</td>
<td>71</td>
<td>31</td>
<td>363</td>
</tr>
<tr>
<td>Hospital childbirth*</td>
<td>28</td>
<td>0</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>Grand total</td>
<td></td>
<td></td>
<td></td>
<td>25,345</td>
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</table>

*wild card symbol for truncation of terms, for example, birth* would search for birth, births, birthing etc.

The advantage of using the above search terms was the potential to cover a wide area on studies about childbirth. The main disadvantage was the number of irrelevant studies retrieved, which had to be sifted to identify the relevant ones. Although indexing terms such as the Medical subject headings (MESH) can be used to minimise the problem (Lowe and Barnett 1994) it was felt in this review that the search should be widened as far as possible to extend coverage before becoming more focused. The identified papers were mainly from UK and the rest of Europe, USA, Canada, New Zealand, and Australia. During this stage, search-terms were assessed according to the number of relevant references they produced and the number of duplicate references already retrieved by other search terms. For example, the search term childbirth was too wide as it produced 22,016 hits.
A quick scan of the studies discovered that most did not address the subject of the review. The search term *childbirth* was, therefore, excluded.

Another finding during the first stage of the search was that the database Bids ISI duplicated references retrieved using the Web of Science database. As Bids ISI database was going to terminate services at the end of July 2000, it was dropped from the list of databases to search. In addition, The Web of Science database identified extra studies not retrieved using Bids ISI. In short, therefore, the preliminary stage paved the way for the second stage of the review, where decisions about the specific question to address and how to go about it were made.

**Second stage**

During the second stage, a research protocol was developed to guide the review. The protocol defined the question and methods to be used, as a way of avoiding bias (Mohar and Olkin 1995). Criteria for inclusion and exclusion of studies were laid down. Search terms and databases to be included were also refined. The main question for the review was to identify studies looking at factors seen by women as influential in the choice of place of delivery.

**Inclusion Criteria**

The studies considered for inclusion in the review were all primary studies about choice of place of delivery, regardless of design.

In addition to the search strategy described in the first stage, the journals kept at the University of Surrey library and shown in Table 3 were hand searched:
Table 3: Journals that were hand searched

<table>
<thead>
<tr>
<th>British Journal of Midwifery</th>
<th>British Journal of Nursing</th>
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</thead>
<tbody>
<tr>
<td>British Journal of Obstetrics and Gynaecology</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>International Journal of Nursing Studies</td>
<td>JAMA</td>
</tr>
<tr>
<td>Journal of Advanced Nursing</td>
<td>Lancet</td>
</tr>
<tr>
<td>Midwives</td>
<td>Midwifery</td>
</tr>
<tr>
<td>Nursing Times</td>
<td>Social Science and Medicine</td>
</tr>
</tbody>
</table>

The reason why the journals shown in Table 3 were hand searched was because they publish research articles related to the subject of the review. It was felt that hand searching might identify references missed in the electronic searches, or those not yet included in the electronic databases. Further studies were discovered by exploding references from already identified individual studies.

Third stage

The third stage concentrated on reviewing papers that were retrieved using the search terms, and selecting those that would be included in the review. To assist in handling and organising the review data, three databases were created using reference manager 8.5. One was the main database, called *systematic review*, where all retrievals were initially stored. From this database, duplicate references were transferred to a database called *duplicate* and irrelevant ones to the third database called *irrelevant*. Studies were assessed based on their relevance to the review question, and the method of conducting and reporting the study using the appraisal criteria shown in Box 1 below.
Box 1: Items used to assess the quality of the studies

<table>
<thead>
<tr>
<th>Item</th>
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<tbody>
<tr>
<td>Are the purpose and importance of the study clearly described?</td>
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<tr>
<td>Is there evidence of a comprehensive literature review to relate the study to what is already known?</td>
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<tr>
<td>Is justification given for the approach taken?</td>
</tr>
<tr>
<td>Is the approach taken clearly described?</td>
</tr>
<tr>
<td>What is the sample size?</td>
</tr>
<tr>
<td>How was the sample selected?</td>
</tr>
<tr>
<td>How was access to the study sample achieved?</td>
</tr>
<tr>
<td>Are characteristics of subjects in the study clearly described?</td>
</tr>
<tr>
<td>How was data collected? Were field notes kept as part of data collection where appropriate?</td>
</tr>
<tr>
<td>Where, when, and how were data collected? Over what time span were data collected?</td>
</tr>
<tr>
<td>How was data recorded? How many people collected the data?</td>
</tr>
<tr>
<td>If more than one, what precautions were taken to ensure consistency?</td>
</tr>
<tr>
<td>Is the context in which the study took place described? Was the researcher new or familiar to the setting?</td>
</tr>
<tr>
<td>Was the researcher’s potential influence discussed?</td>
</tr>
<tr>
<td>How was the data analysed? Is there reference to the notes or memos kept during data collection?</td>
</tr>
<tr>
<td>How was coding of data achieved? Have any quotations from the data been provided?</td>
</tr>
<tr>
<td>Are the findings clearly described?</td>
</tr>
<tr>
<td>How is the literature incorporated in the data?</td>
</tr>
<tr>
<td>What are the implications of the findings for practice and further research?</td>
</tr>
<tr>
<td>How was consent for the study obtained?</td>
</tr>
</tbody>
</table>

The appraisal criteria was used to evaluate the quality of studies to avoid selection bias, which may result when decisions to include studies are determined
solely on the basis of the study results. Figure 1 is a representation of the procedure followed for eliminating irrelevant papers.

**Figure 1: The paper elimination process**
The 10 key words used in the search identified 25,345 studies. The search term childbirth was then eliminated as it was too wide, reducing the number of hits to 3,329. The 3,329 studies were stored in the systematic review database, and all duplicate references identified and transferred to the duplicate database, leaving 477 studies in the main database. All studies that did not relate to childbirth were transferred to the irrelevant database, leaving 150 studies in the pool. The title and abstract of each was read, and if it did not address the issue of choice of place of delivery was considered irrelevant and sent to the irrelevant database, leaving 25 studies for the final review process.

Whole documents of the 25 papers were retrieved, and the studies read in detail applying the inclusion criteria, which specified that studies had to address women's views on factors affecting their choice of place of birth. Nine studies failed to meet the inclusion criteria and were removed, leaving 16 that reported about women's views about the place of birth. Of the 16 studies, only 9 had aimed to ask women about their reasons for choosing their place of delivery. The other 7 studies reported women's views although they did not set out to determine reasons for choosing the place of birth (Bastian 1993; McClain 1983; McClain 1987; Morison, Percival, Hauk et al 1999; Ogden, Shaw, and Zander 1997; Townsend-Fullerton 1982; Waldenstrom and Nilsson 1993). The 7 studies were therefore eliminated from the review. The 9 remaining studies that met the inclusion criteria, and specifically reviewed reasons for choosing a place of delivery are summarised in Table 4.

Information abstracted from the studies and included in Table 4 comprises the study, and where it was conducted, to determine the coverage of studies in different countries. It also includes the study sample, i.e., who is included, how
they were recruited, at what stage of pregnancy, the size of the sample and whether they were followed up. The study sample information was used to determine whether like was being compared with like, and the possible influence of the situation of the sample on the results. Further information included in the tables covers key characteristics of the study (for instance, the data collection tool, and the nature of the question about the place of birth), and, outcome measures. For the purpose of the study, outcome measures are the main reasons given by women in favour of a home or hospital birth. Summary information about the studies is presented in Table 4 which follows:
Table 4: Summary of studies included in the review

<table>
<thead>
<tr>
<th>Study and (location)</th>
<th>Study sample</th>
<th>Key characteristics</th>
<th>Main reasons for choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Chamberlain, Wraith and Crowley 1997)</td>
<td>All women having a baby in the UK during the year 1994</td>
<td>All countries of the UK invited to take part. Confidential prospective study of all women recruited at 37 weeks gestation planning to give birth at home. Control group consisted of women of similar background planning a hospital birth. Questionnaire survey used as a data collection instrument. As part of the study, women were asked about their decision to book a home delivery and the circumstances in which they made their choice. A random sample of 20% from both groups was sent a follow-up questionnaire at 6-8 weeks post-partum to check any shift in attitude with passage of time.</td>
<td>Over 30% said main reason was desire for less interference, 25% cited convenience, 21% were influenced by their previous experience of home and/or hospital birth, 10% were frightened of a hospital birth. 4% of those choosing a home birth found continuity of care as the most important factor while those choosing hospital did not mention continuity of carer. Over 80% of those choosing hospital did so because of safety.</td>
</tr>
<tr>
<td>(Cunningham 1993)</td>
<td>Women in the Sydney metropolitan area who gave birth between July 1986 and June 1987 were contacted within one year of giving birth at the early childhood clinics and asked to participate in the study. 395 women participated, 239 gave birth in hospital, 35 in the birth centre and 121 at home. Unplanned and professionally unattended home births were excluded from the study.</td>
<td>Data collection tool included the omnibus 85 item questionnaire devised to assess reasons for choosing the birth place, evaluation of antenatal preparation, birth experience, analgesia during birth, positive and negative postnatal feelings, and socio-demographic variables. The 11-item Health Locus of Control scale, which measures how much internal and external control over events a person perceives themselves to possess, and the 16-item women in society questionnaire were also among the data collection tools.</td>
<td>Women having a hospital birth were influenced by safety, availability of medical facilities and the proximity of hospital to home. They also mentioned the doctor's suggestion as having influenced their choice. Home birth and birth centre women expressed a wish to have an active birth with control and no intervention. Home birth women wanted to have their family and friends present at the birth.</td>
</tr>
<tr>
<td>(Davies, Hey, Reid et al 1996)</td>
<td>Women resident in the Northern region who expected to deliver in 1993 whose request for a home birth had become known to the local supervisors were invited to participate. 256 women requesting a home birth enrolled, five of whom miscarried. 85% returned the attitudinal questionnaires.</td>
<td>Women were sent six anonymous freepost questionnaires intended to collect factual and attitudinal pre and post delivery information about their choice (time intervals and gestation not stated).</td>
<td>Reasons given before delivery for preferring home birth were: more in control, prefer to be at home, more natural, partner more involved, less intervention, less stress for baby, no need to leave other children, safer at home and no transport worries.</td>
</tr>
<tr>
<td>Study and location</td>
<td>Study sample</td>
<td>Key characteristics</td>
<td>Main reasons for choice</td>
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<tr>
<td>(Fordham 1997) UK</td>
<td>Sample of 340 women of 20-40 years of age registered with the study practice who chose either home or hospital birth were sent a questionnaire. 68% returned the questionnaire.</td>
<td>A self-administered questionnaire asking about age, occupation, parity, place of birth for past confinement, experience of complications requiring treatment and preferred place for future confinements was sent to potential participants. Women were also asked to comment about their main reason for the future preference expressed, what information is required to enable informed choice, and how one might go about arranging a home birth. A 5-point Likert scale of agreement or disagreement was used to get views on the advantages and disadvantages of home and hospital birth.</td>
<td>70% of participants felt it was safer to have a hospital birth, 10% said they had some indication for a hospital birth 7% did not have enough information, and 4% said home birth was a more positive and enjoyable experience. Those in favour of hospital birth talked about safety and pain relief, while those in favour of home birth talked about the duration of labour as likely to be shorter at home, having more chance of a familiar doctor or midwife, being more relaxed and in control, and having more chance of rest at home.</td>
</tr>
<tr>
<td>(Jones and Smith 1996) UK</td>
<td>500 questionnaires with fixed response and open-ended questions were given to parous and nulliparous women. 70% response rate was considered representative. 324 (65%) parous women returned the questionnaire and out of 148 given to nulliparous women 79 (53%) were returned.</td>
<td>Nulliparous women were not pregnant, while parous were pregnant at time of study. 3% parous and 11% nulliparous would prefer home birth. 21% parous would have preferred a different hospital, 48% of these had moved away from area of choice. 74% of parous would have liked information about local maternity services available to them</td>
<td>More parous women were against home because of previous obstetric complications, fear of complications and partner's disagreement with home birth. Women chose a maternity unit closer to home more often (71%), others followed the GP's advice (18%). Those dissatisfied with care chose a different hospital. Influencing factor for choice of hospital was room for partner to stay and known midwife who would assist at delivery.</td>
</tr>
<tr>
<td>Study and (location)</td>
<td>Study sample</td>
<td>Key characteristics</td>
<td>Main reasons for choice</td>
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<tr>
<td>(Kleiverda, Steen, Anderson et al 1990)</td>
<td>Midwives recruited 170 nulliparous women with low-risk pregnancy at first antenatal visit. Interviews were conducted at the 18th week gestation.</td>
<td>Open-ended questions were used to elicit information about motives for choice, semi-structured questions for information about significant others. 1-5 point Likert-type scale developed to measure attitudes towards home and hospital birth. Pro home birth group talked about disadvantages of hospital (86%) but pro hospital group talked less about disadvantages of home (38%). Factor scores of attitude towards place of birth showed that 78% of pro hospital did not think home was unsafe. 38% of hospital group described disadvantages of hospital such as lack of privacy and unknown people. Home birth group were older, more educated and were going to continue working after confinement.</td>
<td>Women with preference for home gave reasons describing advantages of home births, such as, control and privacy. They also described disadvantages of hospital birth, such as, loss of control, lack of company, and lack of privacy. Reasons given by those preferring hospital were safety of the hospital, and, to a lesser extent the disadvantages of home, such as the mess. Other reasons for choice of hospital were lack of experience of birth. Hospital group knew more women with hospital birth than home and the opposite for home birth group.</td>
</tr>
<tr>
<td>(Mackey 1990)</td>
<td>Convenience sample of 61 women attending Lamaze classes with their husbands, and who were planning to use study hospital were invited, all but one participated. Sampling criteria required participants to have at least one living child and that all previous viable pregnancies resulted in normal children.</td>
<td>Tape-recorded in-depth interviews were conducted at 36-38 weeks gestation at the participants’ own home and again during the postpartum hospital stay. The study question asked women how they chose the hospital, physician, and why they did or did not choose the alternative birthing room. Content analysis was used to develop coding categories and to identify trends in responses.</td>
<td>67% of women agreed to use hospital where their physician practiced. 23% chose hospital first and then physician associated with the hospital. 10% chose hospital because they worked there and were familiar with it. 44% because they were satisfied with their previous hospital experience; others thought they might have problems, which were not acceptable in the birthing room. Some said their physician was against birthing room. 56% wanted to use the birthing room because they perceived it as relaxed, pleasant, natural, informal and home-like. More than half did not want to transfer to another room and bed for delivery. They also thought they would have more contact with the baby in the birthing room. Some thought they would have more control of the labour experience in the birthing room.</td>
</tr>
<tr>
<td>Study and (location)</td>
<td>Study sample</td>
<td>Key characteristics</td>
<td>Main reasons for choice</td>
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<tr>
<td>(Mather 1980) USA</td>
<td>Subjects were 15-39 years old women intending to be pregnant in the next 10 years. Those already pregnant were excluded because they had already made up their minds about carer and facility. Sample was obtained by random cluster sampling method. Only one woman per household was asked to participate.</td>
<td>A structured questionnaire was used to collect data and answers recorded on pre coded answer sheet. Questionnaire asked women firstly to rate importance of childbirth options on a four-point scale. Secondly, the research asked about participants' awareness of options, their preferences for and willingness to use each alternative before and after reading descriptions of each alternative. The third section gathered personal data and information about previous experience.</td>
<td>Women showed interest in alternative maternity facilities after reading about them. Home-like atmosphere and comfort were the common reasons for choosing alternative facilities. Previous experience with a service determined how a woman might choose subsequently, 70% would use the same facility. Safety pervaded responses about choice of hospital (55%); participants cited it as the main reason for not choosing alternative options. Many women wanted to have their personal doctor present at the birth (34%).</td>
</tr>
<tr>
<td>(Soderstrom, Stewart, Kaitell et al 1990) Canada</td>
<td>Women who attended pre-natal classes in the Ottawa-Carleton region from April 1 to June 15 1987 were identified and recruited using the case room logbooks in five hospitals with obstetric services, and from midwives who attended home births. Researchers calculated that a sample of 1200 would give a 95% confidence interval of the estimates of interest. The sample would also detect significant differences of at least 10%. Of the 1629 eligible women, 1115 (68.4%) participated.</td>
<td>Self-administered questionnaires were developed and pre-tested on 20 women attending prenatal class and modified as necessary to improve ease of completion. The questionnaire included a brief description of several options for birthplace: case room, birthing room, birth centre or home. The research asked participants which alternative they would prefer if all the places were part of the health care system. 13.6% of the women completed the questionnaire during the prenatal period, 77.8% in hospital and 8.5% at home after the birth.</td>
<td>53% chose the case room because they wanted availability of epidural anaesthesia and use of the nursery. 29.1% chose the birthing room and 15.2% the birth centre because it offered flexibility and choice during labour, delivery and the postpartum. Women choosing the birth centre also wanted to remain in one place throughout their stay. 2.8% chose home birth because they wanted a midwife to look after them, and to have their family present at the birth. Those who chose one of the alternatives to the case room were more likely to plan not to have an epidural, to breastfeed, and to be interested in primary midwifery care. Women were more likely to go back to the place they used last. Those with previous caesarean section or an epidural were more likely than those without to choose the case room.</td>
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Findings of the review

One of the aims of the review was to assess the state of evidence regarding women’s views about factors influencing their preferences for home or hospital birth. As is true for all researches, the weight of evidence is built up by repetitions and replication of studies in different locations, with diverse populations and by employing different methods. Four studies were conducted in the United Kingdom, two in the United States of America, one in Australia, one in The Netherlands, and one in Canada.

Five studies indicated that women choosing out of hospital birth were hoping to have more flexibility, choice and control of the birth process (Davies, Hey, Reid et al 1996; Fordham 1997; Kleiverda, Steen, Anderson et al 1990; Mackey 1990; Soderstrom, Stewart, Kaitell et al 1990). Eight studies found that most women planning a hospital birth were concerned about safety (Chamberlain, Wraight, and Crowley 1997; Cunningham 1993; Fordham 1997; Jones and Smith 1996; Kleiverda, Steen, Anderson et al 1990; Mackey 1990; Mather 1980; Soderstrom, Stewart, Kaitell et al 1990). In one study, women chose hospital because they wanted the availability of pain relief (Soderstrom, Stewart, Kaitell et al 1990). Previous experience with a facility, was found in five studies to influence choice (Chamberlain, Wraight, and Crowley 1997; Jones and Smith 1996; Mackey 1990; Mather 1980; Soderstrom, Stewart, Kaitell et al 1990). Two studies mentioned the doctor’s suggestion of a hospital birth (Cunningham 1993; Jones and Smith 1996), and two mentioned preference for attendance by a doctor (Mackey 1990; Mather 1980) as having influenced their choice. In four studies, women wanted a home birth because they wanted the presence of their family and friends at the birth (Cunningham 1993; Davies, Hey, Reid et al 1996; Kleiverda, Steen, Anderson et al 1990; Soderstrom, Stewart, Kaitell et al 1990).
Quality of studies included in the review

The quality of the nine studies included in the review was assessed using criteria listed in Box 1. Generally, the studies met the criteria; they clearly described the purpose, importance of the studies, the study samples, and how they were selected. The studies also indicated when, how and where, and in most cases the time span within which data were collected. The previous literature and gaps in knowledge were discussed. However, there were a few exceptions, for example, the study by Davies et al (1996) states that six anonymised questionnaires were used to collect data, but it does not say at what stage of the pregnancy, or at what time intervals the questionnaires were administered. Only one study (Chamberlain, Wraight and Crowley 1997) discussed justification for the method used to collect data.

Six studies out of nine used questionnaires as the data collection tool (Cunningham 1993; Davies, Hey, Reid et al 1996; Fordham 1997; Jones and Smith 1996; Mather 1980; Soderstrom, Stewart, Kaitell et al 1990). Only two studies used interviews (Kleiverda, Steen, Anderson et al 1990; Mackey 1990). Interviews give participants a chance to express their own views about the research topic, and may touch on issues that the researcher had not considered. They are therefore a preferred method of data collection in new areas of research such as the one under discussion.

Two studies collected data once during pregnancy (Fordham 1997; Kleiverda, Steen, Anderson et al 1990). When data is collected only once and there is no follow-up, the results will indicate the participants’ original intentions, but without any indication of whether there were any change of plans along the way. Only two studies (Mackey 1990; Chamberlain et al 1997) interviewed
women during pregnancy and then again after delivery. Such an approach gives the women a chance to give their views before delivery and then to determine how the experience of labour and delivery may possibly have affected their views.

Two studies collected data after delivery (Cunningham 1993; Davies, Hey, Reid et al 1996). Results in retrospective studies could be marred by what actually happens during the process of labour and delivery. For example, when women are asked about their preferences for home or hospital birth following delivery, their responses might be indicative of their experiences during the process rather than what initially motivated their choice.

One study included women who were intending to be pregnant in the next ten years (Mather 1980). Women who are not yet pregnant may have different views about childbirth, which might change when they are actually faced with the situation of pregnancy and the prospect of giving birth.

Data collection for most studies was conducted during the second or third trimester of pregnancy. This is an appropriate time as the pregnancy is more likely to be stable. Women are also likely at the second and last trimester to be considering where they might want to give birth.

Discussion

The aim of the systematic review was to identify studies about women's views regarding the place of birth, in terms of how much work has been done, and to identify gaps, if any, in the literature. The theoretical framework derives from risk perception (Douglas and Wildavsky 1982; Johnson and Covello 1987; Kahneman and Tversky 1984; Schwing and Albers 1980) and considered that women's views of risk and safety related to the process of childbirth might have a
role to play in their preferences for home or hospital birth. NHS latest policy on childbirth was also considered, which calls for women to be given more information to allow them to make informed decisions about their care, including where they want to give birth (Department of Health 1993b)

The questions to ask, therefore, in the light of the review, are, firstly, whether there is evidence for risk perception as having an impact on the choice of place of birth. Secondly, did the review provide evidence about whether women are aware of options available to them about the place of birth? The review did not find answers for either question. The reason for this is that, regarding the first question, there is a dearth of studies looking at expectant women's views about why they choose to deliver where they do. Secondly, and most significant, is a lack of exploratory studies to determine the women's views. The few available studies used questionnaires, with specific questions that the researchers wanted to investigate about decision-making regarding the place of birth. The method of data collection used in the studies did not allow for spontaneous responses that might give an indication of women's perceptions of risk related to childbirth.

However, eight out of the nine studies included in the review indicated that women planning a hospital birth were concerned about safety. Secondly, previous experience with a facility influenced where the woman planned to have her baby. For example, some who had previous complications chose hospital in case there was a repeat of the last experience while those who had a good experience of home chose home again. The fear of complications and resultant choice of hospital birth, and the choice of place of birth according to previous experience could be seen to be an expression of perception of risk, resulting in the choice of place perceived to be better equipped to deal with potential problems. As regards the second question, the studies did not give an indication of whether
women had information about what options were available. The paucity of exploratory studies about reasons for preferences of home or hospital birth is a surprise finding, especially in the United Kingdom because the government recommends a woman centred maternity service, which could only be possible if the views of the different women are known.

Only nine studies were identified looking at women’s views about the place of birth. Out of the nine studies, six used questionnaires to tackle the question. It could be argued, therefore, that the studies expressed the investigators views about what women consider when contemplating about the place of birth. When questionnaires are used, the questions might address issues that women did not consider, but which they might nonetheless answer. A more suitable approach would be to conduct a series of exploratory studies first, to determine what the views are before focusing on specific questions about the views. There is therefore clearly a need for further research about factors influencing choice of place of birth. Results of such studies would be useful in understanding women's views of the process of childbirth, and their preferences for home or hospital birth, and thus assist in planning individualised care as recommended by the Department of Health (1993).

Limitations of the search strategy

The study used electronic databases, the MIDIRS literature search service, exploding references from identified studies, and hand searching of some journals at the University of Surrey library. There were no personal contacts and literature from conference proceedings, and therefore it is possible that important unpublished studies may have been missed.
The next chapter discusses methodology of qualitative research, which is recommended for areas of studies where little or nothing is known about the subject of the research.
Chapter 4: Qualitative Research

Introduction

The previous chapter presented the first study of the thesis, a review of literature about the choice of place of birth, and identified not only a dearth of studies, but also, a weakness in the choice of methods used to collect data. Six out of nine studies included in the review used questionnaires. The thesis identified the use of questionnaires as inappropriate because the area has not been well researched. As a result, a recommendation was made that exploratory studies would be more appropriate.

The task of the thesis, in the light of the results of the systematic review, is to contribute to existing knowledge by employing an appropriate method to determine women's views about factors influencing their preference for home or hospital birth. The thesis considered that a qualitative method would be more appropriate to study women's views, as it allows participants to tell their story in their own way without any suggestions from the investigator. Before a discussion of the qualitative study, it seems appropriate to first illuminate qualitative research, by discussing the paradigm of naturalistic inquiry, from which qualitative research derives. It is hoped that the discussion of qualitative research in the present chapter will attest to its appropriateness in the investigation of women's views.

Qualitative research is a form of social inquiry that studies the way people interpret and make sense of their experiences, and the world in which they live. Descriptive data, in the form of people's own written or spoken words and
observable behaviour are used (Holloway 1997; Taylor and Bogdan 1984). The aim is to obtain nuances of descriptions from the participants' perspective about the subject of the research.

The view of qualitative research is that human behaviour can be better understood in the setting in which it occurs (Guba and Lincoln 1994; Lincoln and Guba 1985). It is necessary, therefore, to describe experiences within their natural context to generate theory capable of explaining that behaviour, while at the same time preserving the meaning of the experience. Qualitative research is inductive; concepts, insights, and understandings are developed from patterns in the data (Taylor and Bogdan 1984).

Qualitative research derives from the qualitative paradigm (Creswell 1994; Patton 1991), which is informed by the naturalistic or constructivist approach (Guba 1993; Lincoln and Guba 1985). Naturalistic inquiry is explained in terms of how it addresses questions concerning four philosophical categories of ontology, epistemology, logic and teleology (Creswell 1998; Maylcut and Morehouse 1994). The questions are answered by a set of postulates, or axioms, which make a claim for a way of conducting research. A postulate is something that is stipulated and given the status of acceptance in order to get on with the task at hand (Maylcut and Morehouse 1994). Postulates, therefore, provide the platform for conducting research, by shaping the way researchers approach problems, the methods they use to collect data, and the type of problems they choose to investigate.

The first philosophical area is ontology, which deals with assumptions relating to the nature of reality. One key ontological question is about the nature of reality. Naturalistic inquiry posits that there are multiple realities, which are
socio-psychological constructions, forming an interconnected whole (Maykut and Morehouse 1994). The multiple realities are constructed by those involved in the study, such as the researcher, participants in a study, and the reader or audience interpreting the study (Creswell 1994; Creswell 1998).

In keeping with this view, qualitative research is informal and exploratory in nature (Dey 1993; Mason 1996; Patton 1990). It consists of loosely structured conversations with participants, either individually or in small groups. The aim of the interaction, which is modelled after a conversation between equals, is to throw as much light as possible on participants' images, values, and attitudes, together with the motivations behind their behaviour. Each participant is allowed to express their views in their own way (Taylor and Bogdan 1984). The result is a medley of ideas and impressions, from which patterns are distilled by careful analysis.

The aim of qualitative research is to get an impression or understanding of the lived world or reality of the participant; therefore, it is not desirable to provide ready-made responses, which could strip the participants' responses of their originality. The qualitative researcher is required to record the realities, using extensive quotes from participants, presenting themes that reflect words used by participants, as well as recording his or her own feelings, and observations during the process. It is argued that the results in a naturalistic inquiry are literally created through the hermeneutic-dialectic interaction between and among those involved in the inquiry (Guba 1993).

The second category relates to epistemological assumptions that deal with the origins and nature of knowing, and the construction of knowledge (Guba 1993). Questions raised are: what is the relationship between the knower and the
known? What roles do values play in understanding? Naturalism holds the view
that the knower and the known are interdependent, and knowledge is constructed
(Creswell 1998; Maykut and Morehouse 1994). This would therefore mean that
the knower could not be totally separated from the known and vice versa, as what
is known is subjective to the views of the one who knows.

Values, according to the naturalistic view, mediate and shape what is
understood. Maykut and Morehouse (1994) contend that the role played by
values can be understood in reference to postulates relating to the nature of reality
and knowledge. They argue that values are embedded in the topic chosen for
examination, and the way the topic is examined. Therefore, if reality is
constructed, and the knower and the known are inseparable, then values 'come
with the turf'. The researcher in a qualitative study admits the value-laden nature
of the study, and, therefore, exposes his or her values and biases as well as those
contained in the information from participants (Creswell 1994; Creswell 1998).

The purpose of the interaction between the researcher and participants in
qualitative research is for participants to describe their experiences and for the
researcher to give meaning to those descriptions. Descriptions of the lived
experiences are specific to the participant and not general opinions (Patton 1990).
The researcher, on the other hand, exhibits openness to new and unexpected
phenomena. There are no ready-made categories for interpretation of the data.
The interview itself is focused on particular themes according to the aims of the
research, but it does not have strictly structured questions, neither is it entirely
non-directive (Kvale 1996; Patton 1990; Wiersma 1995).

The interview is an interpersonal situation as much as it is an interaction
between two or more people. The researcher and the participant act in relation to
each other and may influence each other. The interview situation is therefore specific to the moment and the people involved. The interpersonal dynamics of the interaction should be taken into consideration during the time of the interview, and subsequently during the analysis (Dey 1993; Kvale 1996; Sapsford and Jupp 1996). Kvale (1996) argues that the reciprocal influence of interviewer and interviewee on a cognitive and emotional level is not necessarily a source of error, but can be a strong point of qualitative research interviewing. The emphasis therefore should not be on reducing the impact of the interaction, but rather to recognise and apply the knowledge gained from the interpersonal interaction. Maykut and Morehouse (1994) maintain that if the knower and the known are interdependent, there must be integrity between how the researcher experiences the participants in the study, how the participants experience the situation and their participation in it, and how the results are presented.

Logic is the third category, and it deals with principles of demonstration or verification. Pertinent questions about the logic of inquiry are: Are causal links between bits of information possible? What is the possibility of generalisation (Maykut and Morehouse 1994)? The view of the naturalistic approach is that events shape each other, and that multidirectional relationships can be discovered within situations.

Qualitative research is context sensitive, that is, a phenomenon is studied in all its complexity and within a particular situation and environment. Generalisation of a qualitative theory would therefore be restricted within the same context, but should fit all scenarios that may be identified in the larger population. The theory is also considered applicable beyond the immediate group to similar situations, questions, and problems (Morse 1999c). To demonstrate generalisability of qualitative research, a study on privacy conducted in an all-
male nursing home is used (Applegate and Morse 1994). In that study respect for privacy norms occurred whenever people treated one another as they would treat another human being, friend or stranger. If they treated one another not as humans, but objects, then violation of privacy norms occurred. This meant that the type of inter-personal relationships provided the context in which privacy norms are respected or violated. Results are considered applicable to any context in which the problem of privacy violation is a concern.

The last category, teleology, is concerned with questions of purpose. The main questions are: What is the contribution of research to knowledge? What is the purpose of research? The contribution of the naturalistic inquiry to knowledge is through its discovery of salient propositions by observation and careful inspection of patterns, which emerge from the data (Maykut and Morehouse 1994). The discovery comes from the carefully selected, usually small sample in a qualitative inquiry, which is studied in-depth.

The sample size in a qualitative study is relatively small; 6-8 participants for homogenous samples, and 12-20 for maximum variations (Zyzanski, McWhinney, Blake et al 1992). Each participant is selected purposefully for the potential contribution they can make to the emerging theory (Kvale 1996; Mason 1996; Patton 1990). The selection ensures that the theory is comprehensive, complete, saturated, and accounts for negative cases (Morse 1999b). The purposeful selection of participants for the contribution they could make in a research study is called theoretical sampling (Glaser and Strauss 1967; Hammersley 1985; Miles and Huberman 1994; Strauss 1987; Strauss and Corbin 1990) and is the cornerstone in qualitative research.
Theoretical sampling refers to selecting the sample based on their relevance to the theory, research question, theoretical framework, or the explanation being developed (Lincoln and Guba 1985; Mason 1996; Morse 1995; Taylor and Bogdan 1984). The selection of participants is lead by the research question, or theory, which allow for preliminary decisions about the boundary of the investigation. After completing interviews with the first few participants, the type of people interviewed are varied until the full range of perspectives is unearthed, signalled by no new information being uncovered (Miles and Huberman 1994; Taylor and Bogdan 1984). The crucial questions for the researcher in theoretical sampling are: which sources are information-rich? Whom should I talk to, or what should I look at first (Kuzel 1992)?

As theory develops, additional questions arise, such as, which data sources may confirm, challenge or enrich my understanding (Glaser and Strauss 1967; Guba and Lincoln 1985; Guba and Lincoln 1989; Kuzel 1992)? The participants that are initially interviewed help in determining whom to interview next. The theory in a qualitative inquiry is not fixed, but subject to modification or confirmation in the context of the study (Kuzel 1992). Theoretical sampling gives the study direction, and may help the researcher to have more confidence in the categories developing from data as they are constantly and selectively reformulated as the study progresses. Mason (1996) advises against picking only cases that will support the argument and disregarding the inconvenient ones. She asserts that cases should be selected not only to build the theory but also to test it. One way of building and testing the theory is by using procedures of analytic induction (Denzin 1989), where negative or contradictory cases in relation to the developing constructs are sought.
The procedure ensures a vigorous search for instances that may not fit with the developing theory. If such negative cases cannot be found despite looking in places where they are likely to occur, the explanation is strengthened. On the other hand, if some negative cases are found, then the explanation needs to be modified. Sampling in qualitative research continues until saturation is reached (Morse 1989). An edict of qualitative research is to collect data until saturation occurs. Saturation is defined as data adequacy and operationalised as collecting data until no new information is obtained (Morse 1995). One indication of saturation is the repetition of themes already identified. No published guidelines exist in qualitative research for estimating the sample size required to reach saturation, unlike in quantitative research where there are formulas designed for the purpose. Saturation is therefore determined by the researcher and can be discerned from the adequacy and comprehensiveness of the results (Morse 1995).

In qualitative research the social process under investigation determine the sample size (Bertaux and Bertaux-Wiame 1981). The sample variation in terms of demographic variables is also important. According to Bertaux and Bertaux-Wiame, sampling is continued until a picture of what is going on emerges and the data does not yield anything new about the social process. During the first few interviews, data appears diverse and disconnected, but in the process of saturation, patterns begin to form that make sense. However, there are no specific guidelines for a priori estimation of how much data is required in each category. The principle is to illuminate the questions under study, and to increase the scope of range of data exposed to uncover multiple realities (Kuzel 1992).

As data collection and analysis progress, replication of data occurs, signalling saturation. The quantity of data is not important to the process of saturation. Detailed description and not the number of times something is
mentioned make for richness of data (Morse 1995). Morse suggests important questions that may arise about saturation, such as: How does the researcher recognise when results are complete? How does the researcher know when enough data are enough? The answers to the questions lie on the careful and theoretically justified delineation of the sample. When the sample is tight and restrictive, and the domain is clearly delineated, saturation is likely to be reached faster. However, in reality studies begin broad and focus as the investigation continues and interesting aspects are discovered. When enough data to build a comprehensive theory have been collected, data collection ceases, and that is when saturation has been achieved (Morse 1995).

Research inquiries are conducted for the purposes of adding to current knowledge, or to solve a particular problem. For an investigation to achieve this, it must be seen to be credible. The manner of communication of the inquiry must be transparent, so that the findings and the inquiry process by which they were obtained could be checked (Erlandson, Harris, Skipper et al 1993). The transparency of the conduct of the research adds to the study's trustworthiness (Guba 1981; Guba and Lincoln 1989; Lincoln and Guba 1985). The basic issue in relation to trustworthiness, according to Lincoln and Guba (1985), is how a researcher can persuade the audience that the findings are worth paying attention to, and worth taking into account. Trustworthiness limits the chances of results of an investigation being erroneous, although it is impossible to establish the truth of any research beyond reasonable doubt (Murphy, Dingwall, Greatbatch et al 1998). Four criteria have been suggested to establish trustworthiness (Lincoln and Guba 1985).

The first criterion for establishing trustworthiness is credibility, or truth-value, which relates to the degree of confidence that the findings of an
investigation have for the participants involved in the study, as well as the context within which the study was conducted (Lincoln and Guba 1985). Truth-value is demonstrated by showing that the multiple constructions of those involved in an investigation have been adequately represented, and that the reconstructions arrived at in the inquiry are credible to the constructors or participants in a study. A description developed through the inquiry in a particular setting must ring true for those who are members of the setting. People in a given setting will perceive different constructed realities, therefore, a credible outcome is one that adequately represents both the areas in which the realities converge, and the points on which they diverge (Denzin and Lincoln 1994; Erlandson, Harris, Skipper et al 1993).

It is argued that a credible inquiry has a mosaic image on its readers, by being imprecise in terms of defining boundaries and specific relationships, but rich in providing depth of meaning and richness of understanding (Erlandson, Harris, Skipper et al 1993).

Participant check for trustworthiness of findings has been recommended by some authors (Beck 1993; Guba 1981; Guba and Lincoln 1985; Guba and Lincoln 1989; Sandelowski 1986). According to the recommendation, analyses of findings are given back to participants in a study to judge their adequacy, and the ultimate test of validity lies in isomorphism between a study's findings and participants' perceptions. Member checks are intended for correction of errors of fact and interpretation, for obtaining additional information, for putting the participant on record for having agreed that the results are correct, for summarising the findings, and for judging the overall adequacy of the study (Guba and Lincoln 1989).

However, some researchers have disputed the use of participants to check for trustworthiness of findings (Bloor 1983; Bryman 1988; Emerson 1988;
Sandelowski (1993) suggests that participants may forget what they said and therefore are not in a position to verify the accuracy of researcher's accounts. They may also change their mind about what they gave in an interview afterwards. Another argument is that results of a study should be given to participants for their information, use and application, and not for verification (Morse 1998). Morse further argues that good qualitative research involves processes of synthesis, conceptualisation and abstraction. It involves extensive knowledge of the topic, the setting, and social science literature. The researcher uses this education to identify and create new knowledge. Participants, on the other hand, who are usually lay people, do not have these abilities. Additionally, research results are a synthesis of multiple participants' views which one participant may not understand. Morse (1998) considers verification by participants an extraordinary and unrealistic expectation. Furthermore, it is argued that participants cannot be relied upon to read the draft of the analysis with the same kind of critical spirit necessary for the task to be carried out successfully (Emerson 1988). Finally, Bloor (1983) suggests that member checks are limited to asking members to judge whether a researcher's account represents a legitimate elaboration and systematisation of the member's account.

Another method suggested for improving the trustworthiness of a research investigation is triangulation (Hammersley 1992a; LeCompte and Goetz 1982; Lincoln and Guba 1985; Marshall and Rossman 1989; Sandelowski 1986). Triangulation refers to employing more than one method in data collection and analysis. Four types of triangulation have been identified, they are method, data, investigator, and theoretical (Campbell and Fiske 1959; Denzin 1970; Goodwin and Goodwin 1984b; Webb, Campbell, Schwartz et al 1981).
In method triangulation, different methods are used to address the same problem, in data triangulation, different data sources are used, in investigator, different investigators are used, while in theoretical triangulation different theoretical models are used. The aim of triangulation is to establish the convergent validity of findings from complementary approaches. It is argued that triangulation balances distorting effects of any single approach and permits data collected in one way to be used to check the accuracy of data collected in another (LeCompte and Preissle 1993).

Some authors agree on the use of multiple methods in qualitative research, especially to extend the comprehensiveness of findings. Murphy et al (1998) argue that the use of multiple methods may encourage researchers to pay attention to the different perspectives that may be held, and the ways in which results are inevitably the product of the context in which they were produced. Additionally, it is thought that when data from two sources or methods produce dissimilar results, the researcher is prompted to consider how the differences came about, which enriches the analysis (Jick 1979). Similarly, it is argued that differences between two sets of data are just as important as the similarities (Hammersley and Atkinson 1995), and when the use of multiple methods uncovers discrepancies, they call for more investigation, which may lead to deeper understanding (Bryman 1988; Janesick 1994). Furthermore, multiple methods are thought to uncover some unique variance that may otherwise have been neglected by a single method (Oiler 1993). Although generally critical of triangulation, Silverman (1993) acknowledges the usefulness of multiple methods in overcoming the incompleteness of data drawn from a single source.

On the other hand, some authors have warned against using triangulation as an end in itself, or looking at it as an inherent good (Knafl and Breitmayer 82
1991; Stake 1994). It is argued that if used inappropriately, triangulation may compound the weaknesses of a project instead of strengthening it (Knafl and Breitmayer 1991). Secondly, triangulation is thought to assume that there is a single point upon which data collected from different sources or using different methods converge. It also seems to contradict the view of naturalism that there are multiple realities, and there is no single objective or true reality to be confirmed (Richardson 1994; Smith 1984). Similarly, Silverman argues that analysis of data in the context in which it was collected is at the heart of qualitative research, and the fundamental problem with triangulation is that it seeks to overcome the context-boundedness of data (Silverman 1985; Silverman 1993). Additionally, it is argued that the pursuit of trustworthiness through triangulation may lead some researchers to search for a master reality or objective truth in their analysis (Dingwall 1981). Although triangulation may be used to assess the likely truth of a claim, it is argued that it cannot be treated as a simple test of validity (Hammersley 1990a; Hammersley 1990b; Hammersley and Atkinson 1995).

The second criterion suggested for establishing trustworthiness of an inquiry is transferability or applicability. Transferability is concerned with the extent to which findings of a particular inquiry can be applied in other contexts, or with other participants (Lincoln and Guba 1985). In a naturalistic inquiry, the transferability of findings depends on the similarity between the contexts of the situations of applicability. It is therefore incumbent upon the researcher to provide sufficient detail and precision of the context in which the investigation was conducted to allow anyone interested in making the transfer to determine whether it would be appropriate to do so (Guba and Lincoln 1989). Erlandson et al (1993) assert that effective thick description vicariously brings the reader into
the context being studied. They further add that anyone whose first encounter with the setting is through the effective thick description has a sense of *déjà vu* upon actually visiting the setting.

*Dependability, or consistency, is the third criterion, and deals with providing evidence that findings of an inquiry would be repeated if the investigation were to be replicated with similar participants in the same or similar context (Lincoln and Guba 1985). In a qualitative inquiry, instability in findings of an inquiry may be attributed to reality shifts or better insights (Erlandson, Harris, Skipper et al. 1993). The quest is, therefore, not for invariance, but for traceable variance. Consistency is therefore conceived in terms of dependability, which embraces stability and explainable changes (Guba and Lincoln 1981). One way of doing this is by use of an inquiry audit, which is based on the fiscal audit (Guba 1981). The fiscal auditor examines the process by which the accounts were kept, to determine the fairness of the representation of the company's fiscal position. The auditor examines the records for accuracy, by checking that every entry in the account ledgers can be justified, and by sampling entries in the journal to ascertain whether they could be supported by corroborative documents (Lincoln and Guba 1985). In the same way, the researcher must make it possible for an external check to be conducted on the inquiry process. An audit trail, which provides documentation of the process of inquiry, allows for the check to be done (Erlandson, Harris, Skipper et al. 1993; Lincoln and Guba 1985). The documentation would attest to the study's dependability. The product of the investigation, i.e., the findings, interpretation and recommendations, must attest that it is supported by data. This would also establish the study's confirmability, which is the fourth criterion for establishing trustworthiness. Dependability and
confirmability can therefore both be established by a single audit (Lincoln and Guba 1985).

*Confirmability* or neutrality, the fourth criterion, relates to the degree to which findings of an investigation were determined by its focus rather than by the biases of the researcher (Lincoln and Guba 1985). The aim is not to ensure that results are free from contamination by the researcher, but rather to ensure confirmability of the data themselves so that constructions can be tracked to their sources (Erlandson, Harris, Skipper et al 1993). This can be achieved by keeping a detailed report of the process of investigation, sometimes called audit trail. The report of the investigation must provide in detail the process by which data were collected (Beck 1993; Glaser and Strauss 1967; Guba and Lincoln 1981; Jensen 1989; Silverman 1989).

The logic used to assemble the interpretations must also be both explicit and implicit (Guba and Lincoln 1989). Full descriptions of the circumstances and methods of the research enable readers and other researchers to judge the evidence upon which claims are based. The judgements will take account of the range of events the researcher saw, who was interviewed, the kind of experiences encountered, and the feelings that the researcher had.

Athens (1984) argues that scientific credibility is achieved, and not ascribed, therefore, a study is neither intrinsically credible nor incredible; it is incumbent upon the researcher to make it so. To give an accurate account of the process of the inquiry, a researcher must pay particular attention to describing details of how access was obtained to the participants of the study, and how the access was maintained or increased during the period of the study. The argument for this is that formal permission to conduct the study does not necessarily bring
access to all settings, and the data that is collected is limited to what the researcher is allowed to access, and what the participants are willing to share (Athens 1984).

Secondly, the researcher must describe in detail the means by which data was obtained. For example, if in-depth interviews were conducted, the description must include the questions put forward to the participant, and the environment in which the interviews took place (Altheide and Johnson 1994; Athens 1984). It is argued that methods should be explained such that the original report could be used as an operating manual by which to replicate the original study (Howe and Eisenhart 1990; Jensen 1989).

However, it is worth bearing in mind that the formulation of the truth will not necessarily follow from following certain procedures or guidelines (Hammersley 1992b). Judgement should always be used even in the application of any criteria. The risk of checklists is that they can become rigid constraints, which become ends in themselves rather than assisting to increase the trustworthiness of a study (Marshall 1985). Marshall also argues that guidelines may lead to defensive behaviour among researchers and produce sanitised results that have no value. This, however, does not mean that guidelines should be disregarded completely, but that judgement should be applied in how they are used.

Critique of positive features of qualitative research

The strengths of qualitative research can be classified into three; the ability to access participants’ definitions and interpretations, penetrating participants’ public accounts as far as is possible, and flexibility (Murphy, Dingwall, Greatbatch et al. 1998). These will be discussed and reference made to researchers in support of them.
The first is ability to access participants' definitions and interpretations. Qualitative research is credited with offering the possibility of exploring the way that participants define the experiences and practices which are the purpose of the research (Crabtree and Miller 1991; de Vries, Weijts, Dijkstra et al 1992; Jensen 1989; Paget 1983; West 1990). The method is thought to be appropriate because it is seen to uncover the insider's perspective (Jensen 1989), and how participants understand their world (Merriam 1988; Oiler 1993; Secker, Wimbush, Watson et al 1995).

The qualitative interview is also found to be useful in cases where the researcher cannot observe that which needs to be studied, such as, thoughts, feelings, intentions, and experiences (McCracken 1988; Patton 1980). Silverman argues that data generated from interviews grant authentic insights into participants' experiences (Silverman 1993). Additionally, skilful interviewing helps to uncover the meanings, beliefs, understandings and cultures of participants' that help to counter those of the researcher (Secker, Wimbush, Watson et al 1995), as well as preventing imposition of those assumptions upon participants' view of the world (Britten 1995). The use of qualitative interviews also allows the participant's perspective on the subject of interest to unfold as the participant views it (Marshall and Rossman 1989). It is argued that highly structured methods of data collection can prevent the range and depth of participants' feelings and opinions from being uncovered, which may be more accessible through qualitative interviewing (Pill 1995).

The second strength of qualitative research is that it penetrates participants' public accounts (Murphy, Dingwall, Greatbatch et al 1998). It is argued that qualitative methods of interviewing are more likely to uncover a true version of events (Denzin 1970). Qualitative interviewing is also credited with the ability to
access participants' private accounts as maximum rapport may be established (Secker, Wimbush, Watson et al 1995; West 1990).

Some authors have given different views about the value of qualitative research in creating a conducive environment for participants to tell the absolute truth. For example, it is argued that such interviews do not necessarily lead to the exchange of unique human experiences (Silverman 1993). Silverman contends that the approach seems to blend a self-evident truth about humanity with political correctness about the need for mutual understanding and dialogue. Another view is that however informal, an interview is not the same as a conversation because participants are 'put on notice' to talk about something, which may or may not be of interest to them (Dingwall 1997).

The third quality of qualitative research is flexibility, which makes qualitative studies to be especially suitable for exploratory or hypothesis generating enquiries. With qualitative interviews, the researcher is able to open up new dimensions and follow interesting leads which may not have been anticipated before the start of the interview (Britten 1995; Burgess 1982; Denzin 1970). The power of qualitative research to generate ideas and theories is attested to in a study of health education programmes (de Vries, Weijts, Dijkstra et al 1992). In another study looking at lay beliefs and responses to hypertensive therapy, the qualitative interview was shown to be very flexible, allowing the researcher to explore lay logic underpinning their decisions to act in a manner contrary to the advice of their doctor (Morgan and Watkins 1988).
Critique of constraints of qualitative research

One of the questions raised about interviews in general is how one can be sure that what participants tell represents reality (Murphy, Dingwall, Greatbatch et al 1998). It is argued that qualitative interviews are contextual interactions providing opportunities for participants to present themselves as in control to those interviewing them (Goffman 1983). When research interviews are treated as social interactions, interview data are then treated not as accurate reports of external reality, but as occasions for participants to give accounts of their situations or their perception of reality (Dingwall 1997; Murphy, Dingwall, Greatbatch et al 1998).

In a study that combined participant observations with interviews in general practice consultations, inconsistencies were found between reports given by patients about interactions with their doctors with what was actually observed (Stimson and Webb 1975). The patients were observed to be passive and rarely giving open expressions of disagreement or dissatisfaction in the presence of the doctor, on the other hand, patients themselves reported atrocity stories, which presented them as active, and the doctor as passive.

While the inconsistency between the interview and observation could discredit the interview data as biased, Stimson and Webb (1975) took a different view in the analysis of the interview, and considered what the participants could be seen to be doing in giving the accounts that they did. They argue that the atrocity stories help to make the patient appear sensible and balanced, and thus help to redress the imbalance between patient and doctor (Stimson and Webb 1975).
There is an argument for analysing what people are doing in interview talk, rather than taking the data as representation of reality (Baker 1984; Silverman 1985). In this way, interview data would be analysed in terms of the assumptions, and moral and cultural forms that they display (Dingwall 1981; Silverman 1985). Murphy et al (1998) cite Silverman's work of contrasting two studies of children with serious diseases to illustrate the difference between treating interview data as representing reality versus analysing the data. One of the two studies involved parents of children with cystic fibrosis (Burton 1975), and the other included parents of children with congenital heart disease (Baruch 1981).

Both studies reported that parents had expressed concerns about their children to health professionals before the children's diagnosis was made, and in both cases their concerns were dismissed as groundless. Approaches to the analysis of data in the two studies were different. In Burton's study, an interactionist approach was taken, and the reports were viewed as accurate representations of external events (Burton 1975). In contrast, Baruch (1981) analysed the interview data in terms of what the parents could be seen to be doing in the interviews. His argument is that the interview data represent parents' display of their moral responsibility. Murphy et al (1998) note that Baruch, like Stimson and Webb, was concerned with functions of the accounts rather than as straightforward reports of what happened.

Hammersley and Atkinson (1995) do not accept that interview data may never be read for what they tell about the subject to which they refer. They contend that the trustworthiness of interview data should not be taken at face value, but understood in the context in which it was produced. By so doing, they
argue that the inquiry can anticipate potential biases that may threaten the trustworthiness of the information.

The bottom line in the two arguments about interview data is that information is grounded in the context of its production. Caution is recommended in the analysis of such data, but not total abandonment of the use of the method (Hammersley and Atkinson 1995).

Qualitative Data Analysis

The analysis of data in a qualitative study is an ongoing process, and not a one-time event. It is geared towards making sense of the data generated by interviews, which have been described as voluminous, unstructured, and unwieldy (Bryman and Burgess 1994). Data analysis occurs simultaneously with data collection. In the adage of the mountaineer (Maxwell 1996), the experienced researcher is likened to an experienced climber, who begins lunch immediately after finishing breakfast and continues eating lunch as long as he is awake, stopping briefly for dinner (Manning 1960). Maxwell (1996) maintains that in the same way, the experienced researcher begins data analysis immediately after the first interview, and continues to analyse as long as he or she is working on the research, stopping briefly to write reports and papers.

The pattern of data collection-analysis-collection-analysis, ad infinitum is the most significant feature of qualitative research (Erlandson, Harris, Skipper et al 1993; Morse 1999b). It involves a cognitive work of inquiry, in the form of observing patterns in the data and asking questions about the patterns. There is construction of conjectures, deliberate selection of participants to collect data about specific topics, to confirm or refute the conjectures, then continuing.
analysis, asking additional questions, and seeking more data. The process goes on repeatedly until the end of the investigation (Morse 1999a).

Data analysis is an emergent product of a process of gradual induction. Guided by the data being gathered and the topics, questions, and evaluative criteria that provide focus, analysis is the field-worker’s *derivative ordering* (Lofland and Lofland 1995). A number of different strategies exist for the analysis of data, but the process is open-ended in character, and is very much a creative act (Lofland and Lofland 1995). The researcher, therefore, must devise an approach that is flexible and adaptive to the question under study. An important point to note in qualitative data analysis is that the aim is to elicit the richness and vividness of descriptions of phenomena as provided by participants.

A popular approach to analysis is through coding the data (Charmaz 1983; Cuba 1988; Strauss and Corbin 1990). A code is a tag or label for assigning meaning to information compiled during a study (Charmaz 1983; Miles and Huberman 1994). Such organisation of patterns of data has also been referred to as thematic analysis (Aronson 1994; Leininger 1985; Taylor and Bogdan 1984). Lofland and Lofland (1995) suggest asking questions about discrete items in the incoming flow of data, the answers to which will be codes for the data. Such questions could be: of what category is the item before me an instance? What can we think of this as being about? What is this? What does it represent? What is this an example of? (Strauss and Corbin 1990) What is this an example of? (Cuba 1988).

Coding is done in stages (Lofland and Lofland 1995; Strauss 1987; Strauss and Corbin 1990), the initial stage is about discovering what the data has to offer (Charmaz 1983). Lofland and Lofland (1995:192) call this "the emergent
induction of analysis", and say it is where "the rubber hits the road". The research objectives, researcher's interests, expertise, and skills lead the coding.

An important consideration in qualitative data analysis is the conscientious search for, and presentation of negative or deviant cases, i.e., cases that oppose the emerging analysis (Athens 1984; Glaser and Strauss 1965; Henwood and Pidgeon 1993; Lincoln and Guba 1985; Marshall 1985; Mechanic 1989; Phillips 1987). Failure to address negative cases may be a threat to the validity of findings as it introduces holistic bias. Holistic bias is defined as making the data look more patterned than they are (Sandelowski 1986). One of the ways of facilitating the search for negative cases is the use of theoretical sampling as participants are chosen specifically to confirm or refute the findings (Dingwall 1992; Glaser and Strauss 1965; Goodwin and Goodwin 1984a). Deviant cases should be carefully examined to determine how they could be incorporated in the analysis (Secker, Wimbush, Watson et al 1995). The inclusion of negative cases strengthens the credibility of research findings (Silverman 1989), and explains any apparent inconsistencies (Secker, Wimbush, Watson et al 1995).

While some authors argue for inclusion of all cases in the analysis (Secker, Wimbush, Watson et al 1995), others contend that the aim should not be to account for all cases, as this would be a rigid goal (Guba and Lincoln 1989; Lincoln and Guba 1985). The analysis, they argue, should account for most of the available data. The most important elements of the analysis therefore are the systematic coding and analysis of the data, inclusion of disconfirming or exceptional cases, and the modification of the analysis in the light of contrary evidence (Murphy, Dingwall, Greatbatch et al 1998). Such an approach to analysis has been likened to the careful search for falsifying evidence in science, which adds weight to the truth claims of an investigation. Phillips (1987) argues
that while such an approach can never guarantee truth, it supports the elimination of error.

It has been argued that since qualitative researchers are committed to making public the private lives of participants, it is ironical that their own methods of analysis remain private and unavailable for public inspection (Chenail 1995; Constas 1992; Harries-Jones 1995). Constas contends that the provision of detailed descriptions of the development of categories will help dissipate the notion of qualitative research being half science and half chimera, while the absence of such information may vitiate the clarity of a given empirical presentation. Analytical rigour in qualitative research is defined as an attempt to make data and the schemes used to organise it as public and replicable as possible (Denzin 1978). Additionally, Chenail (1995) argues that in a well-done qualitative study, the reader should have many opportunities to examine the particulars of the inquiry, such as, the processing and analysing of the data. He maintains that it is in this spirit of openness that trust is built between the researcher and the reader.

**Summary**

Chapter 4 has discussed the general theory behind the methodology of qualitative research. The main positive features of qualitative research were identified as, firstly, the ability to access participants’ definitions and interpretations (Crabtree and Miller 1991; de Vries et al 1992; Jensen 1989; Paget 1983; West 1990), thus helping the investigator to be part of the participants’ world. Secondly, qualitative research is useful in studying thoughts, feelings, intentions, and experiences which otherwise would not be open to study (McCracken 1988; Patton 1980; Silverman 1993; Secker et al 1995). Another
positive feature of qualitative research is flexibility, which makes it suitable for exploratory or hypothesis generating studies (Britten 1995; Burgess 1982; Denzin 1970). These qualities make qualitative research the method of choice in the study of women's views of the place of birth.

In the next chapter, the method used in the second study of the thesis, looking at women's perceptions of the childbirth process, and factors affecting their choice of place of birth, is described. An effort is made to apply the principles of qualitative research discussed in the present chapter.
Chapter 5: Qualitative Study of Women’s Views of the Process of Childbirth, and Factors Affecting Their Preference for A Place of Birth.

Introduction

The previous chapters collectively laid down the background and theoretical underpinning that inform the thesis. Chapter 4 focused on a discussion of qualitative research, which is the method employed in the present study of women’s perceptions of the process of childbirth and factors that influence their preference for home or hospital birth. The present chapter addresses the research design, methods used, and experiences of the researcher in the field while conducting the qualitative study.

Research design

The aim of the study was to determine pregnant women’s perceptions of the childbirth process, and factors they consider important when deciding where to have their babies. The study considered the views of a diverse population of pregnant women of different parities, gestations and backgrounds who were planning home or hospital delivery. The reason for choosing to include a cross-section of pregnant women of different backgrounds was to endeavour to explore their perceptions broadly. The aim was also to explore the effect of different circumstances on views about childbirth and the place of birth.

The researcher decided, in the light of the results of the systematic review reported in chapter 3, to use a method that would allow women to express their own views as much as possible. Therefore, a qualitative design using the grounded theory approach was chosen. With the grounded theory approach
(Glaser and Strauss 1967), the researcher begins with an area of study, and issues relevant to the area are allowed to develop from the data as data collection and analysis progress (Strauss and Corbin 1990). Two techniques are regarded as being at the core of grounded theory. The first is the constant comparative method (Glaser and Strauss 1967), where data that is collected is coded, and then compared to those from previous interviews. Data collection ceases when saturation, which is when no more new data is forthcoming, has been reached (Morse 1995; Morse 1998). The second technique is theoretical sampling (Guba and Lincoln 1985; Kuzel 1992; Morse 1989; Patton 1980; Strauss and Corbin 1990), where subsequent participants are chosen because of the possible contribution they can make in the already developing story line. The constant comparative method and theoretical sampling were both used in the study.

The next section discusses issues of obtaining ethical approval to conduct the study, access to the study population, sampling, contacting the participants and the actual interview process.

Access to participants

Ethical considerations

During the planning stage of the research, the researcher wrote a letter to the directors of midwifery at the two hospitals where she wanted to conduct the study. The letter explained the purpose of the study, and included a short proposal. The directors advised the researcher to also inform the women’s General practitioners about the study, and they together gave their support to seek ethics approval for the study. The ethics committee approval was obtained, the process involved submitting a research proposal according to the requirements of the committee. The proposal included information about the aims of the study,
potential participants, as well as information about the protection of human subjects. Information about the protection of human participants, as presented in the consent form (see Appendix 3a and 3b), addresses the participants' right to voluntarily participate in the study, and to withdraw at any time during the process. The consent form also included the central aim of the investigation, procedures used in data collection, confidentiality and any known risks associated with participation in the study. Details of the pilot study were included in the proposal. One of the conditions of the committee when they gave their approval was that the consent form should be in two parts. The first part, to be signed prior to the interview, indicating the women's consent to be interviewed (Appendix 3a) and, the second part, to be signed after the interview, representing women's agreement that information obtained from their interview can be used in the study, and stored for a specified period for research purposes. The committee also recommended that women should not be contacted directly by the researcher in the first instance, but by their midwives. They felt that this would ensure that only those women who are interested in the study have contact with the researcher.

Once ethical approval was obtained, the researcher met with community midwives at the two hospitals to discuss details of the study and how it was to be conducted. Only the midwives who were on duty on the day of the meeting attended. It was decided that since the ethics committee advised against the researcher contacting women directly, midwives would act as gatekeepers for access to the women. The plan was that they would distribute information leaflets about the study (Appendix 1) to all pregnant women who did not have any complications. Those women who expressed an interest in taking part in the study would inform them, and give their written permission to be contacted by the
researcher through the telephone (Appendix 2) to arrange an interview meeting. A file was opened which was to be used for storing details of women who were interested in participating in the study. It was agreed that the researcher would telephone the ward every Monday, Wednesday and Friday to check if any women had enrolled and the ward clerk would check the details in the file and then the researcher would go to the hospital to get the names and telephone numbers. After the meeting, the researcher wrote a memo to all midwives, explaining about the study and how it was going to be conducted. The letter also thanked the midwives for agreeing to distribute information leaflets to women. The other purpose of the letter was to inform those midwives who did not attend the meeting about what was agreed.

**Pilot study and Gate keeping Issues**

During the first week following the meetings with the midwives at the two hospitals, a pilot study was conducted to determine the feasibility of the chosen approach. The strategy agreed at the meeting, that midwives would distribute information leaflets to potential participants fell through. The initial enthusiasm shown by the midwives to help in the study waned, and they did not give out information leaflets, with the result that no women enrolled in the study after one month. The researcher lost control of the situation; the midwives that were contacted about the matter said they were very busy as there was a shortage of staff in the ward. The situation was brought to the attention of the nursing sister, who reiterated that the midwives were very busy because of staff shortages. She, however, suggested choosing representatives from different teams who would help with the study. The representatives would be the contact people for communicating with the researcher about the study and they would encourage others in their teams to recruit for the study. This second strategy did not work.
either. Three months passed, there was no progress with recruitment, and it was difficult to get hold of the nursing sister. There was a genuine staff shortage problem at one of the hospitals and the hospital even started recruiting midwives from overseas. At the other hospital, the main problem for the study was the fact that there were no women booking for home birth.

When the researcher was eventually able to meet the midwives again, she proposed to be given access to the antenatal registers so that she could select women who could be potential candidates herself. After identifying the women, the researcher would then ask the particular midwife looking after the woman to give the information leaflet to that woman. The researcher felt that in that way she would be freeing midwives from the task of selecting the women. All they would have to do was inform the already identified women. The researcher would also be dealing directly with a particular midwife and could establish rapport with her, which would make follow up easier.

Midwives and the nursing sister agreed with the proposed plan. The ethics committee was informed and the chairman gave permission to proceed with the proposed strategy. The new plan worked fairly well, although some midwives still did not contact the women, the majority did.

**Pilot Study Sampling and interviews**

The pilot study eventually involved three women, two planning a hospital birth, and one planning a home birth. The interviews started with women planning a hospital birth. The researcher chose one woman from the antenatal register; there were no criteria for picking the first woman. She was planning to have her baby at the hospital, was married and expecting her third child.
After choosing the woman, her midwife was asked to give her an information leaflet (Appendix 1) explaining about the study, as was the agreement. The woman was interested in participating in the study, so she gave the midwife permission to pass her details to the researcher to contact her by phone to arrange an interview using the consent to be contacted form (Appendix 2).

However, women's indication of interest in the study, and their agreement to see the researcher, was not perceived as consent to participate, but merely as a desire for more information. Those who made an appointment to see the researcher had the study explained to them verbally, in addition to the information leaflets they had been given by the midwives. The verbal explanation included the purpose of the study, the estimated amount of time that might be needed to complete the interview, the fact that the interview would be tape recorded, and how the results of the study were going to be used. All were informed that they could terminate the interview at any time if they changed their minds. They were given an opportunity to ask questions, and if they were still interested, asked to sign the first part of the consent form (Appendix 3a). Following the interview, if they were happy, they signed the second part of the consent (Appendix 3b).

The first woman in the pilot study preferred to be interviewed at the clinic following her next appointment with the midwife. At the meeting the researcher introduced herself and gave information about the study. During the interview, the researcher made observations of the participant's behaviour, surroundings, and was aware of her own feelings and interaction with the participant. This was important to help in the analysis of the interview later. At home, the interview was listened to, and more notes made about it.
The interview was transcribed the same evening it was conducted and then analysed to get a general idea of what was expressed as having influenced her choice of place of delivery. The researcher then made a summary of the analysis. During the analysis, the researcher went through the interview process and determined whether there were any questions that should have been addressed that were not addressed. The researcher also assessed the style of questioning, to determine whether she perhaps did not listen as much as she should have, or whether there were any interruptions that could have led to incomplete narratives. This was to study the data at hand, and try to anticipate what was coming and plan for the next interview so that important questions could be followed up, and the style of questioning improved.

The next woman to be interviewed was selectively chosen to ensure that she was planning a hospital birth, unmarried, and expecting her first baby. This was to get a feel of decisions by women of different circumstances, but who were both planning a hospital birth. Like the first participant, she preferred to be interviewed at the clinic following her next appointment with the midwife. The same procedure followed as for the first one. The transcript was compared with that of the first participant to determine any similarities and differences in factors influencing their decision and in the way they conducted themselves during the interview.

A common factor with the two interviews was the fact that it was difficult to get a spare room in which to conduct the interviews, background noise in the clinic, and the fact that the two women appeared in a hurry to go home, which did not afford a relaxed environment for interviewing.
The third participant was the only one in the antenatal home birth register at that time. The woman was married, and pregnant with her fourth child. The procedure followed for recruiting and interviewing was the same as for the other two, i.e., after her name was identified from the register, the midwife looking after her was asked to extend an invitation to her to participate in the study, and to give permission for the researcher to contact her and arrange for an interview. The woman agreed to participate and preferred to be interviewed at her own home as she was receiving her antenatal care from home.

The interview was very relaxed, the woman offered a cup of coffee, which was accepted, and the interview was conducted in her sitting room. After agreeing to participate and signing the first part of the consent form, the woman was asked to relate the events that led her to choose a home birth. She gave intimate details of her two previous pregnancies and the kind of treatment she received in hospital, which was unpleasant, and appeared agitated as she related the events. She also talked about her relationship with her husband and about her previous marriage. She appeared relaxed except when she talked about her previous experiences of hospital births.

It was difficult to control the interview, as it was not easy to anticipate how relevant the information she was giving was going to be. A decision was made to let her recount what she thought was relevant to her decision to have a home birth. The interview lasted one hour and thirty minutes and she was still willing to go on. She offered to be contacted again if more information was needed. She raised many issues, which were useful for subsequent interviews, because it was easier to anticipate the kind of topics the other women might touch on, and to probe for more information. Issues not cleared at the pilot interview could also be brought up with other women to determine how they might be
relevant. The environment of the home interview appeared relaxed and easy compared to the two clinic interviews. As a result, it was decided to conduct all interviews at the women’s own homes if they did not object. The transcript of the interview is displayed in Appendix 4. This transcript serves as a model for all the home birth interviews because it contains all the elements that were subsequently mentioned by others planning a home birth. The interview was also analysed together with the others for the main study.

After the three interviews, the main study was commenced.

The main study

Sample size

The main study followed procedures described in the pilot study, all interviews took place at the women’s own homes. Thirty-three women participated, thirteen that were planning to have a baby at home, and twenty planning a hospital birth. The initial plan was to enrol forty women, twenty planning a home birth and twenty planning a hospital birth. However, after interviewing the tenth participant in each group, no new information was forthcoming, but women were giving different versions or explanations of the same themes. Nevertheless, interviewing was continued beyond the point at which repetitions began to emerge. In the hospital birth group, as it was easy to get participants, twenty women were interviewed. In the home birth group, thirteen women were interviewed. The women were recruited at different stages in their pregnancies. All women invited to participate in the study agreed. This may be an indication of the appeal of the subject of the study to those who took part.
The qualitative nature of the study meant that only a limited number of women could be enrolled as they were going to be studied in-depth (Kvale 1996; Mason 1996; Miles and Huberman 1994; Patton 1990). Qualitative studies yield a lot of data, and too many cases can become unwieldy (Bailey 1982; Miles and Huberman 1994; Sapsford and Jupp 1996). The key point in qualitative research is to stop when data saturation occurs (Morse 1995).

**Sampling**

Following transcription and analysis of the first few interviews, there were some emerging story lines and themes. The researcher used the story lines for selecting the next participants to be interviewed. This method of choosing participants according to emerging theory, aims of the study, or theoretical underpinning, is referred to in qualitative research as purposive or theoretical sampling (Guba and Lincoln 1985). For example, in the study, the two first-time mothers who were interviewed seemed concerned that they did not have any experience of labour and delivery to have made an informed decision about where to have their babies, they just assumed hospital would be best. The researcher wanted to explore the finding further, hence, in the next two interviews, she purposely chose women who were having subsequent babies. This was an attempt to determine whether there was more to the decision than just the lack of experience.

Other variables included as the interviews progressed were mothers that were not married and women of different ages and educational status. For example, one of the women interviewed in the hospital group, who was single, mentioned that she had not discussed where she was going to have the baby with her partner. This was an interesting point, and another one that the researcher
wanted to explore. Consequently, the researcher made a conscious decision to select a married woman to find out from her how the husband was involved in the decision. This was in an effort to understand the emerging construct by looking at different instances of it. The questions that came to mind were: did the woman not discuss the matter with her partner because they are not married, and therefore did not feel obliged to do so? Alternatively, is there another explanation? Would a married woman have behaved differently? Would another unmarried woman approach the issue in a similar fashion?

Another example is a woman whose baby needed resuscitation. The woman, in the hospital group, had previously had a hospital birth. At that time, she was given pethidine during labour, and proceeded to deliver a baby who needed resuscitation. The woman felt that she was lucky to have been in hospital at that time because at home there would have been no suitable resuscitation equipment. She therefore felt that it was best that she was going to have her baby in hospital because any problems will be immediately attended. Another woman with a similar past history who was also planning a hospital birth was interviewed, followed by yet another with a comparable history, but who was planning a home birth. Sampling continued in such a fashion until data collection was completed.

**Procedure of interview**

Data were collected by means of an open interview; the opening for all women was "*please tell me about your decision to have your baby at home/hospital*". In some women, the question was enough to get them talking in detail about their decision and factors that contributed to it. In others, however, a lot of probing was required for them to give the information. If this happened, information about factors mentioned by others in previous interviews was used to
introduce a topic. The following excerpt of a transcript illustrates how probing
was done:

**Researcher:** What is the state of hygiene in the hospital?

**Bothepha:** Oh, it's appalling, this was [name of hospital] before the new
unit was built, and it was just diabolical. There were cockroaches in the toilet, I
am not joking! The food, well, what can I say about the food? They had these
horrible old bright orange and purple curtains, you know, that you pull round
that must have been 100 years old. This was [name of hospital] literally just
before they knocked it down, six months before they knocked it down and built
the new unit. The bath, well I had to take antiseptic stuff and clean the bath
before I could get in it. I wouldn't sit on the toilet seat, I know so many people
that went home with infections. You know, it was unbelievable and that was a
big factor in thinking I don't want to go near a hospital again. Because you
are more likely to come home ill than you are, you know. Oh it was appalling, I
mean the nurses and everything had good standards of hygiene and there was
a cleaner. I was in a ward with, I think there was about 10 of us at least. Some
people coming and going, and visitors and you know, so it was appalling.

The researcher asked Bothepha the question about hygiene towards the
end of the interview, and it is thought unlikely that Bothepha would have
discussed hygiene without being prompted. However, following the question she
discussed hygiene in detail, and even said it was the main reason she was planning
a home birth. This would suggest that issues raised in previous interviews, which
seem important, could produce valuable leads for subsequent interviews.
Most women offered coffee or tea, and in all cases the offer was accepted. This was usually followed by small talk about the weather, and the woman's health. Issues such as how far they were in their pregnancy, and how it had progressed were raised before the actual interview started. In one case, the woman offered coffee and then went on to talk about her recent house move, the people that sold them their new house, and about their neighbours. She seemed to want to talk about everything else except the subject of the study. Eventually she was asked whether she wished for the interview to begin. She was a bit hesitant at the beginning and wanted to change the subject again. The researcher explained to her that she was not at all obliged to take part in the study, and that she could change her mind about giving the interview if that was her wish.

The woman then started to talk, reservedly at first, and then became more involved in what she was saying. It became apparent that she had been planning a home birth, and just two days before the interview, she was informed that she could not go ahead with her plan because her baby was too big. This happened two weeks before her expected date of delivery. The equipment to assist at the birth, which had already been delivered to her home, was taken away. The woman was still very angry and disappointed and found it very difficult to discuss anything to do with the birth. However, as the interview progressed she relaxed into it.

Demographic data about the women were collected directly from their obstetric records to avoid long interview sessions with them. All interviews were tape recorded and later transcribed for analysis. After the interview, reflective notes were written about how the interview had progressed and about the impression given by the participant during the interview (Appendix 5). The
researcher wrote her reflective notes when she arrived at the car after the interview, and/or immediately after arrival at home.

At the researcher's home, the interview tape was listened to, and more notes made about the interview. After this, the labelled tape was sent for transcription. The transcribers were given instructions to type everything verbatim. When the transcribed interviews arrived, they were read again, and all were compared with the original tape to check for consistencies in the transcription, mistakes were immediately corrected.

**The influence of the researcher**

In a qualitative investigation, the researcher's role is more than just data collection. His or her background, gender, social class, ethnicity, curiosity in the subject under study, relationship with participants, and style of collecting and analysing data all have a bearing on the final product of the investigation (Sword 1999). It is therefore important to be aware of the possible influence of the researcher on the results of the investigation.

In the present study, the researcher is a midwife, who has not practised as a midwife in the United Kingdom, and who belongs to the black ethnic minority group. All women were informed of the researcher's status, as regards midwifery practice. It was explained to the women that the researcher was not a proponent of any particular place of delivery, but wished to understand factors women considered of significance in planning where they wanted to have their babies. The researcher's background may have had an impact on the way women interacted with her during the investigation.
All women who participated in the study were white, except one who was of Indian origin. They all seemed relaxed and appeared to talk candidly about their decision-making and previous experiences of childbirth. Some of the women asked about the situation of childbirth where the researcher had worked, but the questions were general and not about the subject of the study. The questions were usually asked after the interview. It is argued that women felt more at ease talking to someone who they may have felt was not part of the establishment about which they were reporting.

The researcher's anxiety in anticipating the interviews was whether women participating in the study would regard her as an outsider, and also whether they would perceive the research as worthwhile. However, the anxieties were expelled soon after the first few interviews by the spontaneity of the women's responses to the research question, the way they shared some very personal information, and by offering to be contacted again if more information was needed.

In an attempt to promote acceptance, and create rapport, the researcher dressed in a smart, but casual manner for the interviews, and initiated casual conversation before the interview commenced. The conversation advanced to asking them about how their pregnancy had progressed up to that point. If there were children in the house, the researcher also interacted with them according to their age. The dialogue with women appeared to be easy and spontaneous, suggesting that they were comfortable with the researcher's presence. A decision was made to tape record the interviews and not to write notes, as this would allow more attention and eye contact with the women, which may signify an interest in what they were sharing.
As the women's stories unravelled, some provoked unanticipated feelings from the researcher. Two women particularly described the difficulties, and sometimes cruelty, they experienced at the hands of their carers. The researcher felt much compassion for the women, and sometimes felt a sense of sadness at the hopelessness of some of their situations, and the fact that the researcher could not take active responsibility in helping, except to refer them to appropriate agencies. Although there was a lot of emotion experienced in the course of the interactions with women, it was important to maintain a neutral attitude (Patton 1990).

In the study, the researcher empathised with the participants, but did not give any opinions as to how the women's cases should have been handled. The women were just asked about how they felt about the situation and whether they would want to talk to someone about it, in which case the appropriate person was informed, and the woman handed over to them.

This section has described the processes used to collect data for the study, the next section will discuss how the data was handled and analysed. The two processes of data collection and analysis in a qualitative study are interactive, which makes it difficult to talk about one without mentioning the other.

**Data Analysis**

Methods used to analyse the data are presented, using as much raw data as possible to give the reader an idea of the type of information that was collected, and the procedures used to analyse it. The extensive use of raw data helps to make public the style and process of analysis. Participants' names are replaced by Setswana (researcher's language) names to protect their identity. The present study tried to follow principles of qualitative data analysis, especially the grounded theory approach (Glaser and Strauss 1967).
The process of analysis was iterative with data collection. During the interview, the researcher listened, as well as observed, the surroundings and participant's non-verbal cues. In this way, the context in which the research took place and aspects of non-verbal communication could be recorded. Points raised during the interview were clarified at appropriate times, for example, periodically, what the participant said was re-phrased and repeated to her, or she was asked additional questions. This kind of questioning and confirming were geared to understanding the participants, to avoid misinterpreting them in the formal analysis. The following example illustrates questioning to get a meaning of the participant's expression:

Nozipho: When I've gone up to the hospital, or to the midwife with my partner, I mean, he has been totally ignored. It's like, you know, it did take two! You are not made to feel..., not special, that's a bit dramatic, but you're like a conveyor belt. It's like, next, and, I guess you're fine, off you go. And I think that because it is such a special thing, it, you should be made to feel perhaps a little more you know, that what you're doing is quite incredible and made to feel that it is really.

Researcher: When you say you are like a conveyor belt, what does it mean?

Nozipho: It is more, um let's say for example at the clinic, they run the flu clinic, you know, you have people coming in, they're having their injection and it is nothing else to the ordinary and, and you're having one person in after another. Um, and that's fine for a flu injection, but when you're actually
you know, you’re carrying a baby un, and especially if it is your first time, to you it is miraculous.

Nozipho used the expression *conveyor belt* to put across that care was very impersonal and hurried at the clinic, without any consideration as to how she felt about her pregnancy. It was necessary to understand the phrase the way she meant it. Other women used the same expression in the same way.

In another example, Mmaoshadi was asked to isolate what she thought were the main reasons why she preferred to have a home birth:

**Researcher:** If you were to isolate just one or two reasons for choosing home birth, what would they be?

**Mmaoshadi:** The familiarity, not having to leave in the middle of it all. It was all much more relaxed, not having to pack my bags, and my children as well. I had one sick child the last time, who my Mum came to look after and she wouldn’t have anything to do with. She was too ill, didn’t want anybody but me and I would have worried about her, if I’d have been in hospital even just for a day. I would have worried about her because I knew that she wasn’t getting..., she was throwing strops every time Mum tried to do anything for her, even my husband she wasn’t particularly interested in. It was me she wanted, and I would have worried about that I think. Yes, so there’s no break in it for them, she woke up in the morning, she’d been awake during the night but she woke up in the morning the baby was there. I hadn’t had to go away, there was no kind of trauma for her either, but, you feel in control, you feel that you’re doing it all at your pace. Yes, that’s probably the main kind of things,
my husband would say that he felt more in control and much more involved in the whole thing being here.

Such questioning helped to check the participant’s response against the information they had already provided. In the above example, Mmaoshadi had already given the same reasons without any prompting, therefore, the response to the question served as confirmation. Some words used by the participant serve as in vivo codes, i.e., codes constructed using elements from participant’s own speech (Strauss and Corbin 1990). These are the underlined words in the quotation above.

Immediately following the interview, when the researcher arrived home, and sometimes in the car, before going home, notes were made about the interview situation. The notes included anything noteworthy that was observed, or anything surprising or unexpected that the participant mentioned or seemed to concentrate on during the interview. The interview style was also reflected on to determine whether it could have been better, and how it could be made more effective in subsequent interviews. After Nnese’s interview, the following notes were made:

Nnese seems upset about her husband’s lack of support for a home birth, but determined to have her baby at home. It was a bit difficult to conduct the interview because Nnese’s son was in the room and wanting attention from her, or making too much noise. However, despite this, Nnese put her point of view across clearly. Perhaps I did not give Nnese adequate time to discuss all factors affecting her decision, or maybe I did not use the right prompts?
As soon as the tape recorder was switched off, she talked at length about the things she does not like about the hospital. These included cleanliness, which seems to be the main factor. She says the toilet and bath are not cleaned properly, and that too many people use the bed linen. She also talked about shortage of staff, which often results in women not having any midwife with them during labour, and she did not want that to happen to her. Noise from other women's babies was another factor she did not like about the hospital environment.

In the coming interviews, perhaps I should prompt for these issues if they are not spontaneously mentioned. The interview was interesting because Nnese is a midwife, so it was interesting to hear her give the same reasons as other women for wanting a home birth. It was also interesting to hear about how midwives may feel about providing home births, having at one point opposed home births herself.

During the interview, Nnese maintained that her only reason for choosing to have home delivery was her son, as there was no one to look after him if she went to hospital. However, as the interview progressed she gave other reasons, including the fact that she did not want to be left alone during labour, and that the hospital was a clinical environment (See Appendix 6 for Nnese’s full interview transcript).

Each interview was transcribed as soon as possible following the interview. Those transcribed by the researcher were done on the night following the interview, while the interview situation was still fresh. However, because of the workload, some of the transcription was done by a secretarial service. The tapes were handed to them on the day of the interview, and it took 2-3 days to get the transcripts back. After transcription, the researcher proof-read all the
transcripts and compared them with the interview tapes to correct mistakes. This also served to make the researcher familiar with the transcripts.

Following transcription, each interview was analysed using line-by-line open coding (Glaser 1992). In this type of coding, there are no preconceived codes, the data themselves suggesting the type of code (Appendix 7). Single words, phrases and sentences were closely examined to give them a label. The following is an example of open coding for part of Nnese’s interview transcript (see Appendix 6 for the full transcript).

**My decision is purely convenience.** *(convenience)*

...my partner and I aren’t of the same vein on this, but he is soon to be *(partner disagrees)*

working away on a weekly basis, Monday to Friday, and

I have 18 month old son and trying to find someone to take me *(concern for son)*

into hospital and someone to look after him is just going to be so difficult in the middle of the night

and I labour very quickly. I had an hour and a half labour with Tefo *(quick labour)*

and I want the reassurance that I am not going to be on my own. *(doesn’t want to be alone)*

So it is really convenient that I call out someone and I know *(convenience)*

I can have a good midwife here within half an hour to help me.

And those are really my reasons.

I have had lots of friends in the area who have had home births

and had really really good experiences and I thought I would do it myself. *(influence of friends)*
The hospital birth I had was very fortunate in that I had chosen a midwife who was a very good friend of mine who came to deliver me (had familiar midwife) and it happened very very quickly, but it was a bit dramatic at the time and a bit clinical, but it had to be (previous quick, dramatic and clinical birth in hospital)

and my husband was very frightened, so it had to be in hospital (husband frightened)

and now that I have a very rapid labour, I think I would like to do it at home. (has rapid labour)

I didn't have much pain relief last time and there is no need for me to go in and be in that clinical environment if I am such a low risk category, (low risk category no need for hospital) which I am. But there is nothing with the hospital, I will go in, if they want me to go in, I will go in, it is not a problem, (will go to hospital if needs be)

but I prefer to have it in a relaxed confines of my own home. (own home more relaxed)

Analysis of this excerpt led to some patterns of experiences and Nnese’s thoughts being listed. These were thought to be influencing factors in her decision. The first thing she mentions is convenience, and then she goes on to point that her husband was not in agreement with her decision. Nnese then outlines why it is convenient to have a home birth by explaining the situation with her first son. Another factor she mentions is that she had a quick labour, and that she did not want to be left on her own. A follow-up question would have established the significance of a short labour and home birth, this was not done in this interview, but subsequent interviews with other women indicated that some feared they might deliver before reaching the hospital, while others thought that
because they previously had short uncomplicated labour it was an indication that
they would not have any problems if they delivered at home. The point about the
reassurance of not being left on her own was later expanded when Nnese
mentioned the shortage of staff in hospital.

The analysis also reveals that Nnese was influenced by the good
experiences of her friends. She also wants to be cared for by a familiar midwife,
in her previous delivery a close friend assisted. Nnese considers the hospital to be
a clinical environment, and herself to be low-risk and therefore does not need to
be in the clinical environment. She, however, points out that she has an open
mind about the hospital because if there is a need to go in she would.

The categories generated by the analysis therefore are:

- Convenience
- Partner disagreement
- Quick labour
- Influence of others
- Familiar midwife
- Clinical environment
- No need for pain relief
- Own environment
- Open mind about the hospital

The purpose of initial analysis was to discover issues that were raised
during the interview, and therefore what to anticipate and follow up in subsequent
ones. The data gave indications of who to interview next and who might help in
clearing issues raised in the present interview (Boulton and Hammersley 1996;
Denzin and Lincoln 1994; Strauss and Corbin 1990). Many categories of analysis
were made as suggested by the data at that time. Issues raised in the previous
interviews were followed up in subsequent ones. If not spontaneously mentioned,
probes and/or questions were used to get the participants’ view on the issue.

There was an active search for negative cases.

A sample of the transcripts were given to a second person to analyse to check that the researcher was making an objective analysis of the interviews. The second person was a nurse lecturer, and she was only given the aims of the study and asked to analyse the transcripts to see what categories she could come up with. There was a remarkable similarity between the themes that the researcher and the second person produced. This was taken by the researcher as an indication that the analysis was objective and therefore she continued with the rest of the transcripts.

Summary sheets in the form of mind maps, depicting the categories that developed were made for each transcript. Figure 2 is an example of a mind map that was made.
Figure 2: Analysis mind map

- **Hospital factors**
  - Very technical
  - Very clinical
  - Birth taken away from you
  - Strapped down in bed
  - Continuous monitoring
  - Hospital busy
  - Attended by strangers
  - Shambles
  - Busy
  - Restricted visiting hours
  - Formal
  - Loss of control
  - Strict routines

- **Home factors**
  - More personal
  - Do what you want
  - Have a bath anytime
  - Take your time
  - Known midwife
  - More control
  - More comfortable
  - Something different
  - More relaxed
  - Easy going
  - More explanation
  - Freedom to move about
  - Flexible
  - Special

- **Other factors**
  - Previous good labour
  - Lack of information

- **Pregnancy factors**
  - Second pregnancy

- **Professional factors**
  - Good midwife
  - Experienced midwife
  - Supportive midwife

- **Partner factors**
  - Prefers home
  - Support
  - Sister led home birth

- **Sources of information**
  - Other women
A mind map is visually similar to a diagram, and is used as an ocular representation of relationships between concepts (Straus and Corbin 1990). It has also been described as a visual format that represents information systematically so that the user can draw valid conclusions and take needed action (Miles and Huberman 1994). The mind maps used in the present analysis allowed one to see a summary of all categories derived in an interview at a glance. It also made it easy to compare codes from different transcripts without having to read through the mass of data to identify them.

The process of data collection and analysis is recursive and dynamic in nature, but, it does not follow that the analysis is finished when all data has been collected (Merriam 1988). On the contrary, analysis becomes more intensive once data collection is finished. In the present study, when all the interviews had been completed, all the transcripts and summary maps were revisited to compare the codes and themes that had developed. This is called focused coding, and it has been argued that as a corpus of initial coding accumulates, it becomes itself an object that should be reviewed (Lofland and Lofland 1995). The more frequently used codes are identified, the less used ones also noted. Relationships between codes were also identified so that they could be brought together under common names that encapsulated a common meaning.

Once similar themes had been combined, the researcher decided to list all the final themes and then go back to the transcripts to identify the excerpts that contributed to the theme formation. This was to attempt to ensure that the themes related directly to the raw data and that the raw data would attest to the genuineness of the themes. The theme was therefore listed, followed by some quotations from different transcripts with pseudonyms and location of the
There are different ways of conducting qualitative data analysis. In the study, subsequent to focused analysis a more in-depth analysis was done following an example from the literature (Rose and Webb 1998). In the example, an excerpt of a poem by Yeates was used to illustrate how analysis could be conducted. The example follows:

An aged man is but a paltry thing,

A tattered coat upon a stick.

Yeates (1972) quoted by Rose and Webb (1998)

The key to understanding the extract lies in understanding the meaning of the symbol, the old man represented by a tattered coat on a stick, representing a scarecrow (Rose and Webb 1998). The scarecrow in relation to old age represents emotions, for example, loss, poverty of spirit, and loneliness (Rose and Webb 1998). Without an understanding of what a scarecrow is, one would not make sense of the image. Furthermore, more cognitive processes are involved to connect the image of the scarecrow to the experience of old age. The language used and the image it conjures combine to bring out the general category of old age.

Rose and Webb (1998) assert that a researcher should be able to make a more sensitive and sympathetic analysis of interview data by using a comparable intellectual technique. The reader of the poem can reach a more profound understanding of what the poet is attempting to convey than merely stating that the poem is about old age (Rose and Webb 1998). The point made by the
illustration is that data analysis is much more than just quotations of participants' words. Additionally, the poem stands to illustrate that the analysis must be made in the context of the data at hand, and not in general terms. A full description of the circumstances under which the data was collected is therefore an integral part of the analysis.

An approach similar to the one above was taken in an attempt to analyse the transcripts in-depth to try to understand the decision-making process. The following quotation is used as an example of how this was attempted:

Gaolape: I think if, if you're at home, I mean don't quote me on this till after I've had the baby (laughs). I think at home things are actually less likely to go wrong, this is my personal opinion, because I know, um not so much of my boy, because it was a very easy birth. But with [my two girls], it was a case of, they are standing there, and they are saying you know, the baby is in distress, if you don't hurry up and push you gonna have to have forceps. And they show you what they are and you're thinking, Oh, my God! You know and you are getting yourself, so, I got myself so worked up, you know because, you know I've seen these things, and I thought, oh no, they're, not going near me. You know and I find I was very very panicked the first two times, you know, and it was a case of, yes, just push for dear life and yes, with the first two girls I ended up with a lot and lot of stitches. And yeah, yeah, with my boy, it was a case of, because, yeah, praise not my old midwife, um, because of how well she was, I mean he was nearly 9 pounds and it was fantastic! You know, no stitches, nothing, because there was no pressure there. Whereas yeah, with the two girls there was so much pressure that you know, it,
it just put me off of birth, full stop. And yet this time, I thought well, at home, you know, once again you're not going to have that pressure because they are not going to say to you, you know hurry up and push this thing out because I've got two more ladies in the next room waiting to give birth, and I can't spend all my time with you. So, I think yeah, at home because I feel you'll be a lot more relaxed, you're less likely for things to go wrong, I mean that's not saying they won't (Gaolape).

At casual reading of the extract it appears the woman is simply trying to justify her decision to have a home birth by saying home is relaxed and things are less likely to go wrong and even laughing about it. The passage raises a lot of issues, and the analysis attempted first to get the overall meaning and then to try and isolate factors, which appear to have influenced her decision to have a home birth.

Firstly, Gaolape starts the passage by making it clear that she has no previous personal knowledge of home birth, "I think...". She then acknowledges that things may not go according to how she thinks they will progress "...don't quote me on this until after I have had the baby". She talks about her previous experiences of hospital deliveries, she has had three children in hospital. In the other two births, she describes scenes of intimidation and blackmail by those looking after her, "the baby is in distress, if you don't hurry up and push you going to have to have forceps! And they show you what they [forceps] are, and you're thinking, Oh, my God! You know and you are getting yourself so, I got myself so worked up, you know because, you know, I've seen these things, and I thought, oh no, they're, not going near me".
The midwife who assisted her told her to hurry up and push. In reality, one does not just push when they want to deliver the baby. Secondly, the woman is shown the forceps, which will be used on her if she does not hurry up and push. This appears like a threat of a punishment she is going to receive if she does not follow orders.

In the process, Gaolape became very anxious and panicked. She says it was a case of "just push for dear life!" The result was that, as she put it, "with the first two girls I ended up with a lot and lot of stitches" and that "it put me off of birth, full stop".

On the other hand, she had a hospital delivery where she received better treatment. That time, although the baby was big, 9 pounds, she did not have any stitches because she was not pressured and therefore she was more relaxed. Gaolape believes that if she delivers at home, there will be no pressure, as there will be no other women waiting for attention at the same time. She finishes by saying things are less likely to go wrong at home but this is not saying that they wont. She seems willing to take the risk.

Gaolape had a very bad experience of a first labour. She chose to go to hospital probably because she trusted everything the hospital represented. She was let down by the midwives who looked after her, and, when she tried a second time the same thing happened. She was told that her baby was in distress, that alone would panic her, but, in addition to that, she is made to feel that it is her fault that the baby is in distress. In the end, she has many stitches, which was physical trauma in addition to the emotional trauma. The experience had a lasting effect on her because she said it put her off having another child for thirteen years.
Gaolape brought up a number of factors that led her to choose home over hospital birth such as:

- *the ill-treatment*
- *impersonal and hurried care*
- *divided attention*
- *interventions*
- *victimisation*

All interview transcripts were scrutinised in a similar fashion to get to the core factors that influenced women’s choice of place of delivery.

After completion of data collection phase, the researcher wrote to the two hospitals to thank the midwives for helping in the study. All women who took part also received a letter thanking them for their participation in the study. The researcher also offered both the women and the midwives a summary of the results and asked those who are interested to indicate so that they could be sent one.

The present chapter has discussed the methods used to collect and analyse data for the study. It has also given an indication of the findings through some of the analysed texts. Data analysis and results are intertwined in qualitative research; a discussion of the analysis is also almost a discussion of findings. The following chapter addresses the results, and there is a lot of overlap with data analysis.
Chapter 6 Results

Introduction

Chapter 6 presents results of the investigation into pregnant women's perceptions of the process of childbirth, and major influences on their preference for a place of delivery. In an effort to understand women's decision-making about the place of birth, theories of risk perception were considered, which, it was thought, might illuminate how women make decisions about the place of birth. Examples reviewed in chapter 3, suggested, among other things, that the perception of risk in decision-making is subjective, depending on the beliefs and individual or group circumstances of those involved in the decision-making. The thesis therefore considered that one of the factors influencing women's choice of place of delivery might be their perception of risk and safety related to childbirth. The proposition was made because home and hospital as places of birth are very different in terms of what facilities are available and who is likely to attend the birth. However, the notion of risk perception was not introduced when questioning the women, the aim was for the theory to emerge from the data if it was relevant in the decision-making. It would therefore be picked up in the analysis.

The present chapter starts by presenting tables of results in terms of demographic characteristics of those who took part, as well as themes identified as having had an influence on the planned place of delivery. As in the previous chapter, raw data are used as much as possible where appropriate. The style adopted in presenting the results by employing raw data is recommended by Chenail (1995:7), who believes that the data "should be the star" in that it should be the focus of the research in all its richness, breadth, and depth. It is also argued
that presentation of much of the data allows the reader to see what they can see in the data, and is a way of sharing the wealth and invites others to continue the inquiry and the conversation (Chenail 1994). Other authors have adopted the same style (Boydell, Goering, and Morrell-Bellai 2000; Karp and Tanarugsachock 2000; Lavender, Walkinshaw, and Walton 1999; Sandelowski and Jones 1996; Waitzkin 1991).

When quotations from raw data are used in published papers, the authors often omit the identifications, normally pseudonyms they used for participants who provided the particular data (Boydell, Goering, and Morrell-Bellai 2000; Karp and Tanarugsachock 2000; Lavender, Walkinshaw, and Walton 1999; Sandelowski and Jones 1996). This would make it difficult to discern whether the information used is from one participant, or a number of them. In this study, pseudonyms for participants are used in all the quotations. As well as showing the variety of respondents who provided the data, it also allows anyone interested in any particular interview transcript to easily identify it.

The study aims were presented to the women, and the opening statement at the interview was:

Please tell me about your decision to have your baby at home/ hospital (depending on the chosen place).

This evoked a variety of responses from the women, covering different subjects. The next section explores issues raised by women about their decision-making, but first the demographic variables are presented.
Findings

Thirty-three women participated in the study, 20 planning a hospital birth and 13 planning a home birth. The age, educational and marital status, and parity of those who participated are presented in Tables 5-8.

Table 5: Age and Planned Place of Delivery

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Home (N=13)</th>
<th>Hospital (N=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>20 - 25</td>
<td>2 (15)</td>
<td>4 (20)</td>
</tr>
<tr>
<td>26 - 31</td>
<td>4 (31)</td>
<td>6 (30)</td>
</tr>
<tr>
<td>32 - 37</td>
<td>6 (46)</td>
<td>8 (40)</td>
</tr>
<tr>
<td>38 - 43</td>
<td>1 (8%)</td>
<td>2 (10%)</td>
</tr>
</tbody>
</table>

Table 6: Educational status

<table>
<thead>
<tr>
<th>Educational level</th>
<th>Home (n=13)</th>
<th>Hospital (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Primary School</td>
<td>3 (23)</td>
<td>8 (40)</td>
</tr>
<tr>
<td>Secondary School</td>
<td>5 (38)</td>
<td>7 (35)</td>
</tr>
<tr>
<td>University or college degree</td>
<td>5 (38)</td>
<td>5 (25)</td>
</tr>
</tbody>
</table>
There were no differences in demographic variables between women planning a home birth and those planning a hospital birth. This may be because theoretical sampling was used, which aimed for women with specific characteristics to match or refute a view raised in a previous interview. There were, however, some differences in educational status. More women in the home birth group had sat secondary school and college or university examinations. Only one woman expecting her first baby was planning a home birth, whereas in the hospital group there was an even distribution of parity.
When asked about where they think is the best place to have a baby, 77% of women planning a home birth and 90% of those planning a hospital birth said that for a first baby it is better to go to hospital as one does not know what to expect. This might explain why there was only one woman expecting a first baby who was planning a home birth. At the time of the study there was no other first time mother planning a home birth.

The results of the investigation are now presented in tables in the form of themes expressed by women. It is important to note that the themes express what women spontaneously expressed, which was then brought together by content analysis. Table 9 lists themes according to place of delivery they refer to (i.e. home or hospital) or just the number that mentioned the theme. For example, looking at the theme comfortable/relaxed, the numbers indicate that 1 woman felt the hospital was comfortable and/or relaxed while 10 felt that way about the home. Numbers under themes convenient, emergencies attended faster, partner against, and safety indicate the number who felt that way about the venue.

However, for the themes first baby best in hospital, good experience/easy birth, influence of others, information from others and reading, no pain relief, partner involved in choice, pregnancy complications, process uncertain, short labour and supportive midwife, the numbers indicate the number in each venue who mentioned the theme (see Table 9).
Table 9: Themes expressed by women in both groups

<table>
<thead>
<tr>
<th>Theme</th>
<th>Home (n=13)</th>
<th>Hospital (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfortable/relaxed</td>
<td>10 (77%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Convenience</td>
<td>7 (54%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Emergencies attended faster</td>
<td>2 (15%)</td>
<td>14 (70%)</td>
</tr>
<tr>
<td>First baby best in hospital</td>
<td>8 (62%)</td>
<td>16 (80%)</td>
</tr>
<tr>
<td>Good experience/easy birth</td>
<td>6 (46%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Influence of others</td>
<td>8 (62%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Information from others and reading</td>
<td>5 (38%)</td>
<td>11 (55%)</td>
</tr>
<tr>
<td>No pain relief</td>
<td>2 (15%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Open mind about pain relief</td>
<td>6 (46%)</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>Partner against</td>
<td>1 (8%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Partner involvement in choice</td>
<td>13 (100%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Pregnancy complications</td>
<td>5 (38%)</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>Process uncertain</td>
<td>8 (62%)</td>
<td>16 (80%)</td>
</tr>
<tr>
<td>Safety</td>
<td>8 (62%)</td>
<td>16 (80%)</td>
</tr>
<tr>
<td>Short labour</td>
<td>8 (62%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Supportive midwife</td>
<td>6 (46%)</td>
<td>2 (10%)</td>
</tr>
</tbody>
</table>

Table 10 presents themes denoting what women planning a home birth found to be negative about the hospital. For example, 77% of the home group felt that the hospital was an alien environment, and 69% said that there is shortage of staff in the hospital, resulting in one being left unattended for long periods. Other negative factors expressed are the fact that one has to change rooms, that the hospital is a clinical environment that the care is impersonal, that one is more likely to have interventions, that it is noisy, there is poor hygiene, and that there are routines in the hospital.
Table 10: Themes expressed about the hospital

<table>
<thead>
<tr>
<th>Theme</th>
<th>(n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alien environment</td>
<td>10 (77%)</td>
</tr>
<tr>
<td>Busy/staff shortage</td>
<td>9 (69%)</td>
</tr>
<tr>
<td>Left alone</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>Change of rooms</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>Clinical environment</td>
<td>9 (69%)</td>
</tr>
<tr>
<td>Impersonal care</td>
<td>5 (38%)</td>
</tr>
<tr>
<td>Interventions</td>
<td>4 (31%)</td>
</tr>
<tr>
<td>Lack of privacy</td>
<td>5 (38%)</td>
</tr>
<tr>
<td>Medicalisation</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>Noise/disturbances</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>Poor hygiene/repairs</td>
<td>8 (62%)</td>
</tr>
<tr>
<td>Routines</td>
<td>8 (62%)</td>
</tr>
<tr>
<td>Scared/dislike of hospital</td>
<td>2 (15%)</td>
</tr>
</tbody>
</table>

Table 11 presents themes expressed exclusively by women about their planned venue. For example, 17 women planning a hospital birth thought there were backup facilities at the hospital in case of emergencies while 9 women planning a home birth thought they were more likely to get continuous care at home. Most of the themes in Table 11 express the positive things identified by women planning a home birth about the home. The only positive feature expressed about the hospital is to do with safety.
Table 11: Themes expressed about the chosen Venue

<table>
<thead>
<tr>
<th>Theme</th>
<th>Home (n=13)</th>
<th>Hospital (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Backup facilities</td>
<td></td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Continuous care</td>
<td>9 (69%)</td>
<td>-</td>
</tr>
<tr>
<td>Control</td>
<td>11 (85%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Familiar environment</td>
<td>10 (77%)</td>
<td>-</td>
</tr>
<tr>
<td>Family and friends presence</td>
<td>9 (69%)</td>
<td>-</td>
</tr>
<tr>
<td>Freedom of movement</td>
<td>8 (62%)</td>
<td>-</td>
</tr>
<tr>
<td>Gentle care</td>
<td>2 (15%)</td>
<td>-</td>
</tr>
<tr>
<td>Natural birth</td>
<td>2 (15%)</td>
<td>-</td>
</tr>
<tr>
<td>Own environment/facilities</td>
<td>8 (62%)</td>
<td>-</td>
</tr>
<tr>
<td>Privacy</td>
<td>5 (38%)</td>
<td>-</td>
</tr>
<tr>
<td>Proximity to hospital</td>
<td>9 (69%)</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 12 presents other themes that were identified. Most of them indicate events leading to a bias towards hospital birth.
Table 12: Other Themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Home (n=13)</th>
<th>Hospital (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence in midwives</td>
<td>9 (69%)</td>
<td>-</td>
</tr>
<tr>
<td>First baby</td>
<td>-</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>Given choice of two hospitals</td>
<td>-</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Gradual process</td>
<td>5 (38%)</td>
<td>-</td>
</tr>
<tr>
<td>Home not mentioned</td>
<td>-</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>Lack of information</td>
<td>-</td>
<td>18 (90%)</td>
</tr>
<tr>
<td>Midwife encouraged hospital</td>
<td>-</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>No discussion with partner</td>
<td>-</td>
<td>15 (75%)</td>
</tr>
<tr>
<td>Open mind about hospital</td>
<td>4 (20%)</td>
<td>-</td>
</tr>
<tr>
<td>Presumed decision</td>
<td>-</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>Previous bad experience</td>
<td>-</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Previous home birth</td>
<td>6 (46%)</td>
<td>-</td>
</tr>
</tbody>
</table>

After identifying the themes shown in Tables 9-12 the ones that had the same meaning were grouped together, and integrated under a common more abstract theme as illustrated in Table 13:

Table 13: Themes that were combined

<table>
<thead>
<tr>
<th>Initial themes</th>
<th>Core theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice of two hospitals, midwife encouraged hospital, no information, home not mentioned, presumed decision, normal course of action</td>
<td>Information</td>
</tr>
<tr>
<td>Left alone, busy, shortage of staff, safety, continuous care, backup facilities, experienced staff, emergencies attended faster, short labour, good experience, easy birth, clinical environment, interventions, medicalisation, routines, influence of others, proximity to hospital, first baby best in hospital, uncertain process, open mind about hospital</td>
<td>Risk perception/safety</td>
</tr>
<tr>
<td>More comfortable/relaxed, control, freedom of movement, own environment, privacy, familiar environment, convenience, change of rooms</td>
<td>Control</td>
</tr>
</tbody>
</table>

135
The results of the study therefore indicate that women's decision-making about the place of birth were somehow determined by factors centred on three main themes of information, risk perception/safety, and control. Most of the themes were related to risk perception. It would be useful to illustrate how the themes relate to risk perception.

Most women in both groups felt that a first baby was better in hospital because one did not know what to expect and therefore it was safer to have the baby in hospital. Influence of others is related to perception of risk and safety because others' experiences, whether good or bad, at a particular venue were shown in the study to influence how women viewed that venue. For example, if one knew someone who had successfully delivered at home without any complications, their perception was that they also could have a safe birth at home. Some women just mentioned that they preferred a venue because of safety. Most women thought childbirth was an uncertain process and preferred a venue that they felt would make them safer.

Women planning a home birth talked about staff shortage in hospital, and perceived that to have increased risk of things going wrong without anybody noticing on time. They therefore preferred home where they thought they would have continuous care. To the home birth group, continuous care was synonymous with safety. Women who had had a good experience at a particular venue preferred to go back to the same venue. The good experience in most cases referred to when emergencies were attended faster, or when the midwife was seen to be caring, and there were no complications. Some women planning a home birth said they had previously had easy short labour and therefore did not want to risk giving birth on the way to hospital, or perceived previous safe birth to mean safe birth this time.
Some women planning a hospital birth recalled instances when they had complications. Their perception of the present pregnancy was therefore that it could also end with complicated or risky labour, and therefore they wanted to be in hospital where there were emergency equipment or backup facilities and more chances of any emergencies attended faster. Women planning a home birth, on the other hand, often mentioned the fact that they lived close to the hospital (proximity to hospital) and therefore could easily transfer if there was an emergency. They also felt that because the home was a familiar environment and they felt comfortable and relaxed, things were less likely to go wrong.

Using similar logic, themes under the umbrella of information, and those under control were also brought together under a common name. The following sections present original quotations from transcripts denoting factors contributing to the planned place of delivery. The factors are denoted by umbrella names of information, safety and control as shown in Table 13. The quotations are intended to illustrate how the original responses led to the development of the themes. They also indicate the different ways that participants expressed the themes. Quotations have been selected because they capture what was expressed about the theme by women in exceptional ways. Care is taken to include different points of view. First, a box of all nom de plumes of those who took part in the study and their planned place of delivery is presented.
Box 2: Pseudonyms of study participants and planned place of delivery

<table>
<thead>
<tr>
<th>Home birth</th>
<th>Hospital birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maipelo</td>
<td>Tshudi</td>
</tr>
<tr>
<td>Senyana</td>
<td>Nozipho</td>
</tr>
<tr>
<td>Nnese</td>
<td>Gaboelwe</td>
</tr>
<tr>
<td>Bonyana</td>
<td>Segosta</td>
</tr>
<tr>
<td>Segametsi</td>
<td>Montdenyane</td>
</tr>
<tr>
<td>Mmanashadi</td>
<td>Boithatele</td>
</tr>
<tr>
<td>Pookana</td>
<td>Selpati</td>
</tr>
<tr>
<td>Boitumelo</td>
<td></td>
</tr>
<tr>
<td>Kgbabonye</td>
<td></td>
</tr>
<tr>
<td>Bothepha</td>
<td>Keabona</td>
</tr>
<tr>
<td>Masego</td>
<td>Mampenene</td>
</tr>
<tr>
<td>Gbolape</td>
<td>Khumo</td>
</tr>
<tr>
<td>Nnuka</td>
<td>Bamile</td>
</tr>
</tbody>
</table>

Information about available options

The first noticeable difference between women planning a home and those planning a hospital birth in the study is the frequency with which women planning a hospital birth mention that they were not informed about home birth. Most women planning a hospital birth (90%) said home birth was not mentioned to them, they therefore assumed they were going to go to hospital. The following quotations from transcripts of women planning a hospital birth show what some of them said about their knowledge of what is available:
Tshidi: Well, I am having it at (name of hospital) because, basically there is nowhere else to have it, I don’t think.

Nozipho: I think at the booking visit I was asked which hospital I would be going to, not have I considered a home birth. Home birth didn’t come up at all, it was just which hospital will you be going to. That was the only decision I had to make really … but I feel that it would have been nice if they could have mentioned it, and then said, but this is the reason why we would prefer you not to… it was almost assumed that I would have it in hospital. No one, no one actually sort of sat me down and said, well have you considered a home birth? Um, so, just, just hospital that was a straightaway decision.

Gaboelwe: I don’t know how I came to the decision that I am going to have my baby in hospital. um (pause) I suppose I probably assumed from the start that I would. I have always presumed that it would be at the hospital. I didn’t even think about having it at home, I don’t know why, I didn’t even consider it… I have never known anybody to have their baby at home before. I just presumed that was the normal thing to do you know.

Segosha: I think you just grow up knowing you are going to have your baby in hospital. Just, you know, you immediately think that you are going to have your baby in hospital. I didn’t really give home birth a thought and I just had hospital in mind really.

Montinyane: Oh it’s only been a choice of hospital, I can’t even remember being asked the question whether I wanted a home birth because I suppose it’s not something I would have thought to ask, it probably wouldn’t
have registered so I can't remember if I was even asked whether I wanted a home birth. I was given the choice of two hospitals, basically [f or g], but again I suppose I was familiar with F, I'd had a baby there I was more than happy with the care that I got there so I saw no reason to go and change to a different hospital.

Boithatelo: I wouldn't say a 100%, but I think they really want you to go to hospital. I would say that they give the information that they have to give, but they would slightly, not force you, that's the wrong word, but in the way that it's presented and the rest of it would encourage you to go to [name of hospital]. Yes, you would probably be encouraged that way.

Selpati: I don't even remember talking about home births at all, I think it always comes from the mother. You have to ask either the midwife or say to the doctor you want a home birth, it is always assumed you want to go to hospital unless you have made that first step.

Pedzani: I don't really remember anybody telling me about the options of home and hospital birth. I think it is just presumed that that is the decision you make and if you are not giving any other decisions you are sort of rail-roaded into that scenario and you don't think of anything else.

Spankinyana: I think you should be given all the options and they should be all equally discussed. The trouble is, it's like the breast feeding issue. It's like, breast feeding, oh yes, we will spend two hours talking about breast feeding, but artificial feeding, which even the wording of it is a bit sort of, you know. If you want to talk about that, we will, but not now. I think that
is the culture, it is wrong in a way because you should be given all the
ingformation and it should be all of equal importance. So this is all the
information on home births, not promoting it, but giving it on a par with
everything else rather than sort of, oh yes you might be able to have a home
birth.

One of the participants poignantly articulated the lack of information about
available options when she said

"when someone plants a seed of thought in your head, like perhaps home
birth, and gives you some information, you may consider it more, but because
that seed was never planted, I didn't even consider it" (Gaboelwe).

Other women expressed similar sentiments about information-giving
regarding home birth:

Senyana: I think women don't know about home births. In general, it
is not something people think about, but because they don't hear about it then
they never consider it. Perhaps if they heard about it more, then they would
consider it. I know there are some areas in the country where they have got
really high home birth rates just because the GP mentioned when they were 6
weeks pregnant. The GP will say "would you like to have a delivery at home"
and that I think gives them about 20% home births. And I think if that was the
case I think more women would take up on it more.

Boithatele: Everything is positioned to encourage you to go to hospital, I
would say. I think you would have to be quite strong person to be able to turn
it round and say No, this is not for me you know, I want to have it at home.
You have to be very persuasive. I heard somebody else saying that they wanted it at home and the midwife tried to convince her not to have it at home, but she had insisted. So I think to get it at home I think you really have to fight.

Malipelo: I think when you are 12 weeks pregnant you have a long time ahead of you, and that is the time to actually discuss the options and the fact that you could have the baby at home, could go in and have a six hour discharge whatever. And, really, unless your midwife is going to actually think about that in advance and she is pro active and she is going to talk to you about the options, then that is a missed opportunity really. I think a lot of them make an assumption and think well, yes, you come under [name of hospital] or [another hospital] or whatever and say, “you will be going along there to have the baby, won’t you?” And, people, unless they have specifically thought about it and are willing to state, “well, actually, no, I won’t,” then they will not get the option at all.

Kebabonye: I would say that the source of information about available options is not great within the NHS. I think they like to encourage mothers to have babies in hospital. I presume they perceive that as being the safest option, but my bet is that it is actually protecting your turf, because that is what happened in New Zealand, it is almost a complete replication of what happened there. As more women become, well start to look at alternative options about where they can have their babies, the turf protection that goes on is absolutely amazing, you know. You will get all sorts of propaganda and of course, if one baby dies during a home delivery, the inflated claims about what went wrong and what could have been done better.
Very few women planning a hospital birth (10%) said that they were not interested in home birth. One of them said that she wanted to have her baby in hospital because if everyone were to have a home birth there would be too much pressure on the NHS, one just thought the hospital was the best place to be:

Montlenyane: You know, for some women, their choices are their own, but I do feel that there are too many pressures on the NHS if we suddenly tried having more women having their births at home. That's my own opinion.

Olebogeng: I couldn't dream of having the baby at home, you know, I couldn't say oh, I want my baby at home, you know, it doesn't appeal to me at all, not at all.

The above are examples of a negative cases, where the view differs from those of the majority of responses. The general view given by women planning a hospital birth is that midwives subtly encouraged them to go to hospital. 50% of the women said they were given a choice of two hospitals and they chose the one closest to them, which was also where the midwives caring for them were working:

Pedzani: I had the choice of two hospitals, so I was sort of told I could use either one of the two hospitals and so, and I have elected to go to F? I decided on F because, if there was, if, my baby was coming in the rush hour traffic, it would be quicker to get to F, than to get to G.

Tebo: They asked what hospital I would like to have a baby. They didn't tell you much about home birth. I'm sure if you wanted the information, and you asked them, they would have given the information. They asked me if I
wanted to go to [name of hospital] or [another hospital]. I chose [F] they didn't really talk much about home birth, I couldn't tell you if they mentioned it or not, they probably talked about it but not great depth as hospital and everything.

Keabona: I was offered choice of two hospitals [G and F]. At the time, all the midwives at the surgery were based at [F], so I thought that showed me to go to F.

Spankinyana: I came to see the midwife and I was told that I had a choice of [G or F]. Er, sort of go away and think about it, but make an appointment to see somebody on the team. But when I went to go out, I was told or asked which team are you having? Where are you going? So literally, you didn't really have a chance to think about it or look into the different options. It was just a case of oh God, oh, right F, because it was closer, so.

Boithatelo: The choice really that I've got is either [G or F] and it was just I suppose umm, the team that were here, the midwives that were here were more encouraging to have it at F than they were at G the first time round.

Segosha: We had the choice of two hospitals, that was the only choice we had to make. Either G or F, we chose F. We automatically had it our heads that we would have it at a hospital.

In some cases, the women said that when asked where they wanted to have their babies, they felt the question meant which hospital, rather than a choice between hospital and home. The following conversation between the researcher
and one of the participants shows how the woman involved interpreted the question about where to have a baby:

Mampenene: I was just asked where I wanted to have my baby and when I said F that was it, it wasn't taken any further they didn't even explain the difference between the two hospitals, when I said F that was it.

Researcher: When you were asked where you wanted to have your baby, what did you understand the question to mean?

Mampenene: Just the literal what... I wasn't asked about wanting a home birth or anything like that. I wasn't asked if I wanted a home birth. I just took it to mean which hospital do I want to go to.

Some women planning a hospital birth said they were not informed they could have a home birth, however, they were still happy to be planning a hospital birth:

Khumo: Well, I was only told about [names of two hospitals] they didn't suggest a home birth to be honest, and I wasn't looking for one and I don't know what the situation would have been if I really wanted one, so, I mean I don't know what the situation would have been if I really wanted one, but I was quite happy to stick with [name of hospital], found the care very good there.

Leungo: I think at the booking visit I was asked which hospital I would be going to, home birth wasn't mentioned. Now we are talking about it, I think perhaps it should have been mentioned as a matter of course. But I feel personally that I, you know, that I'm intelligent enough to decide whether I
want to ask about it, and then I'd make a decision that way. But I suppose it wouldn't instil a lot of confidence in people if it wasn't mentioned at all, and they were there thinking, well, actually I think I like the idea of a home birth. If you then just ask which hospital would you like to go to, I suppose it makes it difficult to say I'd rather have it at home.

Mampenene: Home birth is not something I would have wanted anyway, but it wasn't mentioned.

Boithatelo: I mean you only ever know as much as anybody ever tells you or you bother to find out. I am sure there's lots more information if I can be bothered to find out and things, you know, I can get and do. But I mean, I think you only, I personally only asked as much information as I particularly want to know and once I've got all the information I particularly need them I'm happy, so, you know, I'm happy with the package that I've got.

Pedzani: I had the choice of two hospitals, so I was sort of told I could use either one of the two hospitals. I don't really remember anybody telling me about the option of home, but I know that I wanted to have my baby in hospital, so, even if they had mentioned it, it would probably have been, you know, "you can have your baby at home" and I probably would have said, no thanks, you know. So, I probably wouldn't have let them go any further.

The situation was somehow different for women planning a home birth because, most of them (54%), although not offered information about the available options, still found it in other ways. The following quotations represent
the sentiments of some women planning a home birth about the midwives' attitudes towards giving information:

Maipelo: I think the information you are given is not that good. You do have to ask about things, and even when I said I want a home birth, I already knew the process because I had spoken to my neighbour about it, but there was nothing given to me. I have never seen anything. You have to go looking for it or ask for the information yourself definitely.

Senyana: I think some midwives will not mention home birth to you because they don't feel confident with it. The first midwife I had was very pro home birth, the next one I had was very anti, and I think most are probably somewhere in between that they are willing to do it, but quite, probably happier for you to go to hospital.

Nnese: Some midwives are more pro, some midwives are dubious about home births themselves and so they are not going to sell it as well, but I have a particularly good midwife who is quite happy, very capable and spells out the risks. And she is very willing to come out and deliver me at home and I know I have the support and the back up which makes it my decision to have a home birth much easier.

However, 30% felt supported by their midwives in their choice of home birth, or the midwife herself first suggested the option:

Bonyana: My main midwife, she just said to me, if you want to have it at home you can have it at home, that's no problem. So she was supportive, she
didn't sort of try and persuade me one way or the other, that was really her only comment on it:

Segametsi: I went for my 28-week check and was very nervous about mentioning it to the midwife. I thought I can't possibly ask for a home birth for my first baby, but I did and the idea was welcomed by the midwife.

Senyana: It was only after the midwife suggested the home birth to me that I started reading up about it and reading up about safety, um, so I did that. The midwife said that you will be fine and she didn't really give me any additional information on things like safety. She did give me practical information but she didn't give me any safety information. But I read that book from the library, it was an NCT book. So I read up on that myself.

Maipelo: She said you didn't need much pain relief, you had a straightforward delivery. you are considering home birth then, are you? And she was actually sort of suggesting it, and I said, yes I am. But I was quite taken aback that she said that because I had thought I would have to say that I was considering home birth and they would go "Oh are you? Why is that? But she said "Oh good that's really good!"

Risk perception/safety

The importance of safety as related to the place of birth, which is a component of risk perception, pervaded responses in the study. However, the perception of safety was clearly a personal matter, and varied according to whether the woman preferred home or hospital. 70% of the hospital group expressed the view that in childbirth, problems could occur at any time and
therefore one is safe in an environment that could deal with any potential problems and emergencies immediately. The hospital birth group also felt that the home was unsafe as there could be a delay in transferring to hospital in an emergency, whereas in the hospital emergencies are attended to immediately.

Montlenyane: But with me it has to be safety, that’s the top priority. You don’t have to go back as far as 100 years, 50 years too many women died, and babies died in childbirth, and I still think we take that too much for granted and we forget the reasons why those things don’t happen anymore. Because probably the majority of the women do have their babies in hospital...But for me I think everything about the hospital has to be about safety. You are in the right environment if, God forbid, anything should go wrong.

Gaboelwe: If anything was to happen to you, they have got the facilities there to help you. Um, you know, machinery, other doctors, whatever. If you are at home, I know you have the midwife, but I don’t know, it must be, if there was a problem it must be quicker to sort that problem out if you are in hospital rather than at home. They have got some machinery to use or get another doctor or whatever where it is all to hand at the hospital quite straight, isn’t it?

Boithatelo: I just feel that if the birth goes easily and well it’s the most wonderful thing, but, sometimes it doesn’t, and I just need to be somewhere where they have got everything ready for you.

Khuma: I would rather be around where the technology is to assist with the difficulties. I would be much happier having it in hospital knowing that if
anything went wrong they'd have all the equipment there necessary to help you with a caesarean delivery if necessary.

Segosha: I think it is just in your mind, all the equipment around you, and just if you needed to go into surgery it is always there, and there are extra people, surgeons there at hand, rather than just have the midwife at home with you.

Leungo: I think you just want to make sure that everything goes as well as possible, and you have medical backup if you need it, having medical people immediately at hand if anything went wrong. If you had to have a caesarean everything would be there with medical people rather than just your midwife.

Olebogeng: A textbook pregnancy is, you know, you get pains, you get in labour, you push a couple of times, but, real life is, you can have complications, and I think the best place is in hospital really, for me it is, and I feel that you should have the support around you if anything difficult should happen definitely. If it happens quickly it would just panic me, I mean it would just make me panic during labour, and I think that would just cause me distress, and the baby distress. I think when you are in hospital you know that they have all the equipment around you, and you know that if they see you in distress, or they know that the baby is in distress they can help you like in five seconds, whereas at home you don't know if they have the equipment to help you at that time. So I think for me personally, it's definitely in hospital, and it's not at home.
Ganetsang: I like having the doctors and midwives around. I like to feel that they have everything. If you are at home and something goes wrong, it is a journey to get to some assistance.

Mampenene: I would say hospital is a safer place, everything is there should something go wrong. Um, my sister had a little boy at [name of hospital] last July, and she was given pethidine? And he went flat when he was born? So consequently it’s like panic station, and that even more confirmed my sort of thinking, like had it been at home obviously they would have given her something that would have counteracted it like injection or the oxygen, but they wouldn’t have had all those things on hand.

On the other hand, 62% of the home birth group felt that one is safer at home because there is a guarantee that two midwives will attend the birth. Their concern was that in hospital, one is left alone for long periods, and therefore if problems did occur they would not be recognised on time, whereas at home they have continuous care. The following quotations express what women planning a home birth thought about safety:

Nmese: I want the reassurance that I am not going to be left on my own.

Bonyana: One of the other things I was thinking about a home birth was that with Sean I didn’t get much care from the midwives. Fair enough they were really busy at the hospital, inundated with births and emergency caesareans and there wasn’t really a midwife present throughout my labour, she just popped in and out to grab equipment. I wasn’t examined at all, they didn’t know how far along I was at any point until she popped back for
something else when she said, the head’s crowning, it’s coming, and then in a
couple of pushes it was out. I feel thank goodness nothing did go wrong
because there wasn’t any monitoring going on whereas at least at home you
have a midwife there to help you.

Maipelo: My friend’s second one arrived very quickly at hospital and
she felt what was the point in going there because it was delivered more or less
by her husband because there wasn’t actually a midwife on duty when they
arrived. And that is another consideration as well, [name of hospital] the
ratios are so low, but it can be, especially with your second baby that you don’t
really see anyone until you are almost at the point of delivery anyway. If
you’re delivering at home then you’re guaranteed two midwives. People talk
about safety of home births but from the safety point of view, and my point of
view, they are actually safer because you have two midwives there who are
observing you all the time and if anything is not going to plan, they can tell
in advance, whereas possibly in hospital you are only going to see someone
every now and then because they are between two women, they might not see
that anyway.

Mmaoshadi: most people agree with me that they are so over-stretched in
the hospitals, I feel I have more care at home than in the hospital because the
midwife comes out to the house and she’s there just for you, she’s not running
off to see somebody else....As I said, they were so busy I felt if I wanted
anything I felt I was a nuisance. Nobody made me feel like I was a nuisance
but you didn’t want to bother them. They were busy doing somebody else who
needs them more than me, so I didn’t want to bother them.
Segametsi: I’ve had lots of friends who have had babies and they’ve said they were in a room on their own a lot of the time, which I won’t be, I’ll have the midwives and I think midwives are the right people to assist at births. So I’m hoping, well I feel that it is best for the baby.

Kebabonye: I work in the voluntary sector and do a lot of work with the community health council and, um, they did studies on the shortage of midwives at [name of hospital]. I was horrified about how short staffed they were and I think the midwives are fantastic, but I think they are working with huge constraints and that is another reason why I wasn’t that confident about going into [name of hospital].

Some women planning a home birth just felt that the home was safe, while others thought the safety issue was exaggerated:

Segametsi: I haven’t had a baby, but I feel, and my husband feels that if I’m relaxed and in an environment I feel is safe it would be a more positive experience. I feel safe here and I feel that I’ll be bringing the baby into an environment which is safe. I am not saying the hospital is not safe, I don’t mean that, I just mean this is the home where the baby is going to be and it won’t have the transition from the hospital to here.

Maipel: Safety is the thing that everyone gets worked up about. But when you talk to people, you realise people are having babies all the time so you are constantly with people that have children. Very few of them actually have any problems. There is only a couple I know that have maybe had a little bit of oxygen, couple with cords round their necks, but babies are born with cords
around their neck all the time and it is not really an issue where they are born with the cord round their necks because the midwives know how to deal with it. And I know people that have had emergency caesarean but they are pretty few and far between, so I don’t think safety is not as big an issue as people make it.

Women in the two groups agreed on one issue, and, that is, that the first baby is best born in hospital. When asked where they thought was the best place to have a baby, 62% of the home group and 80% of the hospital group said the first birth was best in hospital as at that time the woman does not know what to expect:

Gaolape: If it’s your first one, then I would definitely say go to the hospital because you don’t know what your body is going to, (pause) I suppose go through. You don’t know whether you’re going to be strong enough to go through it unaided or pain relief. I’d say, get the first one over and done with, and if you’re happy with it, then go for a home birth. Go for being in your own home, I think it’s the best start for a baby.

Keabona: I think definitely home is the best place to have your baby if you know what to expect, as obviously I do, this is my second baby and you know, I mean, if you want an epidural you are not going to be able to have that at home.

Masega: The reason I went for a hospital birth with my first son is, I thought well, I have never done this before, I really don’t know what it is going
to be like and I also suspected that with a first birth the doctors would not be very supportive with the first birth, they would rather you were in hospital.

Leungo: I just thought I would try the hospital for the first time, would put me more at ease. I mean I may well consider the second time around a home birth, but for the first one I didn’t give it much thought.

Malebogo: Personally I feel that for the purposes of the first baby, I would be far happier in hospital just because I know that everything is there should anything go wrong.

Segosha: It’s my first baby, so I think it was safer to have a hospital birth. I will be more confident being in hospital and, er, you have the staff around you and they know exactly what they are doing.

Another factor that appears to have influenced the choice of place of birth in the study is previous experience, which, as discussed earlier, is a component of safety or risk perception. Sixty-two percent of the home birth group reported previous short labour, 42% easy labour and 46% previous home birth that did not have any complications. The perception of those with previous good labour was that the same will follow this time, and therefore they could have a home birth without anticipation of any problems. The following quotations illustrate the experiences:

Maipelo: My first baby was born in hospital and it was quite a quick labour.... Because it went so well and it was so quick, I didn’t think there would be any anticipation of any problems at actually having the second one at home.
Senyana: My first one I had in hospital and it was a very quick
labour. It took about 3 hours, and knowing that, expecting that a subsequent
labour would be much quicker, then I didn’t want to risk trying to go to
hospital and risk having the baby on the roadway or car park.

Masego: I had the last one in hospital but it was very straightforward
and quick and very nice and I stayed in for 6 or 8 hours, whatever it was then.
Um, and then I was pregnant with my next one I thought the last one was so
straightforward, so I might as well have my next one at home.

Bothepha: I had the first one in hospital and the second one at home. The
first one was not a very pleasant experience but the home birth worked really
well. I felt it was such a nicer experience at home and I felt that with my third
baby it should be a better or a quicker delivery.... The whole experience was just
so different as well as being able to walk around my house and have a bath
and do things. But it didn’t feel like a medical, an illness, I think that was
the difference, as soon as you get into hospital, it feels like there is something
medically wrong with you, and they are trying to cure, whereas at home it
feels like a natural process, yes, you are giving birth but it’s sort of normal,
you know.

Thirty-one percent of the home birth group had a previous bad experience
in hospital, which encouraged them to go for home birth. This is how some of
them expressed themselves about the issue:

Gaolape: I remember the scissors cutting me, um, so, that didn’t help,
then they had me on a drip, and one of the midwives which was a trainee
tripped over the drip and pulled it out of my hand, and (laughs), and it was like a scene out of a comedy film. I remember looking thinking, well, hang on, I've just been cut, I've got a drip sticking out of my hand now, you know, I mean, it was just awful. It really was awful, you know, and I remember when she cut me down below, the scissors were cold, so, because I jumped, and it made it cut more than it should have, oh, it was a really really, awful experience. Yeah, but the midwife was such a, (pause) I can honestly say she was awful, and I mean totally, she wasn't sympathetic, she wasn't caring, and, it was just a case of, with her, you know, you're young, you're stupid, you're not married and I'm gonna make you suffer and that's how I felt. You know and after that, you know I say, six years till S. come along. I was petrified. Absolutely petrified, all I kept thinking was, I'll never ever go through that experience again you know, coz you know, I was so scared.

Bothepha: I had the first one in hospital and the second at home and the first one was not a very pleasant experience and I felt very much that being in hospital, you know, made it worse. I felt that I was interfered with quite a lot. Obviously, it was a more difficult delivery and it ended, I ended up having a few epidurals and an episiotomy and forceps and the baby was quite distressed for a few days. It didn't feed for a few days and the whole thing was a bad experience. I felt as soon as I got into hospital then they were doing things to me and I didn't feel in control....I know I'm a bit of a feminist, but I always say that if men had babies then it would be completely different. You know, I think you get a lot of male consultants, but my experience with consultants in obstetrics is appalling. They float in and give a verdict and then they float out
again. When I had my episiotomy the male doctor that sewed me up didn’t even introduce himself to me, you know, he was just sort of talking to me at that end, didn’t even look at my face and er, I think those sorts of things are appalling, treating women like objects basically and I think the higher up the hierarchy the more that happens.

Ponkana: I have already had four children all in hospital and tended to have very long, quite difficult labours with complete medical intervention whereby I have been induced, my waters have been broken and quite often things didn’t go to plan... I encountered a lot of staff who were very very nice, but came across some who it was just a job and there was no empathy build up. And because you are on a continuous conveyor belt of meeting lots of different people in the course of being pregnant you don’t get a chance to build up that empathy, the understanding, some form of friendship so that you feel relaxed in having the baby and everything like that. I ended up requesting a home birth, and hopefully it will be a shorter birth and I could cope with it on my own terms in my own place better than if I was in the hospital.

Kebabonye: I based that decision on really probably the care and attention we had in hospital with my first child. He is nineteen this year so, but his birth was, I think I received between 15 and 22 stitches to put my bottom back together after he was born. He didn’t, when he was born, he didn’t cry I thought as well and as lustily as other people’s babies. He was the smallest in the unit and I was the only mother who didn’t smoke and I found that really distressing....I think I answered your question, my first birth was
just so crappily that, and you know, that was with your full hospital bits and pieces, that I thought quite honestly it can’t get any worse if you do it at home.

Bothepha: I got into hospital and there was this really awful midwife and she said go and lie down on the bed and they stuck me in this horrible dark room with nothing there and you are having these contractions. No idea whether I was 9cms or 1cm dilated. I had nothing to compare it to and she came in and gave me an internal in the middle of a contraction and I remember the pain and I just thought, well, you know, never again.

Thirty percent of the hospital group recalled previous complications they had and wanted to be in hospital should any problems occur this time. The perception in this case was therefore that because there were problems last time, the same might occur this time and the hospital is best placed to deal with them.

Boithatelo: The child that I had last time was in foetal distress. The cord was round his neck so I had an emergency caesarean, so if, because of the equipment of the hospital they were able to discover that the child was obviously in distress very early on, in the early stages of labour. Possibly if I was at home, there might have been damage to the child because of the cord being around his neck, so in my experiences I felt I would prefer to be somewhere where they have as much equipment as possible. Although there is a chance that a midwife would have been able to pick up the baby was in distress at home, I just feel that, you know, they dealt with it very quickly so I could have an emergency caesarean.
Khuma: My first daughter was a caesarean birth a week before she was due because it was picked up she was in a breech position so it was recommended that it would be a caesarean birth and I was quite happy to go along with that because I trust the judgement of the medics and I didn't really want to attempt the delivery the wrong way round. Even prior to that I didn't want a home birth I would rather be around where the technology is to assist with the difficulties and I still feel that way even this time around. I've been told if the baby's the right way round I could have a normal delivery but I would still be much happier having it in hospital knowing that if anything went wrong they'd have all the equipment there necessary to help you with a caesarean delivery if necessary.

Twenty percent of the hospital group had previous good experiences in hospital and did not want to change:

Montlenyane: I've already had one child at [name of hospital] and I thought I got exceptional care there so I saw no reason to change my hospital.

Motlaelepula: Well, I had my first one at [name of hospital] who is now six. I thought they were very good, very nice hospital, and I thought well, had one there, might as well have the second one there, you know, everything went well, there were no problems... Some people like home birth, and I said no, I would rather have it in hospital, because, any complications or anything you know, hospital is the best place to be.

The study showed that 62% of women planning a home birth knew others who had had a home birth, and in many cases had discussed the experience with
them. The experiences of others who had home births were positive, and, therefore, women hearing about them thought they too could have similar safe and satisfying births at home. This is how some women in the home group expressed the situation:

Segametsi: I suppose you are idealistic to a certain extent but the lady who is down the road who has had two babies at home just said that the experiences didn’t compare. You know, having a baby in hospital or having a baby at home is, was just so different and it was just relaxed and you just had the baby and carried on.

Nnese: I have had lots of friends in the area who have home births and have had really really good experiences and I thought I would do it myself.

Maipelo: My neighbour next door also had an influence because she had a baby six months ago and she had a home birth.

Seipati: My Mum had six children and five of us were born at home and she was in her forty’s when she had me. So, I think, you know, we all survived, um why in this day and age I think we should be able to have babies at home if we wish to have them at home and there should be no problems.

Senyana: There were two people who had home births just before me and there was of course my own mother who had a home birth, but there were two [in this town] that were pregnant at the same time as me that delivered just before me. I had already decided to have a home birth at that point, but I went into it with great confidence, I wasn’t worried about it at all. They had reasonably good births.
Gaelape: Okay, I’ll give you a fine example, is my friend’s little boy is, now is about three months old...She phoned the midwife and the midwife arrived, and then the second midwife arrived. And she was stood in her kitchen, having a cup of coffee and a cigarette [laughing] and the midwife said, you know, what are you trying to do to that baby, smoke it out? And they were like laughing and joking? And she said to the midwife, “I think I’m going to start pushing” and they got her washing up bowl, um because she was stood over the kitchen sink at the time and she got a washing up bowl and she put it like between her legs? And she said within like 5 or 10 minutes, a couple of pushes and the baby was out. And she said the experience, I mean she’d had four children, and she said the experience, you couldn’t, you know, you got to be there and to have gone through it. She said it’s bliss... she said it’s lovely, she said I don’t actually feel like I’ve been through anything...She said it’s just unbelievable, she said because you’re so relaxed it’s so quick. After that happened, I thought that was definitely it for me. [laughing] you know, I’m not saying that mine will be like anything near like hers.

Ponkana: I had lots of friends talking to me, one of them is a doctor, she has had six boys and they’ve all been hospital births. All trying to talk me out of having a home birth. So, one of them, a friend of mine, she’s had three kids, the first one and the third one were hospital births. She said the nicest birth was the one at home. It was the one that she could have pain relief and didn’t require it, she just felt completely happy, relaxed about it all, she said for some reason you walk through the hospital doors you’re all tensed up and
everything like that and people who don’t think through what they are saying to you can upset you also.

One woman was advised by others that hospital was best because of emergency equipment.

Bonyana: I did speak to my husband and family, my mum and mum-in-law to get their ideas because both my mum and my mum-in-law had home births and hospital birth to see what they thought. But I think you know, at the end of the day, them and my husband thought that if you are at hospital you’ve got the technical back-up for the baby and that was the niggling thought at the back of my mind anyway. So I would say that they didn’t tell me that I should be having the baby at hospital, they didn’t tell me I should have the baby at home. It was my decision but having said that, if my husband said to me, NO, I don’t want you having it at home, I would certainly take that on board if he felt that strongly. I mean it’s his baby too.

Some women planning a hospital birth, though to a lesser extent (20%), were influenced by others who had had hospital births. They perceived that if others delivered safely in hospital, they too could have similarly safe births in hospital.

Segosha: I was a birthing partner for my friend, she had her baby at [name of hospital] It didn’t put me off at all. No, it was fascinating. It didn’t, you look at films all through life of pregnancies and it was totally different. It was totally relaxed and it, er, just totally different really. It wasn’t so surgical as I thought it would be. The room was more relaxed than I
thought it would be, things have changed. She was able to get around and move around rather than stay in bed all the time. The atmosphere was very calming and friendly.

Leungo: A couple of friends who have had babies had them in hospital the first time round.

Olebogeng: I want to go to [name of hospital] because a lot of my friends had their babies there.

Malebogo: Actually, in the last year I probably know or worked with about three or four people who all had babies at [name of hospital], so that we probably pass with what we see and that's where you go [laughs]. That's where you go and what you do and that's it. I actually don't know anyone who has been to [name of alternative hospital] or quite certainly I don't know anyone who has had a home birth.

The decision I came to was purely from other friends who had had babies. I just went on some of their recommendations I mean, I found them to be very good, I had some close friends who had had babies at [name of hospital] so I went for that option.

The study found an interesting difference between women planning a home birth and those planning a hospital birth related to the partner or husband's involvement in the decision. This was another factor subtly related to safety because the discussions with partners were about what venue was safer. All women planning a home birth had discussed with their partners where they were
going to have the baby and in some cases considered the pros and cons before eventually coming to an agreement.

Senyana: At first he was apprehensive. He is American and they are very used to birth being a very medical thing ...his mother had five caesarean sections, so his attitude was initially was very negative but he came round so quickly, it was like probably took less than a day to convince him.

Gaolape: My husband said to me, whatever you want is fine by me. So, yes, he is quite understanding and just said well, I can't understand why you want to have it at home, but I'm with you 100%.

Maipela: [my husband] is very supportive because, er, he was born at home, as were all his brother and sisters bar one.

Mmaoshadi: My husband’s delighted because he doesn’t like hospitals at all, he found it very frustrating in hospital the first time.

Kebabonye: It was something that [my husband] and I discussed reasonably intensively about where we were going to have this baby and we decided that given that we were living at the time, at the top of the hill, the hospital was at the bottom of the hill. Even if the ambulance broke down, it was a down hill roll so basically you could be at the hospital in 5 minutes.

Bothepha: I was thinking, no and my partner was thinking, I mean it’s his first baby and he was all sort of what ever you want to do. I think he was a little nervous about the fact that being at home, what his role would be. The
midwife came around and spoke to us about it and um, but he was fine and said whatever you want to do

My husband and I had an argument about it last night ... He is frightened, he is very frightened. My husband is just, just hasn’t got the faith that I have because he hasn’t got the knowledge that I have despite what I tell him... But it is a two-way thing, I can’t do this without my husband’s support and I must respect his decision and his attitude. And I can understand where he comes from completely because it is his child as well as mine and I am not going to be selfish and say nope, nope I know best, I am going to have my baby at home, that is not fair on him.

On the other hand, only 2% of the hospital group had discussed the issue of where to have the baby with their partners. The following quotations illustrate what some of those planning a hospital birth said about their husband or partner’s involvement:

Pedzani: We never really discussed where I would have the baby, because, his views I know are the same as mine, um, because his mother is actually a midwife, in hospital. Um, and I mean, he is, he doesn’t really have any preference one way or another, but I know that he’s quite happy with the security aspect of actually having a hospital birth rather than having it at home, so.

Gaboelme: We just assumed it would be in hospital, we didn’t really talk about it. We didn’t discuss it at all.
Montlennyane: I know my husband feels the same, so it is not something we tried to discuss.

Boithatela: We probably discussed the fact that he would prefer to be somewhere where people knew, a lot of people were around to ask questions, so he felt as well really that we wanted to go to hospital. To be honest I cannot sit here and say that he definitely said I want to go to hospital but knowing his personality, I would think he would prefer to have someone else around. He’s quite similar to me in that sense.

Malebogo: I don’t think I gave him any choice at all. I think he would probably have said it was up to me anyway.

Olebogeng: We never really discussed it because we knew when [name of hospital] closed down, we just thought oh well, next time we have a baby it will be at [name of hospital]. So, um, yes, it wasn’t something we discussed, it was just, that was where we were going to go.

One woman planning a hospital birth expressed the husband’s involvement in this way:

Mosibodi: I’ve decided to have it in hospital, the reasons for that really are because it is my first baby and I feel safer. Both my husband and myself have agreed that we’d both feel happier if I was in hospital, especially as my husband works really funny hours and things so if I do have to go on my own there would be lots of people to help me really, I would just feel more safe and secure in hospital.
Some of the spontaneous responses from the women gave indications of their perceptions of the childbirth process as related to risk and safety. Eighty percent of the hospital group and 62% of the home birth group felt that the process of childbirth was uncertain and that problems could arise at any time. The difference was in the type of intervention they wanted, and in how confident they thought their midwife was to recognise and deal with emerging problems.

Women planning a hospital birth thought that because of the uncertainty of the process hospital was the best place to be:

Montlenyane: I think we take it for granted these days, we don't expect to hear of children being born stillborn or anything, but it happens, and there has to be occasions where, there are occasions when we can predict that things may be complicated during the birth. I can understand if the baby is not in the right position, a breech delivery for your past medical history or something like that. But I think no matter how many babies a woman may have there is always that element of the unknown, and that to me in this day and age, since we have facilities available I can see no reason why I shouldn't take advantage of it, so that's why I felt strongly that I would have it in hospital.

Bamile: I feel that if the birth goes easily and well it's the most wonderful thing, but sometimes it doesn't. But I think for me personally it is probably... I feel it is an uncertain, um, you know, an uncertain thing. I think there is always an element of doubt anyway with everybody because everybody is different and anything can happen.

Segosha: I am the sort of person who always has to think, you know, if anything does go wrong, I just can't think that everything is going to be fine.
I am always prepared for the unexpected. Um, and you know, if anything can go wrong. Anything can go wrong, from haemorrhaging to anything like that, so it is just basically the security of having somebody that she [midwife] can call on, another team to come in and take over with her as well.

On the other hand, women planning a home birth thought that although problems may occur during childbirth, it happens gradually rather than suddenly and therefore there was plenty of time to transfer to hospital if need be:

Mmaoshadi: It is very rare that things go wrong right at the last minute and usually they can pick up on things and in which case I’ll go to hospital, if the baby’s heartbeat dropped or something. I’ll do what the midwife recommends, if the midwife wants me to go to hospital, I’ll go to hospital.

Maipelo: But things don’t happen that quickly in childbirth, it is a long process. Even short labours, you know things are happening they have got monitors and you can tell if the baby is getting distressed or something and you have lots of time to act. I don’t think anything happens that quickly that can’t be sorted out.

Masego: I don’t think you should look at it totally dreamy eyed and think it is all going to be wonderful and perfect, because things can go wrong and you have to be aware of that. If the worse comes to the worst, I can always change my mind and go into hospital if it all starts taking hours and hours and hours. I’m pretty confident in the midwives, they’ll watch me carefully if they think there are any reasons, I would go into hospital if I needed to.
One woman thought that problems could occur whether one is in hospital or home.

Kebabonye: As long as you are feeling healthy, and as long as the midwife is comfortable with how your baby is lying and where the placenta is, they really you know, the sorts of things that go wrong from then on in are the sorts of things that go wrong in hospital anyway and if you have got a good midwife with a second midwife set up, then if they can’t deal with it, they you are probably going to lose your baby anyway. so you might as well have it where you want to have it and where you feel most comfortable.

Another factor, still related to safety, was hygiene. While none of the women planning a hospital birth commented about hygiene, sixty-two percent of those planning a home birth were bothered by the state of hygiene at the hospital.

Senyana: I think you worry about hygiene at hospital, but you don’t have to worry about it at home. Your house may not be perfectly clean, but you know it’s your own germs, and not other peoples’. I really didn’t like the hygiene in the hospital.

Bothepha: There were cockroaches in the toilet, I am not joking. ... The bath, well I had to take antiseptic stuff and clean the bath before I could get in it. I wouldn’t sit on the toilet seat, I know so many people that went home with infections, you know, it was unbelievable and that was a big factor in thinking I don’t want to go near a hospital again because you are more likely to come home ill than you are, you know.
Masego: In actual fact they say in some ways it is better at home because you are already immune to all the germs in your own home, whereas when you go to hospital they are all alien to you and you can pickup more infection in hospitals than you can at home.

Maipelo: I mean the bathroom was actually appalling, there is no one to change your sheets, there is no one to really help, you have to buzz goodness knows how many times.

Control

The other factors that women referred to when talking about the place of birth related to control. Women planning a home birth were more concerned about the amount of control they had on the process of childbirth, and the environment in which it occurred. In a very inconspicuous way, the concept of control is also related to safety, because the women felt that at home they feel comfortable and relaxed, they know where everything is and as a result, they feel things were less likely to go wrong. Eighty-five percent of women planning a home birth referred to the home as relaxed, familiar, and giving them more control. The following quotations represent some of the views expressed:

Mmaoshadi: My husband feels more in control at home. He feels more, if the midwife wants something then they ask him and he knows where everything is and he feels he can be a help, whereas in hospital he feels in the way. He just kind of, he's someone who helps me or whatever, but he doesn't feel in control in hospital, he's much more in control here so he is happy with the decision, he's happy so long as I'm happy with the whole thing.
Nyutx1R: We have got more control and we feel more comfortable whereas in hospital they take their time. Well if you need anything specifically, you know, like a cup of tea or anything you can make it, whereas in hospital they take their time.

Bothepha: I felt as soon as I got into hospital then they were doing things to me and I didn’t feel in control. So the second time I decided to have hypnotherapy because I wanted to have the baby at home.

Senyana: You are on your own territory, you can eat what you like, have no rules.

Seipati: because it is your own environment, I felt I was in control and I can do what I want to do. I don’t feel that I’m in an alien situation where, you know, like sometimes in hospital you are scared, I wouldn’t say scared to walk down corridors but you feel someone might suddenly say actually, you shouldn’t be here, go back to where you were, whereas when you are at home you can do what you want. I have also given birth in the bathroom, which seems really natural to me, sort of being near water.

Segametsi: I think at home I can be more pro-active and say I want to do this and want to try this.

Ponkana: I suppose the main factor is that I might have a greater degree of control at least, ... its just being in your family home where you possibly feel much more secure where I actually know where everything is and also whoever will be dealing with your birth. You would have one, maybe two
midwives and that was it, there wouldn't be a constant kind of sea of people coming in and a complete turnover all the time.

Gaolape: I think if you're at home, I mean don't quote me on this till after I've had the baby [laughs], I think at home things are actually less likely to go wrong, this is my personal opinion...So I think yeah, at home because I feel you'll be a lot more relaxed, you're less likely for things to go wrong.

Sixty-two percent of the home birth group talked about the importance of being in their own environment, and using their own facilities. This was also thought to be an element of control, since when one is in one's own environment then one familiar with everything and may control how things are run:

Seipati: It has been really nice getting into my own bed afterwards as well. I think that is absolute bliss being able to have a shower, with my own shower and then just getting into my own bed which is lovely.

Mnese: I have got my own bath and my own toilet all the things that make a difference to a lady

Mmaoshadi: It was immediately after getting into my own bath, my own toilet, my own food and not having to worry about leaving the baby.

Bothepha: Also afterwards obviously being able to get into your own bed and drink tea and have your own mug. Not one of those vending machines.

Maipelo: I have got my own bath and own bathroom and don't have to worry about the state of anything
Sixty-nine percent of women planning a home birth talked about the importance of having their loved ones with them during the process of labour and delivery. This also indicates a desire to be in control and decide who is to be present at the birth:

Segametsi: A very important part for me as well is that my husband will be here, my husband will be here and won't have to leave us and I think he's such a huge part of the family that it's horrible when they have to go home after the baby's born. That worried me a lot so he will be here and we can go to bed as a family and we can wake up in the morning as a family.

Seipati: With the last one I had it was just so nice that like two hours after she was born all the children were there. They had gone to some friends and they came back and they all tiptoed up the stairs. My daughter Victoria cried, she said “I didn't know you were having a baby” and it was really lovely, whereas I don't think I would have got that in hospital.

Nnese: I am quite happy just to be mobile and not worrying about my little boy and that is really the only reason. He will be so much more spiritually happy I am sure. But also, also if I have the baby at home, then my husband, he maybe be here whereas if I had the baby in hospital in the middle of the night, his priority is also T. and he will be looking after T. and won't be in the delivery room.

Boitumelo: I could have my family with me; quite a few people said that in hospital they only allow your partner and one more person. But at home I could have my best friend and my sister and my husband, with me.
Discussion of findings

The themes expressed by women in the study when referring to the place of birth fall under three broad categories of risk perception/safety, information and control. The three categories are related, because ultimately they all point to a desire for a safe birth. Overall, uncertainty was pervasive in the anticipation of childbirth and its outcome as participants expressed ambiguities and unknowns. The two groups agreed on the view that childbirth is an uncertain process, and that for a first birth one is safer in hospital than at home. When asked about where they thought was the best place to have a baby 77% of women planning a home birth and 90% of those planning a hospital birth said that for a first baby it is better to go to hospital as one does not know what to expect. This may explain why there was only one woman expecting a first baby who was planning a home birth. Other studies have also reported an under representation of primiparas in out of hospital births (Anderson and Greener 1991; Cohen 1982; Howe 1988; Littlefield and Adams 1987; Rooks, Weatherby, Ernst et al 1989; Schneider 1986). This finding would suggest that women generally have a high risk perception for a first birth, and therefore consider it more worthy to be delivered in hospital.

When it comes to subsequent deliveries, however, the consensus is still that childbirth is an uncertain process, but women differed in what they perceived as safe or risky, and on what they considered the best place for delivery. Of interest in the study is the way that each felt their planned venue was the right one in the circumstances. While one group wants the reassurance of hospital emergency facilities and the presence of backup staff in case of complications, the other prefers continuous care by a midwife at home. The results would suggest that women have different perceptions of risk and safety, and different
expectations of what would best represent safety. The results are similar to those of Mather’s (1980) study where women cited safety as the most important reason for choosing a maternity setting, whether it was a birthing room, home birth or traditional hospital. On the other hand, in their study, Chamberlain et al (1997) found that women planning a hospital birth were motivated by safety, while those who chose a home birth did not mention safety as a reason for their choice.

Other studies have conceptualised safety differently, and interpreted the belief by women that their choice is the safest, regardless of what risks others may perceive, as bolstering their choice. Bolstering is used to indicate the tendency to see only the best with the desired choice and the worst with the alternative (Janis and Mann 1977; McClain 1983; Pierce 1993; White, Wearing, and Hill 1994). For example, in the study, those women planning a home birth emphasise the fact that at home they will have two midwives who will give continuous care, and that they will be more relaxed and in control, with the result that things will be less likely to go wrong. However, they overlook the fact that if their labour was complicated and they needed to go for an emergency caesarean section, it might not be possible to transfer them to hospital on time, for example, because of rush-hour traffic.

Similarly, the hospital group focus on the fact that if there were any complications they would be attended quickly. Nevertheless, they disregard the point raised by the home birth group that due to staff shortages, it might not be possible for problems to be identified on time. Additionally, they also disregard the fact that the problems that occur might be because of the easy access of equipment they so want. For example, they might be forced to go for a caesarean section because they had an epidural and therefore are unable to push when required. Because of its potential complications and unknown outcomes,
childbirth has been seen as a gamble, and a lottery, in which there will sadly be losers (Szczepinska 1995). The findings of the study that women planning a home and those planning a hospital birth have different perceptions of risk and safety related to the place of birth support the proposition of the thesis that perception of risk in childbirth may influence preference for home or hospital birth.

Another factor that came out, especially from women planning a hospital birth, was that they were not informed of the availability of a home birth as an option, most were given a choice of two hospitals. The practice of only informing women about the hospital, and not home as an option for childbirth would support the argument that women are being persuaded to give birth in hospital (Leap 1996, Stapleton 1997). Others have argued that consumer choice is limited to the services on offer, such that those who extol choice also define the choices available (Kirkham and Perkins 1997). According to women planning a hospital birth in the study, the only available choices were between hospitals and did not include the home. One study found that women felt they were given little choice about the place of birth, and that the only option adequately explained to them was the hospital (Rudat, Roberts, and Chowdhury 1993). In a similar survey, it was found that women were willing to consider alternative maternity facilities after they were given information about them (Mather 1980). Other studies have found midwives and GPs to have negative attitudes and to withhold information about home birth (Bathgate and Ryan 1995; Beech 1995; Devenish 1996; Hosein 1998; Kargar 1998; Leap 1996; Pengelley 1996; Walcott 1997; Warshal 1997). The lack of information about available options as childbirth venues reiterate the view of the House of Commons Health committee (House of Commons Health
Committee 1992) who observed that the available choices are "often more illusory than real." para 51.

On the other hand, women planning a home birth, although not informed about the available options, were aware that they could have a home birth. Other studies have also found that women planning a home birth are generally well informed of the choices available (Kleiverda, Steen, Anderson et al 1990). One explanation for the differences in knowledge of what is available might be the fact that home birth women are generally more educated, and therefore are more likely to read widely and discover other options. In the study, more women in the home birth group had secondary school and college or university degrees compared to those planning a hospital birth. The finding is corroborated by other studies (Cohen 1982), which also found women planning a home birth to be generally more educated (Cohen 1982; Eakins 1989; Rooks, Weatherby, Ernst et al 1989; Schneider 1986; Soderstrom, Stewart, Kaitell et al 1990). The difference in educational standards of women in the two groups might also explain the fact that home birth women were able to assert their right to have a home birth, while those planning a hospital birth just went with what was made available to them.

The thesis considered that one of the factors that might affect women's preferences for home or hospital birth might be their awareness of what is on offer, and the results clearly support the view. Women planning a home birth knew that the option was available to them, and asserted their right to have a home birth. On the other hand, those planning a hospital birth said that the home birth option was not mentioned to them, and that they assumed they were going to go to hospital. However, some of them said that even if they had known about the home option they probably would still have chosen to go to hospital. The point raised by some of the hospital group, that they probably would still have chosen
hospital even if they were informed about home is very important. It suggests that giving women information about all available options does not mean that they are being encouraged to go one way or the other. On the contrary, it may help women to make more informed and confident choices. On the other hand, women planning a hospital birth also felt that one has to be strong to opt for a home birth because it opposes what the midwives believe in. This would suggest that women planning a hospital birth felt that they were not strong enough to plump for a home birth. A woman planning a hospital birth captures the view in the following quotation:

Boithatelo: Everything is positioned to encourage you to go to hospital, I would say. I think you would have to be quite strong person to be able to turn it round and say No, this is not for me you know, I want to have it at home. You have to be very persuasive. I heard somebody else saying that they wanted it at home and the midwife tried to convince her not to have it at home, but she had insisted. So I think to get it at home I think you really have to fight. I wouldn’t say a 100% but maybe in some cases they really want you to go to hospital. I mean I didn’t ask this time round but I don’t know what their opinions would be but I didn’t even ask.

The other proposition made by the thesis is that individual women’s risk perception may also affect their preferences for home or hospital birth. However, in the light of the results about lack of information regarding what is on offer, it could be argued that women cannot consider the risk or safety of a home birth compared to a hospital birth if they are not aware that home birth is available to them. One can only worry about what they see as a possibility.
One of the fascinating findings of the study is that all women planning a home birth had discussed the issue of place of birth with their partners, while only 10% of those planning a hospital did. The finding could have a two-fold interpretation. The first interpretation is that the partner's involvement in the decision-making is related to risk perception, because, the discussion of options with partners in the study centred on which of the venues was safer. The couples therefore discussed the options to make sure they were choosing what each felt was the safest option. The second interpretation relates to information, and reinforces the view expressed by 90% of the hospital group that they were not informed about any other options, in which case there would have been no point in discussing what they knew to be the only option. Since the hospital birth group were not offered a choice of home birth, it could be argued that they resigned themselves to a hospital birth whatever their perceptions of risk or safety related to hospital birth.

Nevertheless, the result contradicts that of the home birth survey (Chamberlain, Wraight, and Crowley 1997), which found that 81% of women choosing to have a baby at the hospital had discussed the planned place with their husbands. One explanation of the differences in the findings might be because in a survey women were presented with a list of alternatives and asked to indicate which one was involved in their decision. In that case, they might have felt obliged to choose at least one of the alternatives, and the husband might have looked the most appropriate. In contrast, in a qualitative interview the responses were spontaneous from the women, which may signify a more accurate representation of the situation. Nonetheless, it may just be that in the population used in the home birth survey (Chamberlain Wraight and Crowley 1997)
husbands were more involved in the decision-making, but the former seems a more plausible explanation.

Eighty-five percent of women planning a home birth referred to the home as relaxed, familiar, and giving them more control. Some of the women even said that because they are relaxed things were less likely to go wrong. Other studies also found that women planning a home birth value the control they perceive to have in their own homes (Cunningham 1993; Schneider 1986; Soderstrom, Stewart, Kaitell et al 1990). Taking control of what is happening to one during labour, and being involved in decision-making about one's care have been associated with a positive experience of labour (Audit Commission 1997; Davenport-Slack and Boylan 1974; Hodnett and Simmons-Tropea 1987; Humenick and Bugen 1981). Loss of control in childbirth is seen as disempowerment of women who strive for normality and are faced with medicalisation (Graham and Oakley 1981; Kitzinger 1980; Oakley 1980). Findings of this study therefore support the view that control is an important element for women in labour (Hodnett and Simmons-Tropea 1987), and that it is the most important variable to having a satisfying birth experience (Humenick and Bugen 1981). Results of the current study also suggest that women planning a home birth perceive control to be related to safety of the childbirth process. The social environment of the home has important effects on stress and the physiological processes such as birth (Hodnett and Abel 1986; Kiritz and Moo 1974). Women in the study might therefore have a point in thinking that being in control makes the childbirth process safer.
Summary

The qualitative study has revealed several factors spontaneously mentioned by women that influenced their planned place of delivery. The most intensively discussed issues related to lack of information about available options, safety, and importance of control, all of which embody risk perception. Women in the study agreed in their perception of childbirth as an uncertain process, and the suitability of the hospital for a first birth. However, they differed on where they thought was the best place for subsequent births and gave their reasons why home or hospital was the best.

The results support the view of the Department of Health (1993) that women do not have information about options available to them. One woman represented the situation very well when she said "when someone plants a seed of thought in your head, like perhaps home birth, and gives you some information, you may consider it more, but because that seed was never planted, I didn't even consider it". The view of risk perception, that different people have different perceptions of risk and safety depending on their circumstances, was also supported by the results.
Chapter 7: Discussion

The thesis explored women’s perceptions of the childbirth process, and factors influencing their choice of place of delivery. It considered that one of the reasons women plan different venues for childbirth might be explained by their different perceptions of risk as related to childbirth. In chapter 1, the thesis tried to understand the present situation of place of birth in the United Kingdom, by looking at the events that led to it. For that reason, it traced the movement of the place of birth from the woman’s own home to the hospital. History of place of birth identified government policy, which was influenced by the opinion of the medical establishment (Ministry of Health 1959; Department of Health and Social Security 1970; House of Commons Social Services Committee 1980), as having contributed to the move. The main argument for the government policy of encouraging hospital birth was that the hospital was safer compared to the home. However, the policy recommendations for hospital deliveries were made with no supporting statistical evidence for the allegations of safety, and, the policy was therefore questioned (Campbell and Macfarlane 1994; Russell 1982; Tew 1977; Tew 1978; Tew 1985; Tew 1990). However, it could be argued that government policy of hospital birth for all women might have left many women thinking that home was a risky place to give birth, while hospital was safe, and that is why they were being encouraged to go to the hospital.

Government policy about maternity care eventually moved away from a prescriptive service, to what should be a woman centred care, introduced by two government committees (Department of Health 1993b; House of Commons Health Committee 1992). The two committees advocate that women should be given information about services available to them to promote informed choice, which would lead to a client centred service. The patriarchal biomedical model that in the past has dominated health care in general, and maternity care in particular, is seen by the policy as out of date (Department of Health 1993b). The new health policy is putting forward a more participatory model in which decision-making is shared by providers and recipients of care. The thesis took on board the Department of Health’s concern that women are not given adequate information to allow them to make informed decisions about their care, and set out to determine whether this was still the case.

The second chapter tried to understand the theoretical view that might inform the way women perceive the process of childbirth, and how various factors might influence their preferences for home or hospital birth. The view of risk perception was considered, which posits that the perception of risk is influenced by individual characteristics and circumstances (Douglas and Wildavsky 1982; Johnson and Covello 1987). Examples were reviewed in the literature about how an event might be viewed as either being risky or not by individuals or groups depending on their circumstances and interests (Abraham et al 1992; Bagnall and Plant 1987; Dawson and Cynamon 1988; De Haes 1987; Douglas and Wildavsky 1982; Johnson and Covello 1987; Regis 1988). The conclusion was that subjective factors influence decision-making, and, consequently, each person’s view can be understood only in the context of their individual circumstances.
It was proposed at the end of chapter 2, that, women’s preferences for home or hospital birth might similarly be an indication of their risk perception related to childbirth, which may be affected by their different interests and circumstances. It was thought that the eventual place of birth might be preferred because it is perceived to be safer than the alternative. The thesis then went on to try to discover what factors influence women’s views about the place of birth. Two studies were conducted; the first, a systematic literature review looking at research into women’s views about the childbirth process, and factors that affect their choice of place of delivery. The review served as an introductory tour of the area, to discover how much is known about women’s views, as well as what to look for that might give clues to women’s perceptions. Only nine published studies were found, thus exposing the lack of studies addressing women’s views about the place of birth. As seen in Chapter 1, the focus of research and debate about the place of birth is safety, and the views of women are not included.

The systematic review also revealed that the few studies that looked at women’s views about the place of birth used questionnaires. Questionnaires devised by professionals tend to seek answers that inform the particular professional’s perspective rather than the participant’s view. A recommendation was therefore made for more studies looking at women’s own perspectives to satisfy the government policy of a woman centred service (Department of Health 1993b; House of Commons Health Committee 1992). Indeed, the traditional role of the client as perhaps the most critical and yet underused resource for improved health care outcomes needs to be urgently reviewed (Chewning and Sleath 1996). For the client to be afforded their rightful role as determinant of the type of care, there must be effective communication and recognition of the patient’s right to
choose (DiMatteo 1994), without any fear of prejudice or retribution (Stapleton 1997).

In an effort to address the need for exploratory studies about women’s views, the second study of the thesis, a qualitative investigation of women’s perceptions of the process of childbirth and factors affecting their preference for a place of birth, was conducted. The aim was to capture original responses from the women, but at the same time act as a test of the hypotheses proposed in chapter three about the influence of information and risk perception on decision-making.

One of the hypotheses proposed about factors influencing decision-making about the place of birth was that information, or the lack of it, might play a role. It became evident from the start, that, indeed women in the study were not informed of home birth as an available option, despite the aspirations of the Department of Health Expert Maternity Group (Department of Health 1993b; Department of Health 1993c) and The Royal College of Obstetricians response to the Department of Health’s report (Royal College of Obstetricians and Gynaecologists 1994). Those planning a hospital birth did not consider a home birth, but only chose between the options of hospitals they were given. On the other hand, those planning a home birth found information about the option of home by other means, and asserted their right to choose their place of delivery.

The results suggest that women’s lack of information about alternatives to hospital birth may present an obstacle to informed choice. The findings would reinforce the recommendation of the Department of Health that women should be made aware of all options available to them so that they could make their own informed choice. Women should also be informed of the potential advantages and disadvantages of both home and hospital. For example, research has revealed
psychosocial advantages of home birth, such as greater maternal satisfaction (Zander 1982), and improved relationships between mother and baby (Fleming, Ruble, Anderson et al 1988).

Other hypotheses proposed in chapter 3 were that sometimes people make conscious decisions about what risks to take or avoid depending on their individual characteristics and circumstances (Dougals and Wildavsky 1987; Fowlkes and Miller 1987; Nelkin 1989). There was a hint of such decision-making in the study, for example, some women planning a home birth had other children at home and did not want to have to leave them as indicated in the following excerpts:

Mmaoshadi: I had one sick child the last time, who my Mum came to look after and she wouldn't have anything to do with. She was too ill, didn't want anybody but me and I would have worried about her, if I'd have been in hospital even just for a day. I would have worried about her because I knew that she wasn't getting..., she was throwing strops every time Mum tried to do anything for her, even my husband she wasn't particularly interested in. It was me she wanted, and I would have worried about that I think.

Nnese: I have an 18-month-old son and trying to find someone to take me into hospital and someone to look after him is just going to be so difficult in the middle of the night

Many other reasons were given by women for preferring their planned place of birth that attested to the role of individual circumstances on decision-making. For example, some women thought the emergency equipment in the hospital was an incentive, while for others it was a deterrent for hospital birth.
Prospect theory (Kahneman and Tversky 1979) suggests that biases rather than rational judgements characterise decision-making. The biases, sometimes called heuristics (Denscombe 1993; Slovic, Fischhoff and Lichtenstein 1980) are reactions to a perception of risk, which might manifest as factors that detract from objective reality and influence how one might react to a situation. The heuristics may take the form of what have been called the dread factor, the vividness of the risk, and a sense of invulnerability (Denscombe 1993; Slovic, Fischhoff and Lichtenstein 1980). The dread factor may manifest where a woman may just have a fear that something may go wrong with the birth. This was demonstrated in the study when women planning a hospital birth constantly referred to the presence of emergency equipment in case of emergency such as the following:

Montlenyane...But for me I think everything about the hospital has to be about safety. You are in the right environment if, God forbid, anything should go wrong.

Boithatelo: I just feel that if the birth goes easily and well it's the most wonderful thing. But sometimes it doesn't, and I just need to be somewhere where they have got everything ready for you.

Another heuristic that could influence decision-making is the vividness of the risk, where a woman might recall an instance where something went wrong, and thinks that the same might happen again. This was also displayed in the study when women referred to past complications as having an impact on the present decision:

Boithatelo: The child that I had last time was in foetal distress, the cord was around his neck so I had an emergency caesarean section....Possibly if I
was at home there might have been damage to the child because of the cord
being around his neck, so, in my experiences I felt I would prefer to be
somewhere where they have as much equipment as possible.

Mampenene: I would say hospital is a safer place, everything is there
should something go wrong. um, my sister had a little boy at [name of
hospital] last July, and she was given pethidine? And he went flat when he was
born? So consequently, it's like panic station, and that even more confirmed
my sort of thinking.

The third heuristic is the sense of invulnerability, where women might
acknowledge potential problems but feel that somehow it would not happen to
them. The sense of invulnerability might result from the fact that the woman has
had problem free childbirth before, or she knows others who have not had
problems, on the other hand, they might just feel invulnerable, such as the
following woman:

Gaoape: I mean we discussed the fact that um, I could bleed, the labour
could go fine, that the actual baby, could come out and there could be
haemorrhaging on my side afterwards, but once again, yeah, you'd get that
whether you're at home or hospital, so the advantages there are the fact that if
that happened you could get run down to theatre, yes, quickly, whereas opposed
to like waiting for an ambulance to come up and then taking you. But, I don't
know, I suppose I sat back and thought no, that won't happen (laughs). I mean
if it does it does (laughs) but I've sat back and thought, no, that's not gonna
happen. You know, I'm such a relaxed person normally anyway, that you
The precaution adoption process proposes that in order to make a decision about a potentially risky situation, people must first recognise that a risk or hazard exists, and that a failure to protect oneself is a reflection of ignorance rather than an underestimation of the threat (Weinstein 1980; Weinstein 1988). In the study, women planning a hospital birth could not evaluate the risk or safety of a home birth since as far as they were concerned home birth was not an option. It could be argued therefore that these women were not given an opportunity to make a decision.

On the other hand, women planning a home birth had considered the two options of home and hospital birth, and discussed with their partners where they wanted to give birth. The home birth group could be seen to have demonstrated what the theory of reasoned action refers to as rationality of choice and systematic use of available information (Ajzen and Fishbein 1980; Fishbein and Ajzen 1975). The theory proposes that the individual’s decision-making is related to their belief about what outcome will follow their decision, as well as the importance they place on the outcome. The home birth group believed that if they gave birth in their own homes they were less likely to have complications. They used the experiences of others who had given birth at home, and/or their own previous experiences of home birth as evidence that they will be safe. Another important factor for the group was being in their own homes, controlling what happened to them, and having their family and friends with them, which they thought added to the safety of a home birth. The theory also suggests that the individual’s social environment and immediate reference group influence what choices the individual
makes (Kronenfeld and Glik 1991). The home birth group could be seen to have involved their social environment and immediate reference group as they made sure to involve their partners in the decision-making, which contributed to the reality of the home birth. They also made their choices because of the experiences of their friends and neighbours.

Responses from women planning a hospital birth when discussing the lack of information about the availability of home birth illuminate the fact that giving information empowers women but does not bias their choices. Some women planning a hospital birth felt that perhaps even if they were given the option of a home birth they would still have preferred to go to hospital. This suggests that when women have been given information about all the available options, there might be some who are interested in a hospital birth, and others interested in home birth. The difference will be that they will have chosen their venues with knowledge of what the alternative could offer.

An interesting finding was the differences in perception of the safest place to give birth for subsequent children, which exposed women’s perceptions and beliefs about childbirth in relation to the specific ideology they had chosen, either actively as in the home birth group, or by default as in the majority of the hospital birth group. The views indicated that generally women view their chosen birth place positively whether it is home or hospital. The different views support the perspective of the cultural theory (Douglas and Wildavsky 1982; Johnson and Covello 1987), that individuals have different perceptions of risk and safety that are influenced by their individual circumstances. It is therefore important to offer women information about what is on offer, to allow them an opportunity to evaluate the options. It is also important to understand individual circumstances.
that may impact on the choices they make about childbirth so that they could be supported in their choices.

**Implications of the findings for women**

Results of the qualitative study suggest that women who took part were not given information about all options available about the place of birth, but were made to believe that the hospital is the only option. Although the findings of this study are compromised by the small sample size, they suggest tentatively that women in the areas served by the two hospitals involved in the study might be in a similar situation of lack of information because they are attended by the same midwives. Women planning a home birth indicated that they became aware of the option of home birth through reading, or from contact with others who had had a home birth. This would imply that childbearing women may not have access to good quality information about all options available to them, and that there appears to be a bias towards hospital birth, which could act as an obstacle towards informed choice about the place of birth.

Information informs decision-making inasmuch as women cannot make informed decisions if they do not know the range of services available to them. For example, if women know about substandard care at a particular hospital, and do not have any other options, they might continue to go to the same hospital and hope for the best. On the other hand, if they knew of an alternative, for example, another hospital nearby, or their home, they might evaluate the alternatives according to what they know about them, and then decide where they think would be the best place to go.

Chapter 1 indicated the powerful nature of policy in determining the type of care consumers expect to get and subsequently accept as the norm. Policy
could therefore be used to provide good quality unbiased information to childbearing women in maternity units. The information could then be distributed to women by word of mouth by all caring for them, as well as in written form. Information about all available services could be printed as part of the antenatal record. Women would therefore have the information with them at all times and accept it as part of their antenatal care. It could also be useful to get women with experience of different options to talk to others about both the positive and negative points about each option. This would give women enough information to choose with more confidence. The information could involve the pros and cons of each option, and the screening procedures, if any, that are used to help decide the suitability of women for each available option.

While women clearly need more information about the available options, an important question is when and how to reach all or the majority who might benefit from the information. The mass media would seem to be a good alternative, with programs introducing women to options available at the different areas of the country, as well as the philosophies of the options (Mather 1980). The mass media could target different groups of women, such as, through community educational programs, childbirth educational programs, women’s groups and church groups.

Implications for Midwives

According to the history of place of birth reviewed in Chapter 1, the rate of home deliveries fell dramatically from about 35% in the 1960’s to 1% in the 1980’s. The current rate is about 2%, and Chamberlain et al (1997) have observed that midwives who trained when the home birth rate was high ended their careers around 1994. The midwives currently in practice may not have experience of
conducting home births, which might explain why they are reluctant to give information about home births, because they might not feel confident to conduct them.

Studies have found that up to 32% of midwives have not attended a home birth in the past year (Chamberlain, Wraight, and Crowley 1997; Floyd 1995; Northern and Yorkshire Regional Health Authority 1994). It has been suggested that midwives' personal anxieties and lack of experience with home birth may lead them to encourage hospital births as a way of alleviating their own distress rather than helping women to make decisions congruent with their needs (Price 1995). It is important to determine the effect of the midwives' lack of experience of conducting home births on the information they give women about available services. It is also important to find ways of empowering midwives to conduct home birth. It has been argued that if midwives are to become confident in conducting home births, they need time to study and adapt to the responsibilities associated with it (Chamberlain Wraight and Crowley 1997).

Finally, as Stapleton (1997) has observed, woman-centred care means fostering an atmosphere where all women – midwives and clients – are encouraged to express their opinions without fear of getting it wrong. If women, or indeed midwives are afraid of retribution if things go wrong, then there will never be free choice about the place of birth.

Implications for research

Results of this study should be accepted only tentatively, and must be verified since they comprise perhaps a first attempt to investigate women's perceptions of risk as related to the birth process. Hence, results only offer hypothesis for further testing, and point to an urgent need for more exploratory
studies looking specifically at women's views about the place of birth. Research is also needed into effective ways of giving women information about available options in a non-threatening way. It is also important to conduct studies looking into why midwives are reluctant to give information about the availability of home births even though they are willing to support those women who know about it.

**Limitations of the study**

The first limitation of the study is the small sample size, which weakens the generalisability of the findings beyond the sample that was involved. Due to the small sample used, results can only illuminate the problem, but cannot be generalised widely although they could possibly be generalised to women in similar circumstances. For example, it could be argued that the results could be generalised to those attending the same hospitals and attended by the same midwives.

The second limitation relates to the differences in educational status of the two groups that were involved in the study. The home birth group were more educated than the hospital group, which may bias the conclusions drawn about the results. Thirdly, women in the study were only interviewed about their choices once during their pregnancy, this might mean that change of plans about the place of birth were missed which may have significance for the women.

Another limitation of the study, which also applies to qualitative research in general, is that it is difficult to determine whether views raised by participants are accurate (Murphy et al 1998). This point was made vivid in the present study especially in one interview where the participant seemed to contradict herself as the interview progressed. The woman started by saying that the midwife who had
looked after her during one of her labour and delivery was fantastic and caring, and then, as the interview progressed the same midwife was portrayed as uncaring and very cruel. The following quotations illustrate:

Gaolape: But with the first pregnancy that I had was E. who is now nearly 12 um, I was at [name of hospital and City] and um, the midwives there were once again fantastic...But I mean, like I said, the hospital was once again was brilliant, the midwife was fantastic, you know, she was caring, thoughtful, and everything else.

The woman then went on discuss other things before going back to talk about the same midwife, but her version had changed:

Gaolape: and with E. um (laughs) my midwife was actually, her name was L. and I can honestly say, as nasty as it sounds, she was a right old bag (laughs)

(See Appendix 4 lines 35-37, 44-46 and 445-467 for the contradictions of the description of the midwife).

Although the apparent contradiction in the above interview could be seen as a weakness, on the contrary, it shows the ability of qualitative research to get the individual to relax, get rid of the initial façade and reveal a true version of events. When one examines Gaolape’s interview transcript (see Appendix 4), at the beginning, her narrative was superficial and she wanted to present a rosy picture of events. However, the richness of the description of what happened to her as the interview progresses almost takes one to the actual time of her delivery, and it is as if one is watching it happen rather than listening to a narrative.
Contribution to research

The thesis has attempted to address the issue of women's views of the process of childbirth, and examined factors that influence women's preferences for a home or hospital birth. The area of risk perception was reviewed and an assessment made of how it could be applicable to childbirth. This was a substantial contribution to childbirth literature as women's risk perceptions related to childbirth and the place of birth have not been researched. Secondly, the thesis considered the Department of Health's view of information giving to allow women to make informed decisions about their care. The thesis investigated whether lack of information still has an impact on decision-making. The findings of the study therefore are a contribution towards evaluating whether the recommendations of the Department of Health (1993b) of giving women information are being addressed.

The thesis conducted two studies, one a systematic review of factors affecting women's preference for a home or hospital birth. The review is a major contribution to literature and could add to the Health Technology Assessment literature (http://www.ncchta.org) that makes up a large body of knowledge for evidence based practice in the United Kingdom. The second study is a primary qualitative study of women's views of the process of childbirth and factors affecting their choice of place of birth. Although limited by the small sample size, the study contributes by adding to exploratory studies looking at women's views, which are urgently needed.
Appendices

Appendix 1: (Information leaflet)

My name is Banyana Madi and I am a midwife, studying for a doctorate at the University of Surrey. I would like to invite you to participate in my study looking into how pregnant women make decisions about the most appropriate place of birth. I will therefore ask those wishing to take part in the study to take me through the process of how they came to decide on where they would like to deliver. This might include information about:

Your understanding of the process of labour and delivery

What you think the appropriate management should be

Your knowledge of the options available about possible places of birth

Your source of the information about the available options

Where you thought you would like to deliver when you first discovered you were pregnant

Whether this has changed at all

Whether you have any prior experience of the place where you want to deliver

What you think is the thing that most influenced your decision

What role your partner has on the decision

Whether you think you have adequate information upon which to make your choice

Whether you think you made a choice about where you want to deliver or whether you just followed what most people do

What interests you most about your planned place of birth

What you don't like about the alternative place
I would really like to know about everything that was involved in coming to this very important decision, and how you think it could be made it easier for you.

If I get a good handle on the issues involved, I may be able to make appropriate recommendations to NHS management. The study is funded by the European Institute of Health and Medical Sciences (EIHMS) of the University of Surrey.

If you are interested in taking part in the study, please sign the form provided by the midwife. This will signify your permission for the midwife to pass your details to me so that I could then contact you to explain the study further, and arrange a suitable time we could meet. Your participation in this very important study will be appreciated.

Many thanks in anticipation of your support.

Appendix 2: Consent to be contacted

I, the under-signed give my midwife permission to pass my telephone number and address to Banyana Madi to contact me about the study of decision-making about the place of birth.

Name:

Signature:

Please write your address, telephone number, and preferred time for telephone calls in the space provided.

Thank you very much for your participation in this very important study. I look forward to working with you.
Appendix 3a Consent form

I, the undersigned voluntarily agree to participate in the study of decision-making about the place of birth. I have read and understood the Information sheet provided. I have been given a full explanation by the investigator of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the information given consequently. I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

Name:

Signature:

Date:

Name of witness:

Appendix 3b: Consent form

I confirm that I have read and understood the above and freely consent to participate in this study. I give my permission for the interview I have given to be used in the study, and for a written record of my interview to be kept December 2001, after which they will be destroyed. I understand that all documentation held on a volunteer is in the strictest confidence and complies with the Data Protection Act (1984). I agree that I will not restrict the use of the results of the study on the understanding that my anonymity is preserved.

Signature:

Appendix 4: Transcript of first home birth interview

(Gaolape)

Okay, Gaolape, like I explained before, I would like you to tell me about what you think about the process of labour and about your decision to have your baby
at home. Anything at all that you think might have contributed to this decision.

1. (laughs) Right, if I start at the beginning, um, I had the other three children in hospital
2. and I’ve always felt like in hospital you’re on conveyor belt system?
3. You go in, you give birth they want to get rid of you as soon as possible,
4. and I didn’t, I’ve never felt relaxed in hospital. Um, with this one, I decided from the beginning
5. that it will be really nice to have your own home,
6. and your things around you, um, give birth, hopefully,
7. I don’t use pain relief anyway, so, you know, totally and utterly
8. what I call natural labour? Um, a nice bath when I want to have one!
9. um, all the (pause) I suppose the added extras of like hopping up to have a drink,
10. and, and everything else? I, then afterwards being able
11. to just lay in bed with the baby and not get moved from one room to another room
12. and have everyone coming poking you around,(laughs) and I know,
13. I’ve had like three friends now
14. that have all given birth at home. And they’ve all said,
15. you know what a magical experience it is to be laying in your bed or on your sofa you know,
16. and have that baby, and, and no no sort of presence of people walking around,
17. other babies crying, and, and, that was it really, I just felt like I wanted something different.
18. This time, you know, rather than sort of, with Our boy, the last one I had,
19. he’s fourteen months old now, um I had to go and be induced because I was over.
20. And although the midwives were wonderful,
21. which they were, they were absolutely brilliant I just felt on edge the whole time
22. because I was in a hospital and I thought, No, you know next time if there is anymore
23. it will be different. So that was it really. It wasn’t media or anything else,
24. it was just me sort of thinking well, I’ve never had a problem during pregnancy or labour?
25. It would be nice to have hopefully a quick nice one at home
26. (Laughs) But not with my luck I’ll probably go overdue and have to go in anyway
27. (laughs) Oh yeah, that was it I just decided that I wanted it in
28. the comfort of my home and that way I haven’t got to worry
29. about the children either, because they will either be in bed or at school.
30. So it’s nice and convenient for me
31. and obviously my husband said to me, whatever you want is fine by him.
32. So, so, yeah, he’s quite understanding and just said well,
33. I can’t understand why you want to have it at home,
34. but I’m with you a 100% So that was it.
35. But with the first pregnancy that I had was Emma who is now nearly 12.
36. Um, I was at [name of hospital and city]
37. And um, the midwives there were once again fantastic,
38. but it was a long process. I got induced at (pause) 9 o’clock in the morning
39. and she arrived at half past seven in the evening?
40. And I was put on a drip, and I ended up having an epidural,
41. and it, (pause) it put me off of childbirth because Sophie didn’t follow
42. till six years later, (laughs). Because I thought well, you know,
43. I’m not going through that experience ever again.
44. But I mean, like I said, the hospital was once again was brilliant,
45. the midwife was fantastic, you know
46. she was caring, thoughtful, and everything else.
47. But yes, the actual pain and (pause) I suppose how long winded it all was
48. I thought never again. And yeah, I fell pregnant for Sophie,
49. who is now coming up for six and I had her at [name of hospital] 
50. and I was the only one in the whole hospital that night 
51. I went in (laughs) and they were all sitting, the two midwives 
52. that were there were sitting playing cards. 
53. And I remember her saying to me, you know, 
54. couldn’t you wait till I’ve finished this hand. 
55. And like we had a laugh and a joke. And I was the only one in, 
56. you know I had the whole hospital like to myself and um 
57. I was shown into a private room afterwards, 
58. the labour went brilliantly, three hours start to finish? 
59. No stitches, and yeah, taken to a private room, which was lovely. 
60. I stayed in about six hours and was taken home. 
61. It was absolutely fantastic 
62. and then obviously yeah, once, like I said with Our boy 
63. it was hospital again induced, and, but the only thing is you, 
64. you I was passed at [name of hospital] from one room to another room, 
65. and then I was moved to another ward. And then I said you know 
66. I want to go home because but this time I was just so tired and fed up 
67. of being, I supposed pushed from pillar to post (laughs). 
68. I thought, you know oh God it would be really nice to get home 
69. and that, I had him at 9 o’clock in the morning and the paediatrician 
70. come out at 3 o’clock in the afternoon and checked that he was okay 
71. to leave hospital? which he was? And yeah, we came home 
72. and you know from walking in the door it was, it was 
73. completely different, you know you’re at home and you can 
74. porter around and it was lovely. So yeah, and that, that was basically 
75. made the decision, that that was it,
76. the next one was being born here (laughs). You know, not in hospital
77. and my midwife, K. at the health centre was brilliant you know,
78. she sat me down she explained to me that if there is a problem, um
79. would I consent to going in by ambulance or whatever else?
80. and I said yes of course I want what’s best for the baby. You know,
81. she said, she was, she has been behind me a 100% you know she hasn’t,
82. nobody’s tried to talk me out of it, they’ve all said to me, you know
83. it’s your decision and you know, are you happy? do you realise
84. this can happen, and that can happen? and I said yes, I’m willing
85. to take that chance. I mean, I think my point of view is
86. what can happen at home would also have happened in hospital anyway.
87. I know okay you have the advantage that the medical staff
88. are all in the hospital with you, but at home I feel that because
89. of how more relaxed you could be, um, a lot of, I suppose a lot of it
90. can be avoided, so I, we’ll give it a try (laughs).
91. Roll on the next three weeks (laughs).

- What information were you given about the place of birth?
92. I can honestly say with the first birth, with Emma, I was only 18 anyway,
93. and I was very young, very naive, and it was a case of got
94. pregnant, you will go there to have the birth. I wasn’t shown
95. around the hospital before having her, I was absolutely petrified,
96. (laughs), and I mean petrified
97. and yeah, once again with Sophie it was a case of well, you’re booked
98. into that hospital. Um, yeah, I don’t think there’s ever been
99. enough choices given to you, You know the only choices and the only
100. way you ever get spoken to is through books that you buy, and
101. magazines, you know, nobody ever actually sits you down
102. and says to you, well, this can happen, that can happen, and, they
I feel they don't talk to you enough, so, you know, I buy all the magazines, like the pregnancy magazines, mother and baby, practical parenting, you know every sort of couple of weeks I have a new magazine, I read up about all the tips on birth, on how to bring up the children, on their behaviour, obviously, and I found all my information has come out of magazines (laughs). So and I know there's a lot of mums that feel the same that enough information isn't given. Like with our boy I wanted originally to have a water birth in hospital, and I asked about it, and it was a case of yes, we do do it, we'll speak about it nearer the time and then it was I suppose avoided? Every time I sort or mentioned it it was brushed aside and I thought oh well, perhaps you won't have that. So I feel that yeah, they don't give you enough information. But then, once again it does depend on the midwife. Coz some will sit down and take time with you and others will try and brush things aside because they're in a rush? But my midwife last time with our boy was wonderful, it was just the fact that she was trying to avoid the subject of water birth (laughs), but she was still a wonderful person and she done a really good job, so, but yeah, no, there is not enough information around.

- Now with this pregnancy, did someone tell you about the options?

Yes, they did, they did, yes, um, um, it's funny this, when I went for my first scan, I had my scan at 12 weeks um, at the Cambridge hospital in Aldershot and it was a man that done it. And he was, I was laid on the couch and he was chatting to me about, showing me all the bits on the baby, and he looked at my notes and he said, Gaolape you're a dab hand at this
130. why are you wasting the hospital’s time? he said, you might as well
131. stay at home and have it and he was joking, obviously, and I come home
132. and I thought, you know, he was right! You know
133. it would be nice, so, yeah, I suppose it was him mentioning it,
134. rather than the midwife, because the midwives have never mentioned it
to me. It was him that was mentioning it
135. and making a joke of it, but yes, made me think, oh yeah,
136. I’d like that you know, and I found out the more about it the
137. more I could, and obviously, when I mentioned it to the midwife,
138. um she said to me Yes, it can be done, but talk to me nearer
139. the time. So (laughs) I said okay so, and I think actually looking
140. at notes (opens her ante-natal notes) I don’t think it was actually
141. reached until I was about six months pregnant. (reads notes) –
142. talking about home confinement and that was in July, so and
143. I found out I was pregnant in February so yeah, till July
144. before she sort of said, okay we sort of talk about it nearer the time
145. and then, yeah it wasn’t actually, it was still considering at
146. the beginning of September, and obviously the 15th September
147. was when she said yes, okay. So, yeah, it took a lot of, (pause),
148. I suppose keep saying, yes I want a home birth
149. for them to I suppose be with me? But they did tell me that
150. the doctors don’t approve, my doctor at the surgery doesn’t
151. approve of home birth, so there is no point in going to them
152. and discussing it. You know, it had to be literally with the
153. midwives? So, I said, that’s fine (laughs) You know I know
154. what I want so, I think yeah, as a parent you do get to the stage
155. where you think oh, you know, hang on, you know,
156. I want what I want. If there’d been a problem during the pregnancy,
Um, or if I felt that I couldn't manage on natural pain relief or

gas and air then yeah, I would've sort of thought well, we'll go to

the hospital for the last one. But I'm so confident that I'm

thinking well, no, I will manage at home. So, (laughs)

Now when you look back at your previous pregnancies and probably how this
pregnancy has progressed. What is your perception of the process of
childbirth? How should it be managed?

Um, I would say possibly if you are a first time mum, then yeah,
it should definitely be a hospital because you don't know, sort of
like, you don't know yourself, what your body is going to
go through, you don't know what your body is capable of,
a natural birth and, and obviously if you want pain relief and
everything else then the hospital is the place to have it,
I would say that. But I'd say that, you know, as, as a mother
you, (pause) I can't spell it, you, your body knows what feels right?
And I think, you know, once again if you're strong person you can
cope without pain relief and everything else then you can

have your baby wherever you want it. But you know

if you're first time and you think there's gonna be problems
then yeah, I'd recommend anybody hospital, because
all the staff are there and obviously they want to do the best
for you and the baby. Whereas I've been lucky because obviously
never having any problems, you know, if I'd had problems prior,
then I wouldn't have considered it myself. (laughs).

So what do you think is the main advantage of having a baby at home?
I think it's just the fact that you're secure in your own
environment and you're free to, I suppose do
what you want to do. You know if you want to slouch,
over the chair then go ahead (laughs) if you want to roll
on the floor in agony go ahead, but I think it’s the fact that yeah, you’ve got everything around you um, as long as the house is clean, warm, the best that you can make it, then I think it’s lovely for a baby to come into the world in its own home.

And about the hospital, what is the thing that you don’t like most? I think it is the fact that, which isn’t the midwives fault, because they have a lot of mums in, but I do feel that you are treated sometimes like a conveyor belt you know, you come in here now, and you do, I suppose basically what they tell you to do?

Like I’ll give an example, um, with Sophie, I was happy laying in the water in the bath, and the midwife said to me, You must get out of the bath now Yeah, I laid in the bath with Sophie, yes, and I remember laying there and she said you must get out of there now, and I said, well, no, I don’t want to, and you know I’m not asking you, she said, I’m telling you!! (with a high voice) And as it was, Sophie didn’t come out for another two hours, whereas I was so (pause) laying in the bath in the water around me, it was lovely, I was so relaxed, and you know, they sort of, I suppose it’s the case or they want you up on that bed and deliver, because you know they might have another one, one or two people coming in at the same time, so, yeah, I’d say that (pause), I think hospitals just aren’t relaxing, but then that could just be me coz I’ve never liked hospitals. But I didn’t, I have never felt relaxed in hospital. I’ve always felt like yeah, you’re there to get it over and done with, and out the back door sort of thing (laughs) it might not be that bad for everybody, but that’s how I felt, so (laughs).
You mentioned that you had friends who had their babies at home?

Yeah, I'll give you a fine example, is my friend's little boy is, now is about three months old, and she got up at 4 o'clock in the morning, went to the toilet and her waters broke. Um she phoned her midwife and she said my waters have broke I'm not having contractions as such of yet, but obviously I'm phoning to let you know. The midwife said okay when you need me phone back. And it got to I think it was 6 o'clock and the contractions were like very very quick, so she phoned the midwife and the midwife arrived, and then the second midwife arrived. And she was stood in her kitchen, having a cup of coffee and a cigarette (laughs) and the midwife said, you know, what are you trying to do to that baby, smoke it out? And they were like laughing and joking? And she said to the midwife, I think I'm going to start pushing and they got her washing up bowl, um because she was stood over the kitchen sink at the time and she got a washing up bowl and she put it like between her legs? and she said within like 5 or 10 minutes, a couple of pushes, and the baby was out, and she said the experience I mean she'd had four children, and she said the experience, you couldn't, you know you got to be there and to have gone through it. But it's how she stood, she said with her coffee on the side, her cigarette was burning in the ash tray, you know, which wasn't a good thing for the baby, we know, but she said you know, and it was a case of oh, I think I have to push you know, she had no stitches, there was no problems at all, and after the birth, she said you know, it was a case of the midwife's got rid of everything, the placenta, there was no mess, one of them
went up and ran the bath for her and her husband was away on a business course that day, so he missed the birth. (laughs)

And he’d left at 2 o’clock in the morning and um, when she phoned him he was stuck in the traffic, so he missed the birth,

but um, yeah, she said the midwife, one of the other midwives ran a bath for her. She went and had the bath, she come down she phoned me at quarter past nine and said to me, I’ve got a little boy and I said when, when? and she said a couple of hours ago and I said what are you doing on the phone? she said I’m laying on the sofa, my feet are up, the baby is asleep in his bed, he’s had his bottle. She said I’m having a cup of coffee, a biscuit and a cigarette, coz she’s a very very heavy smoker. She said um, she said it’s bliss, she said the midwives have cleaned up, they’ve gone. She had a doctor going out that afternoon to just check she was okay and she said it’s lovely, she said I don’t actually feel like I’ve been through anything. And I went to see her the following day, and you know, I said you know, “what was it like?” sort of thing, she said it’s just unbelievable, she said because you’re so relaxed it’s so quick. She said you know it was a case of standing one minute and the next minute thinking, oh no, I’ve got to push, you know, how am I going to make it to the bed? and she said no I’m not, you know, it’s got to come out here. Yes, she was actually crouched over the sink, and he was 9 pounds 2, no, 9 pounds 3 and she didn’t have any stitches or anything, and like she said, you know, it was amazing, it really was a really good experience.

And after that happened, I thought that is definitely it for me, (laughs) you know, not saying that mine will be like anything near like hers, but like she said, she was another one that never liked the
hospital system. You know, it was a case of yes, she said the same,
you’re in you give birth, and within like a couple of hours
they can’t wait to get rid of you. So, you know (laughs) and she said
with her last one she would have loved to stayed in hospital
a bit longer, coz she wanted a break, but they wouldn’t have her.
it was a case of you know yeah, you’re all well, go, sort of thing.
And she said when you go home to four other kids,
sometimes you sort of think to yourself, now, it would be nice
to spend a week in here. (laughs). but yeah, and that was it, you know,
so, we was chatting and me sort of being round at home and holding the
baby
and everything and looking at how well she looked.
And, she said the best thing was to actually give birth,
have your bath, get changed into what you wanted to wear,
lay on the sofa and she didn’t move the rest of the day.
And she said it was just fantastic, there was no one coming in,
there was no other babies crying, there was no, you know,
there’s your dinner sort of thing. She said it was lovely.
So I thought right, you know that’s it. I think if, if you’re at home,
I mean don’t quote me on this till after I’ve had the baby (laughs),
I think at home things are actually less likely to go wrong,
this is my personal opinion, because I know, um not so much of
our boy, coz it was a very easy birth, but with Sophie and Emma, it
was a case of they are standing there, and they are saying you
know, the baby is in distress if you don’t hurry up and push you are
going to have to have forceps and they show you what they are
and you’re thinking Oh, my God! you know and you’re getting
yourself, so, I got myself so worked up, you know because,
you know I’ve seen these things, and I thought, oh no, they’re,
not going near me, you know and I find I was very very panicked
the first two times, you know, and it was a case of yes, just push for
dear life and yeah, with the first two girls I ended up with a lot and
lot of stitches, and yeah, yeah, with our boy, it was a case of
because, yeah, praise not my old midwife, Um, because of how well
she was, I mean my boy was nearly 9 pounds and it was fantastic!
you know, no stitches, nothing, because there was
no pressure there, Whereas yeah, with the two girls
there was so much pressure that you know
it, it just put me off of birth, full stop. And yet this time,
I thought well, at home, you know, once again you’re
not going to have that pressure because they are not going to say
to you, you know hurry up and push this thing out because
I’ve got two more ladies in the next room waiting to give birth,
and I can’t spend all my time with you. So, I think yeah, at home
because I feel you’ll be a lot more relaxed, you’re less likely for
things to go wrong. I mean that’s not saying they won’t,
I mean we discussed the fact that um, I could bleed, the labour
could go fine, that the actual baby, could come out and there
could be haemorrhaging on my side afterwards,
but once again, yeah, you’d get that whether you’re at home or hospital,
so the advantages there are the fact that if that happened you could
get run down to theatre, yes, quickly, whereas opposed to like
waiting for an ambulance to come up and then taking you,
but, I don’t know, I suppose I sat back and thought no, that won’t
happen (laughs). I mean if it does it does (laughs)
but I’ve sat back and thought, no, that’s not going to happen.
You know, I’m such a relaxed person normally anyway,
that you know, we take everything in our stride if, and

what is it that they say? If it comes to, we cross that bridge then (laughs).

But yeah, I just feel that having a home birth, yeah would

be more relaxed so that I feel there’d be less problems. So,

and obviously you’ve got the midwife’s full attention because

there’s no other mums around you, that need her attention.

So, we wait and see.

• You sound very happy

Very much so, very, very much so. My first, the two girls

are from my first marriage, which broke down,

then I met My husband, and he took on like my two girls,

and we discussed it and he said, you know, we, I’d like children

because he’d never been married and had children.

And I thought at the time, no I can’t ever go through birth again! (laughs)

And in the end after two years of marriage I was persuaded that yes,

okay, we’d have one, and then obviously, having the boy and how

supportive he was throughout the pregnancy, coz we run

our own business and we worked together all day long

when I was pregnant and I didn’t pack up work until two days

before [our boy] was born? Um because I wanted to keep busy. So

yeah, we work together, so I had the support at home, of you

know, “well, you go up and put your feet up for half an hour now,

and leave me to it” and like, when the actual birth come with

our boy, David spent the night sleeping in the hospital car park (laughs)

because I went in to be induced in the evening and it didn’t work,

but they wouldn’t let me home, um, they said to me, no,

we try again at 7 o’clock in the morning,
and I said, well, you know, I don’t want my husband to leave me,
so I was a bit of chicken, and they said oh no, hell, have to go
home, so they sent him packing at about half past ten, they
said you know, you’ve got to go home nothing’s happened we try
again in the morning. So he didn’t wane come all the way home,
because the lady said, another midwife had said to him, oh
yeah it might not work now, but give it a couple of hours it might
hit full force. He was very worried I suppose being his first child
that he’d miss everything? So, he went out to the car which was in
the car park, he drove home he had a wash, he had a shower,
a change of clothes he had something to eat and then he went back
to the hospital and he slept in the car (laughs).
The midwife, K, was my midwife in the health centre arrived at the
hospital at 5 o’clock and my contractions were like full force,
and I said to her can you phone my husband? and she said
of course I can and she phoned him on his mobile, he said,
I’m in the car park I’ll be two minutes. Yeah, I mean he come up
pounding in, you know, and I can honestly say I mean, having him
there um, when the actual contractions that were very bad
and he was laying rubbing my back. He was absolutely fantastic,
and I mean fantastic. And between like him and K, the midwife,
it was what it was, it was really nice, and you know, even afterwards,
like seeing our boy come out and, everything else, I think it was
brilliant and he said to me, well, if that’s how easy it is,
you will have them at home, coz he kept thinking and teasing me,
he kept saying my dear you can make it look so easy.
And I said, well, I can assure you it wasn’t, but you know (laughs).
So yeah, that’s why he decided that yeah, if that’s what I wanted
then he'd be there. So, the only thing he laughed about was, he kept teasing me, he's bought plastic dust sheets and he keeps saying he's going to cello tape them from the kitchen all the way up the stairs to the bedroom and bathroom coz I'm not ruining his carpet (laughs). Oh, that's the only thing that we've sort of like mucked about on, you know plastic dust sheets and a plastic sheet for the bed that he's put on already in case anything happens. And, that's you know, if (pause) he's got a very very good sense of humour like that. Yeah, he was against it, I suppose at the beginning when I first mentioned home birth, it was a case of darling, what if something goes wrong? And I said, but you can say that in hospital as well, I said, so, you know, it's a chance you've got to take? And he sat down, and I bought a magazine, and we read that together, and it was pros and cons! And believe it or not even in the magazine there was more pros to having a home birth than cons. So he sat back and he said give me a couple of days, I said alright and then we sat down one evening when he wasn't at work and he said, Okay, if that's what you want. You know and he's been brilliant since! There has been no hostility from him about it, when the midwife was I suppose sitting and chatting about it, I was expecting him to sort of sit back and think you know well, hang on, he didn't, he was with me 100%. So (pause)

• What worried him most about the home birth?

Um, I think it, like he said, it was a case of if anything went wrong, um, having to wait for an ambulance to come, and then the ambulance to take me from here to the hospital, he was worried that it might threaten my life?

And when I explained to him that (pause) they know in advance,
it’s not as if something goes wrong at that exact moment.

They know that if you’re having trouble with the delivery or anything else, they know in advance, they can see, they can phone an ambulance straightaway. And after that he was fine, and like she said, having what they call three perfect pregnancies, and three perfect births, there is no reason why the fourth one shouldn’t run along smoothly, so, after that he was fine! (laughs)

I think he still is a bit worried, then he was worried when I was pregnant with Our boy as well, so, I think that’s just his nature. Yeah that’s just his nature because after having Our boy he was holding it and then all he kept saying was like thank you, thank you, thank you, thank you, and all he kept saying was I’m so glad you’re alright. And I’m thinking, well, of course I am, what did you think? (laughs) You know, but yeah, once again because he hadn’t been through it, to him it was all new, so he said, you know you made it look so easy, it wasn’t what I anticipated. And I said, why?

and he said well you hear all these men say about their women swearing at them he said, and everything else, he said you were so good. And I said well, that’s because I was high on gas and air.

But (laughs) I think, yeah, I think he has been brilliant since,

I (pause), we’ve had no problems at all, none whatsoever.

And you say you never used any pain..

No, I had an epidural the first time, with the first one and (pause) I think (pause) How can I explain it? The fear of the needle, made me very very tense (laughs) and it never took, you know, they say that it numbs you from like the waist downwards, I could still feel everything and after that, I thought well, if that’s pain relief, forget it, I’ll go through it naturally, so all I’ve ever had is like a couple of
puffs of gas and air. That's it, and even like, with our boy, it was a
couple of puffs of gas and air and I thought, no, it makes me
feel sick, so I just pushed it away, and yeah it was natural, no
pethidine or anything. And I can honestly say, I don't think
the pain is actually that bad if you concentrate with it. I mean what
I normally, two days later thinking to myself it doesn't really hurt,
it's all in your mind, but then my stomach says no it's not,
it's definitely here (laughs) but yeah, it's, it's I don't think
sometimes pain relief actually helps. I think your body
is obviously designed to give birth, so, why try and block it?
Let it give birth.
And, with the previous pregnancies, did you have one midwife looking
after you?
No, um, only with our boy, the last one I had like the same
midwife right through, and luckily she was there on the day that I
went in to have him? But no, with Sophie and Emma, it was
a case of you saw a different midwife every time
you went to ante-natal, and then yeah, it was a different midwife
entirely when it actually came to give birth? And with Emma,
um (laughs) my midwife was actually, her name was L. and
I can honestly say, as nasty as it sounds, she was a right old bag
(laughs) she, she was about, about 50, 55, she hadn't had children
of her own, and I remember her giving me a really really hard time,
and because I wasn't married to Emma's father at the time we were
both together, he was there at the birth, But because we
weren't married she was giving me a hard time on young
unmarried mothers. And (laughs) you know, I said to her,
well from young unmarried or not it doesn't matter, (laughs)
you, I said, you're here to deliver my baby. And, yes, she was really awful, you know the whole time, and she was supposed to go off-duty, I think it was about half past six, and because I was being so nasty to her, because I told her I thought she was an old bag, she said I'm going to stay here and make sure I see this baby born. And then the baby's head come down and she said to me we're going to cut you um, because obviously, she said, we don't know if the head is going to come through. And I remember thinking, oh, my God, you know, coz of being so young as well, and I remember the scissors cutting me, um, so, that didn't help, then they had me on a drip, and one of the midwives which was a trainee tripped over the drip and pulled it out of my hand, and (laughs), and it was like a scene out of a comedy film, I remember looking thinking, well, hang on, I've just been cut, I've got a drip sticking out of my hand now, you know, you know, I mean, it was just awful. It really was awful, you know, and I remember when she cut me down below, the scissors were cold, so coz I jumped, and it made it cut more than it should have oh, it was really really, awful experience. yeah, but the midwife was such a, (pause) I can honestly say she was awful and I mean totally, she wasn't sympathetic, she wasn't caring, and, it was just a case of, with her, you know, you're young, you're stupid, you're not married and I'm going to make you suffer and that's how I felt. You know and after that, you know I say, six years till Sophie come along, I was petrified. Absolutely petrified, all I kept thinking was, I'll never ever go through that experience again (laughs) you know, coz you know, I was so
scared, but yeah, (laughs) but yes, she was an awful midwife. I still
(pause) um sort of sit back now and I think to myself how unlucky
I was the first time. You know, to have had somebody like that,
and how if it’d been somebody more caring, you know,
then perhaps my views would have been different (laughs)
but oh, it was awful.
After that how do you feel about having a midwife looking after you throughout?
Fantastic, absolutely fantastic, K., down the health centre
I saw her nearly every visit with our boy and I went in like I said
the night before to hospital to be induced and luckily, she come on
that morning, um, she, she was brilliant, because she’d seen me
nearly every visit, she obviously knew me, she knew my husband,
er and my husband got on very very well
coz she come to all my ante-natal visits with me!
So, you know, she was chatting to him, she was well, fantastic.
It really did make a difference, and like this time,
I think nearly every ante-natal visit again has been by K..
so I’m hoping that yeah, she will actually be the one to deliver.
I have asked her especially, she’s lovely. And, I said you know,
under no circumstance send anyone else I want you. (laughs)
But all of the Team, I must admit they’ve all been lovely you know,
I’ve met them all now over the past two pregnancies
and they’ve been fantastic. You know, they, I mean I had a student
in with K. when I had our boy, and even the student, she was
brilliant. You know, she lay there and she was like stroking the hair
off my face and saying to me, you know well done, come on
you’re doing really well, she was lovely, you know, really really
nice. And the funny thing was afterwards um, I was giving like
our boy his first bottle, and I said to her, you know, I'm dying
for a cigarette, and I'm not a heavy smoker at all by all
means when I'm pregnant like I suppose like one every three,
four hours? I've really like stopped when I'm pregnant.
And she said to me, ah, she said, you've had three kids now,
how can you afford to smoke? You know, and she was so,
she really was nice, and she like pushed me downstairs in
the wheelchair, because they wouldn't let me walk, although I said
I was capable of walking. She said, oh no, I'm not having you
pass out on me, she said, I'll take you in the chair you know, she
was lovely, and she's just, the student now, she's just qualified
from what I hear, so I said to K., so if you are busy, I'll have her
(laughs). Yeah, the care was brilliant, getting to know the midwives
and then having them at the actual delivery is fantastic.
It is a much better system more than what it used to be sort of like
six years ago. So they have improved you know the quality of care
and everything. But yeah, K. is fantastic, you couldn't wish for a
better midwife.
Have you been going for ante-natal classes?
No, um, I did the first time! First time round, and I've never gone
back, um (pause) I find that yeah, you can go to ante-natal for like
nine months, to breathing classes and everything else you want to
call it. But on the actual day of delivery, I think you're in so much
pain (laughs) you forget the breathing exercises (laughs) and
everything else, so yeah, no, I've never bothered since, I always go
to like ante natal care to have like the blood pressure checked, and
things like that, but yeah, breathing classes and everything else they
give you no, no, I've done it the once, never again (laughs). I knew what to expect, so, you know (laughs) it's different, I mean I think the classes are good, you know, if (pause) I suppose you, yeah, you're an inexperienced mother, but once you've been to one set of classes, I don't see the need to go back.

So, how were you monitored when you were in hospital?

Ah, yeah, (pause) I had monitoring um, (pause) with the first two right through. One, Emma had a probe on her head, um, they put it in, and with Sophie it was monitored with two belts? With our boy it was only monitored for (pause) I think, about ten minutes at the beginning, of when the contractions were strong to check the intensity of them, and after that K. just done it with a hand held one every now and again? Which once again made it a lot more relaxed, because obviously you've not got to worry about how you can move.

Yeah, K. used to come over every so often check blood pressure, and listen to make sure heart beat was fine. So yeah, that was the only monitoring that was actually done last time. Which was really nice.

I prefer the hand one, I prefer (pause) um, sort of midwife, yeah, to be able to just come over to you, have a quick listen to make sure it is okay, and walk away again.

I suppose too on the electronic monitoring you've got to stay in one position, you know, you can't move, then you know, you sort of like, if you try to move you end up loosing a heart beat and things like that and it makes you more panicky, so yeah, I think the hand held one in labour is fantastic, you know the mothers feel a lot more relaxed, so, and I know that
through friends as well, they've all mentioned this monitoring
coz it's something that all mums have sat back
and said we hate being monitored (laughs). But I mean, obviously
if it's needed for the baby, then, you know, you're happy to go
along with it. But it is nice to every often come
and listen, and leave you alone again.

Have you had assisted delivery?
No, no, just cutting the first time, and nothing since. I've been
lucky (laughs) I have been lucky.

Is there anything else you would like to share? What would you say to someone who was undecided about the place of birth?
I would like to say to them like, I've had, I've got a friend actually
who's pregnant as well, she's only, I think she's just come up
to twelve weeks, and we, she comes round once a week and we have
coffee and the children go to mother and toddler together. And I
said to her, you know, are you goanna consider a home birth?
And she said to me, yes I am this time. And I said, well, yeah,
I said, I gave her all my magazines actually that I had
and I given her them to read, but I will say to any mother,
if it's your first one, then I would definitely say go to the hospital
because you don't know what your body is going to, (pause)
I suppose go through. You don't know whether you're going to be
strong enough to go through it unaided or pain relief. I'd say, get
the first one over and done with, and if you're happy with it, then
go for a home birth. Go for being in your own home, I think it's
the best start for a baby. So, that's the only advice I can give them,
go along with what's right for you, you know, if you feel, like a
home birth, and you got pressure or opposition against it, um,
fight it, you know, if you want it at home have it. So, (laughs)

obviously you'll have to ask me again in a couple of weeks when

I've had it, I might say never again. (laughs) well, now, I'm very

happy and relaxed about it so, I'm sure, I mean, mothers do it in all

parts of the world everyday, don't they? I mean, its not as

if,(pause) I mean, some, like countries obviously they give birth

well, what was it that my dad said? Like in paddy fields some of

them, you know it's a case of give birth, and you know get back to

work, so, you know, like he said it's a natural thing your body is

designed to do it, you know, it shouldn't matter whether you

have it at home or hospital but go along with what you happy with.

So and obviously I was happy to have it here.

You sound really happy!

Yeah, I think it has been nice this time, because I felt relaxed

about having like I've had care at home as well.

So there's been no sitting in the clinic for like two hours because

the midwife's running late? And things like that? You know it's

been a case of she's come to me, I've made her a cup of tea or

coffee and we've sat and it's been it's been lovely, really nice, so I'd

definitely recommend it to anybody. So, and it makes a difference coz

our boy being so young as well, the fact that yeah, I haven't got to

log him backwards and forwards to doctors and hospitals, you

know, because everything is being done here. You know, he is

oblivious to what's happening (laughs) yeah, he doesn't mind, he's going to

know in a couple of weeks when he sees his brother or sister for

the first time, but yeah, it's been really nice, really nice.

(long pause)

Thank you, thank you very much.
Appendix 5: Reflective notes

Nnese seems upset about her husband’s lack of support for a home birth, but determined to have her baby at home. It was a bit difficult to conduct the interview because Nnese’s son was in the room and wanting attention from her, or making too much noise. However, despite this, Nnese put her point of view across clearly. Perhaps I did not give Nnese adequate time to discuss all factors affecting her decision, or maybe I did not use the right prompts?

As soon as the tape recorder was switched off, she talked at length about the things she does not like about the hospital. These included cleanliness, which seems to be the main factor. She says the toilet and bath are not cleaned properly, and that too many people use the bed linen. She also talked about shortage of staff, which often results in women not having any midwife with them during labour, and she did not want that to happen to her. Noise from other women’s babies was another factor she did not like about the hospital environment.

In the coming interviews, perhaps I should prompt for these issues if they are not spontaneously mentioned. The interview was interesting because Nnese is a midwife, so it was interesting to hear her give the same reasons as other women for wanting a home birth. It was also interesting to hear about how midwives may feel about providing home births, having at one point opposed home births herself.

Appendix 6: Nnese’s transcript

Nnese, I would like you to please tell me about your decision to have a home birth

My decision is purely convenience, my partner and I aren’t of the same vein on this, but he is soon to be working away on a weekly basis, Monday to Friday, and I have 18 month old son and trying to find someone to take me
into hospital and someone to look after him is just going to be so difficult in the middle of the night and I labour very quickly. I had an hour and a half labour with Tefo and I want the reassurance that I am not going to be on my own. So it is really convenient that I call out someone and I know I can have a good midwife here within half an hour to help me. And those are really my reasons. I have had lots of friends in the area who have had home births and have had really really good experiences and I thought I would do it myself. The hospital birth I had was very fortunate in that I had chosen a midwife who was a very good friend of mine who came to deliver me and it happened very very quickly, but it was a bit dramatic at the time and a bit clinical, but it had to be and my husband was very frightened, so it had to be in hospital and now that I have a very rapid labour, I think I would like to do it at home. I didn’t have much pain relief last time and there is no need for me to go in and be in that clinical environment if I am such a low risk category, which I am. But there is nothing with the hospital, I will go in, if they want me to go in, I will go in, it is not a problem, but I prefer to have it in a relaxed confines of my own home.

How do you feel about the information that is given to you about the options that are available?

It depends on the midwife, it does depend on the midwife. Some midwives are more pro, some midwives are dubious about home births themselves and so they are not going to sell it as well, but I have a particularly good midwife who is quite happy. Very capable and spells out the risks and she is very willing to come out and deliver me at home and I know I have the support and the back up which makes my decision to have a home birth much easier. It is the same team of midwives that delivered me in there that will be delivering me now, so I know them. We have lived here for a couple of years now. But, um, I am not worried at all, in fact very relieved that I can have a home birth, although my husband is not particularly keen on it. But he won’t be here. So all in all I am very happy with it and much happier now that I have got a home birth.
What do you think of the situation with home births at the moment?

I think we need to educate our midwives and suss out why midwives are so against home births, some midwives are and some midwives aren’t. But I think birth has been in the hospital so long, for the last 20 years, um, that it is almost inbred in us that a hospital birth is the only option and there are not many midwives that can see further than that and are quite happy at home, but I can understand that the risk is very small but it is still a risk and if women are prepared to take that risk and have the benefits of a home birth, then that is fine, but the midwife has to be very unbiased in giving an informed choice and I think most, some midwives are biased to hospital births, only because of staff shortages and it is far easier to look after a couple of women if you are in hospital and when you do a home birth it is two staff completely out of the work place so I can understand the staff shortage problem but I think the home birth, if it can be done is definitely by far the better option, if providing you are non risk patient.

Now, talk as both a mother and a midwife, how do you feel about home births?

when I was on the community I was very against home births, because for ten years, or twelve years I had been a labour ward midwife always. Never on the post natal ward, never on the ante natal ward, always at the sharp end of the labour and the odd instances of placenta previa or an abrupton or other frightening things going wrong very quickly, then I could not see the point of anyone taking the risk of this in their own home, but that was quite naive because that was before I had children myself and I can now appreciate that there are a lot more factors as to why women choose a home birth and as long as they know the risk, and they are very minimal, and they are still there and as long as they know the risks and can trust that they can be resuscitated either the mother or baby by a competent midwife then I think that there is no problem with those women who are a low risk groups. And I trained in the era that there were very very few home births. I trained in 1986 and home births were just not done, only as an objection of coming into hospital, it wasn’t offered as an option at all, but then they offered a scheme which was the
domino scheme which you will know about and that seemed to be the best half way house where women would have their own midwife but not be in the confines on their own home, they would be taken back by the midwife, but that is out of fashion now again isn’t it and we now only have the two options and there is no in-between and I actually think as a midwife that the domino system was better.

Why is it losing popularity?

I don’t know, I don’t know why the domino system is out, I don’t know, I presume it is commitment to the community staff because it is a great big commitment, especially a primip labourer who could be at for 12 hours to have the one midwife with her, that is an awful commitment for the midwife herself and with staff shortages and the way work place attitudes are now, midwives are left unable to give 120% than they used to be for various reasons.

So what are your own personal reasons for choosing a home birth?

I have great faith in my colleagues at the hospital and fortunate enough to have been given the privilege of choosing my midwife again and um, my midwife is a very senior 4 grade who is clinically excellent and is quite happy doing a home birth or a hospital birth. Hospitals don’t frighten me, they don’t faze me out, I’m not worried about what can happen to me in hospital, I’m not worried about what can happen out of hospital. Because I have faith in the system and I have faith in the midwives at (name of hospital), so it is I’m afraid to say there is nothing spiritual in my decision it is totally utterly Thomas, he is my one consideration because his father won’t be around to help me out. He is my top priority and doing it this way seems to be the best thing. However, my husband and I had an argument about it last night and he said that if he was at home I would have to go into hospital, which is at the weekend.

Really?

He is frightened, he is very frightened, because when Tom was born he had meconium, he had variable heart rate. At 3-4 centimetres, everything was
going horribly wrong and suddenly out of the blue I wanted to push and what it was he was a such a rapid decent, and I had dilated so quickly and he sort of got a bit distressed on the way out and that was all it was, but at one stage I was going to the crash section and everyone was coming into the room and 4 cms and then I had a (inaudible) for 10 minutes and there were so many people in the room swinging various catheters and ventouse, you know what it is like when you go to the crash section and suddenly I pushed him out and my husband was completely fazed out by this and was absolutely terrified and his reason is that it could happen again and it could, and I know that, I know it could. But T. was very small, he was only 5lb 12, but this feels bigger already, so I know that it might be a bit bigger this time. But of course I will go in if there is any deceleration at all, whatever the date. Of course I would be happy to go in. But my husband is just, just hasn’t got the faith that I have because he hasn’t got the knowledge that I have. Despite what I tell him, but he is seeing my chosen midwife, D., on Friday to have a talk with her and hopefully she is going to sort him out. But it is a two way thing, I can’t do this without my husband’s support and I must respect his decision and his attitude and I can understand where he comes from completely because it is his child as well as mine and I am not going to be selfish and say nope, nope I know best, I am going to have my baby at home, that is not fair on him. But, if he is not here, then he is not here to give me support or tell me not to, so I will have it at home.

For me, I know I’m an insider and I am a midwife, but for my peace of mind I am so much more relieved now I have made a conscious decision that from Monday to Friday I am going to have a home birth and then from Friday 7.00 pm to Monday morning 6.00 it is going to be a fight because I still want my baby at home, but I still do have to think about what he has to go through. I definitely desperately want a home birth and the more I think about it the happier I am and I am only saying that because I have, I know I have a very very confident midwife to look after me and I know, and she told me as soon as there is any shenanigans then I go to hospital and that’s fine, I trust her so completely. So that is really my reasons

You sound like you want it for much more than just convenience
Um, I like the idea of being more relaxed at home. I like the idea of having testing and having it if I want it. But because the hospital environment is not alien to me, because I am perfectly relaxed in that environment, being a midwife myself, then it won't faze me out. I would like to have it at home, I would. I have got my own bath and my own toilet all the things that make a difference to a lady and the whole thing, but primarily it is nothing spiritual, it's not because I will be more relaxed. That is not my priority, my priority without question is my son. I must admit I thought everyone wanted home births because it was more fulfilling and more relaxing and they all had water birth pools. Well I'm not doing any of that. I am quite happy just to be mobile and not worrying about my little boy and that is really the only reason. He will be so much more spiritually happy I am sure. But also, also if I have the baby at home, then my husband, he maybe here whereas if I had the baby in hospital in the middle of the night, his priority is also T. and he will be looking after T. and won't be in the delivery room. And he will miss out on that, although he is not too worried. He did try and escape the last time, but there were so many people coming through the door he couldn't get out, there wasn't any time, so he had to be in there, but he is not one of these chaps who feels that it is a fulfilling experience. He will be there for me if I want him. But in your own home, things are so much more relaxed. That is it really.

Appendix 7: Line coding (Nnuku’s transcript)

- Ok, Nnuku, please share with me how you came to decide to have your baby at home this time.
  1. There wasn’t any real major factor, umm I think it’s, we’d both
  2. been married before, so both of our, my husband’s got three
  3. children from a previous marriage and I’ve got one from my
  4. previous marriage. When we decided that we were going to try
  5. for a baby I just sort of said what do you think about me
  6. having a home delivery (partner involvement)
and he was quite sort of happy with it. (partner support)
8. I think it’s just that much more personal. (personal)
9. umm, there was no real medical reasons. I can’t even say...well
10. I didn’t have a bad time at [hospital] with my first baby. (previous experience)
11. it was just to make it very much more, that more personal
12. to [my husband] and I. (personal)
13. When you say personal, what do you mean?
14. Well I think as soon as you get into a hospital they have to be very technical and very clinical (hospital clinical)
15. because obviously that’s their job, but it’s like it’s all sort...
16. of taken away very much from me. (loss of control)
17. Because we have had children before I feel hopefully I don’t have to call the midwife out the minute we think that something’s happening so I can do what I want. I can have a bath (freedom and control)
18. I can wander round and I won’t be bunged in a bed and strapped down (no restrictions)
19. and monitors and goodness knows what else around me,
20. so you know we can take our time over a certain amount of it and do it in our sort of speed (control)
21. you know, obviously the baby takes over and the body does what it’s got to do but umm, I don’t know what your views are (talking to husband) I mean when I first said to you about having a home delivery you were quite happy about it, weren’t you?
22. I mean you didn’t have any bad experiences in particular did you with the three deliveries? (asking for husband’s point of view)
23. I mean I think in a lot of ways it’s more important what
a man thinks, (partner involvement)

because a woman’s body just takes over and, well they’re sort of like there on the outside but it’s very much their wife and their baby that, and there’s not a lot they can really do

about it (laughing) it’s the same whether you’re at home or in hospital in that respect but, umm, as I was saying earlier it’s more personal (personal)

We’ve got to know Pat haven’t we? (opportunity to know midwife)

Yes, we’ve got more control and we feel more comfortable (control)

whereas in hospital they take their time. Well if you need anything specifically you know, like a cup of tea or anything you can make it, (control)

whereas in hospital they take their time they’ve got half a dozen other people to sort them out at the same time as you (limited attention from midwives)

it’s not their particular fault, it’s just the amount of people they’ve got to attend to

And, you mentioned about getting to know the midwife...

P, the midwife, she’s sort of, umm, as soon as we knew we were pregnant and I phoned in the surgery she came here for the first visit and I’ve seen her sort of throughout, so it’s like a familiar face it’s, umm, we’ve got to know her because [my husband] has come to each of my clinic appointments with her as well (familiar midwife)

you know it’s not like going into hospital where they are going to be total strangers, (unknown staff in hospital)

even a total stranger coming into your house which, you know, so
you are dealing with somebody you know who you build up some
confidence with, umm, I mean she’s been very good, hasn’t she?

Umm, so you know I mean, we do know if anything goes wrong,
we will go into hospital and there’s nothing you can do about that, (open
mind about hospital)

but you know I’m sure, she can handle it, she’s not the youngest
person in the world, But you know, she’s obviously got an awful
lot of experience, umm, (mature experienced midwife)
you know we’re not dealing with sort of someone who’s just come
out of Midwives school, which I know they still have a lot of
experience but she’s obviously done quite a lot of home deliveries
and hospital deliveries and all the rest of it, otherwise she wouldn’t
be prepared to do it now so, you know, you feel a lot more

confident I think with an older person who you know, (confidence in
midwife)
you feel has probably seen every situation that could possible come
up and know how to deal with it and be prepared to deal with it
and if it is above what she knows she, you know, she has made it
quite clear that if there is a problem, you know, straight down to
(hospital)

I am interested in how the decision developed

I had almost made the decision up before I got pregnant, (decision before
pregnancy)

I’d said that that was what I would like umm, and I asked
my husband how he felt about it, (partner involvement)
He sort of said, Yes, fine, if that’s what you want Umm.
then go for it, (partner support)
when I did find out I was pregnant, umm, I was put through to P
from the Doctor’s surgery, and again I didn’t know if I could have
one, you know, it's very well saying I'd like that, one doesn't know which areas, a lot of areas I think you can't go to. If
and she straightaway said, Yes we can. (midwife support)
well was it a first baby, had I had problems and obviously made a
evaluation on what I had told her initially which is when she said
yes you can have home delivery, if that's the choice that you want,
so I think we were both very relieved that we thought we could,

at least have that choice. (allowed to choose)
but you know, I did, I must admit I suppose about three months,
Am I doing the right thing? Should I go into hospital where,
you know, but the last time we went to [hospital] it was such a
shambles that I did know we'd made the right decision (laughing),
its still what we're doing. Umm, I know they're busy. so are we,
you know we've got a business to run and sitting in a hospital for
three hours and having no answer whatsoever for the reason we
came for seems totally a waste of time. (hospital busy)
I mean as I say we definitely know we're definitely having the baby
at home, so.

Now, when you compare the kind of care you had with your first baby
and the care you are having now, what can you say?
I wouldn't say it was an awful lot different, probably when I had
my first baby I was at the clinic a lot more, probably because I went
to classes, did all the breathing things, and all the sort of ante-natal
things, where as we haven't done this time, because Pat sort of said
she didn't feel the need for them, then, unfortunately, because we
run our own business we haven't sort of had the time, and I can't
say they were terribly useful. Umm, the first time round.

How were they not useful?
Well I didn't feel, you are told that everything's going to be so simple and so easy, (withholding information)

um, it is so different in that situation and I don't think they give you the full picture, I think they paint a nice little rosey sort of picture over it. Umm, again I mean I had a situation where, umm, the cervix didn't open correctly, so I had, I don't know the special word for it, so I was in labour a lot longer than I should have been, but you know, nobody tells you of these like things, I don't know I just think, you're not told it's a picnic, but I think you are given different picture to how it actually is, I don't know, I'm waffling now! Laughing, I just didn't I don't know, I just afterwards I thought I don't know why I spent all those times going to those classes because it was nothing like what they told to practice, you get laid on the floor, and your supposed to think of a Nursery Rhyme and I couldn't do the breathing, I just couldn't I couldn't, I was just one of those people, I couldn't sort of out of the situation imagine sitting there going phew, phew (breathing sounds) it just didn't work for me, I just didn't sit there and do it. all I thought was the whole thing was a total joke so, yes, for some people I am sure it's absolutely wonderful and they think it's the best thing they ever did, but not me.

Is there anything in particular, you don't like about the hospital? Umm, it's very difficult. I think because it is very clinical, (clinical)

again because I had this hip thing, I had to have a monitor on the whole time, so you couldn't even get out of bed. (restricted movement, continuous monitoring)

umm, even like afterwards, you know, I think their visiting hours
are longer now, but, like no-one was allowed to come to see you
until 2 o'clock in the afternoon, (restricted visiting hours)
which is a long time for a husband to wait to come back
I don’t know, I can’t, I don’t think it is that we don’t like the
hospital it’s just wanting something different now, (want something different)
I mean, I can’t criticise [the hospital], I’ve not had what I would say
a bad experience or anything like that, (no bad experience)
I mean my husband’s had three there, I’ve only had the one, umm,
I think it’s just wanting something different really, (something different)
it’s not much criticism of one of needing something else
it’s just wanting to do something else. Unfortunately, there isn’t,
you know I can’t pin point something and say, I’m definitely not
walking through [hospital] now and going in their labour ward
because of, umm, again I’m fully open although we plan to have
the baby at home, I’m fully open if needs be
then I’m straight up [hospital], (open mind about hospital)
it’s not a case of No, no, no you know, don’t let
me through those doors I am not going in there you know,
we just feel it would be more personal to [my husband]
and I and it’s just something that we want (personal)
And what do you see as the positive things about a home birth?
I think because it will be more relaxed, (more relaxed)
again we don’t know (laughing), so until the situation comes and
it happens, I mean, perhaps you ought to come back in a couple of
weeks time and can tell you more (laughing) I think it will
be more relaxed, I hope it will be more relaxed, (more relaxed)
Umm, because again, I think it’s like everybody, you’re nervous of
like Doctors and nurses and that, and you feel sort of ‘Yes Sir’, ‘No Sir’, (hospital formal) you know, they tell you you’ve got to do this and I must do that, (loss of control) I can’t do that Umm... I just think it will be just more relaxed, more easy going situation. (more relaxed) Again, I mean P will have more time. I mean if my husband says ‘Well can’t you give her something for goodness sake’, she’ll probably say ‘No because..’ and she’ll have time to explain it (more time at home) all to [my husband], why she can’t or reasons for not doing that. (more time to explain things) Whereas in hospital, you know, I mean I know when I had Sam, they scoot you in and be checking your monitors and making sure everything’s alright and scooting you off somewhere else, (hurried care) where as, you know P will be able to say well no, you know, because she had her last lot of pethidine or what have you at such and such a time, she can’t have anymore for another ex amount of hours or, you know, (more explanation at home) she’ll be able to explain it to him, rather than him thinking ‘Well that was good, what was the point of her whizzing in then, she’s done nothing, we’re still in the same situation’ again one of these typical things with hospitals, they have their guidelines and if you don’t fit right in that pattern, then there’s a problem (hospital routines) and quite often there isn’t, so I was strapped down for the whole time, and I didn’t like it (continuous monitoring) and that was one thing I didn’t like at all was this fact that you couldn’t sort of sit up or get up (restricted movement) I mean, I’m not one of these, I certainly didn’t want to go jogging (laughing), or into bathing pools and all that type of thing. I am
sure for some people they're wonderful, but just having a bit of freedom to be able to move around. (wants freedom of movement)
you know, well anybody gets uncomfortable laying down for a long period of time anyway.
And what about the pain relief, what are your thoughts on that?
I've got gas and air, I've got pethidine, umm, again when I had Sam, I had just gas and air and nothing else, you know if I have to have gas and air, I'll go with whatever I need (laughing).
If I can manage with gas and air, fine, but if I need pethidine I'll have pethidine. It might be the other way round darling,
my husband might have the pethidine and I'll have the gas and air (laughing).
Again, I mean it's just, I mean you have all this birthing plan thing and it might not be followed. I think it makes people despondent because you have these great ideas about I'm not going to do this and I'm not going to have that. you know you can only do what you want at the time. (fixed plans not appropriate)
I mean I would be more than happy if I can manage on gas and air, but if I need pethidine, I'll have it, I'm not brave (laughing). I've got everything. we're covered for most areas. The only thing I wouldn't like is one of those epidurals, I think it's just the idea that its to do with the spine, I wouldn't like one of those, but again other people have told me they're wonderful. I think it's the idea of an injection in the spine. No, I've got no real major plan.
just take it as it comes.
Thank you, is there anything else you would like to add?
No I haven't, everyone keeps saying to me that we're mad.
Don't they? As I say we haven't made the decision because
we are anti hospitals or anything about the treatment or anything like that, it was just a decision I suppose it was a whim initially, thinking (impulse decision) because initially we said we would never have children because he’s got three and I’ve got one, and at our ages we thought well, we don’t want anymore, And when we did decide we’d have a baby of our own I just sort of said I would like you know, if we could, and so it really went from a whim if you like, and as I say we feel it would make it that much special for the two of us How did you know about a home birth in the first place? I was born at home so it comes from there I don’t actually remember it, (born at home) it was 37 years ago. No, I mean I always, you do every now and then you hear someone talking about home deliveries (word of mouth) it is very, very rare these days. umm, I mean I know it is an option but its very much a knowing and who happens to be your midwife (information depends on midwife) and, I mean at the end of the day, when I first went through the Doctor’s surgery, if they said No, no way, I suppose we would have just accepted it Would you? I think I probably would have done, I’m a bit like that, I’m a bit of a coward. If they’d sort of said, well no, it has to be (hospital), or you know, whichever other hospital I suppose I would have accepted (would have accepted if refused choice) if that is how it is done now. I think it is accepted more now just to go in into hospital But where do you think is the ideal place to have a baby, do you think there is an ideal place to have a baby? I think at home, as long as it, well I don’t think, it’s difficult to say,
241. it's very personal, (best place personal matter)
242. because again if you've got half a dozen children at home,
243. you know, that are going to want Mum and be frightened
244. by all these things and what have you, going on then it's probably
245. better they are elsewhere. I think all options should be there. (all options should be available)
246. I think we should have the choice to have a baby at home, (choice of home should be an option)
247. it perhaps would be nice to have the old Nursing Homes
248. or Maternity Units that we used to have where it was very much
249. family orientated, it was still, although it was clinical in a hospital
250. ground, I think really just a choice to choose what
251. each individual wants. (individuals should have a choice)
252. I am sure some people would be scared stiff of having
253. a baby at home, so why should that option be taken away, because
254. ex amount of people want babies at home
255. Do you think there's that freedom there for people to choose?
256. I don't think there is, freedom to choose, it is like they couldn't
257. wait to get you in, you know, if we get the opportunity we will still
258. get you in here, (no freedom of choice)
259. so, umm. I also know a lot of people who have had
260. babies at hospital and ended up with severely handicapped children.
261. so you know they say it's the safest place so, again it isn't my
262. reason for not to choosing to do with that, that's about it really.
Appendix 8: Thematic analysis

Home themes with supporting quotations

Good place

It is lovely for a baby to come into the world in its own home. I suppose you are idealistic to a certain extent but the lady who is down the road who has had two babies at home just said that the experiences didn’t compare. You know having a baby in hospital or having a baby at home is was just so different and it was just relaxed and you just had the baby and carried on. I think it must be far nicer just being in your own surroundings, and just being with your folks.

Convenience

My decision is purely convenience I have 18 month old son and trying to find someone to take me into hospital and someone to look after him is just going to be so difficult in the middle of the night (Nurse 1-5)

Relaxed/informal

This time, I thought well, at home, you know, once again you’re not going to have that pressure because they are not going to say to you, you know hurry up and push this thing out because I’ve got two more ladies in the next room waiting to give birth, and I can’t spend all my time with you. So, I think yeah, at home because I feel you’ll be a lot more relaxed, you’re less likely for things to go wrong, I mean that’s not saying they won’t. (Gaelape 7-325)

More attention from midwives

You’ve got the midwives full attention because there’s no other mums around you, that need her attention.

So one of the things I was thinking about having a home birth was again I might have a Midwife, because at the hospital you can’t guarantee it. (Bonyana 56-59)
If you're delivering at home then you're guaranteed two midwives, so people talk about safety of home births but from the safety point of view, and my point of view, they are actually safer because you have two midwives there who are observing you all the time, and if anything is not going to plan, they can tell in advance. Whereas possibly in hospital you are only going to see someone every now and then because they are between two women, they might now see that anyway. (Maípelo 72-82)

I want the reassurance that I am not going to be on my own. So it is really convenient that I call out someone and I know I can have a good midwife here within half an hour to help me. (Mmese 11-17)

I feel I have more care at home than in the hospital because the midwife comes out to the house and she's there just for you she's not running off to see somebody else  I felt they were there just for me, they weren't distracted by anybody else (Mmaoshadi 86-89)
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