Birthing Outside the System:  
Wanting the best and safest  

A grounded theory study about what motivates women to choose a high-risk homebirth or freebirth  

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

..........................................................  (Signature)
Acknowledgements

As the saying goes, ‘it takes a village to raise a child.’ What I have also learnt is that it takes a village to complete a doctoral degree. The initial advice from my supervisor, Professor Hannah Dahlen, was to choose a thesis topic that interested me, so as to maintain my interest throughout the project. After mulling over what this incredibly interesting topic might be, I shot up out of bed part way through the night and wrote down, ‘birthing outside the system.’ From there grew what lies before you in thesis form. Yet one does not get from concept to thesis alone; it takes a village to grow a thesis, and I would like to acknowledge all of the ‘village folk’ who have made this thesis possible.

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**Publications**


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Glossary and Abbreviations

Glossary

2009 National Maternity Review (NMR) – This was a review of Australian maternity services led by the Chief Nurse and Midwifery Officer (Ms Rosemary Bryant), which included submissions from the public and interest groups as part of the data collection process. The purpose of this review was to canvas the current maternity services in order to direct policy and funding for future planning in maternity care. (http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview)

Birth centre – Birth centres are midwife-led units and are usually co-located with a hospital in Australia. They usually provide team/caseload midwifery care in a home-like environment for labour and birth (Laws, Lim, Tracy & Sullivan, 2009, p. 290), but exclude women with identified medical or social risk factors or based on previous obstetric history (Laws et al, 2009, p. 292).

‘Birthing outside the system’ – For the purpose of this study, ‘birth outside the system’ is defined to be any birth for which the current mainstream maternity system does not cater. Hospital birth in the public and private sector, including within birth centres and low-risk homebirth, are classified as being ‘inside the system.’ The two birth choices that are considered outside the system are, homebirth, where the woman has risk factors that would normally exclude her from a public homebirth program or birth centre, or where she falls outside the guidelines for consultation and referral (stipulated by the ACM). Similarly, freebirth sits outside of the currently accepted or available birth options. Thus, births outside the system include high-risk women who hire midwives and who choose to birth at home, or freebirth.

Born before arrival (BBA) – Refers to a scenario where a woman is booked to give birth in hospital but is unable to make it to the hospital on time, and so the baby is born before arrival to hospital. In a homebirth context, the baby can be born before the arrival of the midwife, but this difference will be qualified within the text.

Continuity of care (models) – A continuity of care model means that care is provided by a single known care provider, or a team of known care providers (Fahy, Foureur, & Hastie, 2008; Homer, Brodie, & Leap, 2008).

Eligible Midwife – In Australia, an eligible midwife is one who is trained, registered and insured. S/he is also eligible for a Medicare provider number, which allows her clients to claim back a portion of their fees from Medicare. Eligible midwives can also refer clients for pathology tests, such as blood tests and ultrasounds, and if they have completed the requirements, they can also prescribe medications from a restricted list.

Fetal death – The intrauterine death of a fetus, or the death of a fetus weighing at least 400gms and/or after 20 or more weeks of gestation (Harris, Nagy, & Vardaxis, 2006, p. 676).

Fragmented care – Fragmented care denotes the standard care offered in the public sector (Homer et al., 2009) whereby the woman receives care from multiple unknown care providers each time she enters the hospital service for maternity care, including
antenatal, birth and postnatal care. This differs from continuity of care models where the woman receives care exclusively from a known care provider or team of providers.

**Freebirth** – A freebirth is a planned homebirth that is intentionally arranged to be unattended by any midwife or obstetrically trained professional. In this respect, freebirth goes beyond traditional planned homebirth, which is intentionally attended, and unplanned homebirth, which is unintentionally unattended (Newman, 2008, p. 451). Australian definitions of freebirth assume that the birth was only unassisted in the instance that a trained birth professional (that is, a midwife or doctor) was not asked to be present. There is no official data available regarding freebirth rates in Australia (Newman, 2008), so precise statistics on how many women make this choice are unknown.

**General Practitioner (GP)** – A doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to specialists or a hospital. Some GPs are also qualified to provide pregnancy and postnatal care to women.

**High-risk homebirth** – High-risk homebirth is defined as any planned homebirth attended by a midwife that is accompanied by maternal or fetal risk factors that would normally exclude a woman from a publicly funded homebirth program or birth centre. A homebirth can also be considered a high-risk homebirth if it is considered to be outside the midwives’ scope of practice according to the Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral* (ACM, 2013).

**Homebirth** – For the purposes of this thesis, the term homebirth is used to designate a planned homebirth attended by qualified and registered midwives. If the birth is an unplanned homebirth or unattended homebirth, this will be qualified within the text.

**Medical birthing model** – For the purposes of this thesis, medical birthing models are depicted as those in which birth occurs in a hospital under the care of midwives and doctors, but in which birth is managed with the use of technical equipment and kept on a timeline. In medical birthing models, interventions are frequent and routine, and maternity care providers are believed to be the authority and the decision-makers (Kitzinger, 2012; Wagner, 2001).

**Medicalisation** – This term means ‘to make medical’ (Ballard & Elston, 2005; Conrad, 1992). Medicalisation involves the extension of medical authority beyond a legitimate social boundary (Rose, 2007), whereby social phenomena – such as childbirth – come to be defined and treated as disease when previously they were not (Ballard & Elston, 2005; McLellan, 2007). Medicalisation relies on defining a problem or event in medical terms and then using a medical intervention to treat or manage it (Conrad, 1992).

**Medicare** – Medicare is a publicly funded universal health care scheme in Australia. The primary funder of health care in Australia, Medicare funds primary health care for Australian citizens and permanent residents, who are entitled to subsidised treatment from medical practitioners, eligible midwives, nurse practitioners and allied health professionals who have been issued a Medicare provider number. Medicare also covers free treatment in public hospitals.


**Multipara/multiparous** – This term designates a woman who has given birth to more than one viable (>20 weeks) infant (Harris, et al., 2006, p. 1134). Midwives will often
refer to women who are pregnant with their second child or subsequent children as multiparous, frequently abbreviated to ‘multip.’

**Neonatal death** – This refers to the death of a live-born infant during the first 28 days after birth. Early neonatal death is usually considered to be one that occurs during the first seven days (Harris, et al., 2006, p. 1171).

**Perinatal mortality** – This refers to the number of perinatal deaths per 1000 live births (the perinatal period is the interval extending from 20 weeks gestation to the 28th day after birth) (P. Harris, et al., 2006, p. 1322).

**Primipara/primiparous** – This pertains to a woman who has borne one child and/or given birth to one viable infant (Harris, et al., 2006, p. 1408). Midwives often call women who are pregnant with their first child, and who have not yet given birth, primiparous, abbreviated to ‘primip.’

**Private Midwife** – In Australia, a private midwife is a registered midwife who has chosen to be self employed rather than work for a health service (such as a hospital, birth centre or health clinic). Private midwives are usually sole proprietors who run their own business. Clients contact them directly in order to engage their care. The majority of private midwives provide continuity of care and attend homebirths.

**Social birthing model** – This term designates a social framework of childbirth that prioritises the occurrence of birth in the woman’s home or community, amongst friends and family, with the birth being allowed to unfold physiologically with minimal interruption or intervention (Jordan, 1987; Kitzinger, 2000; Johanson, Newburn, & Mcfarlane, 2002).
Abbreviations

ACM – Australian College of Midwives
AHPRA – Australian Health Practitioner Regulation Agency
AMA – Australian Medical Association
GP – General Practitioner
HBA – Homebirth Australia
NICE – National Institute for Health and Clinical Excellence
NICU – Neonatal intensive care unit
NMBA – Nursing and Midwifery Board of Australia
OECD – Organisation for Economic Cooperation and Development
PBS – Pharmaceutical Benefits Scheme
PII – Professional indemnity insurance
RANZCOG – Royal Australian and New Zealand College of Obstetricians and Gynecologists
RCT – Randomised controlled trial
VBAC – Vaginal birth after caesarean
WHO – World Health Organization
Abstract

Childbirth in Australia occurs largely in a medicalised context, with 96.9% of births occurring in hospital, 2.2% in birth centres and 0.4% at home as planned homebirths (Li, Zeki, Hilder, & Sullivan, 2013). Only a small percentage of women choose to birth outside the system – that is, have no midwife present (freebirth), or elect to have a homebirth with medical risk factors. In Australia, women with risk factors have little choice but to birth in hospital under obstetric care as they are often excluded from midwifery care programs, birth centres and publicly funded homebirth. In Australia, the choice to birth at home is often met with hostility from medical practitioners, while attracting disapproval from the majority of society. It is within this context that the women in this study have made their choice to birth outside the system.

The research question for this study is: what motivates women to birth outside the system – that is, to have a homebirth with risk factors present, or a freebirth where the birth at home is intentionally unattended by health professionals.

Grounded theory was selected as the most suitable research method for this study, because it is both qualitative and enlightening in circumstances where relatively little is known about a subject. Data from 13 women choosing homebirth and 15 choosing freebirth were analysed using grounded theory techniques of open coding, constant comparison and theoretical sampling. Eleven of the homebirth women were interviewed, with one woman’s story sourced from the 2009 National Review of Maternity Services in Australia (NMR), and another from a story sourced via the internet. Nine of the freebirth women were interviewed, some face-to-face and others by phone, with the remaining six being sourced from the NMR.
The core category that emerged in this research project was ‘wanting the best and safest,’ which describes the women’s decision to birth outside the system because they believed it was the best and safest for them and their baby. How they came to this belief is explicated through the subcategories: ‘previous birth experiences,’ ‘perspectives on childbirth,’ ‘perspectives on risk’ and ‘the hospital can’t provide the best or safest.’ The basic social process was ‘finding a better way.’ This explains the journey that the women took as they pursued the best and safest, and as they arrived at the decision to birth outside the system. This process is elucidated through the subcategories: ‘considering birth options,’ ‘managing opposition,’ ‘mitigating the risks of birth at home’ and ‘becoming the expert.’

Birth outside the system was considered by the women in this study to be the best and safest option compared to the other birthing options available. Shortfalls in the Australian maternity care system were a major contributing factor to women’s choice to birth outside the system. In particular, previously traumatic births, lack of choice, high rates of intervention, and a sense of impersonal care led these women to pursue birth outside the system.

If maternity care services become more flexible and increase access to midwifery models of care, the level of satisfaction with these services may be higher, and women may be less inclined to choose to birth outside the system. Reducing unnecessary intervention during labour and birth, and facilitating care that is emotionally, mentally, socially, culturally and physically safe, is a priority if all women are to feel safe birthing in the system. Humanising maternity care should be a key priority for maternity care providers and policy makers in order to ensure the optimal safety for women, and to make them feel confident that they are safe within the birthing environment.
Chapter One: Introduction and background

This study explores what motivates Australian women to *birth outside the system*. For the purposes of this thesis, *birth outside the system* is defined as: freebirth, which is birth at home that is intentionally planned to be unattended by any registered maternity care provider, as well as high-risk homebirth. A high-risk homebirth is any planned homebirth attended by a midwife that is accompanied by maternal or fetal risk factors that would normally exclude a woman from a publicly funded homebirth program or birth centre, or else a birth that is considered outside midwives’ scope of practice according to the Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral* (ACM, 2013). These two birth choices are neither supported nor endorsed by the maternity care system in Australia, and sit outside what is considered safe practice. There has been very little investigation into these two birth options, and no such investigation has been conducted in Australia, making this research unique.

This thesis commences by providing a background and context to this study. Chapter Two then reviews the available scientific literature regarding outcomes of both low-risk and high-risk homebirth and freebirth, and also covers why women choose to homebirth.

Chapter Three discusses the grounded theory methodology that was used for this study. This chapter will describe the study’s recruitment methods and will elucidate the relevant ethical considerations. It will also explain how the data were collected and analysed. Finally, the relative strengths and weaknesses of grounded theory as a method will be explored.

Chapter Four is the first of two chapters reporting the findings of the study, and will detail the core category, ‘wanting the best and safest,’ which explains why women *birth outside the system*. This chapter will begin with a storyline of the findings, which was
formulated in the advanced stages of analysis. The findings will then be explored in more
detail throughout the chapter under a series of categories and subcategories.

Chapter Five continues investigating the findings by detailing the basic social process,
‘finding a better way,’ which explains the process experienced by the women as they
pursued the best and safest birth options. The findings will then be explored in more
detail throughout the chapter under a series of categories and subcategories. Chapters
Four and Five also offer diagrammatic representations of the research findings.

In Chapter Six, the findings of the study are discussed under seven headings: ‘concepts
of safety,’ ‘safety in social and biomedical birthing models,’ ‘risk and risk management,’
‘trauma in childbirth,’ ‘maternal choice,’ ‘control and autonomy’ and ‘authoritative
knowledge.’

Chapter Seven is the final chapter and presents the overall conclusion, the implications
for the future and recommendations for change, research limitations and
recommendations for future research. This chapter is followed by a short epilogue,
which details my personal journey with birth outside the system as experienced with my first
child during the final stages of this research.
**Background to the study**

This background chapter will establish the context for this study, first by explaining the Australian maternity care system, and then by giving an overview of childbirth in Australia. This will be followed by a general discussion about why women choose to homebirth. The peer-reviewed literature around high-risk homebirth and freebirth will be explored in depth in Chapter Two. Finally, the regulatory framework governing homebirth in Australia and the political climate around homebirth will be discussed to demonstrate the precarious position in which birth at home sits within the Australian context.

**The Australian maternity care system**

Australia is a developed, resource-rich country with a population of approximately 22.7 million people and a vast land mass (Australian Government, 2012). According to recent data, of the 297,126 women who gave birth in Australia in 2011, 96.9% did so in hospital, 2.2% in birth centres, 0.4% had planned homebirths and 0.4% of births were classified as ‘other,’ representing babies born before arrival to hospital and in some cases, freebirth (Li, Zeki, Hilder, & Sullivan, 2013). In 2011, of all the women who gave birth, 28.8% lived outside of major cities, and 2.8% of these women were considered remotely or very remotely located (Li, et al., 2013). Because of the distribution of the Australian population, there are vastly different levels of accessibility to the various birthing options depending on a woman’s locality (Homer, Biggs, & Vaughan, 2011).

Giving birth in Australia is considered very safe. Of the 301,810 babies born in 2011, the perinatal mortality rate was 9.9/1,000 births with 7.4 fetal deaths/1,000 births and 2.6 neonatal deaths/1,000 live births (Li, et al., 2013). This rate compares favourably to other

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1 It is noteworthy that not all freebirths would be captured by these data, since only freebirths who transfer to hospital would be recorded in the Perinatal Data Collection.
Organisation for Economic Cooperation and Development (OECD) countries; Australian perinatal mortality rates are lower than those found in the United States, New Zealand, The Netherlands and the United Kingdom (DHA, 2009). In Australia, the health of Indigenous mothers and babies has always been poorer than for the non-Indigenous cohort, with the fetal death rate of babies born to Aboriginal or Torres Strait Islander mothers being 13.3/1,000 births, compared to 7.1/1,000 births for non-Indigenous mothers (Li, et al., 2013). Similarly, the overall maternal mortality rate in Australia is 7.9/100,000, while among the Indigenous community it sits at 21.5/100,000, demonstrating a significant gap between the health status of Indigenous and non-Indigenous women (AIHW, 2008).

Birthing options in Australia are accessible through the public or private sector. In the public sector, women receive free care because public services are funded by the Medicare system (Moorin, 2006). Seventy-one percent of women who birth in hospitals will do so in the public sector (Li, et al., 2013). In the public sector, most women do not have a choice of their care providers, and are generally allocated to a midwife or general practitioner (GP) if they are deemed to be in a low-risk category, or are assigned to obstetric care if classified as high-risk. The majority of women will receive fragmented care (Homer, et al., 2009), although a small percentage will have access to continuity of care models (AMWAC, 2004). Depending on where they live, some women in the public sector may also have access to birth centres (Commonwealth of Australia, 2009) or publicly funded homebirth (Catling-Paull, Foureur, & Homer, 2012). However, these options are rare, and hospital policies determine which women can access them; women with medical risk factors are usually excluded (Newman, 2008).
The private sector offers care through private hospitals, and to a lesser degree public hospitals and private residences (as with homebirth). It offers care under an obstetrician or midwife, chosen by the woman, with the same carers involved for the duration of the pregnancy and birth. This choice of carer, and access to continuity of care, is considered a benefit of having care in the private sector (RWH, 2008). In 2011, of all women giving birth in Australia, 29% had private obstetric care in a private hospital (Li, et al., 2013). Private hospitals are funded partially by the government and partially by consumers when they purchase private health insurance. If the woman has private health insurance, this pays fees to the obstetrician, if not, she would pay them out-of-pocket (Duckett, 2005; Elliot, 2006). The private sector also includes private midwives who are paid directly by the woman. A small number of private health insurers offer rebates for a private midwife (Catling-Paull, et al., 2012), and Medicare rebates can be accessed by eligible private midwives (Wilkes, Teakle, & Gamble, 2009). Homebirth in Australia is attended by privately practising midwives and midwives employed by the public health sector where the programs are available.

Rather than choosing one of the aforementioned options, there is a cohort of women who choose to freebirth (Newman, 2008). A freebirth is ‘a planned homebirth that the parents arrange to be intentionally unattended by any registered midwife or obstetrically trained registered professional’ (Newman, 2008, p. 451). There is no official data available regarding freebirth rates in Australia (Brown, 2009; Newman, 2008), so exact numbers of women who make this choice are unknown. It is feared that if the practice of private midwife-attended homebirth becomes more politically, systematically and financially difficult, private midwives will be deterred from practising, and women who would have once chosen homebirth will increasingly choose to freebirth rather than entering mainstream maternity services (Newman, 2008).
In a 2009 *National Review of Maternity Services in Australia* (NMR), out of over 900 submissions, 60% mentioned homebirth and 21 submissions discussed the choice to freebirth. These freebirth submissions indicated that existing maternity services are not currently meeting women’s needs (Dahlen, Jackson, & Stevens, 2011). A rise in the occurrence of freebirths is reported in two countries, Australia and the United States of America, with both nations demonstrating high intervention rates in birth and limited access to midwife-led continuity of care models at present (Dahlen, Jackson, et al., 2011; Freeze, 2008). Women may also choose to freebirth out of general dissatisfaction with the birthing options offered within the mainstream maternity system, or as a result of previous negative birth experiences (Freeze, 2008). A rise in freebirth rates in Australia, therefore, may be symptomatic of inadequate maternity care options (Dahlen, Jackson, et al., 2011).

**Birth in Australia**

For most of human history, birth was considered a normal social event (Hoope-Bender, 1997; Oakley, 1984). A social framework of childbirth prioritises the occurrence of birth in the woman’s home or community, amongst friends and family, where the birth is allowed to unfold physiologically with minimal interruption or intervention (Jordan, 1987; Kitzinger, 2000; Richard, et al., 2002). Modern day versions of social birth practices are seen in the homebirth setting, with midwives, or in the case of freebirth, with women chosen from the community, such as doulas or lay midwives. To a lesser degree, this is also seen in midwife-led units and birth centres that seek to emulate the home environment. The Australian medical community does not readily embrace social birthing practices, particularly homebirth, arguing that it is unsafe. The Australian Medical Association (AMA) ‘do not support homebirth because of the safety concerns for mother and baby’ (AMA, 2010b, p.1). Similarly, the Royal Australian and New
Zealand College of Obstetrics and Gynecology (RANZCOG) does not support homebirth, irrespective of the mother’s preparedness or risk status (RANZCOG, 2011).

In Australia, the dominant discourse around childbirth is informed by a medical belief system that assumes childbirth to be a risky, pathological event that should be managed by medical professionals in a highly regulated medical setting. The hegemony of this discourse indicates that birth in Australia is medicalised (Ballard & Elston, 2005; Donnellan-Fernandez, 2011; Hunter, 2006; McLellan, 2007; Murphy-Lawless, 1998). The word medicalisation – literally meaning ‘to make medical’ – denotes medicine’s dominance over the process of birth (Conrad, 1992). Additionally, although midwives are seen as the ‘guardians’ of normal birth (Fahy, et al., 2008), the current structure of the maternity care system prevents them from practising to their full capacity, thus diminishing the quality of care that they are able to provide (Homer, et al., 2009). In turn, this perpetuates the dominant model where a medical, interventionist approach prevails.

The medicalisation of birth in Australia is reflected in the labour and birth data reported in the 2011 *Australia’s Mothers and Babies Report* released by the *Australian Institute of Health and Welfare* (Li, et al., 2013). The report showed that only 54.8% of women went into spontaneous labour (56.1% in 2009), 19.1% of women had an elective caesarean (18.4% in 2009) and labour was induced for 26% of women (25.3% in 2009) (Li, McNally, Hilder, & Sullivan, 2011; Li, et al., 2013). Labour was augmented for 17.9% of women, which was one third of women who went into spontaneous labour. Of all women who gave birth, 67.7% had a vaginal birth and 12.1% had an instrumental vaginal delivery using forceps or vacuum extraction (Li, et al., 2013).
Similarly, the caesarean section rate has increased over the last 10 years, from 23.3% in 2000 to 31.5% in 2009 (Li, et al., 2011). Despite governmental efforts to reduce it by promoting normal birth (NSW Health, 2010), it has continued to rise to 32.3% in 2011 (Li, et al., 2013). Historically the WHO has suggested that a caesarean section rate of greater than 15% represents an overuse of this intervention (Gibbons et al., 2010). For women attempting a VBAC in Australia, 84.1% had a repeat caesarean section (Li, et al., 2013). The WHO recommends that a previous caesarean is not an indication for a repeat caesarean (WHO, 1985), and the National Institute of Health (NIH) Consensus Statement of 2010 recommends that, given the best available evidence, a trial of labour is a reasonable option for many women who have previously had a caesarean section (Cunningham et al., 2010; NIH, 2010). Intervention rates in private hospitals are disproportionately higher than those in public hospitals (Dahlen et al., 2012). Women who gave birth in public hospitals had higher levels of non-instrumental vaginal births compared to those who gave birth in private hospitals under private obstetric care (59.3% vs 41.9%). Although the overall caesarean section rate in Australia is 32.3%, the rate in private hospitals is 42.8% compared to 29.4% in public hospitals (Li, et al., 2013).

While birth in Australia is predominantly managed as a medical event, it was not always this way. As a young country with an Indigenous population, records of what birth was like before European colonisation (in 1788) provide insight into the traditional birthing culture (Australian Government, 2012). Vidas (1947) provides an ethnographic account of birth in the Aranda tribe of Alice Springs in rural Australia. The Aboriginal women had no method for calculating gestation and relied on the baby’s first movements to confirm that the woman was pregnant and to determine the baby’s approximate age. They estimated the time of birth by when the baby moved low into the woman’s pelvis, indicating that labour was drawing closer. During labour, female family members
prepared a place on the ground for the woman to birth the baby. They supported her with massage and helped her to squat and get into an all fours position. There was no interference in the mechanism of birth, and the baby was born without anyone touching either the mother’s vulva or the baby. After birth, the baby was not stimulated to breathe. The baby was also kept attached to the placenta by the umbilical cord until the placenta was born. Although normal, uncomplicated birth was allowed to unfold without interference, the Aboriginal women had very few skills to manage complications (Vidas, 1947).

Recognising Australia’s problem with increasing intervention rates and reduced spontaneous vaginal birth rates, the New South Wales Health Department issued a policy in 2010 entitled *Towards Normal Birth in NSW*. This initiative was aimed at increasing the rate of normal vaginal birth by reducing unnecessary intervention, promoting water immersion and one-to-one midwifery support, facilitating VBAC and increasing the number of women starting labour spontaneously (NSW Health, 2010). This policy is a step in the direction of reasserting the primacy of the natural physiological process of childbirth.

**Accessing midwife-led continuity of care models in Australia**

A continuity of care model means care is provided by a single known person, or a team of known care providers (Fahy, et al., 2008; Homer, et al., 2008). Midwifery-led continuity of care models are considered to be the gold standard of maternity care, with a recent Cochrane systematic review concluding that most women should be offered access to this option, given its benefits (Sandall, Soltani, Gates, Shennan, & Devane, 2013). It has been found that women who have access to midwife-led continuity of care models develop an enhanced confidence and belief in themselves, and that this is partially engendered by their unique and personal relationship with their nominated
caregivers (Leap, Sandall, Buckland, & Huber, 2010). Women giving birth in the context of a continuity of care model demonstrate higher levels of satisfaction compared to those who are receiving standard care options. This is because the former generally feel a greater sense of control (Homer, Davis, Cooke, & Barclay, 2002) and perceive their care to be more respectful (Hatem, Sandall, Devane, Soltani, & Gates, 2008; Sandall, et al., 2013; Williams, Lago, Lainchbury, & Eagar, 2010).

Continuity of care models have been shown to lead to lower rates of intervention (Homer, Davis, Cooke, & Barclay, 2002), with women experiencing a reduction in regional analgesia, episiotomy and instrumental birth. Continuity of care models are also linked to a higher rate of spontaneous vaginal birth with no intrapartum analgesia (Sandall, et al., 2013). Continuity of care models thus produce lower rates of intervention than standard hospital-based care (Hartz, Foureur, & Tracy, 2012). Similarly, a 2012 Australian randomised controlled trial (RCT) showed continuity of care caseload midwifery for low-risk women led to a significant reduction in caesarean rates, with women more likely to have a spontaneous vaginal birth and less likely to have epidural analgesia or episiotomy. Also, newborns were less likely to be admitted to special or neonatal intensive care, and no infant outcomes favoured standard care (McLachlan et al., 2012). More recently, Tracy et al (2014) demonstrated that low-risk primiparous women in continuity of care models were more likely to have a spontaneous onset of labour and an unassisted vaginal birth (58.5% compared to 48.2% for standard hospital care and 30.8% with private obstetric care). They were also significantly less likely to have an elective caesarean section (1.6% versus 5.3% with standard care and 17.2% with private obstetric care) (Tracy et al., 2014). Similarly the ‘M@NGO’ RCT included all-risk pregnant women, and the authors stated that ‘for women of any risk, caseload midwifery is safe and cost effective’ (Tracy et al., 2013, p.1723), making midwifery-led continuity of
care a suitable choice for most women in Australia. Continuity of care models are highly acceptable to women (Walsh, 1999) and are significantly more cost effective than standard care (Homer, Matha, Jordan, Wills, & Davis, 2001; Tracy, et al., 2014).

Currently, around 3% of women in Australia have access to midwifery-led continuity of care, which is available in some public hospitals, or for women who have hired a private midwife (Commonwealth of Australia, 2009; Homer, et al., 2002). An analysis of the submissions to the NMR showed that access to midwifery-led continuity of care models was a predominant public concern (Dahlen, Jackson, Schmied, Tracy, & Priddis, 2010), indicating that a significant number of Australian women are seeking access to midwife-led continuity of care.

**Accessing homebirth in Australia**

Homebirth is an option for a limited number of women in Australia and is accessed through a publicly funded model or by hiring a private midwife (Dahlen et al., 2011). Approximately 0.4% of women had a planned birth at home in 2011, representing only 1,267 women in total (Li, et al., 2013). Australia is increasingly setting up publicly funded homebirth programs, which operate as part of public hospital services (Catling-Paull, Coddington, Foureur, & Homer, 2013; Catling-Paull, et al., 2012; Department of Health WA, 2001). This has been occurring in South Australia (Nixon, Byrne, & Church, 2003) and Western Australia (CMWA, 2006) for over a decade, and has been implemented in New South Wales and the Northern Territory within the last five years (dept. of health and community services, 2005). Publicly funded homebirth programs are relatively new, with only one existing prior to 2004 and the oldest commencing in 1996. There are currently 12 publicly funded homebirth programs available in Australia, with none available in Queensland, Tasmania and the Australian Capital Territory, leaving a large number of women without a publicly funded homebirth option. In a 2012 survey of 12
homebirth programs, of the 10 eligible for the study, it was reported that only 519 women were booked to birth at home during that year (Catling-Paull, et al., 2012). Publicly funded homebirth programs limit the number of women they accept, since the number of midwives who work in these models is small. These programs are only available to women who are considered very low-risk (Catling-Paull, et al., 2012). Women with risk factors may choose private options so they can still access homebirth under the care of a midwife (Newman, 2008). Women also turn to private midwifery models after being turned away from a publicly funded homebirth model due to risk factors or geographic restrictions.

Although many women would prefer to hire a private midwife to attend them at home, they may face considerable challenges in terms of accessing such a service. There is a limited number of midwives offering private services, and the out-of-pocket cost for this service (ranging from $4,000 to $6,000) renders it prohibitive for many women (Dahlen, Schmied, et al., 2011). One of the current shortfalls of the Australian maternity system is that there is little opportunity for women classified as high-risk to have anything other than a medically managed birth with an obstetrician as they are excluded from birth centres, publicly funded homebirths and most midwife-led continuity of care models.

The choice to homebirth

In general, women choose to birth at home because they believe birth is a normal physiological process, they wish to avoid intervention, see homebirth as a safe option, want control, choice and autonomy, have previously had an unsatisfactory or traumatic experience in hospital and are dissatisfied with hospital-based birthing options. The literature on women’s choice of birthplace does not clearly differentiate between high and low-risk homebirths or freebirth, so it is uncertain whether women choosing a high-risk homebirth or freebirth have different reasons for this choice.
Birth as a normal physiological event

An overarching philosophy of women who choose to birth at home is that pregnancy and birth are not an illness, but rather a natural process (Jouhki, 2012). Vissainen interviewed parents who explained that they chose homebirth ‘in order to have as natural birth as possible’ (Vissainen, 2001, p.1113). Part of the parents’ definition of ‘natural’ included minimal involvement of medical technologies and the avoidance of analgesia. The home was described ‘harmonious, calm and pleasant’ and more conducive to a natural birth (Vissainen, 2001, p.1114). Similarly, Boucher et al reported that the comforting features of a home environment were believed to facilitate a physiological birth (Boucher, Bennett, McFarlin, & Freeze, 2009). In Bastian’s 1993 study, 95.8% of respondents cited the desire for a natural birth as their primary reason for choosing to birth at home (Bastian, 1993). Interventions and hospital procedures were seen as disrupting the flow and forces of nature, and women who wished to avoid these negative inputs were motivated to birth at home (Boucher, et al., 2009). Not only were medical interventions during birth a concern to the women, but the women in Bernhard et al’s (2014) study also made reference to the interference of moving into hospital during the labour as disruptive to their birth process. They also spoke of the inevitable interruptions experienced in hospital during their postnatal period, which prevented them from getting sufficient rest and from bonding with their baby (Bernhard, Zielinski, Ackerson, & English, 2014).

Home is the safest setting

A medical model of care focuses on the physical safety of mother and baby, but women’s concept of safety is generally more complex (Edwards, 1997, p. 10), and goes beyond achieving physical safety alone. As Edwards explains, women will prioritise ‘the long-term physical and emotional well-being of themselves, their babies and their relationships’
(Edwards, 1997, p. 10). Furthermore, the attention of a known midwife was seen to enhance safety, a feature that is guaranteed when women hire their own midwife (Edwards, 1997, p. 10). Boucher et al (2009) reported that 24% of respondents planned to birth at home because they felt it was the safest place to give birth (Boucher, et al., 2009). Similarly, the majority of women (60.2%) in Bastian’s study believed home to be a safer place to birth than the hospital (Bastian, 1993). Boucher et al (2009) found that women who choose to birth at home equated medical intervention with reduced safety (Boucher, et al., 2009).

**Desiring autonomy and control**

Women choosing homebirth express a desire to maintain autonomy, choice and control throughout their care (Murray-Davis et al., 2012). This was expressed by women in a study by Jouhki, where birthing at home was seen as the sole avenue through which they could experience the type of autonomy they desired; for example, being able to handpick their care provider (Jouhki, 2012). In their literature review, Ashley and Weaver found that a key theme in women’s decision was that homebirth allowed them to maintain control over their birth and their environment, something they felt was not possible in a hospital environment (Ashley & Weaver, 2012). This desire for personal control was also evident in a follow-up study in which all participants expressed a desire for some level of control during their birth (Ashley & Weaver, 2012). A major theme to emerge from Vissainen’s study was women’s desire to have control at their birth, and to have an active role in the decision-making processes (Vissainen, 2001). As Vissainen observes, ‘at its fullest, the motivation to achieve control of the birth process was expressed by some of the parents as a resistance to the supervisory role that society has over them in general and especially to the authoritative status of biomedical thinking’ (Vissainen, 2001, p. 1115). Women described what they meant by having control at their birth, expressing the
desire ‘to be the primary person making decisions and choices regarding treatment and care’ (Boucher, et al., 2009, p. 123). The desire for control during birth is longstanding, with a study in 1979 describing the western technocratic way of birthing as a threat and frustration to women’s autonomy (L’Esperance, 1979). In this sense, avoidance of such situations was reported by women as a motivation to birth at home, where they would have control and could avoid the ‘dehumanising treatment received in hospitals’ (Schneider, 1986, p. 1014). Bernhard et al interviewed women choosing homebirth after hospital birth. These respondents explained that birthing at home offered them choices they did not know existed for their first birth (Bernhard, et al., 2014). Similarly, Murray-Davis et al found that the key factors that influenced women’s desire for homebirth was that they wanted to optimise choice, comfort and control and have their family involved in the birth (Murray-Davis, et al., 2012). The women also felt that homebirth offered them more choice for pain management including the option of water birth (Murray-Davis, et al., 2012).

**Negative previous birth experience**

Previous birth trauma or a negative birth experience is proposed as a reason why women avoid birthing in hospital for subsequent births. Ashlea and Weaver suggest that a previous negative experience is a greater motivator to homebirth than a previous positive experience in causing women to change their mind about where to birth (Ashley & Weaver, 2012). After a negative hospital experience, homebirth can become a default option, rather than a choice that results from a systematic and rational decision-making process (Ashley & Weaver, 2012). Nonetheless, Vissainen found that a decision to birth at home was often related to a specific event in the woman’s past, most often ‘an unpleasant and traumatic experience of giving birth in hospital’ (Vissainen, 2001, p. 1114). This also emerged as a motivator in Boucher et al’s study, where approximately a quarter
of respondents cited a previous negative hospital experience as the reason they chose to
birth at home (Boucher, et al., 2009). Similarly, nearly 60% of the participants in Bastian’s
study asserted that their dissatisfaction with a previous hospital birth was their reason for
planning a homebirth (Bastian, 1993). Jouhki also reported that a previous negative birth
experience in hospital, or a previous positive experience at home, encouraged women to
choose homebirth (Jouhki, 2012).

**Dissatisfaction with the maternity care system**

As reported throughout the literature, women often choose a homebirth due to a general
dissatisfaction with the birthing options offered within mainstream services. When
hospital services do not meet a woman’s emotional or social needs, or their basic human
rights, women will avoid these services (United Nations Population Fund, 2004).

Baumeister et al explain that as an adaptive survival method, humans learn what events,
actions and locations are ‘bad’ and actively avoid them (Baumeister, Bratslavsky,
Finenauer, & Vohs, 2001, p. 323). Dissatisfaction with maternity care options is not a
new development, with L’Esperance suggesting, in 1979, that ‘these women are
responding in a normal, healthy manner to threats imposed by present maternity care’
(L’Esperance, 1979, p. 227).

In her account of the birth practices within ‘The Farm’ community during the 1960’s and
70’s in Tennesee (America), Gaskin describes how freebirthing became the norm,
because the women within this community felt it was safer to birth amongst friends and
with their partners than to enter a hospital and be exposed to medical procedures
(Gaskin, 2002). Similarly, Jouhki reported that women chose homebirth not only out of a
mistrust of the medical establishment, but also because they felt the hospital would not
be able to fulfill their expectations and cater to their desires, such as having their children
at the birth (Jouhki, 2012). Although Ashley and Weaver found that women appreciated
the need for some operational structures and rhythms in a hospital, the women nonetheless perceived these as fundamentally impeding the flow of the normal birth process. In particular, the women expressed dissatisfaction about not knowing who their care providers would be; given that there were shift changes throughout their labour and birth, the women were exposed to multiple care providers, many of whom were unknown to them (Ashley & Weaver, 2012). The women in a study by Bernhard et al recounted feelings of being dismissed during their previous births. They felt that the hospital staff were more interested in the fetal monitor and their uterus, rather than engaging with them as a person. Similarly, in the postnatal period, the focus shifted to the baby and they felt ignored. This dehumanising care motivated them to choose homebirth for subsequent pregnancies (Bernhard, et al., 2014). Amongst multiparous women, the pattern seems to be that the choice to homebirth after hospital birth is connected to dissatisfaction with their hospital experience. Merg and Carmoney found that, women felt that they were treated with respect and had autonomy at home, compared to hospital birth were they felt disrespected and coerced (Merg & Carmoney, 2012). Homebirth Australia (HBA) suggest that, ‘[w]omen make the choice to give birth outside a hospital with identified risk factors due to their profound dissatisfaction with the current maternity care system and in some cases because of previous hospital experiences that have left them deeply traumatised’ (HBA, 2012, p.1). This is not always the case, however, with Catling-Paull et al reporting that, multiparous women who choose a publicly funded homebirth program demonstrate a strong confidence in their body to give birth without intervention due to a previous positive birth in a hospital (Catling-Paull, Homer, & Dahlen, 2010).

**Regulatory frameworks for private practice midwives in Australia**

Private practice midwifery is regulated by guidelines and legislation to which all
practitioners must adhere in the provision of their professional services. The Nursing and Midwifery Board of Australia (NMBA) governs and registers midwives (AHPRA, 2012). In order to be registered, each midwife must hold professional indemnity insurance (PII). For midwives working for a health service, insurance is provided by their employer, while midwives in private practice must purchase it themselves (NMBA, 2012c). Between 2001 and 2010, privately practising midwives did not have access to PII. Since July 2010, however, government-subsidised products have become available, although these do not cover intrapartum care at home. Because of this, NMBA has allowed an exemption from the registration rules on insurance to ensure that privately practising midwives can continue to be registered (NMBA, 2012b). In 2010, this exemption was granted until 2013, and when a solution could not be found, a further extension on the exemption was given until June 30, 2015 (DHA, 2012).

In order to be exempt from the PII legislation, midwives must demonstrate that they meet a set of requirements. Firstly, the midwife must inform her/his clients that s/he does not have PII for intrapartum care, secondly, the midwife is to practice according to the code of professional conduct for midwives in Australia, code of ethics for midwives in Australia and the national competency standards for the midwife (NMBA, 2012b). Midwives must also demonstrate that they are practising according to the ‘quality and safety framework,’ which includes compliance with the ACM National Midwifery Guidelines for Consultation and Referral (ACM, 2013) and the National Guidance on Collaborative Maternity Care (NHMRC, 2010; NMBA, 2012b). If their clients develop complexities, the midwife should follow the path detailed in the ACM National Midwifery Guidelines for Consultation and Referral. Where the client declines consultation or referral, the midwife is to fill out an ‘Appendix B: Record of Understanding,’ which documents that the midwife has informed the client of the risks of her choice, and the midwife and client are free to continue with their care
arrangement, or the midwife can choose to withdraw care if it is not deemed an emergency scenario (ACM, 2013). As a result of this legislation, a registered private midwife providing intrapartum care at a home is only lawfully permitted to do so if either PII covering intrapartum care is in place (this is unavailable at present), or the conditions for the insurance exemption are satisfied, which is the current reality.

As already discussed, in 2010, midwives were accorded Medicare eligibility and prescribing rights for specified medications listed on the PBS (Wilkes, et al., 2009). This means that midwives have the authority to order and prescribe laboratory testing and some medications. Their clients are also able to claim back a portion of their fees from Medicare. This Medicare eligibility comes with a set of requirements in addition to those already in place for registration (NMBA, 2012a; Wilkes, et al., 2009). Prior to September 2013, midwives were required to demonstrate a ‘collaborative arrangement’ in order to fully exercise Medicare and prescribing privileges (Wilkes, et al., 2009). A collaborative arrangement was described as an arrangement between an eligible midwife and a medical practitioner. The purpose of this collaboration was not only to allow midwives access to Medicare rebates, but also to ensure that each midwife had a referral pathway if consultation or referral was required. However, multiple problems became apparent and many midwives were dissatisfied with the requirement to collaborate (Wilkes, et al., 2009). Medical practitioners were largely happy with the arrangement (and had advocated for it in the first place) as it conferred on them a measure of control over the midwifery profession. This ensured that medical practitioners would not be left ‘out of the loop’ (AMA, 2010a, p. 3). As eligible midwives attempted to develop collaborative arrangements, however, it became obvious that the majority of medical practitioners were unwilling to participate (AMA, 2010a). For many eligible midwives, this essentially meant that their full scope of practice and Medicare rights had been blocked by the
inability to find supportive medical practitioners with whom to collaborate. To remedy this, the Australian Government promised to modify the ‘collaborative arrangement’ to allow midwives to have an arrangement with a health service or hospital (DHA, 2012). This angered medical groups who immediately condemned the decision, which they proclaimed ‘was as dangerous as it was unexpected’ (AMA, 2012). As of September 2013, eligible midwives can now collaborate with an ‘entity’ such as a health centre, medical practice or hospital that employs obstetric staff (DHA, 2013). To date, there has been no access agreements granted between private midwives and hospitals.

Despite these regulations being in place, midwives can completely avoid the registration requirements by electing not to be registered at all (except in South Australia where legislation has recently changed). A 2012 South Australian coronial inquest found that ‘the [current registration] scheme operates as a disincentive against registration’ (South Australian coroner, 2012, p. 59). Due to the complexity of the new legislation, there is a concern that some midwives will consider relinquishing their midwifery registration in order to practise homebirth unabated. The legislative challenges facing private midwives in Australia came under the microscope in a coroner’s case, which came to a conclusion in 2012. This inquest centred on midwife Lisa Barrett and four babies who died under her care (South Australian coroner, 2012). The coroner reported that, ‘[i]n early 2011 Ms Barrett relinquished her registration as a midwife and continued her practice as a ‘birth advocate’ (South Australian coroner, 2012, p. 9). Ms Barrett asserted that she had de-registered herself as a midwife soon after the legislative changes of July 2010. It was acknowledged by the court that, ‘as matters currently stand, unregistered practising midwives providing care for women having planned homebirths are essentially beyond the reach of the law ... there was no legislative prohibition or sanctions prohibiting an unregistered person from providing midwifery services, provided the person does not
assert that they are registered’ (South Australian coroner, 2012, p. 101). While it is not illegal to practise midwifery unregistered, national law renders it an offence for a person to knowingly or recklessly use the title of ‘midwife’ in a way that would induce a belief in others that the person is registered in accordance with the current national legislation (South Australian coroner, 2012). Therefore, if one makes it known to their client that they are not a midwife, they are still legally allowed to practise midwifery. It is, however, illegal to practise after falsely claiming to be a midwife. In order to close this loophole, South Australia amended the *Health Practitioner National Law (South Australia)* in 2013 to make it illegal for any person, other than a registered midwife, medical practitioner or student midwife (under supervision), to provide birth assistance to women as their care provider. The penalty for doing so is $30,000 or 12 months imprisonment (South Australian Government, 2013). To date, this is only applicable in South Australia; however, Australia’s other states and territories are considering similar legislation. The South Australian coroner presiding over the case of Lisa Barrett acknowledged that ‘the strict regulation of privately practising midwives in the homebirth environment might have the effect of driving those women who are intent on undergoing a homebirth underground, thereby leaving them without professional assistance or support and in the position of choosing freebirth over entering a hospital’ (South Australian coroner, 2012, p.104).

Australia is not the only country where there is growing concern about sending homebirth underground, or driving women to freebirth. Similarly, events in the United Kingdom are threatening the freedom of midwives to practise privately and to attend homebirths. It is feared that lack of support for midwives to continue practising will lead to higher numbers of pregnant women opting for freebirth as a default position (Gillen, 2012). According to the consumer advocacy group *Homebirth Australia* (HBA), a lack of
access to quality maternity care and sensitive care providers will force women to choose homebirths over hospital births. HBA contends that further legislation and restriction on homebirth will inevitably serve to marginalise this choice and make it less safe (HBA, 2012). These perspectives stand to highlight the precarious position of private midwives within the Australian maternity care system, and the impact that this can have on women trying to access midwifery services in conjunction with the option of homebirth.

**The politics of birth at home in Australia**

The aforementioned coroner’s case highlighted the political circumstances surrounding high-risk homebirth; it found that all four planned homebirths attended by Lisa Barrett were considered to be ‘high-risk’ (South Australian coroner, 2012). The expert witnesses suggested that planned homebirths in ‘risky’ situations were not recommended. It was the AMA President’s position that, ‘the AMA (S.A.) and the medical profession has no general objection to homebirth, but maintained an objection to homebirth attended by the well-known risks’ (South Australian coroner, 2012, p. 41). The Royal Australian and New Zealand College of Obstetricians and Gynecologists (RANZCOG), in their 2011 position statement, maintained that homebirth is associated with an unacceptably high rate of adverse outcomes and should not be offered as a model of care at all (RANZCOG, 2011). Representing the ACM, Professor Dahlen asserted that ‘the evidence at large shows that planned homebirth is a safe option for women and their babies when women are at low-risk of complications, and when they receive care from suitably qualified attendants with adequate access to support, advice and referral and transfer mechanisms’ (South Australian coroner, 2012, p. 45). Professor Dahlen also told the court that ‘the College [ACM] would not recommend homebirth in situations involving increased risk’ (South Australian coroner, 2012, p. 46). In their position statement on homebirth, the ACM does make allowances for this, stating that ‘some
women may choose a planned homebirth when this is not recommended, but that these women should continue to have access to midwifery care whatever their choice’ (ACM, 2011b, p.1). The availability of the ‘Appendix B’ in the ACM National Midwifery Guidelines for Consultation and Referral (2013) provides midwives with a template for clear documentation of information provided to the woman, to help her make an informed choice, in situations where risk is present and where she opts for a homebirth despite advice given.

Another coroner’s case in Australia in 2012 focused on a freebirth where the baby died. The mother involved was Janet Fraser, the convener of an online freebirth community, Joyous Birth (NSW Coroner, 2012). On March 22, 2009, The Age newspaper interviewed Ms Fraser, who at the time was in labour and intended to freebirth (Elder, 2009). The article quoted obstetrician Pieter Mourik, who referred to the Joyous Birth group as ‘a bunch of nutters’ and who derided Ms Fraser as ‘a fool’ (Elder, 2009). The Daily Telegraph tabloid later reported that the ‘water birth of her third child, a girl, at her home, went horribly wrong in the early hours of March 27’ (Lawrence, 2009), and was now to be the subject of a coronial inquest. The coroner described the information on the Joyous Birth website as ‘propaganda’ and ‘typical of an intention to convert women who visit the site to the view that medical and hospital involvement in their pregnancies and births is undesirable and contrary to their interests as women and mothers and that professional involvement, including the involvement of professional midwives, should be kept to a minimum’ (NSW Coroner, 2012, p. 16). The coroner stated that the views expressed on the website are, in his opinion, ‘wrong views, extravagantly expressed and quite insensitive to the harm they may do to others, whether inexperienced mothers or children like Roisin [the baby who died] whose chance of life was so unnecessarily put at risk’ (NSW Coroner, 2012, p. 17). By portraying women who choose to freebirth in a
negative light, the media coverage and comments by the coroner may have polarised public opinion around the issue of safety and planned homebirth (Dahlen, 2009).

Given the sensationalism of most media reports on births that occur at home, the public will often take the opportunity to add their opinion to the debate. This was no more obvious than when this study was referenced in a discussion about homebirth and freebirth in The Sunday Telegraph (Squires, 2011). The public responses to the article revealed high levels of anger towards the women who choose to birth at home, with or without a midwife. Comments labelled these women variously as ‘insane,’ ‘stupid,’ ‘self obsessed’ and ‘willing to risk the lives of their babies.’ One female commentator stated that ‘[t]hese women are selfish, arrogant and irresponsible – all the qualities a good mother doesn’t have,’ thus explicitly correlating the choice for homebirth with being a bad mother. A male commentator similarly accused women of birthing outside a hospital ‘purely for ignorant and self-centred ideological reasons,’ describing their actions as ‘selfish stupidity’ (Squires, 2011). These responses gave insight into a prevalent public sentiment, not only toward women who birth outside the system, but also toward low-risk, midwife-attended homebirth, two distinct categories that are often conflated in this rhetoric.

These views about women who birth outside the system are not only expressed by coroners, the media and the general public, but there is also dissent within the homebirth community. In a recent article written by a homebirth advocate, she explains how she felt ‘compelled to speak out against freebirthing and other dangerous homebirth practices such as twin births,’ suggesting that, ‘[t]he homebirth community is being dragged into supporting a culture of reckless birth which is no better than the culture of over-medicalisation we seek to subvert’ (Attwell, 2012). When high-risk homebirth and
freebirths are publicised, she explains, they get bundled along with low-risk, midwife-attended homebirth. This in turn casts a negative light on low-risk midwife-attended homebirth. ‘Women who believe that they should have the ‘right’ to have high-risk births at home either alone or with a skilled or lay midwife are bringing death and controversy into what should be a logical option for low-risk birthing mothers,’ she said (Attwell, 2012).

From this discussion, we can see that homebirth and birth outside the system remain relatively unacceptable practices in Australia. When publicised, these practices often become the subject of ridicule. This demonstrates the hostile political and social environment in which birthing at home is embedded.

**Conclusion**

This chapter has provided an overview of birth in Australia and the care options available to women. Overall, the context of birthing in Australia is medicalised, and there are few options for women who wish to opt out of a medical approach to birth, and even fewer for women who have risk factors. Models of care available in the public sector are limited, leaving the majority of women with access to fragmented care. Accessing publicly funded homebirth, birth centres or midwife-led continuity of care models is difficult as these services are limited and have strict acceptance criteria. Within the private sector, women can have continuity of care with their chosen provider regardless of risk status. Private sector services, however, can be costly and difficult to access. The private sector affords the opportunity for high-risk women to have a midwife-attended homebirth, rendering it attractive to those who are ineligible for public homebirth services. A small portion of the population decides to disengage from health care providers altogether in order to freebirth. In general, women who are not satisfied with
maternity care in the public sector have few other readily accessible birthing options if they wish to have a midwife-attended birth. One way in which Australian women can access midwife-led continuity of care is to hire a private midwife. However, it is becoming increasingly difficult to practise as a private midwife due to recent legislative changes. Therefore, women can experience difficulty in securing the services of a private midwife. As the legislative climate becomes increasingly complex, there is growing concern that homebirth practices will be driven underground, with more women opting for freebirth. There is a low level of social and political acceptance of birth at home in Australia. Professional bodies and legislative committees tolerate the practice of homebirth in low-risk situations, with the exception of the ACM, which supports it, but who recommend against homebirth where the mother has risk factors or has no trained professional attending her. It is within this health care system alongside a complex legislative, social and political framework that the women involved in this study make their choice to birth outside the system.

The next chapter provides a literature review and will cover the safety, risks and outcomes of low-risk homebirth, high-risk homebirth and also freebirth. A literature review on low-risk homebirth has also been included to show that this practice is a safe and acceptable option. The literature on low-risk homebirth is contrasted against the literature on higher-risk homebirth and freebirth to show the differences in outcomes, and to demonstrate how the safety and risks of these latter options are less clear. Given that the safety and risks of birth outside the system are different to those of low-risk homebirth, it is possible that women’s reasoning for choosing birth outside the system is based on more than just safety.
Chapter Two: Literature review

In the previous chapter, an overview of the context of birth in Australia, and specifically the practices of homebirth and freebirth, was introduced to set the scene for this study. In this chapter, literature related to homebirth involving low and high-risk women and freebirth is explored. In line with grounded theory, and as will be described further in Chapter Three, the review of the literature was undertaken once data analysis had commenced. Chapter Two commences with a review of the safety of low-risk homebirth compared to that of high-risk homebirth. No studies have been conducted to specifically examine the outcomes of high-risk homebirths; however, studies that include women with risk factors will be examined separately to those that only include low-risk women, to report on how they compare. There has been one study that gives some insight into the outcomes of freebirth, and this will also be discussed. Following this, a review of qualitative studies exploring why women choose to birth at home in high-risk circumstances, and a review of the literature on the choice to freebirth, is presented. Rather than explore the large volume of research that has been published on homebirth in general, this literature review will focus on studies that provide insight into why women may birth outside the system, in order to use this opportunity to delve deeper into the specific subject matter of this thesis. Rather than taking an integrated approach to this review, each individual study has been addressed separately and reviewed from newest to oldest. This approach was selected because the literature on all-risk women is often not the focus of studies, which predominantly prioritise data on low-risk women. Thus explaining the findings of these studies seems more coherent if each article is reviewed separately.
Search strategy

A keyword search for ‘homebirth,’ ‘home birth,’ ‘home childbirth,’ ‘freebirth,’ ‘free birth,’ ‘unassisted birth,’ ‘unassisted childbirth,’ ‘unattended birth’ and ‘unattended childbirth’ was undertaken through CINAHL (EBSCO Host), MEDLINE (Ovid SP and Walters Kluwer), the Cochrane Database of Systematic Reviews, INFORMIT and PUBMED (NCBI). This search yielded 3,875 results, which were then limited to full-text, English, peer-reviewed articles. Only homebirth in developed countries and relating specifically to the safety, risks, outcomes and maternal choice and experience were included. Studies that inadvertently or deliberately included unintended or unplanned homebirth as part of their data were excluded, because the results are not generalisable to planned homebirth or freebirth. Due to the number of papers found, literature published prior to 1990 was excluded. All Australian studies undertaken after this date were included (as this current research project is restricted to the Australian context); however, for the quantitative data, international studies with less than 1,000 participants were excluded because of the large number of studies available. An additional search was conducted through the University of Western Sydney Library search engine for the same keywords, to capture articles that were not identified in the original search. Citation snowballing was then conducted within each of the included articles to ensure that all the literature had been accounted for. This literature search was repeated in April 2014 to capture new literature, and as a component of the process of analysing the data and writing up the discussion.

Low-risk homebirth: the safety, risks and outcomes

Although randomised controlled trials (RCTs) are one of the most rigorous of all research methods to determine cause and effect (De Jonge et al., 2009; NHMRC, 2009), the safety of homebirth has never been tested by an adequately powered RCT (Olsen, 1997; Olsen & Clausen, 2012). An RCT randomising women to birthplace has not been
attainable for multiple reasons. When choosing their place of birth, women prioritise their autonomy to choose; therefore the process of randomisation is not well received (Hendrix et al., 2009). Also, it is argued that the number of participants required for an RCT would be unfeasible (Dowswell, Thornton, Hewison, & Lilford, 1996), with thousands of women needing to be recruited to determine rates of rare outcomes in a low-risk population (Lilford, 1987; Olsen & Clausen, 2012). This problem would be further compounded by the complexity in accounting for variables when comparing home and hospital births (Newburn & Dodds, 1996). According to Johnson and Daviss, regardless of research methodology, there will always be residual confounding factors in the data between home and hospital birth (Johnson & Daviss, 2005). In order to recruit enough women, some experts contend that a multi-centre collaboration would be required (Lilford, 1987), and moreover that each centre would approach care differently given the lack of universal management of homebirth and hospital birth (Macfarlane, 1996). This would make the data inconsistent and impede accurate analysis. For these reasons, randomising women to their place of birth does not seem feasible, and despite attempts (Dowswell, et al., 1996), this is a study that is yet to be achieved (Williams, 2009). A Cochrane review identified two RCTs – one provided outcome data, but only had 11 participants, rendering the study’s findings irrelevant (Olsen & Clausen, 2012).

Other methods of research must therefore be relied upon if we wish to answer the question of safety and risk associated with homebirth. De Jong et al suggest that in the absence of RCTs, the safety of homebirth can be determined from good quality routine registration and databases that capture a birthing population in its entirety (de Jonge, et al., 2009). However, Johnson and Daviss argue that prospective cohort studies remain the most comprehensive instruments available to investigate homebirth (Johnson & Daviss, 2005). As the quality of evidence in favour of homebirth from observational studies is steadily increasing, Olsen et al suggest a systematic review of these data, rather
than prioritise the commencement of a randomised controlled trial (Olsen & Clausen, 2012).

Catling-Paull et al reported retrospectively on maternal and neonatal outcomes for Australian women planning a publicly funded homebirth between the years 2005 and 2010. Nine homebirth programs provided data representing 97% of women birthing in these programs, with the total number of women being 1,807 (Catling-Paull, et al., 2013). Although the study was not powered to draw conclusions about safety of homebirth in Australia, it nevertheless provided an opportunity to evaluate publicly funded homebirth programs to some degree. In total, 84% of the women (1,521/1,807) gave birth at home with 17% (315) being transferred to hospital during labour or within a week of giving birth. A small number of babies (48 or 3%) were admitted to special care nursery, and there were two stillbirths and four early neonatal deaths (within the first week after birth). Three of these deaths were expected due to previously diagnosed fetal anomalies, so were not related to place of birth. When the expected deaths were excluded, the combined rate of stillbirth and early neonatal mortality was 1.7/1,000 births. Ninety percent of the women had a normal vaginal birth and there were no maternal deaths. Outcomes for mode of birth were also very positive, with only 5.4% of women requiring caesarean section and 3.8% requiring assisted vaginal birth (Catling-Paull, et al., 2013). The authors concluded that their findings mirrored the outcomes of other reputable studies into low-risk homebirth. Given previous research on homebirth safety for low-risk women, this new information is relatively unsurprising; it does, however, provide a positive evaluation of publicly funded homebirth programs in Australia.

Currently, the highest-level evidence on the outcomes of planned low-risk homebirth is from the 2011 Birthplace in England National Prospective Cohort Study (Birthplace in England Collaborative Group, 2011). Involving 64,538 low-risk women, this study differed from
others insofar as it captured data on the ‘intended place at onset of labour’ as part of the inclusion criteria. Other studies, conversely, have included women in their homebirth groups from the commencement of antenatal care (Kennare, Keirse, Tucker, & Chan, 2010; Wax et al., 2010; Woodcock, Read, & Bower, 1994), which wrongly categorises women who change their mind during pregnancy. The inclusion of only low-risk women at onset of labour, who received care from registered midwives employed by a public hospital organisation (the NHS Trust) limited variations in care, making the findings more accurate. Also, the sample size had the power to detect rare outcomes. The findings demonstrated transfer rates from non-obstetric units or home were much higher for primiparous women (36–45%) than for multiparous women (9–13%). The incidence of adverse perinatal outcomes was low in all settings; however, there was a significant increase in perinatal morbidity for primiparous women who gave birth at home. While low-risk primiparous women were shown to have poorer primary outcomes (a composite of stillbirth after the start of care in labour, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus, and fractured clavicle), any woman planning to give birth at home was significantly less likely to have an instrumental or operative delivery, or to receive medical interventions. Furthermore, these women were significantly more likely to have a ‘normal birth’ compared to women in obstetric units (Birthplace in England Collaborative Group, 2011).

The largest study on the safety of homebirth was undertaken by De Jonge et al who retrospectively analysed national perinatal and neonatal registration data in The Netherlands to compare outcomes for 529,688 low-risk women who were in midwife-led care at the onset of labour. The study included over 60% of women intending to birth at home and 30.8% planned to give birth in hospital. The databases captured 99–100% of
maternity care, providing a complete data set. Combined with the large sample size, this provided the power to detect differences in rare adverse outcomes. No significant differences in perinatal mortality or severe perinatal morbidity between planned home and planned hospital birth groups were found, showing that in a low-risk population birthing at home, there is no higher risk of mortality or admission to NICU compared to hospital (De Jonge, et al., 2009). The integration of homebirth into The Netherlands’ maternity system may have contributed to these positive findings and also allowed for rigorous collection of data.

Janssen et al performed a retrospective analysis of routinely collected data to compare outcomes of low-risk planned homebirths attended by midwives with low-risk planned hospital births attended by midwives or physicians. With 2,889 women in the homebirth cohort, and 4,752 in the planned hospital cohort, all subjects met the same eligibility criteria and were attended by the same cohort of midwives. The strengths of this study were that data were analysed based on planned place of birth at the commencement of labour, and the database used for data collection captured all but 0.01% of the birthing population. This study presented similar findings to other studies – that is, for low-risk women, planned homebirth attended by a registered midwife is associated with comparable rates of perinatal death and reduced rates of obstetric interventions and adverse maternal outcomes compared with planned hospital birth (Janssen et al., 2009).

Wiegers et al performed a prospective study on 1,836 low-risk pregnant women who had planned to birth at home or in hospital across 54 midwifery practices in the Netherlands (Wiegers, Keirse, van der Zee, & Berghs, 1996). Unlike the Birth Place Study, these researchers found that, when variables were controlled for, there was no association between planned place of birth and adverse perinatal outcomes in primiparous women.
However, the sample size was much smaller, which may have impacted the findings. In multiparous women, perinatal outcomes were significantly better for planned homebirths than for planned hospital births, with or without controlling for background variables (Wiegers, et al., 1996).

Anderson et al conducted a retrospective study on the outcomes of 11,788 low-risk homebirths in the United States. The intrapartum and neonatal mortality was 2/1,000, and with the exclusion of congenital anomalies, this dropped to 0.9/1,000 (Anderson & Murphy, 1995). This represents a low mortality rate. However, this study was compromised because data collection was not rigorous. Midwives were sent data collection forms that were developed by an ‘ad-hoc committee,’ they were not pilot tested, and the response rate was only 66%. Furthermore, there was no comparison group so conclusions cannot be made about how these outcomes compared to those where the women birthed in a hospital environment. Nonetheless, these findings are in line with other research that has shown that for low-risk women, planned homebirth with qualified care providers can be a safe option (Anderson & Murphy, 1995).

Other literature examining outcomes of low-risk homebirth

Leslie and Romano (2007) performed a systematic review of the homebirth literature on low-risk women who were cared for by qualified midwives. They concluded that research shows that equally good or better outcomes can be achieved for low-risk women choosing homebirth (Leslie & Romano, 2007). The authors provided scant detail about the review process, however, their conclusion does nonetheless mirror what had been found in the preceding literature.

Rather than assessing the general safety of homebirth some studies have focused on specific outcomes. For example, Nove et al (2012) performed an observational study to
compare the odds of postpartum haemorrhage at home compared to in hospital. They included only low-risk women having planned homebirth, and excluded pre-term births along with elective caesareans and inductions. A total of 273,872 pregnancies over 15 hospitals were included in the analysis, and the classification of a postpartum haemorrhage was blood loss of greater than 1,000 ml. Of all the subjects in the study, 5,998 women were in the planned homebirth group from the commencement of labour. The researchers took into account variables such as parity. Amongst the study group, there were 2,808 cases of postpartum haemorrhage with the incidence significantly higher in the hospital group compared with the homebirth group (1.04% and 0.38% respectively). Given these findings, the authors raised questions about the safety of hospital birth for the mother, and suggested that there is a statistical correlation between place of birth and PPH. While they could not explain why this was the case, they concluded that women should be informed that the risk of PPH is higher in hospital when compared to giving birth home (Nove, Berrington, & Matthews, 2012).

In a 2013 study undertaken in the Netherlands, De Jong et al tested the hypothesis that low-risk women at the onset of labour with planned homebirth would have a higher rate of severe acute maternal morbidity than women with planned hospital birth. This study also compared the rate of postpartum haemorrhage and manual removal of placenta (De Jonge et al., 2013). They performed a cohort study using a linked data set; of the 146,752 women included, 92,333 (62.9%) planned a homebirth and 54,419 (37.1%) planned hospital births. The overall rate of severe acute maternal morbidity was 2.0/1,000 births. For primiparous women, the rate for planned home versus planned hospital birth was 2.3 versus 3.1/1,000 births. Postpartum haemorrhage was 43.1 versus 43.3/1,000, and the rate of manual removal of placenta was 29.0 versus 29.8/1,000. For multiparous women, the rate of severe acute maternal morbidity for planned home versus planned
hospital birth was 1.0 versus 2.3/1,000 births, postpartum haemorrhage was 19.6 versus 37.6/1,000 and the rate of manual removal of placenta was 8.5 versus 19.6/1,000. The authors concluded that low-risk women planning homebirths had lower rates of severe acute maternal morbidity, and that the differences between home and hospital were statistically significant for multiparous women. This large study shows that there is no evidence that planned homebirth for low-risk women leads to severe adverse maternal outcomes in a maternity care system that supports homebirth (De Jonge, et al., 2013).

From this literature, we can conclude that evidence supports planned, midwife-attended homebirths as being equally as safe as hospital births for low-risk women, and indeed safer in terms of rates of obstetric intervention and PPH. However, primiparous women planning a homebirth may not expect neonatal outcomes as positive as those experienced by multiparous women. Primiparous women are also significantly more likely to require transfer. However, if they choose to birth at home, all women can expect to be exposed to fewer interventions during labour and birth, higher rates of normal vaginal birth and lower resultant morbidity, such as PPH.

**All-risk homebirth: the safety risk and outcomes**

In this section of the literature review, I will examine studies that included women with risk factors giving birth at home. I will consider these studies from the most recent to those now much older; the most recent being from 2014 and the oldest 1994. It must be noted, however, that there have been no studies focusing exclusively on the outcomes for high-risk women having homebirths. Some studies have compared home, hospital and birth centre outcomes, while others have only focused on perinatal outcomes.

Cheyney et al assessed the outcomes of care for 16,924 planned homebirths in the United States. This sample consisted of all planned homebirths and did not exclude high-
risk participants. Of the participants planning a homebirth at the onset of labour, it was found that over 89% birthed at home with 1.2% requiring assisted delivery and 5.2% requiring caesarean section. Overall, the spontaneous vaginal birth rate was 93.6%. Excluding lethal anomalies, the intrapartum, early neonatal and late neonatal mortality rates were 1.30, 0.41 and 0.35 per 1,000 respectively. The authors concluded that low-risk women experienced high rates of physiological birth and low rates of intervention without an increase in adverse outcomes (Cheyney et al., 2014). Despite reporting positive outcomes for low-risk women, this study was limited by the nature of the data set. This study used data collected by The Midwives Alliance of North America (MANA), which collects data on homebirths from midwives. Submission of data to MANA, however, is voluntary, and it is estimated that only 20–30% of practising midwives contribute. This contrasts to the 2005 study by Johnson and Daviss, which included all homebirths in one year from all midwives across the United States (Johnson & Daviss, 2005). The use of the MANA database presents a problem when using it for evidence of safety as midwives could choose not to report poor outcomes. This creates an incomplete data set that does not account for the majority of homebirths planned within the specified study period. Furthermore, ‘unlicensed,’ ‘naturopathic midwives’ and ‘other’ practitioners contributed to the data set, and for readers outside of the American context, it is unclear whether these types of practitioners are registered or properly trained as midwives. It is possible, therefore, that freebirths might have been included in the data set. Within the study group, there were 60 sets of twins, 1,054 of the participants had had a previous caesarean, 168 women had gestational diabetes, preeclampsia, eclampsia or Rhesus sensitisation, there were 222 breech vaginal births, and pre and post-term births were also included. Babies born breech had an intrapartum death rate of 13.51/1,000 compared to vertex presentations at 1.09/1,000. Furthermore, similar to the findings in the Birthplace Study, primiparous women were at greater risk of experiencing a neonatal
death than multiparous women. Women having a VBAC also experienced a higher rate of intrapartum fetal death compared with low-risk multiparous women (2.85/1,000 versus 0.66/1,000). Interestingly, there was no increase in neonatal or fetal deaths for twin births, a finding that is inconsistent with other studies; this may be due to the small number of twins in a large data set. Overall these findings indicate that homebirth for low-risk women has favourable outcomes, but that the same cannot be said for the higher-risk participants (Cheyney, et al., 2014).

Grunebaum et al assessed infant outcomes including, Apgar scores of 0 at 5 minutes, neonatal seizures and serious neurological dysfunction, in relation to birth setting, and found in favour of hospital-based births for better outcomes. They used birth certificate data for 13,891,274 singleton births greater than 37 weeks gestation and weighing over 2,500 g. They found that babies were at most risk of an Apgar score of 0 and neonatal seizures at home or in midwife-led birth centres, concluding that women should be advised toward hospital birth for this reason (Grunebaum et al., 2013). This study, however, had several limitations (Vedam, Stoll, Schummers, & Fulton, 2013). For example, it did not exclude for the majority of maternal or neonatal risk factors, rendering their study population all-risk. It also reported that an Apgar of 0 could have been attributed to known stillbirth or known fetal anomalies, but that these could not be separated out. For this reason, not all the low Apgars can be attributed to place of birth. Furthermore, the findings are inconsistent with reported rates on the Centre for Disease Controls website, and US birth certificate data are insufficient to allow comparisons of outcomes between settings or care providers (Vedam, et al., 2013). Given the extreme limitations of the data set and the inability to identify or allow for variables, these findings do not provide helpful information as we seek to assess the safety of home or hospital birth for babies.
Blix et al performed a retrospective cohort study assessing outcomes of planned homebirths and planned low-risk hospital births in Norway. While their study only included 1,631 planned homebirths, it did conclude that the act of planning a homebirth was associated with a reduction in interventions and complications (Blix, Huitfeldt, Oian, Straume, & Kumle, 2012). Although the control group was considered low-risk, the homebirth group was all-risk and included breech presentation, VBAC, and post and pre-term births. The authors found that 5.1% of primiparous women who planned a homebirth had a caesarean delivery compared to 6.5% in the hospital group, and for multiparous women planning a homebirth, 1% had a caesarean compared to 1.8% for women planning hospital births. Primiparous women who planned for homebirths also had lower rates of assisted vaginal delivery, epidural analgesia, dystocia and anal sphincter tears compared to primiparas in the hospital group. There were no significant differences between the groups in terms of risks for having an episiotomy or postpartum haemorrhage. Similarly, multiparous women who planned a homebirth had lower rates of assisted vaginal delivery, epidural analgesia, episiotomy, anal sphincter tear, dystocia and postpartum haemorrhage (Blix, et al., 2012).

In an Australian study, Kennare et al performed a retrospective population-based study on all births in South Australia between 1991 and 2006. The homebirth cohort included any birth that at the time of antenatal booking was intended to be at home, however, the number of women who were planning to give birth at home at the onset of labour was unknown by the authors. Although there were 1,141 women in the homebirth group, only 792 of these births actually occurred at home. Overall, women who planned a homebirth had a perinatal mortality rate similar to that of planned hospital births (7.9 vs 8.2/1,000 births). There were nine deaths in the planned homebirth group, but only two
among the 792 women who actually gave birth at home (one of the babies died of lethal anomalies and the other was a stillbirth). The seven remaining deaths occurred in the 349 women who planned a homebirth but birthed in hospital. These included deaths of the second twin after delayed transfer and two women who declined intervention despite a change in their risk status; three deaths were unrelated to the type of care received. The authors concluded that the safety of homebirths ‘may be improved by better adherence to risk assessment, timely transfer to hospital when needed and closer fetal monitoring’ (Kennare, et al., 2010, p.79). This study had several limitations including the small number of women in the homebirth group. There was also no way of determining whether the homebirths were attended or unattended, and women were included in the homebirth group who had actually planned a hospital birth (Dahlen, Homer, Tracy, & Bisits, 2010). Nonetheless, women experiencing high-risk pregnancies were over-represented in the perinatal mortality findings. This indicates that high-risk homebirth may be less safe than low-risk homebirth. Despite the possible disadvantages for the babies of high-risk mothers, this study showed lower caesarean, instrumental birth and perineal damage rates for homebirth women compared to the women who birthed in hospital.

Malloy analysed infant outcomes for 1,335,471 term, singleton vaginal births attended by midwives in the USA. This study did not exclude women with risk factors, except those with twin and pre-term births. Ninety four percent birthed in hospital (2% in a freestanding birth centre), while 4% were homebirths (Malloy, 2010). Homebirths attended by both certified nurse-midwives and ‘other’ midwives were found to have a higher risk of mortality than births in hospital attended by midwives, with a mortality rate of 2.8 per 1,000 births in the homebirth group and 0.9 per 1,000 births in the hospital group. The authors concluded that homebirths in America were associated with a higher
rate of mortality than hospital births, but failed to qualify that this was in an all-risk population. Additional findings from this study not reported by the authors included that babies born in hospital under the care of midwives were at higher risk of hyaline membrane disease (2.7/1,000 vs 1.4/1,000), injury at birth (4.6/1,000 vs 4.1/1,000), mechanical ventilation (35.9/1,000 vs 26.4/1,000) and meconium aspiration (3.2/1,000 vs 2.8/1,000), which suggests that neonatal morbidity was more prevalent for the hospital group than the homebirth group. Methodologically, this study was poor, with the authors reporting a mixing of the study groups and a difficulty in determining the planned place of birth from the data used (Malloy, 2010). Furthermore, the exclusion of births by caesarean section does not present a true indication of mortality or morbidity rates for either setting.

Symon et al conducted a retrospective matched comparison study using United Kingdom databases to compare clinical outcomes for 8,676 women employing an independent private midwife (IPM) or birthing in NHS maternity units. Both high and low-risk women were included in the IPM cohort and matched with participants in a hospital cohort. Women having a birth with an IPM were significantly more likely to have an unassisted vertex birth than the NHS cohort (77.9% vs 54.3%), but they were also more likely to have a stillbirth or neonatal death (1.7% vs 0.6%). Of the 25 deaths in the IPM group, seven were born before 32 weeks gestation, seven occurred to a twin (mostly the second twin), three were vaginal breech births, and four occurred to women with a complicated medical or obstetric history. When the authors excluded high-risk women, the perinatal mortality rate for the IPM cohort was not significantly different compared to the NHS cohort (4.8 vs 3.3/1000 births). The women in the IPM group had more medical complications, and high-risk situations such as pre-term birth, twin pregnancy and vaginal breech birth at home were associated with unfavourable outcomes (Symon,
Winter, Inkster, & Donnan, 2009). Despite the higher perinatal mortality rates for high-risk cases, the clinical outcomes across a range of other variables were significantly better for women accessing an IPM. Like previous studies, regardless of risk status, maternal outcomes for homebirths were better than hospital births, but this may be to the detriment of neonatal wellbeing. This study is considered to have good validity and indicates that perinatal mortality is more likely in high-risk homebirths than low-risk ones, but that women using an IPM fared better across a range of clinical outcomes compared to those birthing in hospital (Symon, et al., 2009).

Hutton et al compared data on 6,692 women attended by Canadian midwives who had homebirths with similar women who planned a hospital birth (Hutton, Reitsma, & Kaufman, 2009). This study was conducted in the province of Ontario where regulatory bodies set out eligibility criteria for women having homebirths that allows for the inclusion of women wishing to have a VBAC and those between 42 and 43 weeks gestation. The study cohort therefore included women who in Australia are considered high-risk (ACM, 2013). The rate of perinatal and neonatal mortality was 1/1,000 for both groups, and indicated that even with the addition of VBAC and post-date births, outcomes are comparable. All measures of maternal morbidity were lower in the planned homebirth group, as were rates for all interventions. The authors concluded that where women are cared for at home by trained midwives, perinatal and neonatal mortality is comparable to hospital births (Hutton, et al., 2009). Primiparous women choosing homebirth, however, may expect a higher rate of transfer to hospital than multiparas, as has been found in other studies already discussed.

Johnson and Daviss performed a prospective cohort study with 5,418 women under the care of a midwife (Johnson & Daviss, 2005). The prospective nature of the study allowed
consistent and rigorous data collection methods, with data from all midwives across the USA and Canada being collected for one year. Rates of intervention for homebirth were less than half when compared with hospital rates, a finding consistent with other studies (Kennare, et al., 2010; Symon, et al., 2009). The neonatal mortality was 1.7/1,000 for low-risk homebirths after planned breeches and twins were excluded. Among the 80 planned breeches at home, there were two deaths and none among the 13 sets of twins. This study shows that low-risk attended planned homebirths are just as safe as a hospital birth, but that planned breech birth at home may have a higher risk of death. It is unclear how this compares to outcomes for breech births in hospital. Unfortunately, this study did not include a matched hospital group for comparison.

Parratt and Johnston conducted a small study of 440 planned homebirths in Victoria, Australia where the participants were both high and low-risk (Parratt & Johnston, 2002). The risk factors represented in the cohort included 29 grand multiparas, 9 breech presentations, 13 premature births, 5 births at 43 weeks gestation or more, 3 sets of twins and 22 women who were planning a VBAC. Of the 440 planned homebirths, 5 babies died, 3 prior to labour at 34, 36 and 39 weeks, two deaths were unexplained and one was due to multiple fetal abnormalities. Two other deaths occurred: one born in hospital at 26 weeks and the other was born at home with Trisomy 13 and died at four and a half months old. None of these deaths was attributable to place of birth, and they likely would have occurred regardless of planned place of birth. The homebirth group had a 91.6% rate of spontaneous vaginal birth and the total transfer rate was 20%. As with other studies, primiparous women were much more likely to transfer to hospital than multiparous women. The authors noted that it was not the ‘high-risk’ participants who contributed to the mortality data, as only one of these was high-risk. Furthermore, the authors reject the conclusions drawn by Mehl-Madrona et al (1997) and Bastian (1998)
that suggest that when higher-risk women are included in the planned homebirth group, there is greater likelihood of adverse outcomes. Furthermore, Parratt and Johnston asserted that conclusions could not be drawn from what they considered to be poor-quality studies (Parratt & Johnston, 2002). It is possible, however, that the authors may also have a bias toward an all-risk approach to homebirth.

Bastian et al assessed the risk of perinatal death at planned homebirths in Australia. They found that fifty perinatal deaths (7.1 deaths per 1,000) occurred in 7,007 planned homebirths from 1985 to 1990; 52% were associated with intrapartum asphyxia. The authors concluded that Australian homebirths carried a high death rate compared with all Australian births and homebirths elsewhere. The largest contributors to the high mortality rate were post-term births, twin pregnancy, breech presentation, and a lack of response to fetal distress. Post-term pregnancies were over-represented in the homebirth cohort, which mirrored the findings of Kennare et al (2010), and carried a death rate twice that of other homebirths. Homebirth mortality was 1 in 14 for breech presentation and 1 in 7 for twins (Bastian, Keirse, & Lancaster, 1998). When women with risk factors were excluded from the analysis, low-risk homebirths compared favourably to hospital births, a finding that mirrors the findings of other low-risk studies. Despite the positive findings for low-risk homebirth, data collection methods for this study were inconsistent. Some data were reported by participating midwives and other data were obtained from birth notifications and homebirth newsletters found by the authors. Data on poor outcomes were specifically pursued to gather missing data, and the method for gathering these was not made transparent. Despite being of poor quality, this study does provide some evidence that high-risk homebirth has less than optimal outcomes compared to low-risk homebirth.
Murphy and Fullerton performed a prospective study using uniform data collection to describe the outcomes of planned homebirths attended by certified nurse-midwives. The study cohort of 1,221 was a combination of low and high-risk women with an estimate of 22% of participants having indications of higher perinatal risk. 102/1,221 (8.3%) women in the homebirth cohort were transferred to the hospital during labour, with ten women and 14 neonates transferred to hospital after birth. A gestational age of greater than 42 weeks and the presence of meconium greatly increased the risk of transfer and were over-represented in the perinatal mortality data, a similar finding to the Bastian et al (Bastian, et al., 1998) study. Intrapartum fetal and neonatal mortality for women beginning labour with the intention of birthing at home was 2.5/1,000. The authors concluded that homebirth can be accomplished with good outcomes under the care of qualified practitioners and within a system that facilitates transfer to hospital care. They also concluded that post-date births carried a greater risk of perinatal mortality. This study’s strength was that it was prospective; however, its findings are limited by the small number of participants, the inability to determine a consistent acceptance criteria, the exclusion of some data due to midwives’ unwillingness to participate, and the absence of a comparison group. Nonetheless, this research gives some indication that the risk factor of post-date pregnancy could present an increased risk of poor perinatal outcomes compared to low-risk pregnancies (Murphy & Fullerton, 1998).

Mehl-Medrona and Mehl-Medrona assessed the effect of attending breech, twins and post-date pregnancies on homebirth outcomes. Previous studies have shown that these three risk factors may increase homebirth mortality rates (Bastian, et al., 1998; Kennare, et al., 2010). In their matched cohort of 1,000 pairs of women, one group was attended at home by midwives and the other in hospital by physicians. Perinatal mortality was 14/1,000 for homebirths and 5/1,000 for hospital births, showing a significant difference.
When post-dates, breeches and twins were removed from the analysis, the mortality rates were comparable, confirming findings from previous studies that hospital births are no safer than homebirth for low-risk women, but that where risk factors are present, poorer outcomes at home may be experienced, raising questions about the safety of high-risk birth at home (Mehl-Madrona & Mehl-Madrona, 1997). This study was limited by the small number of participants and the fact that the data were collected retrospectively. Nonetheless, the authors concluded that a high-risk population birthing at home was 3.1 times more likely to experience a mortality event than a low-risk population birthing at home (Mehl-Madrona & Mehl-Madrona, 1997). This study subsequently came under scrutiny, with Wagner (1998) suggesting that while there was a higher incidence of mortality amongst the post-date homebirths, there was no evidence to suggest that this was related to place of birth or the care provider (Wagner, 1998).

In a retrospective matched cohort study in Western Australia, Woodcock et al reported that women planning a homebirth were 95% less likely to be induced, 75% less likely to have an emergency caesarean section, and were at less risk of fetal distress in labour. Women birthing at home, however, were reported to be at increased risk of postpartum haemorrhage (Woodcock, et al., 1994). In line with the findings of previous studies, the researchers found that, overall, women fare better when cared for at home compared to in a hospital setting. Unlike later studies, however, PPH seemed increased in this study. Twin births and lethal anomalies were excluded from the analysis; however, breech births and maternal risk factors were retained. Crude perinatal mortality rates were 5.1/1,000 births in the homebirth group and 4.1/1,000 in the hospital group, which is not a significant difference, even though breech births and maternal risk factors were included.

A weakness of this study, as with that of Kennare et al (2010), is that the homebirth group was allocated based on antenatal booking, so all antenatal and intrapartum
transfers were counted as a homebirth, whereas some may have been planned to occur in hospital. Nonetheless, the authors concluded that, ‘[p]lanned homebirths in WA appear to be associated with less overall maternal and neonatal morbidity and less intervention than hospital births’ (Woodcock, et al., 1994, p. 125). Unlike other studies that include a high-risk population, there was no reference to post-date pregnancies producing poorer outcomes at home (Woodcock, et al., 1994).

**Systematic reviews**

Wax et al undertook a systematic review assessing maternal and newborn safety in planned homebirths versus planned hospital births. Amongst a cohort of high and low-risk women, the authors concluded that planned homebirths were associated with fewer maternal interventions and morbidities. However, planned homebirths were reported as being associated with significantly higher neonatal mortality rates, leading the authors to conclude that fewer interventions at homebirths were associated with a tripling of the neonatal mortality rate. This study came under intense scrutiny for failure to accurately represent data or adhere to the due process of a systematic analysis (Crowther, Gilkison, & Hunter, 2010; De Jonge, et al., 2009; Kirby & Frost, 2011; Sandall, 2011). The Australian College of Midwives (ACM) criticised the study for omitting the large neonatal dataset from De Jonge (2009) in the sensitivity analysis (ACM, 2011a; Davey & Flood, 2011). Indeed, the ACM considered the quality of the study so poor that it was excluded altogether from their homebirth literature review. Keirse (2010) observes that Wax et al’s (2010) study perfectly illustrates how a meta-analysis can be developed into an art to suit whatever the authors hope to achieve (Crowther, et al., 2010; Keirse, 2010). Indeed, Wax et al (2010) misrepresented findings of the included studies and selectively excluded studies with relevant data from one outcome assessment but not another (Keirse, 2010; Kirby & Frost, 2011). Wax et al (2010) state that ‘outcome data were extracted by two
physicians, with differences resolved by consensus’ (p.245). As Keirse notes, the authors did not, however, make this process transparent (Keirse, 2010), raising questions about how much bias was imposed on the research process (Crowther, et al., 2010). Furthermore their definition of ‘perinatal death’ was different to that of the included studies, which created statistical anomalies between the respective mortality rates cited (Crowther, et al., 2010). While Wax et al (2010) report that their meta-analysis was on planned homebirths, the inclusion of Pang et al (Pang, Heffelfinger, & Hunag, 2002) (a study that included planned and unplanned homebirths) partly contributed to the threefold higher risk of neonatal death (Gyte et al., 2010; Keirse, 2010; Kirby & Frost, 2011), as did the deliberate exclusion of the largest study into homebirth by De Jonge. These criticisms suggest that Wax et al (2010) used a convenience sample of data rather than conducting a rigorous and transparent meta-analysis (Crowther, et al., 2010), thus rendering the final conclusions and results unreliable (Kirby & Frost, 2011).

Multiple criticisms were also leveled at Wax et al (2009) due to their comparison of perinatal morbidity by delivery location using birth certificate data. The data set included 733,143 births occurring in hospital, 4,661 in birth centres and 7,427 at home. Multiple gestations, births prior to 37 weeks, smokers, women with diabetes, hypertensive disorders of pregnancy, or prior caesarean were excluded. No mention was made of breech presentation and post-date pregnancies, so it is assumed that these were amongst the data set. Furthermore, there was variation in birth attendants providing care, and the data set could have included lay midwives and freebirths, because for 4,801 births, the care provider was unknown. Similarly, unplanned out-of-hospital births were included in the home or hospital groups because they could not be differentiated. Homebirths were associated with higher rates of low 5-minute Apgar scores. However, home and birthing centre deliveries were associated with less chorioamnionitis, fetal intolerance of labour,
meconium staining, assisted ventilation, neonatal intensive care admissions, and birth weight less than 2,500 g. These results cannot give any insight into the expectations of outcomes for any birth location, because the birth certificate data attributed homebirth transfers to hospital births, which could have underestimated the risk of homebirths.

Olsen conducted a meta-analysis of six observational studies that assessed the perinatal outcomes for 24,092 women having planned homebirths (Olsen, 1997), and included studies were deemed to be the best, methodologically. Olsen found that perinatal mortality was not significantly different between the home or hospital groups. However, there were significantly fewer babies born with low Apgar scores in the homebirth group, while for the women giving birth, there were fewer perineal lacerations, fewer inductions, augmentations, assisted vaginal births, caesareans and episiotomies. The authors concluded that homebirth is an acceptable alternative to hospital for women, and that homebirth leads to reduced intervention (Olsen, 1997). Despite the positive findings of the meta-analysis, upon close inspection, multiple methodological flaws are apparent, rendering its findings inapplicable to low-risk homebirth. At least two of the studies included had twin, breech and VBAC births. Births attended by lay midwives were also included. Two of the studies did not report whether the homebirths were planned or unplanned, so data on babies born before arrival would also have been included.

The level of evidence available shows that women with risk factors including twin, breech, and pre and post-term births may not expect as good neonatal outcomes when compared to low-risk homebirths; it is uncertain however how high-risk homebirths compare to high-risk hospital births. Despite this, higher-risk women who birth at home could expect to be exposed to fewer interventions and potentially have better maternal outcomes than if they decided to birth in hospital, but this may be to the detriment of their babies’ wellbeing.
Freebirth: safety risks and outcomes

There has been one investigation into the outcomes of births under the care of lay midwives. Durrand (1992) retrospectively analysed the pregnancy outcomes for 1,707 women between 1971 and 1989 who birthed through the homebirth service at ‘The Farm’ in America. These women were all attended by lay midwives, and the findings were compared to 14,033 hospital births attended by physicians (Durrand, 1992). Based on the rates of perinatal death, lower rates of Apgars and a composite analysis of labour complications in the homebirth group, it was concluded that under certain circumstances, homebirths attended by lay midwives can be accomplished as safely as physician-attended hospital births (Durrand, 1992). The homebirth group from ‘The Farm’ was considered to be very healthy and prepared for birth and also very low-risk (with the exception of some VBACs occurring after 1985), and this was a factor that contributed to the positive findings. However, due to the small number of participants and the retrospective nature of the study, conclusions about the risks or safety of freebirth or lay midwife-attended births could not be made from these data. However, mention of its existence seemed essential given the subject matter of this literature review.

Why women choose high-risk homebirth

There have been no studies specifically addressing the question of why women choose to birth at home if they are considered high-risk. In my search for literature, I singled out specific risk factors, such as twin pregnancies, VBAC and breech births. Establishing these parameters also yielded very little information. To date, there is a limited amount of literature that gives insight into why women shun medical management and pursue homebirth when they are deemed to be in a high-risk category. One study giving insight into why women with risk factors would choose homebirth has been identified.
Following on from the Symon et al (2009) UK study that has already been discussed, 15 case notes for 9 stillbirths and 6 neonatal deaths were analysed, and the independent midwives involved in the cases were interviewed (Symon, et al., 2009). The authors set out to examine independent midwives’ management and decision-making in these cases.

The 2009 study showed an overall higher perinatal mortality rate for women booked with independent midwives, compared to those cared for through the National Health Service (Symon, Winter, Donnan, & Kirkham, 2010). Homebirth was attempted in 13 of the 15 cases, and 13 of the 15 deaths occurred to women who had significant antenatal risk factors, including four twin pregnancies, three planned VBACs, two VBAC breech presentations and cases of maternal illness; only two of the women were low-risk at the time of their antenatal booking. Midwives reported that the women involved took great responsibility and expressed a willingness to accept a positive or negative outcome provided that they made the decisions. Despite the advice of their midwives, many of the women declined various antenatal and intrapartum screening services, and some refused transfer to hospital. One midwife suggested that some women declined entering the hospital because they feared it. In three cases, the midwives stated that the women would have definitely birthed unassisted had they declined to continue caring for them; a further three suggested they probably would have. It was found that several women made their choices in order to avoid risks that they saw as important. In five of the cases, the women told their midwives that they wanted to avoid hospital birth due a previous traumatic experience. Seven of the cases were deemed unpreventable, and in the other eight it was thought that elective caesarean may have produced a more positive outcome, although in seven of these cases the women had declined this option. The women reported that they had declined due to previous traumatic experiences, and some wanted to prioritise ‘low-tech’ care. Hospital-based management was considered an unacceptable compromise for them. The authors concluded that, ‘the women in this review had
reportedly accepted the potential consequences of their high-risk situations’ and that ‘if reality is to match rhetoric about patient autonomy, such decision-making in high-risk situations must be accepted’ (Symon, et al., 2010, p. 280). It is important to note, however, that the women were not interviewed, and that they may well have had different recollections of their care to that of the midwives.

**The choice to freebirth**

There is a limited amount of literature on the topic of freebirth, nonetheless, this review addresses the literature that is relevant to what motivates women to choose freebirth.

Brown (2009) undertook a study for her Masters degree entitled ‘Birth Visionaries: An Examination of Unassisted Childbirth,’ in which she explored women’s motivations for choosing unassisted childbirth and their lived experience of unassisted childbirth. Her study analysed nine interviews using a grounded theory approach. Brown (2009) states that ‘women who birth unassisted are as far from the common medical model that you could get, they represent the extreme rejection of the normative way of giving birth’ (Brown, 2009, p. 2). Out of 26 women who matched her selection criteria, Brown chose to interview nine, although she did not make clear her reasons for this choice. By birthing unassisted, Brown (2009) reports that the women in her study were rejecting medical models of birth. Furthermore, she contends that in the majority of these cases, their choice emerged as a result of previous traumatic experiences, and the sense that the medical establishment claims control over the mother. The feeling of lack of agency was intensified in the participants who fell into a ‘high-risk’ category. Women’s traumatic experiences were reportedly due to previous disrespectful treatment, leaving them feeling violated, disempowered and angry. Furthermore, all the women reported having to fight to get the kind of care they wanted in the hospital, which subsequently motivated them...
to birth unassisted. The women rejected medical management because they perceived its routine interventions to be unnecessary; however, Brown reports that ‘these women do not object to medical intervention when it is necessary, but they believe the vast majority of medical interventions in childbirth today are unnecessary and potentially harmful’ (Brown, 2009, p. 22). After an initial rejection of the medical model, the participants in Brown’s study went on what she calls, ‘the search for alternatives.’ In so doing, the women discovered their ability to resist medical authority and challenge the birthing norm. Brown suggests that by pursuing freebirth, the women were honouring their desire to listen to their own bodies and their own ‘inner knowledge,’ rather than deferring to a conventional paradigm of medical knowledge. In addition, the decision to freebirth sprung from the legal circumstances around homebirth in America, preventing them from having access to midwives and making the midwives more reluctant to assist at homebirths (Brown, 2009). As Brown notes, ‘the radical choice to birth unassisted grows to seem practical given the hostile circumstances of birth environments otherwise available’ (Brown, 2009, p. 40).

Turton’s (2007) Masters thesis ‘Going it Alone,’ describes her investigation into unattended birth in the UK and USA. Turton (2007) included a section on the motivations to practise unattended birth, which is of most interest for this literature review. Turton (2007) analysed a number of online forums in order to make conclusions about the motivations behind the choice to freebirth. Data were also gathered from magazines, newspapers and online forums and websites. There was no information offered as to how the data were collected or analysed. She concluded that there are three overarching motivations for women choosing freebirth: to minimise interventions, a belief that a woman is her own best care-giver; and a previous traumatic birth experience (Turton, 2007).
Turton herself states that there are no data regarding the safety of freebirth, and that making conclusions from both ‘born before arrival’ and planned homebirth statistics is problematic for various reasons. However, she then concludes that the absence of a trained care provider is ‘likely to increase morbidity’ (Turton, 2007, p. 9). This may be a result of the potential bias against freebirth; Turton states earlier in her thesis that she was ‘skeptical of the acceptability of a practice that appears to unnecessarily introduce risk to mother and foetus,’ (Turton, 2007, p. 3).

In her PhD thesis, ‘Born Free: Unassisted Childbirth in North America,’ Freeze (2008) states that ‘unassisted birth is truly off the grid in many ways: it lies outside of social control, governmental surveillance and medical or professional supervision. It challenges the canonical knowledge about birth, moving outside of the boundaries of both obstetrical and midwifery texts and practice’ (Freeze, 2008, p. 25). Freeze’s research aims to leave her audience with ‘a fair and complete understanding of why women choose unassisted birth’ (Freeze, 2008, p. 16). A significant portion of her research was internet-based, involving over 100,000 posts about unassisted birth. She also included 61 survey responses, 17 phone interviews and email correspondence with five midwives as data. Freeze (2008) found that the women who embraced unassisted birth did so out of a deep trust in the inherent safety of the birth process and a belief in a woman’s innate ability to give birth. Furthermore, Freeze found their choice to be a reaction to the increasing medicalisation of pregnancy and birth (Freeze, 2008). Choosing to birth unassisted is a choice made through relationships and within a community that shares a core set of beliefs, Freeze reports. However, it can also be a last-resort option where women feel cornered into making the choice because of a lack of other acceptable birth options. In her findings, Freeze ranks the reasons why women choose unassisted birth from most to least common in the following order: ‘dangers of hospitals and unnecessary
interventions,’ ‘trust and confidence in birth and their bodies,’ ‘privacy,’ ‘autonomy and control,’ ‘lack of midwives/midwives were a bad fit,’ ‘safety,’ ‘comfort and peace of home environment,’ ‘birth as a family event,’ ‘always wanted a homebirth/unassisted birth,’ ‘belief in instinct/intuition,’ ‘wanting to avoid birth trauma or a previous traumatic birth,’ ‘just felt right,’ ‘do-it-yourself ethic,’ and ‘desire to take responsibility for the birth’ (Freeze, 2008, p. 94). In regards to safety, Freeze argues that, ‘even with the best designed study about unassisted childbirth; we would never satisfactorily end the debate about safety’ (Freeze 2008, p. 197). She contends that safety for women who choose unassisted birth is not an issue of statistics but rather stems from a belief system. Freeze concludes that ‘the debate over safety is a struggle over who, if anyone, should have the monopoly on defining which behaviours are appropriate and what are not ... [the] safety debate sits at the heart of a fundamental philosophical divide between women’s autonomy and institutional control’ (p. 198). Freeze’s research is a helpful addition to the literature on why women choose freebirth.

In her article ‘Midwife to Myself,’ Miller (2009) uses detailed narratives about freebirth experiences to inform her study, and describes freebirth as ‘a deviant decision’ (p. 53). Miller (2009) searched the internet for forum posts and websites, locating 127 freebirth stories. She then interviewed six women who had experienced freebirths, reporting that ‘the in-depth interviews allowed for some verification of the commonality of the online stories as well as the opportunity for further exploration through questioning of some of the key points in the published stories’ (Miller, 2009, p. 61). Although the number of women interviewed was small, their stories were similar to those narratives found online. Miller (2009) presents her findings under two headings. Under the heading ‘the decision to birth unassisted,’ she explains that most women who choose to freebirth had initially intended to have a midwife-attended homebirth, and were averse to medical
management of birth from the outset. In these circumstances, the decision to freebirth resulted from their research into birthing options, which introduced them to the concept of freebirth. Miller (2009) reported that most commonly, the participants chose to freebirth because the options of medical and/or midwifery care were considered and rejected due to the participant’s fundamental rejection of the biomedical discourse around birth. Under the second heading, ‘how I wanted it to happen,’ she describes the independence and self-determination expressed by these women as they pursued their choice (Miller, 2009).

Although there is some research into why women choose to freebirth in the USA and UK, there is no research to date on why more Australian women are making this choice. What we currently know about the choice to freebirth in other countries is that it is motivated by a rejection of a medical model of birth, combined with a belief in the intrinsic safety of the birth process and a woman’s instinctive capacity to give birth. In their rejection of a medical birthing model, women who freebirth are valorising their own knowledge over medical knowledge, and demonstrating a desire to exercise volition when they give birth. The women perceived freebirth to be a better choice when they considered their options, because it allowed them to avoid unnecessary or harmful interventions, and to experience a more natural birth. For many women, the choice to freebirth was a reaction to their previous birth experiences, which left them traumatised and stripped of a sense of control. Finally, women chose freebirth as a reaction to the increasing medicalisation of pregnancy and birth, and out of a lack of what they perceived to be acceptable birthing alternatives.

**Conclusion**

This chapter explored the literature on the safety and outcomes of low and high-risk homebirth. While the safety of homebirth for low-risk women is supported with
evidence, the same cannot be said for high-risk homebirth or freebirth. Why women with risk factors make the choice to freebirth or have a homebirth is a question that has had little investigation. The available literature has been discussed in this chapter. To date, there is limited Australian research offering any sort of insight into why women make the decision to birth outside the system. The lack of existing literature renders this an ideal research topic. The next chapter will detail the methods used in this study.
Chapter Three: Research method chapter

Introduction

This chapter describes the grounded theory method used for this research. Firstly, it is briefly explained that grounded theory is a qualitative research method designed to yield a theory that is grounded in the data. The principles of using grounded theory are then explored in detail. This study was based upon what Birks and Mills (2010) term the ‘ten essential elements of grounded theory,’ which have been suggested based on the earlier work of Glaser and Strauss, the inventors of grounded theory. The essential grounded theory elements used were: initial coding and categorisation of data, concurrent generation or collection of data and analysis, writing memos, theoretical sampling, constant comparative analysis, theoretical sensitivity, intermediate coding, identifying a core category, advanced coding and theoretical integration and generating a theory (Birks & Mills, 2011). Following this, the suitability of grounded theory for this research is explained, along with details of how my research was undertaken. Recruitment methods are explained, including the use of a snowball sampling method and theoretical sampling. Following this, how ethical conduct was maintained through the interview and data collection process will be explained, followed by the types of data used for this study. Following the discussion on data collection is an explanation of how the data were analysed. The place of philosophical assumptions of researchers will also be explored along with a declaration of my own personal philosophies and understandings. The strengths and weaknesses of grounded theory will also be elucidated. A discussion on determining quality and rigour in grounded theory research will be offered, including examples of how this study demonstrates the qualities of a rigorous research process. This chapter integrates explanations of grounded theory, alongside demonstrations of how this theory was applied and executed for this study.
**What is grounded theory?**

Grounded theory is a qualitative research method and ‘the word qualitative implies an emphasis on the qualities of entities and on processes and meanings’ (Denzin & Lincoln, 2005, p. 10). Qualitative methods are used to study phenomena in an attempt to ‘make sense of, or interpret them’ (Denzin & Lincoln, 2005, p.3). The benefit of qualitative designs is that they can be used where comparatively little is known about a subject, because the purpose is exploratory rather than explanatory (Gerrish & Lacey, 2006). They are also useful when attempting to ‘explore an experience, culture or situation in depth, taking account of context and complexity’ (Gerrish & Lacey, 2006, p. 21).

Developed by Barney Glaser and Anselm Strauss, grounded theory is explicated in their seminal book, *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). While undertaking their study on dying, Glaser and Strauss developed systematic strategies that allowed them to develop theories inductively, grounded in their data (Charmaz, 2006). After using and refining grounded theory methods in conducting their own study, they suggested that the components that should define grounded theory must include concurrent data collection and analysis where the researcher collects and analyses data contemporaneously, which allows the researcher to taper their data collection around their emerging findings. Analysis should involve the construction of codes and categories from the data; this is an essential component of grounded theory. Coding can be done using a line-by-line strategy, which helps the researcher break down the data and categorise it, allowing for it to be subsequently rebuilt and developed into an overarching theory. Glaser and Strauss also stress the imperative of applying constant comparative analysis to advance theory development, memo-writing, theoretical sampling to recruit participants and the use of literature after independent analysis (Charmaz, 2006; Glaser & Strauss, 1967). These essential elements of grounded theory will be explored and
explained later in this chapter, with specific reference to how they were applied to this study.

The purpose of grounded theory is to produce a theory (Glaser, 1992). The analysis and final findings should not develop out of a preconceived idea about a phenomenon, but rather be grounded in the data. At the end, the research product is a theoretical formulation or a set of conceptual hypotheses; the yield from grounded theory research is just hypotheses, grounded in the data (Glaser, 1992). Glaser and Strauss (1967) proposed that a theory should have explanatory and predictive power (Glaser & Strauss, 1967). Throughout data collection and simultaneous data analysis, the researcher observes emerging themes and ultimately formulates a resounding theory that overarches and defines what has emerged from the research process. A grounded theory should be inductively derived and is discovered, developed and verified through systematic data collection and analysis. One does not begin with a theory; rather, the researcher begins with an area of study, and what is relevant is allowed to emerge throughout the research process (Strauss & Corbin, 1990).

In the years since their seminal study, Glaser and Strauss have taken grounded theory in divergent directions, and are in fact no longer in agreement about how grounded theory research should be conducted (Charmaz, 2006). The catalyst for Glaser and Strauss’ parting of ways was Strauss’ collaboration with Juliet Corbin to write the book *Basics Of Qualitative Research* (1988). This prompted Glaser to respond by writing the book *Emergence vs Forcing: Basics of Grounded Theory Analysis*, (1992) in which he asserts that Strauss perverts the method of grounded theory by encouraging users to force findings from the data, rather than allowing them to simply emerge. From Glaser’s perspective, emergence is an essential element to ensure that the final theory is grounded in the data.
Glaser’s stance is that by the application of grounded theory principles – such as constant comparison and coding and analysing – categories and their properties will emerge. Glaser posits this as a fundamental difference between grounded theory and other qualitative research methods (Glaser, 1992), going on to observe that although Strauss and Corbin describe a legitimate way of conducting research, it can not accurately be described as grounded theory. This schism has opened up opportunities for other authors to suggest strategies for the successful use of grounded theory; at the same time, however, it renders the terrain problematic for the novice researcher, who must arrive at their own conclusions about which approach is most likely to produce a theory grounded in the data. While I personally gravitate more to a Glaserian approach, I will explain why the rigid adherence to one theorist’s methods is not as important as it may seem.

Using grounded theory

Many authors have written about how grounded theory should be used, and the novice researcher can easily become confused about how best to proceed. Using grounded theory is a daunting task in any case, because conducting the research poorly would mean that a grounded theory is not produced. As Birks and Mills explain, ‘if the process of abstraction is inadequately demonstrated, there will be doubts about how effectively this theory is grounded in the data’ (Birks & Mills, 2011, p. 16). Birks and Mills (2011) suggest that ‘[m]ethodologically, there are no right or wrong approaches to using grounded theory methods,’ (p. 7); instead, they contend that ‘there is a set of methods essential to grounded theory research design that must be used in order for the final product to be considered as such’ (p. 5). It is not necessary to subscribe exclusively to one version of grounded theory, Birks and Mills contend. Furthermore, they note that the researcher’s philosophical position will partly contribute to their gravitation towards some authors
and not others. Charmaz (2006) adds to this, explaining that ‘grounded theory methodology consists of systematic yet flexible guidelines for collecting and analysing qualitative data ... the guidelines offer a set of general principles and heuristic devices rather than formulaic rules’ (Charmaz, 2006, p. 2).

Based on the original work of Glaser and Strauss, researchers Birks and Mills (2011) suggest ten essential elements that should be used in the research process if a grounded theory is to be produced. These are: initial coding and categorisation of data, concurrent generation or collection of data and analysis, writing memos, theoretical sampling, constant comparative analysis, theoretical sensitivity, intermediate coding, identifying a core category, advanced coding and theoretical integration and generating a theory.

Given that Birks and Mills (2011) and Charmaz (2006) suggest approaching grounded theory under the guidance of its general principles, and the general principles that they propose are similar to that of the creators of grounded theory, Glaser and Strauss, the application of Birks and Mills’ (2011) suggestion of adhering to the ten essential elements seems appropriate. These ten essential elements will be explored in detail in this chapter.

**Suitability of grounded theory for this research**

As has been noted in the literature, grounded theory is particularly helpful for research topics where there is little or no existing theory to guide the research process (Artinian, Giske, & Cone, 2009; Birks & Mills, 2011). Explains Glaser, ‘if there is virtually no work in the area or just the barest of straight descriptions, then the grounded theory opens up the area with relevant concepts and hypotheses and has many directions and leads for future research’ (Glaser, 1992, p. 32). Grounded theory is an apposite approach for an under-researched area such as *birth outside the system*, because it will pave the way for future research in the area. Indeed, Glaser explicitly favours ‘areas that need opening up as the
richest focus for grounded theory or a field with a sparse amount of literature, so contributions are clear and strong’ (Glaser, 1992, p. 34).

Grounded theory serves to answer ‘why’ questions in addition to the ‘what’ questions of the phenomena being studied, thus resulting in the generation of new knowledge (Birks & Mills, 2011). This renders it an ideal tool with which to pose the question ‘what motivates women to birth outside the system?’ Because a qualitative study examining birth outside the system has never been undertaken in Australia, there is no existing theory or data to guide the research process; grounded theory can therefore dynamically and directly address the research question. Additionally, grounded theory is used whenever the researcher aims to move past mere description in order to offer an explanation of the phenomenon under investigation (Birks & Mills, 2011).

**Undertaking grounded theory research**

This next section provides the specific detail of how I applied the method of grounded theory to discover what motivates women to birth outside the system. I will start by explaining the recruitment methods used in grounded theory and how these were applied in this study, along with details of my participant inclusion criteria. Following this, the ethical decisions made during this research will be explained. I will then move on to describe the different types of data collection that can be used for grounded theory and the type of data that were collected for this study. The majority of data used for this research were collected by interview. Following this, I will provide a detailed explanation of how these data were analysed using grounded theory methods.

**Recruitment methods and participants**

The process of selecting research participants for grounded theory studies differs from that of other research methods. Grounded theory relies on the use of ‘theoretical
sampling,’ which is unique to grounded theory and is thought to be responsible for making the research process an emergent one (Birks & Mills, 2011, p. 69). Glaser and Strauss (1967) defined theoretical sampling as ‘the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses the data and decides what data to collect next and where to find them, in order to develop his theory as it emerges’ (p. 45). Theoretical sampling allows the researcher to gather more data that focuses on a specific category or emerging theme, seeking and collecting pertinent data to elaborate and refine categories as the theory emerges (Charmaz, 2006). Theoretical sampling is used to focus and feed constant comparative analysis and helps the researcher to saturate categories by finding more about each category’s properties (Birks & Mills, 2011). Theoretical sampling is conducted to develop the properties of your categories until no new properties emerge (Charmaz, 2006).

At the beginning of data collection in grounded theory, a ‘snowball’ method of participant recruitment is used. Snowball sampling is a technique for developing a research sample where existing study subjects recruit future subjects from among their acquaintances. The sample group thus grows like a rolling snowball. This sampling technique is often used in hidden populations that are difficult for researchers to access (Gerrish & Lacey, 2006). As explained by Birks and Mills (2011), the starting point of theoretical sampling is that your initial sampling will be purposeful, whereby the researcher identifies a source of data relevant to the area of study and proceeds from there. For this research project, I started by interviewing two acquaintances, one who had experienced a high-risk homebirth, and another who had chosen to freebirth; these two women were purposefully selected to commence the study. From there, a snowball method was used in conjunction with careful screening of respondents, which enabled me to sample theoretically and ensure that potential participants fitted the participant
criteria. A call for participants was also made at an Australian homebirth conference in July 2010. Twenty women responded, providing relevant detail about how they complied with the participant criteria. As the study progressed, participants where theoretically sampled based on the information they had offered about their experience during recruitment, rather than me personally interviewing every respondent. This approach is in line with the principles espoused by Charmaz (2006), who believes that theoretical sampling only becomes of value once your categories have been developed, as this enables the researcher to confirm and clarify these categories. This approach was helpful for me, since the number of participants from whom data could have been collected from was small. Corbin and Strauss (2008) suggest that it is necessary at times to accept what is available, and that every effort should be made to apply the principles of theoretical sampling within these constraints (Corbin & Strauss, 2008). Similarly, Birks and Mills (2011) contend that a ‘lack of access to data sources can often impede attempts to employ theoretical sampling’ (Birks & Mills, 2011, p. 72). In total, the stories of 28 women were included in the data for this research, 13 who had chosen homebirth and 15 who had chosen freebirth. Eleven women who had chosen homebirth were interviewed, with the additional two women’s stories being sourced from the National Maternity Review (of 2009) and the internet respectively. Nine women choosing freebirth were interviewed, with the remaining six sourced from the NMR submissions.

For Birks and Mills (2011), the ‘application of theoretical sampling in its purest form would see you undertake a single data collection event followed by analysis of the data’ (p. 71), which as you can see by the ‘audit trail’ below, was executed for the majority of my study. In response to this Birks and Mills suggestion, at the end of each participant interview, I revised the key prompts or questions for the next participant, based on what was discovered in previous interviews. Broad and open-ended, my questions were aimed
at discovering new information that had not yet been explored. The questions were also a means of clarifying existing ideas that were developing through the research. In line with the principles of theoretical sampling, and as the analysis progressed, women whose stories sounded familiar and related to categories that were already considered ‘saturated’ were not pursued for information, while those who expressed a new idea were recruited for interview. This allowed new information to be generated through the process of theoretical sampling.
<table>
<thead>
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<th>Date</th>
<th>Task completed</th>
<th>Correlating GT stage/principle</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/8/2010</td>
<td>Interview (1) FB01</td>
<td>Data collection</td>
</tr>
<tr>
<td>3/8/2010</td>
<td>Field notes and memos written about interview FB01</td>
<td>Data generation – memo writing</td>
</tr>
<tr>
<td>4–6/8/2010</td>
<td>Initial coding of FB01 transcript (manual)</td>
<td>Initial coding, concurrent data analysis and collection</td>
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<td>6/8/2010</td>
<td>Interview (2) HB01</td>
<td>Data collection</td>
</tr>
<tr>
<td>7–12/8/2010</td>
<td>Initial coding of HB02 transcript (manual)</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison</td>
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<tr>
<td>19/8/2010</td>
<td>Interview (3) FB02</td>
<td>Data collection</td>
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<tr>
<td>19/8/2010</td>
<td>Field notes and memos written about interview FB02</td>
<td>Data generation – memo writing</td>
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<tr>
<td>25/8/2010</td>
<td>Interview (4) HB02</td>
<td>Data collection</td>
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<td>13/9/2010</td>
<td>Interview (5) HB03</td>
<td>Data collection</td>
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<tr>
<td>13/9/2010</td>
<td>Field notes and memos written about interview HB03</td>
<td>Data generation – memo writing</td>
</tr>
<tr>
<td>14–17/9/2010</td>
<td>Initial coding of HB02 &amp; HB03</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison</td>
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<tr>
<td>17–20/9/2010</td>
<td>General memos written about developing thoughts</td>
<td>Data generation – memo writing</td>
</tr>
<tr>
<td>23/9/2010</td>
<td>Attended meeting of homebirth/freebirth mothers’ group in the Blue Mountains, New South Wales, to discuss emerging findings</td>
<td>Member checking</td>
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<tr>
<td>23/9–4/10/2010</td>
<td>Memo writing and documentation of developing ideas</td>
<td>Data generation – memo writing</td>
</tr>
<tr>
<td>30/9/2010</td>
<td>Interview (6) HB04</td>
<td>Data collection</td>
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<tr>
<td>30/9/2010</td>
<td>Memos and field notes written about HB04 interview</td>
<td>Data generation – memo writing</td>
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<tr>
<td>4/10/2010</td>
<td>Interview (7) HB05</td>
<td>Data collection</td>
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<tr>
<td>4/10/2010</td>
<td>Memos and field notes written about HB05 interview</td>
<td>Data generation – memo writing</td>
</tr>
<tr>
<td>13/10/2010</td>
<td>Interview (8) HP01</td>
<td>Data collection</td>
</tr>
<tr>
<td>2/11/2010–15/11/2010</td>
<td>Initial coding of HB04 &amp; HB05 along with resulting memos</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
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<tr>
<td>3/11/2010</td>
<td>Interview (9) FB03</td>
<td>Data collection</td>
</tr>
<tr>
<td>Date</td>
<td>Activity Description</td>
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<tr>
<td>17/11/2010</td>
<td>Initial coding FB03 and subsequent memo writing</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
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<tr>
<td>18/11/2010</td>
<td>Interview (10) HB06</td>
<td>Data collection</td>
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<tr>
<td>21/11/2010</td>
<td>Read <em>The Emperor's New Clothes</em> (childrens book)</td>
<td>Using literature as data, data generation – memo writing</td>
</tr>
<tr>
<td>22/11/2010</td>
<td>Interview (11) HB07</td>
<td>Data collection</td>
</tr>
<tr>
<td>23/11/2010</td>
<td>Memo writing and documentation of developing ideas during a conference about the concept of power</td>
<td>Data collection – using literature as data, data generation – memo writing</td>
</tr>
<tr>
<td>27/11/2010</td>
<td>Interview (12) FB04</td>
<td>Data collection</td>
</tr>
<tr>
<td>30/11/2010</td>
<td>Interview (13) HB08</td>
<td>Data collection</td>
</tr>
<tr>
<td>1/12/2010</td>
<td>Watched film <em>Temple Grandin</em> (2010, dir. Mick Jackson) for data, quotations and to generate ideas listed in memos</td>
<td>Everything is data, data generation – memo writing</td>
</tr>
<tr>
<td>2/12/2010</td>
<td>Meeting with research supervisors, generated memos</td>
<td>Data generation – memo writing</td>
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<tr>
<td>6/12/2010</td>
<td>Initial coding findings and memos used to write a storyline about findings to date in the data set</td>
<td>Storyline</td>
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<tr>
<td>8/12/2010</td>
<td>Initial coding continues of FB04 and subsequent memo writing</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
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<td>8/12/2010</td>
<td>Interview (14) FB05</td>
<td>Data collection</td>
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<tr>
<td>16/12/2010</td>
<td>Initial coding of HB06 &amp; HB07 with subsequent memo writing</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
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<td>20/12/2010</td>
<td>Interview (15) FB06</td>
<td>Data collection</td>
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<td>31/1/2011</td>
<td>Initial coding of FB05</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison</td>
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<td>1/2/2011</td>
<td>Read book <em>Birth Crisis</em> by Sheila Kitzinger, subsequent memos made</td>
<td>Using literature as data, data generation – memo writing</td>
</tr>
<tr>
<td>2/2/2011</td>
<td>Met with research supervisors, generated memos</td>
<td>Data generation – memo writing</td>
</tr>
<tr>
<td>8/2/2011</td>
<td>Interview (16) FB07</td>
<td>Data collection</td>
</tr>
<tr>
<td>8/2/2011</td>
<td>Interview (17) FB08</td>
<td>Data collection</td>
</tr>
<tr>
<td>14/2/2011</td>
<td>Interview (18) HP02</td>
<td>Data collection</td>
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<tr>
<td>15/2/2011</td>
<td>Initial coding of FB07 &amp;</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison</td>
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<tr>
<td>Date</td>
<td>Event Description</td>
<td>Notes</td>
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<tr>
<td>15/2/2011</td>
<td>Data from blog site suggested by FB08 and internet birth stories added to data for analysis</td>
<td>Everything is data, data collection</td>
</tr>
<tr>
<td>15/2/2011–3/3/2011</td>
<td>Continued analysis and subsequent memos of collected data</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
</tr>
<tr>
<td>3/3/2011</td>
<td>Initial coding of HB08 with subsequent memos generated</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
</tr>
<tr>
<td>4/3/2011</td>
<td>Watched documentary <em>The Business of Being Born</em> memos generated</td>
<td>Everything is data, data collection, data generation – memo writing</td>
</tr>
<tr>
<td>13/4/2011</td>
<td>Interview (19) HB09</td>
<td>Data collection</td>
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<td>15/4/2011</td>
<td>Interview (20) HB10</td>
<td>Data collection</td>
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<tr>
<td>30/4/2011</td>
<td>Attended Nvivo training course and made decision to move to electronic data analysis instead of manual/paper-based analysis. Moved existing analysis into Nvivo</td>
<td>Data analysis</td>
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<td>5/5/2011</td>
<td>Presentation of initial findings at midwifery conference</td>
<td>Presentation</td>
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<tr>
<td>9/5/2011</td>
<td>Interview (21) HB11</td>
<td>Data collection</td>
</tr>
<tr>
<td>9/5/2011</td>
<td>Field notes and memos written about interview HB11</td>
<td>Data generation – memo writing</td>
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<tr>
<td>9/5–16/6/2011</td>
<td>Initial coding and data analysis continues, including entering data into Nvivo</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
</tr>
<tr>
<td>9/6/2011</td>
<td>Presentation of initial findings at midwifery conference</td>
<td>Presentation</td>
</tr>
<tr>
<td>1/7/2011</td>
<td>Nvivo coding of HB05</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
</tr>
<tr>
<td>5/7/2011</td>
<td>Presentation of initial findings at midwifery conference</td>
<td>Presentation</td>
</tr>
<tr>
<td>7/7/2011</td>
<td>Commenced writing paper for publication on findings on ‘risk’</td>
<td>Data analysis</td>
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<tr>
<td>7/7–</td>
<td>Continued writing for</td>
<td>Data analysis</td>
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<tr>
<td>Date</td>
<td>Event Description</td>
<td>Category</td>
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<tr>
<td>10/8/2011</td>
<td>publication and initial coding using ‘Nvivo’</td>
<td></td>
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<tr>
<td>29/8/2011</td>
<td>Met with research supervisors, generated memos and made decision to complete initial coding by November 2011</td>
<td>Data generation – memo writing</td>
</tr>
<tr>
<td>31/8–15/9/2011</td>
<td>Initial coding of interview transcripts using Nvivo</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
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<tr>
<td>22/9/2011</td>
<td>Commenced writing ‘method’ chapter for thesis document</td>
<td>Writing</td>
</tr>
<tr>
<td>26/9–6/10/2011</td>
<td>Initial coding of interview transcripts using Nvivo</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
</tr>
<tr>
<td>9/10/2011</td>
<td>Accessed maternity review submissions to be used as data</td>
<td>Data collection</td>
</tr>
<tr>
<td>10/10–12/10/2011</td>
<td>Initial coding of interview transcripts using Nvivo</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
</tr>
<tr>
<td>17–18/10/2011</td>
<td>Initial coding of maternity review submissions in Nvivo</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
</tr>
<tr>
<td>19/10/2011</td>
<td>Presentation of initial findings at midwifery conference</td>
<td>Presentation (Glaser suggests this)</td>
</tr>
<tr>
<td>25/10–31/10/2011</td>
<td>Initial coding of interview transcripts and maternity review submissions using Nvivo</td>
<td>Initial coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
</tr>
<tr>
<td>31/10/2011</td>
<td>Moved from initial coding to intermediate coding within Nvivo to merge data</td>
<td>Intermediate coding, concurrent data analysis and collection, constant comparison and data generation with memo writing</td>
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<tr>
<td>31/10/2011–27/2/2012</td>
<td>Intermediate data analysis moved from Nvivo back to manual/paper-based analysis using diagrams to track development of categories and theory</td>
<td>Intermediate coding, concurrent data analysis and collection, constant comparison and data generation with memo writing, use of diagrams</td>
</tr>
<tr>
<td>27/2–26/3/2012</td>
<td>Use of storyline and diagrammatic representation of findings and concepts for data analysis</td>
<td>Advanced coding, storyline and use of diagrams</td>
</tr>
<tr>
<td>27/3/2012–30/6/2014</td>
<td>Thesis development</td>
<td>Presentation and dissemination of findings</td>
</tr>
</tbody>
</table>
Continuing on from the discussion on theoretical sampling is the inclusion criteria for the participants that was applied at the start of this study:

**Freebirth Participants:**

- Have had a freebirth in the past
- Are pregnant and are planning a freebirth
- Are intending to have a freebirth in the future
- Women classified as both low or high-risk
- Participants were included in this study if their intention was to birth unassisted, and they then required assistance or transfer during the pregnancy or at the time of labour and birth

**High-risk homebirth participants:**

- Have had a high-risk homebirth in the past
- Were presently experiencing a high-risk pregnancy and were planning a homebirth
- Were aware that future pregnancies will be considered high-risk and were intending on planning a homebirth in the future
- Participants were included if their original intention and plan was to birth at home, and they then required transfer during pregnancy or at the time of labour and birth

The criteria were defined as such because I was interested in what motivated a woman’s choice to birth outside the system. Whether or not the woman had achieved a birth outside the system was therefore irrelevant, because what was important were the factors that had led them to consider this birthing option in the first place. Women interested in participating in this study were given this criteria and asked which one they believed they satisfied before they were recruited to the study. In line with the principles of grounded theory, other participants – including midwives and doulas – were interviewed as the research progressed. The individual midwives and doulas were interviewed as they were mentioned as key players in the woman’s choice to birth outside the system; thus their input would likely shed further light on the motivators behind this choice. One midwife and one doula were interviewed, as well as an anthropologist whose work was of interest to this study. These participants were mentioned by name by the women interviewed, and I personally contacted these people to ascertain whether they would be interested in
participating in the study. Relevant information about the project was sent to them by
email, and they were asked to respond if they were interested, which they did. I felt it
important to interview them to gain a better understanding of what the women had been
speaking about, and in order to delve deeper into the subject matter. While these
professionals were interviewed, their interviews were not analysed. By speaking with
them personally, however, I was able to gain a deeper understanding of the women’s
perspectives, which in turn allowed me to more confidently understand and analyse the
women’s stories. To provide some insight into the women who were interviewed, their
short (de-identified) stories are provided in the Appendices section at the end of this
thesis.

*Ethical considerations for this research*

The choice to *birth outside the system* is an uncommon one, and the women who make this
choice are portrayed as negligent and ignorant and are often judged by society (Squires,
2011). In the context of contemporary western culture, women who *birth outside the system*
are a marginalised minority, and this raises specific ethical considerations for this
research.

As noted by Stake (1993), ‘[q]ualitative research is seen as potentially volatile, even
hazardous, requiring careful consideration and preparation’ (Stake, 1994, p. 83). As a
researcher, I was aware of the potential for my research activities to disturb the
participants, and thus I was aware of the risk of exploiting an already vulnerable
population. Creswell suggests actively seeking to address any power imbalances between
the researcher and the participants (Creswell, 2007). Acts such as identifying that the
participants own their stories and information, and that they are at liberty to withdraw
from the study at any time, being respectful toward the participant by using their name
and employing language that they can understand, and being non-judgemental toward
their choices – all of this empowers the participants and thus reduces the risk of exploitation or further marginalisation (Creswell, 2007). To facilitate an equitable power balance, participants in my study were given ample opportunity to ask about the research process and findings, and also to enquire about the researcher’s interest in the research. Several of the participants availed themselves of the opportunity to pose questions, with one woman asking, ‘what is this going to mean for freebirth? Will finding this stuff out mean it will be harder for women to freebirth?’ (FB01). I felt it was important to maintain transparency in the research process and allow participants to air any concerns or questions about the research and about myself. From my experience as a midwife, I have found women who make alternative birth choices to be generally inquisitive, curious, skeptical and assertive, so I knew from the outset that there would be some suspicion and interest in my motivation for the study. In anticipation of this, I consciously prepared and was willing to offer this information. This approach is supported by Birks and Mills, who discuss strategies to ensure that the researcher and the participants have an equal share of power, and that the interview process is closely aligned with the ethical principle of beneficence (first do no harm) (Birks & Mills, 2011). For example, all participants in my study were given a choice as to where they would like to conduct their interview, affording them input that would determine certain aspects of the process. Face-to-face interviews were all conducted in the women’s respective homes. When in their homes, I made concerted efforts to be honouring and respectful by removing my shoes upon entry, commenting favourably on aspects I found pleasing about their home environment, asking them where they would like me to sit, eating and drinking whatever they had prepared for me, commenting on family photos in the home, engaging in conversation on topics other than the research project, greeting other people in the home (including their children), ensuring pleasant interaction, and thanking them for their time and generosity in participating.
With qualitative research, most ethical concerns centre on the issues of harm, consent, deception, privacy and confidentiality (Stake, 1994) and the moral principles of respect and beneficence (Marshall & Rossman, 2011). In order to address all of these issues, and to comply with the ethical requirements of the institution at which my doctoral candidature took place, ethics approval for this research project was sought and gained from the University of Western Sydney Human Research Ethics Committee (Approval Number: H8248) through the submission of a National Ethics Application Form (NEAF). Although ethics approval was sought and gained through due process for this research project, Marshall and Rossman (2011) rightly assert that ‘ethical practice is on-going’ (p. 48). That is, ethical conduct is not judged merely on the researcher’s ability to collect and store participants’ signatures on informed consent forms and distribute information leaflets. Rather, ethical conduct of a research project requires continual sensitivity of the researcher toward the participant group, and this is something that was taken very seriously throughout the entirety of my research project.

It is considered an essential ethical requirement that research participants express informed consent. As Stake puts it, ‘the subjects of the research have the right to be informed that they are being researched and also about the nature of the research,’ after which time they should sign an ‘informed consent’ form, which also advises that they are able to withdraw their consent at any time (Stake, 1994, p. 90). In line with this, and in accordance with NEAF requirements, consent forms were drafted for this project (included in the Appendices section at the end of this thesis) and given to the potential participants before being recruited, as were information sheets detailing key aspects of the study (also in the Appendices section) These were given to women before conducting their interviews to ensure that they were fully informed before participating, and to avoid any deception or coercion of the participants. The consent form informed
participants that they were free to withdraw from the study at any time during or after the data collection process. None of the participants requested to withdraw from the study.

According to Stake, ‘[c]onventional practice and ethical codes espouse the view that various safeguards should protect the privacy and identity of research subjects’ (Stake, 1994, p. 92). To maintain confidentiality, the consent forms and identifiable data remained in a secure locked environment, in accordance with the University of Western Sydney’s Record Management Policy. Only the academics (Melanie Jackson, Hannah Dahlen and Virginia Schmied) involved in this research had access to identifiable data. Furthermore, all data were de-identified for publication and presentations, in order to protect the identities of the participants. Other information – such as details about their residential location, or the names of health care institutions with which they engaged – was removed to maintain anonymity. There is general consensus amongst researchers that settings and respondents should not be identifiable, in order that they do not suffer harm or embarrassment as a consequence of participating in research and its subsequent publication (Stake, 1994). This imperative was taken very seriously throughout this project, particularly given the sensitivity of the subject and the vulnerability of the participant group.

This study was also granted ethics approval to collect data from support people or partners of the women and also from health professionals. It was anticipated that partners or support people may be interviewed, because they may have had a role in the decision-making process around where and how the baby would be born. It was anticipated that health care professionals might also be interviewed due to their various influences on women’s birth choices. Information sheets, consent forms and demographic forms were specifically designed for these participants and approved by the
ethics committee. Ultimately no support people were interviewed.

Due to my involvement in the homebirth community, it was likely that the research participants would be aware of my identity. Indeed, some would know me personally. In an effort to ensure that the relationship between the participants and me as the researcher remained professional, and that personal relationships remained intact, all participants were approached and contacted in the same manner and due process was taken with each participant to ensure none felt coerced to participate or received any different treatment.

When planning a research project, the researcher must consider whether their research will harm their participants. In this study, the perceived risks anticipated for the participants included possible emotional trauma through the recounting of negative birth or life experiences during the interview process. To counteract the risk of inducing such trauma, participants were offered the option of ceasing the interview at any time if they were distressed; moreover they were offered contact information for counseling services if required. Two participants were asked if they would like to cease the interview after I noted possible distress; however, in both cases, the participant requested that the interview continue. An unexpected outcome of this research was that many participants were thankful for the opportunity to share their story, and appreciated me listening with uncritical interest. While some felt distress when revisiting unhappy events, others found it cathartic to talk them through.

Data collection throughout a grounded theory study

Grounded theory relies on the collection of rich, detailed data that will reveal the participants’ views, feelings, intentions and actions, as well as their contexts and life structure (Charmaz, 2006). Collecting these data means engaging in detailed narratives
with participants, and writing extensive field notes and memos about the experiences, feelings and ideas conveyed. This allows the researcher to fully explore a phenomenon or idea (Charmaz, 2006). There are multiple types of data, including interview transcripts, field notes, memos, questionnaires and surveys, policy documents, scholarly literature, novels, images, videos and music. Glaser and Strauss (1967) encourage the use of a range of data, stating that ‘different kind of data give the analyst different views or vantage points from which to understand the findings… there are no limits to the techniques of data collection, the way they are used or the types of data acquired’ (p. 65). This study collected interview data, demographic data and secondary data from the NMR and an online source.

**The use of academic literature in grounded theory**

Before fully delving into a discussion on data types and collection methods, it is worthwhile pausing for a discussion on the use of academic literature in grounded theory as a data source. For researchers planning to embark upon a grounded theory study, there is general agreement that a systematic review of the literature relating to the broad area of enquiry should be avoided (Birks & Mills, 2011). A grounded theory study is intended to generate a theory based upon the data collected throughout the research process. Glaser (1992) argues that indulging in the literature from the outset could interfere with the researcher’s ability to ground the findings in the data, as the existing literature has already influenced their preconceived ideas about the area being studied (Glaser, 1992). He explains that grounded theory is for ‘the discovery of concepts and hypotheses ... thus the license and mandate of grounded theory is to be free to discover in every way possible ... free from the claims of related literature ... it need make no bows to the existing literature’ (Glaser, 1992, p. 32). This stance, however, need only be maintained in the initial stages of research. When the developing theory seems
sufficiently grounded and a core category has emerged through the intermediate and advanced stages of analysis, the researcher is encouraged to pursue the literature and begin to relate it to their own work (Glaser, 1992). By reading the literature at a later stage in the research process, contends Glaser, the researcher needs only to read that which is relevant to their developing findings. This is ‘far more efficient than reading the literature beforehand with no clear notion of relevance’ (Glaser, 1992, p. 33). Birks and Mills (2011) suggest that the researcher can go to the literature when theoretical sampling directs them. Glaser (2008) would concur, noting that the literature should be treated like data from any other source. Alternatively, Corbin and Strauss (2008) recommend grounded theorists read the literature throughout the research process to increase their theoretical sensitivity; they furthermore suggest that through the comparison of theoretical concepts with the coded data of the research project, the literature can potentially become a source of data itself (Corbin & Strauss, 2008). I avoided delving into the literature early in the research process. However, a literature review was performed with the intention of determining a need for the current research through the identification of a gap in the corpus of existing literature. Once it was ascertained that there was indeed a need for a study of this nature, the literature on this topic was not sought out until the advanced stages of data analysis.

The use of interview in grounded theory

The main source of data for this research was interviews. Through the process of interviewing, ‘the researcher seeks to follow the major concerns or point of view of the respondent’ (Wimpenny & Gass, 2000, p. 1487). Given that grounded theory attempts to understand the world of the individual from their own subjective perspective, participant interviews are considered to be the most commonly used method for data collection (Birks & Mills, 2011). Throughout my research process, twenty women and three
professionals (a doula, an anthropologist and a private midwife) were interviewed. Participants were interviewed at a location and time of their choosing, and I adopted a flexible interview style and used open-ended questions from a semi-structured list of interview questions (which varied from participant to participant). Seven interviews were conducted by telephone due to geographical and logistical constraints. The data generated by these interviews did not differ in quality or content to those done face to face; however, some authors warn that telephone interviewing renders subtle non-verbal cues more difficult to record or interpret, thus according a higher degree of focus on the verbal content of the interview (Elmir, Schmied, Jackson, & Wilkes, 2011; Nagy, Mills, Waters, & Birks, 2010). All interviews were conducted, recorded and transcribed by me in preparation for analysis. Birks and Mills (2011) assert that interview transcripts, combined with field notes and memos, provide a rich data set.

The use of secondary data in grounded theory

The initial intention of this research was to collect interview data, demographic data and birth stories from public blogs and homebirth websites. In an effort to seek out further information about freebirth participants and to determine whether saturation of the categories was achieved, twenty-one submissions to the NMR were accessed after the conclusion of all interviews. These were accessed because they mentioned freebirth. Seven of these were analysed and included in the data collected (six women spoke of having freebirths and one had a homebirth). The others were omitted as they did not thoroughly explain their reason for electing to birth outside the system. This information from the NMR submissions was collected because it became obvious throughout the research process that women who birth outside the system are part of close-knit communities and often express similar views and demonstrate similar philosophical positions. Concerned that this might influence the findings of the research, I wanted to
seek out information other than that accessed by the snowball method of recruitment that I had hitherto employed. The collection of this additional data was helpful, because it allowed me to check whether my existing data analysis inductions were accurate. That is, if the analysis of the NMR submissions was similar to the data that I had already collected, then this would be reassuring insofar as it would indicate that the data already collected were representative of the participant group and had not been influenced by my interview questioning or my personal biases. Being uninvolved in the information collated in the NMR submissions offered a helpful comparison during the research process, adding a wealth of data to the research as it was compared to the other data collected. In addition to the interview data (from 20 women), NMR submissions (from seven women), one online story (which thoroughly explained one Australian woman’s motivations for birthing her twins at home) was also used as data for analysis. Once analysis was completed, it was discovered that no new information was apparent, and the categories were indeed saturated; therefore, no new online stories were sought.

The use of this secondary data (such as the NMR submissions and the online story) in a grounded theory study is thought to be a disadvantage due to its inherent limitations in terms of theoretical sampling (Birks & Mills, 2011). I believe, however, that this disadvantage was overcome by omitting the NMR submissions that did not satisfy the research aims, and by using this secondary data after initial analysis of primary data. This meant that I had already developed ideas about the data before being influenced by secondary data, and had thus used the secondary data as more of a checkpoint in the research process to determine whether or not any major themes had been overlooked. When compared to existing data, no new findings emerged from the NMR submissions or online story; rather, they simply served to bolster existing categories and confirm that saturation had been reached. Furthermore, the application of coding and categorisation
to the secondary data minimised the disadvantages of its use; which is a strategy suggested by Birks and Mills (2011). On the use of secondary data from non-professional and popular literature, Glaser (1992) comments that if they are to be used, ‘these materials should be related to the substantive area being studied and therefore are to be considered just more data to be constantly compared for generating categories and properties’ (Glaser, 1992, p. 37). This is how the data were utilised for this study. Many of the women interviewed had cited and offered other sources of data that they thought would be of assistance to the research process. The participant designated ‘FB01’, for example, directed me to an article in a homebirth magazine that recounted her experience of abuse in the system; she also pointed me in the direction of literature that had helped inform her decision-making process. Similarly, ‘FB08’ had developed a very detailed blog that collated freebirth birth stories. These data were collected with the purpose of informing the research process, and gaining an insider understanding of the issue. The data were not, however, used as part of the analysis.

The use of anecdotal comparison as data in grounded theory

Another type or ‘slice’ of data identified by Glaser and Strauss (1967) that they suggest should be used by the researcher is that of ‘anecdotal comparison’ (Glaser & Strauss, 1967, p. 67). Accessing these data involves tapping into the existing anecdotal information or knowledge that the researcher has within them – whether from life experience, general knowledge or reading. The researcher is then accorded the permission to incorporate these subjective experiences and knowledge into their data set. Glaser and Strauss (1967) explain that ‘anecdotal comparisons are especially useful in starting research and developing core categories. The researcher can ask himself where else he has learnt about the category and make quick comparisons to start to develop it’ (p. 67). I was particularly grateful for the inclusion of anecdotal comparison throughout
the research process, as I felt I had a wealth of knowledge about the homebirth community that would contribute to my overall understanding of the women’s stories and allow for more depth of understanding and explanation throughout the development of the findings. Had I been required to deny this part of my understanding, the research process or findings would not be as rich or in-depth as they have become.

**The place of data generation in grounded theory: memos and field notes**

In grounded theory, there is both data collection and data generation. The term ‘data generation’ acknowledges the involvement of the researcher in engaging with the data sources, and their relation to the process of data acquisition (Birks & Mills, 2011, p. 73). Acknowledging the place of data generation in grounded theory legitimises the use of memos and field notes as data for analysis. Throughout the research process, the writing of detailed field notes and memos was performed after each data collection and data analysis session. Excerpts from both a memo and a field note are provided below.

**Field note:**

Attended interview in Sydney, this participant contacted me to say she was happy to participate as one of her friends had told her about the study. She has 4 children, I asked her if she was home schooling as I noticed educational tools around the home. She said, ‘well I am supposed to be.’ She made me tea before the interview. I noticed Bible verses written on paper plastered through the kitchen and on house walls. Arrived at 13.00 to find the house very messy, chaotic and dirty and clothes were hanging on the trees at the front of the house to dry. The front door was open on arrival. The participant didn’t apologise for the mess and one of her children was running around with no pants on and the two youngest had dirty faces and yellow snot on their noses. One child was making herself a wrap from a plate of prepared chopped food. While I was organising the interview with this participant in the days leading up to our meeting, she mentioned that she was trying to finish an assignment which she didn’t end up getting in on time – she mentioned there was a lot of stuff going on in her life at the moment so she applied for special consideration. I got the impression from our time together that she generally
was not on top of things in her life and it was all out of control, but she conducted herself in a calm way and didn’t appear or behave overwhelmed. She had a lip ring and was dressed ‘alternatively.’ At present she and her husband are doing an extension on the house also.

Memo segment:

After theming HB04 I started thinking about the idea of necessity – this mother wanted a homebirth to avoid another caesarean, which she felt wasn’t necessary after already having 2. She felt that the hospital would deem it necessary and she would be at great risk of a repeat caesarean if she birthed at hospital. To reduce her risk of this, she chose homebirth. She weighed up the risk of uterine rupture which is what the hospital and doctor stated was her biggest risk and decided that the risk was a reasonable one to take considering the low percentage of uterine rupture for VBAC. She was aware of the risks and made a reasonable choice based on this. She was more fearful of the risk of caesarean than the risk of uterine rupture and therefore avoided all situations that would increase her risk of section, which based upon the rupture risk she felt was an unnecessary intervention as the medical risk was low in her eyes and caesarean carried more risk than rupture.

Her definition of ‘necessary intervention’ was that it was medically indicated for the safety of mum or baby ... an unnecessary intervention is one that is not directly medically indicated and is rather an iatrogenic intervention created by the system for a reason other than for the medical safety of the mother as it has become obvious that mothers have a different view of necessity than the system.

In attending to memos and field notes, this research was done in line with the grounded theory methodology, and also generated data that would ultimately contribute to the overall development of a theory.

The generation of memos throughout the research process is considered an essential element of grounded theory, with memos seen to be and memos are ‘the bedrock of theory generation’ (Glaser, 1978, p. 83). Memo writing is used to record and detail major
analytical phases of the research journey in a spontaneous, informal and unofficial way. Rules for writing memos are few, but a memo should ‘catch your thoughts, capture the comparisons and connections you make and crystallise questions and directions for you to pursue’ (Charmaz, 2006, p. 72). Memos are kept, and it is expected that they will become a useful tool during the analysis process. Glaser defines memos as ‘the theorising write-up of ideas as they emerge ... they are written up as they strike the analyst when constant comparison, coding and analysing’ (Glaser, 1992, p. 108). In this sense, memo writing is an important part of expressing thoughts during the time of data analysis, assisting the researcher to inch closer to forming a grounded theory. Memos become most useful in the advanced stages of analysis, as the researcher integrates the theory (Glaser, 2005). As an essential component of grounded theory, memos are seen as an important part of ensuring quality and rigour in grounded theory (Birks & Mills, 2011; Lampert, 2007). Memos are also used by the researcher to keep an audit trail of the research process, and to maintain a record for the rationale for the decisions made along the way. Memos thus assist with the process of abstraction from the data, ensuring that momentum is maintained throughout the process of analysis (Birks & Mills, 2011).

Birks and Mills (2011) suggest developing a habitual pattern to memoing throughout the research process. For this study, I felt a natural inclination to record my thought processes after every research session, whether this was directly after the collection of data or during the analysis process. Memoing allowed me to record my thought processes, so that none of my reactions, interpretations and responses were lost. As explained by Birks and Mills (2011), when working with data, ideas are often sparked, and when this occurs you should stop what you are doing and write a memo (Birks & Mills, 2011). This is the exact habit that I developed throughout my research; indeed, often ideas were sparked at the most unlikely of times – for example, listening to a
speech, watching a movie, during conversation and of course, whilst engaging directly in research activities. Recording memos in this way is adhering to Glaser’s (1978) ‘prime rule’: that is, whereby as an idea ‘sparks,’ the researcher should record it (Glaser, 1978, p. 83).

Grounded theory also encourages researchers to generate ‘field notes.’ Observations made in the field are recorded in the form of field notes. As important records of events, activities and the researcher’s response, field notes should be made after each interview in order to retain details of the physical environment, the researcher’s immediate responses and to capture the participant’s non-verbal behaviour (Birks & Mills, 2011). As demonstrated in the audit trail (on p. 82), in accordance with the principles of grounded theory, my field notes were written immediately after most of the interviews.

As explained, data collected for a grounded theory study can include interviews, secondary data and anecdotal information, as well as the later inclusion of appropriate literature. Grounded theory also allows for the use of generated data in the form of memos and field notes to become part of the data set for analysis. Twenty interviews, secondary data from seven NMR submissions, one online story, along with the corresponding field notes and memos, formed the data set for this research. The process of how these data were analysed is explained in the following section.

**Demographic data**

Demographic data were collected from the 20 women before their interviews, so the group could be better understood. The median age of the women interviewed was 34 years old; this, however, does not give an indication of the age they were when they decided to birth outside the system. All of the participants were born in developed countries,
with the majority born in Australia. No Aboriginal or Torres Strait Islander women were interviewed. The majority of women had their first baby within the system, with only two women birthing outside the system for their first baby. Nine out of the 20 women were employed at the time of interview. The most remarkable finding from these data was the participant group’s high level of education.

Compared to the general population, all participants were highly educated, with demographic data indicating that 14 out of the 20 had a bachelor degree or higher. One participant had a doctoral degree, and overall, 70% of the participants had a tertiary qualification. In 2010, 26.9% of Australians between 25 and 64 years of age held a bachelor degree or higher (Australian Bureau of Statistics, 2011), which is around two thirds less than the study cohort (Jackson, Dahlen, & Schmied, 2012). This indicates that the participants belong to a highly educated group.

Nineteen out of the 20 women were living with their partners (in a married or de facto relationship), which is significant considering the divorce rate in Australia is approximately 34% (AIFS, 2012) and the percentage of single parent households is approximately 15% (ABS, 2012). For the protection of the participants’ privacy, their exact distance to a maternity care hospital has not been listed (although these data were collected). It was found that all of the participants lived within a 30-minute drive to a hospital that provided maternity care. It is possible, therefore, that the choice to birth outside the system was considered more reasonable given the women’s relative proximity to emergency care in the event that it was required.

Four of the twenty participants in this study were midwives; one choosing freebirth and three choosing homebirth. This adds an interesting dimension, as these women had insider knowledge of mainstream maternity services. Their decision to birth outside the
system indicated that they believed this to be a safer option than giving birth in hospital. These women felt that their choice of place of birth gave them greater control over external factors, thus presenting them with fewer possible risks at birth. Similarly, in a study by Lindgren et al (2010), a pediatrician cites the risk of infection for mother and baby alike as a primary factor in why she perceived birthing in a hospital to be more risky than at home (Lindgren, Radestad, Christensen, Wally-Bystrom, & Hildingsson, 2010).

A summary of the demographic information collected for this study is detailed below in table 2.
<table>
<thead>
<tr>
<th>Age</th>
<th>Place of birth</th>
<th>No. of children</th>
<th>Employed</th>
<th>Highest qualification</th>
<th>Marital status</th>
<th>Antenatal care</th>
<th>Previous births</th>
<th>State</th>
<th>Closest hospital</th>
</tr>
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<tbody>
<tr>
<td>FB01</td>
<td>Australia</td>
<td>3</td>
<td>Yes</td>
<td>School certificate</td>
<td>Married</td>
<td>none</td>
<td>1st Birth Centre 2nd Freebirth 3rd Freebirth</td>
<td>New South Wales</td>
<td>5–10 mins</td>
</tr>
<tr>
<td>FB02</td>
<td>Australia</td>
<td>4</td>
<td>No</td>
<td>University degree</td>
<td>Separated</td>
<td>none</td>
<td>1st &amp; 2nd Birth Centre 3rd Homebirth 4th Freebirth</td>
<td>New South Wales</td>
<td>20 mins</td>
</tr>
<tr>
<td>FB03</td>
<td>United Kingdom</td>
<td>3</td>
<td>Yes</td>
<td>University degree</td>
<td>Married</td>
<td>Registered midwife</td>
<td>1st Delivery Ward 2nd Homebirth 3rd Freebirth</td>
<td>Northern Territory</td>
<td>5 mins</td>
</tr>
<tr>
<td>FB04</td>
<td>New Zealand</td>
<td>2</td>
<td>No</td>
<td>Certificate/Diploma</td>
<td>Married</td>
<td>Hospital midwife clinic</td>
<td>1st Birth Centre 2nd Freebirth</td>
<td>New South Wales</td>
<td>20 mins</td>
</tr>
<tr>
<td>FB05</td>
<td>Australia</td>
<td>4</td>
<td>No</td>
<td>Post-graduate degree</td>
<td>Married</td>
<td>1st &amp; 2nd Registered midwife 3rd &amp; 4th self</td>
<td>1st Homebirth 2nd Freebirth 3rd Freebirth 4th Freebirth</td>
<td>Queensland</td>
<td>15 km</td>
</tr>
<tr>
<td>FB06</td>
<td>Australia</td>
<td>4</td>
<td>No</td>
<td>Advanced Diploma</td>
<td>De facto</td>
<td>1st &amp; 2nd private midwife 3rd &amp; 4th self</td>
<td>1st Homebirth 2nd Homebirth 3rd &amp; 4th Freebirth</td>
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<td>7 mins</td>
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<td>No</td>
<td>Certificate/Diploma</td>
<td>Married</td>
<td>1st &amp; 2nd delivery hospital midwife 3rd &amp; 4th</td>
<td>1st &amp; 2nd Delivery ward 3rd Homebirth 4th Freebirth</td>
<td>New South Wales</td>
<td>20 km</td>
</tr>
<tr>
<td>FB08</td>
<td>Australia</td>
<td>2</td>
<td>No</td>
<td>Post graduate degree</td>
<td>De-facto</td>
<td>none</td>
<td>1st &amp; 2nd Freebirth</td>
<td>Victoria</td>
<td>10 mins</td>
</tr>
<tr>
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<td>1</td>
<td>No</td>
<td>Certificate/Diploma</td>
<td>De-facto</td>
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<td>1st Freebirth 2nd Homebirth</td>
<td>New South Wales</td>
<td>5 mins</td>
</tr>
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<td>Yes</td>
<td>University degree</td>
<td>Married</td>
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<td>New South Wales</td>
<td>10 mins</td>
</tr>
<tr>
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<td>Australia</td>
<td>3</td>
<td>Yes</td>
<td>Post-graduate degree</td>
<td>Married</td>
<td>Registered midwife</td>
<td>1st and 2nd delivery ward 3rd Homebirth</td>
<td>New South Wales</td>
<td>10–20 mins</td>
</tr>
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<td>HB03</td>
<td>Australia</td>
<td>1</td>
<td>Yes</td>
<td>Post-graduate degree</td>
<td>Married</td>
<td>Registered midwife</td>
<td>1st Delivery ward 2nd Homebirth</td>
<td>New South Wales</td>
<td>5–10 mins</td>
</tr>
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<td>New Zealand</td>
<td>3</td>
<td>No</td>
<td>Post-graduate degree</td>
<td>De-facto</td>
<td>Registered midwife</td>
<td>1st Delivery ward 2nd Birth Centre 3rd Homebirth</td>
<td>New South Wales</td>
<td>20 km</td>
</tr>
<tr>
<td>HB05</td>
<td>Australia</td>
<td>2</td>
<td>Yes</td>
<td>Post-graduate degree</td>
<td>Married</td>
<td>Obstetrician</td>
<td>1st Delivery Ward 2nd Delivery ward</td>
<td>New South Wales</td>
<td>15 km</td>
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<td>University degree</td>
<td>De-facto</td>
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<td>1st Delivery ward 2nd Birth Centre</td>
<td>Queensland</td>
<td>2 km</td>
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<td>2</td>
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<td>Certificate/diploma</td>
<td>Married</td>
<td>Registered midwife</td>
<td>1st Delivery ward 2nd Delivery</td>
<td>New South Wales</td>
<td>10–20 mins</td>
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<td>HB08</td>
<td>Australia</td>
<td>4</td>
<td>Yes</td>
<td>Post-graduate degree</td>
<td>Married</td>
<td>Registered midwife</td>
<td>1st &amp; 2nd twins planned 3rd Birth Centre 4th Homebirth</td>
<td>New South Wales</td>
<td>5 mins</td>
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<td>Post-graduate degree</td>
<td>Married</td>
<td>Registered midwife</td>
<td>1st Delivery ward 2nd Homebirth</td>
<td>New South Wales</td>
<td>5 mins</td>
</tr>
<tr>
<td>HB10</td>
<td>Australia</td>
<td>1</td>
<td>No</td>
<td>University degree</td>
<td>Married</td>
<td>Registered midwife</td>
<td>1st private hospital</td>
<td>New South Wales</td>
<td>10 mins</td>
</tr>
<tr>
<td>HB11</td>
<td>England</td>
<td>2</td>
<td>Yes</td>
<td>University degree</td>
<td>Married</td>
<td>Registered midwife</td>
<td>1st Delivery ward 2nd Delivery ward</td>
<td>New South Wales</td>
<td>8 km/10 mins</td>
</tr>
</tbody>
</table>
Data analysis

Many research methods allow the researcher to collect all data in the first instance, and then proceed to the next phase, which is data analysis. Grounded theory offers a radical departure from this structure, since the researcher embarks upon data analysis immediately after the first data are collected. This process of analysis will be explained in detail below.

Concurrent data collection and analysis

Grounded theory ‘is an iterative analytical method of constantly comparing and collecting or generating data that results in high-level conceptual abstract categories rich with meaning, possessive properties and providing an explanation of variance through categorical dimensionalisation’ (Birks & Mills, 2011, p. 94). A fundamental principle of grounded theory is that data collection and data analysis occur simultaneously, and are in reciprocity throughout the research process (Birks & Mills, 2011). This means that as data are collected, they are analysed before endeavoring to collect more. Concurrent data collection and analysis is an essential method that differentiates grounded theory from other interpretative research designs (Birks & Mills, 2011). It is the concurrent process that allows the researcher to discern from the outset what major categories are emerging. The researcher then uses this information to dictate where and from whom they will collect further data (Charmaz, 2006). The grounded theory approach of simultaneous data collection and analysis helps the researcher to keep pursuing these emphases as they shape their data collection to inform the emerging analysis (Charmaz, 2006). As you will see in the audit trail (see pg. 82), for the majority of my study, this concurrent process was honoured.
Constant comparative analysis

Another fundamental principle of grounded theory is the process of constant comparative analysis, whereby the researcher compares incidences, codes and categories, thus building theory up from the data itself (Birks & Mills, 2011). Glaser refers to the constant comparative method as ‘comparing data to data and then concepts to more data to further saturate and integrate categories and their properties’ (Glaser, 1992, p. 56). In so doing, the inductive process of grounded theory is adhered to and the theory that is generated is grounded in the data. Glaser (1992) suggests that there are two analytic procedures that are fundamental to the constant comparative method of coding; the first is the process of drawing comparisons of incidents in the data, while the second concerns the use of grounded theory coding techniques (Glaser, 1992). This latter process will be discussed in detail in the next section. The idea of constant comparative analysis is to look for patterns in the data ‘so that a pattern of many similar incidences can be given a conceptual name’ (Glaser, 1992, p. 40), which will later form a category. For example, I noticed that many of the women referred to traumatic birth experiences, and so I named a category ‘previous trauma’ to account for this pattern. Glaser and Strauss (1967) refer to comparative analysis as a key strategy for generating theory. They propose that the process of constant comparison of data collected from various sources serves as a fact-checking exercise whereby initial data, representing facts, are replicated with comparative evidence. They suggest that ‘replications are the best means for validating fact’ (Glaser & Strauss, 1967, p. 23). Based on this logic, the process of constant comparative analysis in grounded theory serves to check the data for ‘truths’ discovered about the subject. The discovery of ‘facts’ throughout data collection and constant comparative analysis form the foundation for the development of conceptual categories. The discovery of facts in the research process, therefore, helps the researcher to develop a concept that assists in the process of theoretical abstraction regarding the
area under investigation (Glaser & Strauss, 1967, p. 23). Another function of comparative analysis is to establish the generality of fact. As Glaser and Strauss (1967) note, ‘by comparing where facts are similar or different, we can generate properties of categories that increase the categories’ generality and explanatory power’ (Glaser & Strauss, 1967, p. 24). Constant comparative analysis was aided in this research project by the use of ‘Nvivo’, a data management software program that allows the researcher to group similar aspects of various data sources together. The use of ‘Nvivo’ will be discussed later in this thesis.

**Coding and categorising data in grounded theory**

The purpose of data analysis in grounded theory is conceptual development; this is done by coding and categorising the data (Birks & Mills, 2011). Analysis begins with coding, where ‘coding means categorising segments of data with a short name that simultaneously summarises and accounts for each piece of data’ (Charmaz, 2006, p. 43). Codes are a form of shorthand that the researcher can use to identify conceptual occurrences and similarities throughout the data (Birks & Mills, 2011). Using grounded theory, the researcher codes for categories and properties and lets ‘codes emerge where they may’ (Glaser, 1992, p. 63). Coding consists of three phases, and these have been given various names and descriptions by different authors. For ease of explanation, I have termed them initial, intermediate and advanced coding, to correlate them with the different stages of coding. This description allows for how the different stages advance in depth and theoretical complexity throughout the research process.

**Initial coding**

Initial or ‘open’ (Glaser, 1992) coding is the first step of analysis and involves coding data word-by-word and line-by-line, whereby the author identifies important words or groups
of words, and labels them accordingly (Birks & Mills, 2011). An example of how this was done during my analysis is as follows:

...I was definitely going to have a homebirth (planning a homebirth), there was no – and to me it wasn’t necessarily – like I thought home was safer (home was safer) but for me the real deciding factor was my total and utter fear of going to the hospital (fear of the hospital) again and any of that happening to me (avoiding a previous experience). At that point in time, my husband knew that unless I was dying he was not to take me to a hospital and in fact I would have preferred death over having to live through my first birth again (a fate worse than death). (FB01)

For Glaser (1992), the mandate of, what he calls, ‘open’ coding is that the analysis starts with a conceptual nothing (p. 38). He describes a concept as ‘[t]he underlying meaning, uniformity and/or pattern within a set of descriptive incidences’ (Glaser, 1992, p. 38). In this stage of analysis, Charmaz (2006) argues for the use of ‘gerunds’ (verbs used as nouns that always finish with ‘ing’) when labeling codes as a way to identify processes that have been recorded in the data. My supervisor suggested that I ask myself ‘what is going on here?’ as I coded the data. This helped to form ‘gerunds’ from within the data by identifying and labeling the processes with which the participants were engaging as they made decisions to birth outside the system. For example: ‘feeling unheard,’ ‘wanting more,’ ‘managing opposition,’ ‘disengaging from care providers.’ Asking questions of the data is encouraged as a technique by Glaser (1992), who notes that it can be helpful to ask, ‘what is actually happening in the data?’ (Glaser, 1992, p. 51). Another way researchers can capture what the data are saying within a code is to use ‘in vivo’ labels, whereby the participants’ words are lifted directly from the data and used as a label for a code (Birks & Mills, 2011). This was done for some of the codes in this research where I considered that the participants’ words were sufficiently descriptive. For example: ‘I had to find a better way,’ and ‘the clock was ticking.’ Furthermore, Glaser encapsulates the creative nature of grounded theory when he observes that ‘the codes will just occur in
the analyst’s head as he immerses himself in the data’ (Glaser, 1992, p. 45). Indeed, I found this to be the case for my own experiences. Initial coding continues until categories start to form, which indicates to the researcher that their data are moving from initial analysis into more intermediate analysis. At this stage, the line-by-line and word-by-word nature of initial coding becomes redundant, as the researcher gains a sense of conceptual understanding about what is emerging from the data (Birks & Mills, 2011). Glaser (1992) suggests that open (initial) coding may come to an end once categories have been identified (Glaser, 1992).

**The use of conceptual maps and diagrams for data analysis**

Proponents of grounded theory encourage the production of diagrams and conceptual maps throughout the research process (Birks & Mills, 2011), with Strauss and Corbin (1990) advocating for their use from the beginning of the study in conjunction with the generation of memos (Strauss & Corbin, 1990). Being a visual learner, the development of mind maps and diagrams to sort and make sense of my data was attractive to me, so these are scattered throughout my memos. They were also helpful in conveying information and findings to my supervisors in a succinct way, enabling others to visualise the conceptual progression of my data analysis process. The production of diagrams also forced me to connect together codes from initial data analysis, and to commence the development of categories, which aided a natural progression into intermediate data analysis. As Birks and Mills (2011) explain, ‘generally initial coding results in messy and intricate diagrams which will evolve into neat and simple diagrams as you move into intermediate and advanced coding stages’ (p,105). This mirrors my personal experience with the use of diagrams as a data analysis tool.

**Intermediate coding**
The second stage of coding, intermediate coding, has also been called ‘focused,’ ‘selective’ (Glaser, 1992, p. 75), or ‘axial’ coding (Birks & Mills, 2011, p. 12; Strauss & Corbin, 1990). In this stage, data and codes are linked and similar codes are clustered together to form categories (Birks & Mills, 2011; Charmaz, 2006). As Charmaz (2006) explains, ‘during initial coding, the aim is to stay open to all possible theoretical directions indicated by your reading of the data. Later you use focused coding [what I have called ‘intermediate’ coding] to pinpoint and develop the most salient categories in large batches of data’ (Charmaz, 2006, p. 46). The development of a category represents a higher level concept than the initial coding process (Birks & Mills, 2011), moving the researcher conceptually closer to a grounded theory. Grounded theory categories are multi-dimensional and may consist of subcategories that together explain the broader concept. These categories and subcategories also have properties that are defined and explained by the researcher as they develop conceptual depth throughout the intermediate analysis phase. It is during the phase of intermediate analysis that gaps and holes in the data become pertinent and compel the researcher, with the use of theoretical sampling, to pursue further data collection (Birks & Mills, 2011). This theoretical sampling continues through the more advanced stages of analysis until theoretical saturation is achieved.

**Theoretical saturation**

Theoretical saturation was the term used by Glaser and Strauss (1967) to describe the criteria that determines when one stops gathering data. They suggest that saturation means that ‘no additional data are being found’ (Glaser & Strauss, 1967, p. 61). Strauss and Corbin describe theoretical saturation as occurring when there are no new codes identified in later rounds of data collection and analysis, and where a category, along with its subcategories, is well described and explained (Strauss & Corbin, 1990). Morse adds
that ‘researchers cease data collection when they have enough data to build a comprehensive and convincing theory’ (Morse, 1995, p. 148). He also notes, however, that saturation must be viewed in abstract terms; indeed, Morse questions whether this state can ever truly be achieved (Morse, 1995). Wiener (2007) suggests that saturation can be defined as the ‘judgment that there is no need to collect further data’ (Bryant & Charmaz, 2007, p. 306). I identified saturation as having occurred as I was undertaking initial coding for the last three interviews, which correlated with some fieldwork I undertook at the 2011 Homebirth Australia conference in Newcastle (New South Wales). I felt saturation had been reached because as I undertook initial coding of the interview transcripts, I found that all data could be sorted into existing codes or categories that had already developed throughout concurrent data collection and analysis of previous data. This phenomenon is explained by Glaser and Strauss (1967), ‘As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated’ (Glaser & Strauss, 1967, p. 61). I commented in my memos and to my supervisors that the data were not surprising, and had become less exciting to analyse because nothing new was emerging. As I explained, I felt that I was undertaking the time-consuming task of initial data analysis by way of due process, rather than to advance my developing concepts and theory. At the same time, while doing fieldwork at the 2011 Homebirth Australia conference, I sat for an hour to listen to four birth stories from women who chose to birth at home with risk factors. These stories were also unsurprising and familiar to me, as I mentally inserted the main points of their stories into the existing codes and categories that had developed through the research process. As I listened to their stories, it occurred to me that they had said nothing that would add further depth to the research data. It was at this point that I felt that saturation had been reached. As a mark of rigour in the research process, Glaser encourages the researcher to
always validate ‘fit’ and ‘relevance,’ by reaching saturation (Glaser, 1992, p. 18). I believe that this was attained in my research.

**Identification of the core category**

Birks and Mills (2011) suggest the identification of a core category to be one of the essential elements in the grounded theory research process. Strauss and Corbin define a core category as the central phenomenon around which all other categories are integrated, which describes how categories and their subcategories integrate together to form the grounded theory (Strauss & Corbin, 1990). For Glaser, the core category is generalisable and has ‘grab; it should be a high-impact dependent variable of great importance and hard to resist; it happens automatically with ease (Bryant & Charmaz, 2007). For some researchers, the core category comes through strong early on in the research process. At other times, it can emerge in the intermediate stages of coding (Birks & Mills, 2011). For me, some of the major categories became obvious in the intermediate stages of coding, but putting my finger on the exact core category was more difficult. Initially, the core category that stood out was ‘pursuing the best and safest birth for me and my baby,’ so it was placed as a possible core category during intermediate data analysis with the understanding that this could change.

As the research progressed into the advanced coding stages, it was suggested that perhaps the research had yielded what appeared to be two core categories. Looking at the research data, it was difficult to determine whether ‘becoming the expert’ or ‘finding a better way’ was the core category, rather than ‘pursuing the best and safest for me and my baby,’ the latter of which did not seem to account for all data. Glaser speaks of this outcome as being possible but rare, adding that it is ‘essential to make a decision on
which to focus the research’ rather than attempt to fully develop the two core categories (Glaser, 1992, p. 79). One way to address the existence of two core categories, suggests Glaser, is to choose one and then assign the other as a sub-core category (Glaser, 1992). The core category should be designated based on the category’s ability to account for the ‘most variation in the problematic pattern’ (Glaser, 1992, p. 79). Therefore, after much consideration of the data in the advanced stages of analysis, I selected ‘wanting the best and safest’ as the core category: I felt that it held a greater explanatory power, and accounted for all the codes developed during previous stages of data analysis. It was also true, however, that the participants were ‘finding a better way’ as they pursued birth outside the system. So, as data analysis progressed, rather than positioning ‘becoming the expert’ as a sub-core category, it was trialed as a component of the ‘basic social process.’ Ultimately, I concluded that becoming the expert was an integral part of ‘finding a better way,’ so ‘finding a better way’ became the basic social process. By categorising the findings in this way, all of the data could be accounted for and presented in the theoretical manner demanded by the values of grounded theory.

**Identification of the basic social process**

Alongside the generation of a core category, the researcher may describe the ‘basic social process.’ The description of a ‘process’ is considered, by some, as a characteristic feature of grounded theory (Birks & Mills, 2011). For Glaser (1978), however, while the explanation of a process is possible, it is not an integral element (Glaser, 1978). He explains that the basic social process is ‘theoretical in nature, reflecting and summarising the patterned, systematic uniformity flows of social life’ (Glaser, 1978, p. 100). Furthermore, the identification of a basic social process is not considered as one of the essential elements of grounded theory by Birks and Mills (2010). On the other hand, Charmaz (2006) suggests that the identification of process in grounded theory is essential,
because emphasising process during analysis forces the researcher to identify relationships in the study area (Charmaz, 2006). To this end, the basic social process in this study is ‘finding a better way,’ and will be discussed in full in the findings.

**Advanced coding**

After intermediate stages of coding and analysis, the researcher embarks on a process of advanced coding and theoretical integration. As noted by Birks and Mills, ‘theoretical integration requires the application of advanced analytical strategies in order to raise the analysis to the highest conceptual level possible’ (Birks & Mills, 2011, p. 113). As the last stage of analysis, advanced coding is a process designed to bring the grounded theory together (Birks & Mills, 2011). ‘The result sought in grounded theory is a small set of highly relevant categories and their properties connected by theoretical codes into an integrated theory’ (Glaser, 1992, p. 42); it is during advanced coding that the aim of grounded theory is fully achieved. Advanced levels of analysis are designed to lift data analysis and the findings beyond qualitative description and into the hallmark of grounded theory and theoretical abstraction (Birks & Mills, 2011). A fully integrated grounded theory that has undergone the high-level conceptual processes of advanced analysis possesses explanatory power (Birks & Mills, 2011). It is at this stage, alongside the data already analysed, that the researcher is encouraged to sort their memos (Glaser, 1992). The purpose of this is to facilitate the integration process by identifying relationships and unifying concepts in the data that were not previously evident (Corbin & Strauss, 2008). Birks and Mills (2011) propose that there are three things required to allow for the integration of a grounded theory in the advanced stages of coding: 1) an identified core category, 2) theoretical saturation of the major categories, and 3) a bank of analytical memos (Birks & Mills, 2011, p. 115). During the advanced stages of coding for this study, all of these elements had been fulfilled, which indicated that the research
process was adhering to the grounded theory method and had potential to produce theory as an end product.

Initial coding methods result in the development of codes, and these codes are then combined to develop categories and subcategories throughout the intermediate coding phase. The developing categories are then subjected to ‘theoretical coding’ in the advanced coding phase. According to Birks and Mills, ‘[t]heoretical codes are advanced abstractions that provide a framework for enhancing the explanatory power of your storyline and its potential theory’ (Birks & Mills, 2011, p. 123).

The place of abduction in grounded theory analysis

While grounded theory calls for an inductive process of analysis, abductive reasoning occurs throughout all stages of the research process; in particular during advanced coding where the research findings become more theoretical (Birks & Mills, 2011). The process of abduction is described as ‘a cerebral process, an intellectual act, a mental leap, that brings together things which one had never associated with one another: a cognitive logic of discovery’ (Reinhertz, 2007, p. 220). The process of abduction relies on the researcher’s ability to theoretically integrate the data that has been collected as they take it through the different stages of data analysis. Data analysis, along with its coding and categorising, is undertaken with the aim of conceptual development. The ability of the researcher to abductively reason through the data and partake in conceptual development relies in part on their theoretical sensitivity.

Theoretical sensitivity

A personal attribute or developed skill referred to as ‘theoretical sensitivity’ is considered to be essential in the researcher if they are to emerge from their study with a grounded theory. Without theoretical sensitivity, the researcher risks completing their project, only
to discover that they have an informed and knowledgeable description of the studied phenomenon, but that they lack a theory.

Theoretical sensitivity refers to the researcher’s knowledge, understanding and skill which foster his generation of categories and properties and increase his ability to relate them into hypotheses, and to further integrate the hypotheses, according to emergent theoretical codes ...

Theoretical sensitivity is an ability to generate concepts from data (Glaser, 1992, p. 27).

When reading about the concept of theoretical sensitivity, it is difficult to determine whether you do indeed have what it takes to be a theoretically sensitive researcher. For those who may initially lack the requisite theoretical sensitivity, Glaser (1992) reassures that it can be cultivated throughout the research process, as long as the researcher possesses a level of awareness of its necessity and a capacity for reflective practice. Furthermore, Glaser believes that the development of theoretical sensitivity will be nurtured if the researcher were to ‘study theory constantly’ (Glaser, 1992, p. 28). Glaser also states that ‘professional experience, personal experience and in-depth knowledge of the data in the area under study truly help in the substantive sensitivity necessary to generate categories’ (Glaser, 1992, p. 28). Having theoretical sensitivity ensures that key concepts and categories that emerge during the analysis of the data are identified and further developed and refined by the researcher. Theoretical sensitivity is deeply personal and reflects the researcher’s level of insight and intellectual history, insofar as ‘researchers are the sum of all they have experienced. The concept of theoretical sensitivity acknowledges this fact and accounts for it in the research process’ (Birks & Mills, 2011, p. 11)

The use of ‘storyline’ as an analysis tool

In terms of strategies to aid the coding process, Strauss and Corbin (1990) and Birks and Mills (2011) suggest the use of storyline as a tool that can be used to assist with advanced
coding in particular (Birks & Mills, 2011; Strauss & Corbin, 1990). Midway through my doctoral journey, I felt stuck in a valley between two mountains that represented initial and intermediate coding (a mountain I had already overcome) and advanced coding (the somewhat daunting process on which I was about to embark). I had no tools to propel me into advanced coding, until my supervisors suggested the use of storytelling as a technique and encouraged me to ‘write the story.’ I read about the idea of storytelling as a technique and discovered that it is useful as a tool to assist the researcher to move into the advanced stages of analysis. It was also comforting to learn that the feeling of being ‘stuck’ at this stage of the research process was not an uncommon phenomenon, as described by Birks and Mills: ‘[y]our activities during early data analysis phases will generate a large body of data, codes and categories. At this point you can feel stuck, finding it difficult to move beyond description to the development of medium to high level concepts’ (Birks & Mills, 2011, p. 109). Their description encapsulated precisely how I felt and where I was in the research process. It was very helpful for me to use the tool of storyline at this stage. Strauss and Corbin (1990) define ‘story’ as ‘a descriptive narrative about the central phenomenon of the study’ and ‘storyline’ as ‘the conceptualisation of the story’ (Strauss & Corbin, 1990; p. 116). Storyline is thus inherently suggesting coherence and continuity in the findings, which in turn provides an explanation of the phenomenon (Birks & Mills 2011). Birks and Mills (2011) suggest that not only can the use of storyline assist in the production of the final theory, but that it also enables the theory to be presented to the reader in an accessible, intelligible and palatable format.

After data analysis is complete and the researcher commences final sorting and writing up of the data, this is an appropriate time, suggests Glaser, to integrate and weave in existing literature on the topic (as opposed to at the beginning of the research process,
where it could influence the findings of the investigation) (Glaser, 1998). Assuming that the aforementioned data collection and analysis processes are followed in line with the grounded theory methodology, then ‘the final product of a grounded theory study is an integrated and comprehensive grounded theory that explains a process or scheme associated with a phenomenon’ (Birks & Mills 2011, p. 12).

**The place of philosophical assumptions in grounded theory**

‘All research is interpretative; it is guided by the researcher’s set of beliefs and feelings about the world and how it should be understood and studied. Some beliefs may be taken for granted, invisible, only assumed, whereas others are highly problematic and controversial’ (Denzin & Lincoln, 2005, p. 22). Acknowledging existing assumptions is an effective method for establishing where the researcher stands in relation to the proposed study. Moreover, by considering and articulating one’s assumptions and subjective outlook before actually commencing the study, the researcher maintains transparency from the outset. This prevents assumptions from impairing the research process and product (Birks & Mills, 2011). It is worth noting, however, that obviously as human beings, we make assumptions about the world and we all hold a set of beliefs and understandings about how the world operates. This is an inescapable fact, as noted by Creswell, who observes that ‘researchers bring their own world views, paradigms or set of beliefs to the research project and these inform the conduct and writing of the qualitative study’ (Creswell, 2007, p. 15). Given that every researcher’s set of beliefs will inevitably inform the conduct and writing of a study to some extent, it would seem pertinent that not only does the researcher make their own assumptions clear to themselves, but also to the reader and their supervisory team to ensure that the research process is not inadvertently hijacked by the researcher’s hidden assumptions. This will also promote a climate of impartiality, allowing the findings of the study to represent the
phenomenon under investigation rather than being reflective of the researcher’s worldview and preconceived ideas.

Grounded theory has several inbuilt mechanisms that minimise external impositions. These mechanisms include constant comparison, saturation and core relevance (Glaser, 1992). As Denzin and Lincoln assert, ‘[q]ualitative research is endlessly creative and interpretive ... Qualitative interpretations are constructed’ (Denzin & Lincoln, 2005, p. 26). Thus, to discount the researcher’s contribution to this interpretation is to assume that their personal position has no impact upon the findings.

So, throughout the process of undertaking qualitative research, the researcher is intricately linked with the ultimate findings. Indeed, my chosen method of grounded theory is certainly not immune to this – on the contrary, it is to some extent reliant upon the researcher’s participation in interpreting the data to construct a theory. Or, as Birks and Mills put it, ‘[t]he final product of a grounded theory study is an abstract construction of the researcher’s making, with both researcher and participants generating data that informs this theory’ (Birks & Mills, 2011, p. 56). Similarly, Charmaz (2006) states that as researchers, we are ‘part of our constructed theory and this theory reflects the vantage points inherent in our varied experience, whether or not we are aware of them’ (Charmaz, 2006, p. 149). A declaration of my personal philosophies will therefore assist the critical reader to determine the quality of this work. Birks and Mills (2011) suggest that from the outset, the researcher should document and ultimately declare her philosophical position, how she sees the world, what she already knows about the topic (formally, anecdotally and from personal experience), and lastly what she expects to find in her research. What follows is my documentation of these issues.
Philosophical declaration of the researcher – positioning the researcher within the research process

I had a blessed upbringing. I am the firstborn of two daughters to migrant parents whose first language was not English. My father had very little education in his homeland of Cyprus, and my mother was the only one of her five siblings to attend university. My parents married young and worked hard to establish themselves and educate their children. Corbin and Strauss (2008) identify a number of assets that foster quality in research, many of which relate to personal and professional characteristics, including self-awareness, clarity of purpose, commitment to hard work and internal motivation (Corbin & Strauss, 2008). My possession of these traits is largely attributable to my upbringing, and this ideally positions me to undertake this research project.

Based on the cultural influence of my Cypriot parents and large extended family, I have come to value the importance of close family ties and the importance of relationships as an essential element to a happy existence. This is further bolstered by my Christian belief that mankind was made to inherently desire closeness with others. To be in relationships, therefore, is an essential part of our earthly existence.

I hold tertiary qualifications in naturopathy, biblical theology, nursing and midwifery. Having studied naturopathy, my philosophical position on the body, medicine and health care are holistic, whereby the body’s parts and systems are all connected and reliant upon each other for proper functioning. This sits in contrast to the mechanistic and biomedical principles that underpin the paradigm of modern, western medicine, in which the mind and body are seen as distinct entities, and body parts and systems are diagnosed and treated discretely and in isolation from each other. Conversely, it is my belief that our bodies have an innate ability and wisdom to heal and function, and that often medical
management of the body does not take this into account.

It is my philosophical stance that drives my practice as a naturopath, and also why I was never suited to the practice of nursing, which in my opinion relied too heavily on the application of a biomedical model in the provision of care. My philosophical position was what attracted me to the sphere of midwifery. Midwifery situates itself within a wellness model of care, whereby our clientele are well, healthy women. Midwifery sees pregnancy, birth and the postpartum period as normal events in a woman's life, rather than as a pathological development or process. Indeed, the philosophy underpinning the practice of midwifery is very much in line with the naturopathic philosophy, and this is what made it so attractive to me.

Having completed a Graduate Diploma in Midwifery and graduating with distinction at the top of my class in 2008, I couldn’t help but cast a critical eye over and question the way in which birthing women are treated in hospital. As part of my midwifery training, I spent one year working as a student midwife in a hospital. Frequently, I found myself screaming in my head 'this is wrong!' and early on in my training I promised myself that I would never practise midwifery in a hospital. In the hospital context, it seemed to me that the basic needs of a birthing woman were not being met. The women and their babies were not respected, and their treatment was over-medicalised. In the hospital, I witnessed birth being managed like an illness, which I could neither rationalise nor comprehend. In my midwifery training, I felt forced to do things to birthing women and their babies that were against my principles, and contrary to all my understandings of how a woman and her child should be treated. At the completion of my training, I registered as a midwife and set up business as a private midwife, where I predominantly provided midwifery care to women choosing homebirth. I have practised in this manner
this since 2009, and hope to continue to do so for as long as my mind and body will allow me.

My role as a private midwife ideally positions me for this research, as it has allowed me to be fully immersed in homebirth culture, and to understand the challenges surrounding homebirth and the challenges experienced by women who choose it. It has also given me a clear understanding of how and where to access participants for this research. I believe that my professional identity as a private midwife enhanced the willingness of participants to offer their time and stories for this study, since they felt a certain degree of trust towards how I would represent their choice to *birth outside the system*. Being a private midwife also puts me at a distinct disadvantage, because I already have a strong understanding of the general substantive area explored in this research. This means that I brought opinions, understandings and preconceived ideas to the study that another researcher may not have, and I was aware of the potential for this to negatively impact on the study’s findings. However, as espoused by Clark and Charmaz, I employed reflexivity in the research process, since this helps the researcher to limit negative impacts upon the research process and findings (Charmaz, 2006; Clark, 2005).

Being a private midwife has provided me with a rich understanding of women's general dissatisfactions with mainstream maternity services. Hearing their birth stories has created in me a sympathy and understanding of their birth experiences. I was acutely aware throughout the research process that this would predispose me to side with my participants, and that it would create in me a passionate desire to represent their stories in a sympathetic manner. Throughout the research process, I was constantly challenged by my supervisors to think critically of my research participants and their stories in order to draw as much out of the data as possible, as opposed to colouring the data and its
subsequent findings with my preconceived ideas and assumptions. Having said this, Glaser (1992) explains that every researcher comes to a project with something, and that this experience can be used as data within a grounded theory approach (Glaser, 1992). While I acknowledge that my previous experience leaves me open to forcing the data in the direction in which I believe it should go, I also consider the fact that my experience has conferred more benefit than disadvantage. Throughout this project, I made a conscious decision to utilise my previous experience as data, thus propelling the research to a deeper level than that which could be achieved by a researcher with less life experience in the area of midwifery.

As a private midwife, I believe that homebirth, for low-risk women, is a safe and appropriate choice. For women with risk factors or without a midwife I am less sure, as there is less certainty with the outcomes. I don't have a particular view about whether women with risk factors or women choosing freebirth should or should not pursue these choices. I very much believe that women have the right to opt for whichever birth choice they desire, even when it might differ from the choice that I would make in their situation.

The use of memo writing facilitates reflexivity throughout the research process. For Birks and Mills (2011), reflexivity is a key strategy to promote quality in the use of grounded theory, and systematically developing insight into your work to help guide future research actions’. Charmaz and Clark are of the opinion that researchers should be reflexive in their approach to grounded theory, (Charmaz, 2006; Clark, 2005) while Glaser and Neill are somewhat less convinced by the value of reflexivity (Glaser, 2001; Neill, 2006). Nevertheless, by way of personality and preference, and throughout the research process in concert with my supervisors, I have employed reflexivity throughout
my memoing process in a bid to monitor my influence on the data collection and analysis. I felt that this was particularly important since I am aware of the impact that my role as a private midwife could have on the interpretation of the data. In order to be reflexive throughout the research process, I constantly asked myself, ‘what is the data saying?’ This kept the findings grounded in the data. Regular meetings with my supervisors translated to having my work frequently checked and edited, which afforded the opportunity for me to be constantly challenged on assumptions that may have been inadvertently integrated into the developing theory. My supervisors furthermore suggested activities to which I could commit in order to ensure that my findings remained true to the data. One of these included presenting the women’s quotes alongside the labels of emerging codes and categories. In so doing, I was able to assure my supervisors and myself that there was sufficient data to support each developing code and category.

After completion of the findings chapter of this thesis and beginning writing my discussion and conclusion chapters, I discovered that I was pregnant with my first child. Given that I was declared healthy and considered low-risk, I chose to pursue a homebirth with midwives. As my pregnancy continued, I developed a few small risk factors including some early spotting and ultimately a prolonged labour. I birthed at home at thirty-six and a half weeks gestation (putting me in a high-risk category). My baby was of low birth weight (2,300 g) and would have been managed in special care nursery had I not birthed at home. Having what would be considered a ‘high-risk homebirth’ positioned me as an insider in this research project. However, I would maintain that this (inadvertent) positioning was not influential on the findings of this thesis, since the findings and research process had already been concluded before I underwent my own birthing experience. However, I have offered an epilogue about my birth appended to this thesis, in order to reflect upon my experience in relation to what
has been discovered through my research. Having made the same birthing choice as that made by the participants in this study only served to solidify in my mind the fact that the findings were true to the data; they certainly were true for me.

*Strengths and weaknesses of a grounded theory research method*

The major strength of grounded theory is that it is a substantiated method of formulating theory and has the ability to move data from a descriptive level to a conceptual and theoretical level (Artinian, et al., 2009). A benefit of grounded theory is that it can be used by a researcher who knows very little about the subject or participant group being studied (Artinian, et al., 2009). Another strength of grounded theory is that it is thought to be a self-correcting approach to research, insofar as any errors in the data collection and analysis process would eventually be extinguished if the essential elements of grounded theory are applied consistently (Birks & Mills, 2011).

Any flaws or weaknesses that stem from a grounded theory method are thought to originate with the user rather than the method. The most difficult and common problem encountered by researchers is their conscious or unconscious unwillingness to let go of preconceived ideas. By holding on to preconceived ideas, the researcher will ultimately have difficulty trusting emergence from the data which inhibits the achievement of a theoretical conclusion (Artinian, et al., 2009).

Using grounded theory for the first time as a researcher is daunting, as you don’t really know if you are using the method properly until you are some way through the research process. This circumstance is a result of the differing beliefs about the use of grounded theory by various authors. In this instance, it was most helpful to have research supervisors who are familiar with the method and could give guidance in the best way to
proceed. However, fortunately grounded theory appears to be a flexible method with a set of guidelines rather than ridged rules and so the user has some flexibility in how they choose to apply the method. It is also most comforting that no prior knowledge of the subject matter is required for the use of grounded theory and makes the method an exciting and revolutionary approach to research. From experience, the weaknesses of grounded theory can be overcome by having close supervision of the student researcher by experienced and honest supervisors who are vigilant at keeping the student accountable.

**Determining quality and rigour in grounded theory studies**

Researchers have proposed various strategies for how to best assess the quality and rigour of a grounded theory study. As previously mentioned, my own study was performed in accordance with the recommendations of Birks and Mills (2011), who espouse ten essential elements of grounded theory. It seems fitting, therefore, to also gauge the quality my study against their suggested quality and rigour criteria (Birks & Mills, 2011). For Birks and Mills (2011), ‘it is the quality of your data and how you apply grounded theory methods in its collection, generation and analysis that will determine whether your research will be deemed a quality study’ (p. 147).

In their discussion on rigour, Birks and Mills (2011) suggest that when evaluating a grounded theory study, one can start with an informal and intuitive evaluation. This means making a preliminary judgement of the overall feel for the quality of a piece of grounded theory research, since this allows the reviewer to establish from the outset whether or not the author has moved beyond a fundamental description of phenomena and into the realm of theoretical abstraction (Birks & Mills, 2011). After this, they propose some ‘classic criteria’ by which a grounded theory study can be judged. In this
context, Birks and Mills explicate Glaser and Strauss’ original criteria for judging the credibility of a grounded theory study. Glaser and Strauss (1967) felt that a completed grounded theory should demonstrate: a close fit with the data, usefulness, conceptual density, durability over time, modifiability and explanatory power (Glaser & Strauss, 1967). In other words, grounded theory should ‘fit with the field of its intended use, should be understandable by those who work in the area, be general enough that it can be flexible in application while allowing the user control over its use’ (Birks & Mills, 2011, p. 150). Birks and Mills (2011) do stress, however, that their emphasis is predominantly on rigour in the application of grounded theory strategies, techniques and methods, which is more in line with the later-mentioned importance of ensuring methodological congruence and procedural precision as markers of quality and rigour in grounded theory (Birks & Mills, 2011).

Glaser moves on from the aforementioned original criterion proposed by Strauss and himself to state that ‘a well-constructed grounded theory will meet its four most central criteria: fit, work, relevance and modifiability’ (Glaser, 1992, p. 15). If a grounded theory is induced from the research process correctly, Glaser (1992) contends, then it will ‘fit the realities under study in the eyes of subjects’ (p. 15). A grounded theory is thought to ‘work’ if it can explain the major variations in behaviour in the area being researched (Glaser, 1992). An example of how the findings of this research were modified to ensure that they ‘worked’ was in the reassessment, at regular intervals, of both the core category and basic social process. By revisiting these frameworks on a regular basis throughout the research process, I was asking myself regularly whether the headings I had formulated still ‘worked’ to explain what motivated women to birth outside the system. For Glaser, ‘if it fits and works, the grounded theory has achieved relevance’ (Glaser, 1992, p. 15). Finally, ‘modifiability’ dictates that the grounded theory should be pliable and
modifiable if new data presents variations; thus the project should be able to accommodate the integration of new concepts (Glaser, 1992, p. 15). Glaser (1992) proposes that if these criteria have been met, then the researcher can be assured that the developed grounded theory provides a conceptual approach to the actions being researched.

**Comprehensive evaluation of grounded theory**

In addition to a preliminary assessment of the quality of the research, Birks and Mills (2011) give suggestions of ways to perform a ‘comprehensive evaluation’ which would assess 1) researcher expertise, 2) methodological congruence, and 3) procedural precision, all of which can be used as indicators of a quality grounded theory.

The first aspect of determining quality in grounded theory research is to assess the researcher’s expertise. To this end, Birks and Mills (2011) encourage evaluators to ask questions such as ‘[d]oes the researcher demonstrate skills in scholarly writing? Is there evidence that the researcher is familiar with grounded theory methods? Has the researcher presented citations of relevant methodological resources? Are limitations in the study design and research process acknowledged and addressed?’ (p. 153).

The second aspect of determining quality and rigour in the research process and ultimately the grounded theory is the demonstration of methodological congruence (Birks & Mills, 2011). An essential component of achieving methodological congruence is for the researcher to acknowledge their personal philosophy in relation to their study area (Birks & Mills, 2011). For my study, this has been undertaken previously in this chapter. As Birks and Mills put it, ‘[m]ethodological congruence occurs when there is accordance between personal philosophical position, the aims of your research and the
methodological approach you are employing to fulfill these aims’ (Birks & Mills, 2011, p. 36). Methodological congruence is thought to be the foundation of a credible research study, and involves being honest about the limitations of the research and the acknowledgment of methodological inconsistencies along with their rectification (Birks & Mills, 2011). In order to judge whether the author has demonstrated methodological congruence, Birks and Mills (2011) suggest asking the following questions: ‘[h]as the researcher articulated their philosophical position? Is grounded theory an appropriate research strategy for the stated aims of the study? Do the outcomes of the research achieve the stated aims? Is the grounded theory presented as the end product of the research? Are philosophical and methodological inconsistencies identified and addressed?’ (Birks & Mills, 2011, p. 153).

Thirdly, the demonstration of procedural precision is another way of determining rigour and quality in the research process. Procedural rigour specifically focuses on the process of generation and collection of data (Burns, 1989, p. 49). Integrity in this process is predicated upon the documentation of an audit trail, the careful management of data and a demonstration of procedural logic (Birks & Mills, 2011). Meticulous documentation of the research process allows the author to explain and detail the process, conferring transparency and accountability, and thereby enhancing the rigour of their research (Birks & Mills, 2011). One way of increasing rigour in the research process is the use of qualitative data analysis systems and management programs. It was my initial intent from the outset of my research to eschew the use of electronic databases, because I was concerned that their use might impede my ability to coherently sort, find and use the data I had collected. Moreover, I was fearful of having to learn a new program and system. However, after collecting and analysing data for the first seven months of this project, as the quantity and quality of data increased, I found it increasingly difficult to keep track of
my findings and move on from initial data analysis to the more advanced stages of analysis. I also found that undertaking data analysis manually on basic electronic word documents and on paper limited my ability to quickly find and collate data and compare findings across the data. To compensate for this, I found myself writing lengthy and detailed memos to keep track of my thought processes; inevitably, then, the process of data management became slow and cumbersome. Recognising the need to find a solution, I undertook a two-day training course in the use of ‘Nvivo’. After learning to use this program, I felt it was the perfect tool to sort and manage the vast amount of data that I had collected. Using ‘Nvivo’, I could rapidly code and categorise the data, which made the grounded theory approach of constant comparative analysis far more streamlined and expeditious. I took the time to enter in all the research data and line-by-line and word-by-word analysis that I had already undertaken into the program, and continued my analysis with the aid of this program. ‘Nvivo’ was used simply as a data management tool, to sort and code the data; it was not used to draw conclusions or actually perform analysis. The use of ‘Nvivo’ ensured that I did not lose data or ideas or connections made within the data, unlike when the process was done manually. It also allowed me to rapidly visualise the connections and commonalities across all the data sources. My experience with Nvivo was very positive and its very purpose is to fragment and categorise the data in such a way as to allow the researcher to rebuild it in an explanatory way. In my case, Nvivo was simply used to breakdown and categorise the data with the reconstructing and analysing done manually, away from the program. On the advice of my supervisors, Nvivo was not used to reconstruct the data in meaningful ways, this was done more intimately by myself and my supervisors, with close attention to idiosyncrasies, than could be provided by a computer program.
‘Nvivo’ offers the functionality to add date stamps, which allows the researcher to keep track of the research process, essentially creating an electronic audit trail. Both the use of an audit trail and the establishment of structured mechanisms for management of data are investments in the credibility of the research process (Birks & Mills, 2011), both of which were executed by the use of Nvivo to assist with the research process and facilitate procedural precision. Birks and Mills (2011) suggest that an assessor asks themselves the following questions to help determine whether the author of a study has demonstrated procedural precision: ‘Is there evidence that the researcher has employed memoing in support of the study? Has the researcher indicated the mechanisms by which an audit trail was maintained? Are procedures described for the management of data and resources? Is there evidence that the researcher has applied the essential grounded theory methods appropriately in the context of the study described? Does the researcher make logical connections between the data and abstractions? Is there evidence that the theory is grounded in the data? Is the final theory credible? Are potential applications examined and explored?’ (p. 153).

**Conclusion**

In conclusion, this study used grounded theory to explain what motivates women to *birth outside the system*. In total, the stories of 28 women were included as data, 13 choosing homebirth and 15 choosing freebirth. Ten essential elements of grounded theory were applied in order to develop the final findings and produce a theory grounded in the data. What follows in Chapters Four and Five are the findings of the study. They are presented as the core category (Chapter Four) and basic social process (Chapter Five).
Chapter Four: The findings – the core category

Introduction

Chapters Four and Five will detail the findings from this research. Chapter Four commences with a storyline of the findings, which gives a full summary of what was discovered throughout the research process. The storyline explores both the core category ‘wanting the best and safest,’ and the basic social process ‘finding a better way.’ Following this is a visual representation of the findings, allowing the categories and subcategories to be understood at a glance. After this, a detailed explanation of the findings is provided. The quotes used to support the findings are finished with either ‘HB’ indicating that the woman had chosen homebirth, or ‘FB’ indicating that she had chosen freebirth. The number alongside indicates in which order the women were interviewed (that is, HB08 designates the eighth homebirth woman to be interviewed).

As previously mentioned, a storyline technique was used in the advanced stages of analysis. It was the use of this technique that ultimately revealed with clarity what had emerged from the research process. It is with this storyline that we begin our journey through the findings.

The storyline

This research project has established that the core of what motivates women to birth outside the system is ‘wanting the best and safest’ for themselves and their babies. There are three criteria by which the participants judge ‘best’ and ‘safest.’ These are: having a natural birth without intervention, having their family close and being respected as the authority throughout their care. If a birth option cannot cater to one of these criteria, it is not considered the best or the safest, and is therefore deemed unacceptable.
After becoming traumatised by their previous birth experiences, the participants learnt that a birth inside the system could not offer them the safety and the standard of care that they desired. Of their previous experiences of giving birth in a hospital environment, participants reported being assaulted, degraded, bullied, dismissed, not being listened to, experiencing side effects from a birth procedure, being separated from their family, being abandoned by supporters and not having their expectations met. These circumstances taught the participants that this birth option could not offer them safety, because it had already presented itself as emotionally, mentally, socially, culturally and physically dangerous and traumatising. For this reason, the participants perceived their previous births inside the system to be a more risky and less safe choice than a birth outside the system. This belief was accentuated by the participants’ experience of the impact their trauma had on their lives. Some of the participants’ experience of birth trauma was life changing, an effect they were not willing to compound by returning to the place that was the source of their original trauma. Indeed, so traumatic was the experience for the participants, that some reported outcomes such as the development of mental illnesses and pathological behaviours, the inability to embody the type of mothers they wanted to be, and the inability to function with their other relationships. The participants learnt from their previous experiences that birth inside the system could not offer them the best and safest and so they had to find a better way.

The participants’ philosophical standpoint on childbirth played a particular role in their choice to birth outside the system, because it shaped what they believed would be the best and safest. The participants believed that childbirth imprints on one’s life, is a normal process and needs ideal circumstances to work best. With the understanding that childbirth imprints on one’s life, participants pursued birth outside the system in the hope
that the imprinting would be positive not negative. The participants’ belief that childbirth is a normal bodily function predisposed them to question the need for hospitalisation and fueled their belief that childbirth has been unnecessarily medicalised. Finally, the participants reported a detailed list of circumstances that they believe are required to ensure birth works best. These included: adequate hormonal function, an optimal environment, privacy and relaxation, active birth positioning and good physical, emotional and mental preparation. Based on their previous experiences, the participants believed that the hospital was not capable of facilitating the circumstances that birth needed to work best, and was therefore incapable of providing the best and safest.

Just as the participants’ perspectives on childbirth informed their choice to birth outside the system, so too did their perspectives on risk. The participants’ perceptions of risk were that birth always entails an element of risk, the hospital is not the safest place to have a baby, and interference is a risk. The participants believed that birth always has an element of risk and that their chosen place of birth may not mitigate the risk inherent in birth. They believed that the hospital is not the safest place to have a baby, citing additional and unique risks associated with this option. Finally, the participants perceived that interference in the birth process is a risk, and that interventions in the birth process created more problems than they prevented. Because the participants wanted the best and safest for themselves and their babies, they sought out birth options that would limit risk. Hospital was perceived to be more risky, and the most likely site where birth would be interfered with, so it was discounted as a suitable birth option.

Participants’ previous experiences with the hospital system, paired with their beliefs on childbirth and risk, led them to assume that the hospital could not provide the best or the safest, because they could not cater to their three criteria by which ‘safest’ and ‘best’
were judged. The participants cited multiple reasons why the hospital was incapable of providing the best of safest and these have been categorised under the headings, ‘not enough resources to cope with demand’, ‘the environment was not like home’, ‘it’s like a cattle yard’, ‘staff are bound by hospital policy’, ‘they intervene’, ‘they fear birth’, ‘there would be tension around my autonomy’ and ‘hospital management of birth is emotionally unsafe’. For the reasons explicated under these headings, the hospital was discounted as an acceptable birth option.

Given that the participants concluded that the hospital could not provide the best or the safest, they set out on the journey towards ‘finding a better way,’ (this is detailed in Basic Social Process – see Chapter Five), which ultimately led them to birth outside the system.

As the participants set out to find a better way to birth, they start by considering all of their birth options. As they embarked upon their journey, they came to learn that there are multiple birth options available to them, and that they were not obliged to return to the hospital. Armed with this information, they met with a variety of care providers to discuss these newly found options. The information they gathered helped them to weigh up all their options, and to determine whether they were in fact the best and safest, or at the very least ‘better’ than their previous experiences. Birthing options that were not considered better were quickly discounted. For the women who chose high-risk homebirth, their process of discovery of birth options stopped here; they hired a midwife and followed through with their midwife-assisted homebirth. For those who chose freebirth, the process of considering their options continued. The majority of participants reported a preference to have a midwife in attendance, but ultimately freebirthed because they felt they had no other option, and that it was the best and safest option available to them at the time.
In the process of finding a better way to birth, the participants realised that their chosen option subverted normative models of childbirth, and that if they were going to see their plan come to fruition, they would have to effectively manage opposition. The participants reported that managing opposition was hard work, and they were compelled to actively adopt strategies to avoid having their birth plans thwarted. These strategies included: arming themselves with knowledge so they could effectively defend their choice, strategic engagement of care providers – avoiding those who would oppose their choice and engaging those who would facilitate it, selective disclosure of their plans to avoid conflict, having people on their side to help advocate for their choice, and ‘playing the game,’ which involved bartering with and manipulating the system to ultimately get what they wanted without having to compromise on the best and safest.

Given that the participants made their birth choices based on their desire for risk reduction, and that they understand that birth always entails an element of risk, they sought to mitigate the risks associated with birth at home. They did this by getting mentally and physically prepared. By focusing on their mental and physical preparation, they believed they would experience the most optimal birth outcomes. They also gathered knowledge, skills and supplies to ensure that they were adequately prepared for their unique circumstances and to mitigate their personal risks. They also planned for all possibilities, so that if the worst should occur, they were clear in their minds what plan of action would be taken. In the circumstance of an emergency, the participants believed that transferring to hospital became the new best and safest, and were prepared to do this.
Throughout the process of finding a better way, the participants simultaneously and unwittingly became experts in their pregnancy and birthing journeys, and came to value their own ability to make informed and safe choices over that of their care providers. The participants described themselves as different to other women because they are ‘always bucking against the system’, ‘take responsibility’, ‘investigate to ensure that they know’, ‘believe in their ability to ‘know,” ‘have a sense of entitlement to choose’, and ‘posses confidence in their ability to birth’. These characteristics facilitated the development of their expertise as they pursued a better way and ultimately led them to birth outside the system.
Table 3- the core category

**CORE CATEGORY**

Wanting the Best and Safest

1. Having a natural birth without intervention
   2. Having my family close
   3. Respected as the authority at my birth

1. Previous birth experiences
   1a. Becoming traumatised
      - being assaulted
      - being degraded
      - being bullied
      - not being listened to
      - experiencing side effects
      - being separated from family
      - being abandoned by supporters
      - expectations not met
      - had a lot going on in life
   1b. Experiencing birth trauma is life changing

2. Perspectives on childbirth
   2a. Childbirth imprints on one's life
   2b. Childbirth is a normal process
   2c. Childbirth needs ideal circumstances to work well

3. Perspectives on risk
   3a. Birth always has an element of risk
   3b. The hospital is not the safest place to have a baby
   3c. Interference is a risk

4. The hospital can't provide the best or the safest
   4a. Not enough resources to cope with demand
   4b. It's not like home
   4c. It's like a cattle yard
   4d. Bound by hospital policies
   4e. They intervene
   4f. The system fears birth
   4g. Tension around my autonomy
   4h. Hospital management is emotionally unsafe
The core category – wanting the best and safest

The core reason behind women’s decision to *birth outside the system* was wanting the best and safest for themselves and their babies. One participant explained what motivated her to *birth outside the system*:

In an effort to want to make my own choices and to be in control and to feel safe, and like the decisions were truly mine and the decisions that are the best for not just you and not just your baby, not just your husband, but just the whole picture. Its what’s best for me and this baby and my other children and my husband, it’s wanting the best and to get the best I feel like I need to be in control and for me to be in control and to be safe means I need to be at home. (HB05)

Women wanted the best possible experience and outcome, and felt that a *birth outside the system* was the best way to achieve this:

It was the best, it really was the best choice for me in terms of all the information that I’d read, all my research and my informed choice was that this was going to be the best fit for us as a family. (FB06)

I just wanted it to be a good experience for all of us and I thought however I can achieve that, then I’ll be happy. (HB09)

The participants made a point of positioning themselves like every other mother, as wanting the best and safest for their children. One woman explained:

I’m just a normal person that just happens to think that this is the best thing that I can do for myself and for the baby. (HB07)

Another woman explained how in her pursuit of the best and safest, she investigated her birthing options and found that birthing outside the system represented a better choice when she compared it to birthing in hospital. She elaborated:

I like to investigate, make sure I know ... I want to know for myself that this is the optimal choice for me and for birth, the hospital was not it, it couldn’t come anywhere near it. (FB05)
For the participants, safety did not just mean keeping physically safe, but also emotionally, socially, culturally and mentally safe. *Birth outside the system* was seen to offer holistic safety that the participants felt would not be available if they birthed inside the system. Firstly, the participants believed birth at home to be the best way to keep themselves and their babies physically safe. One woman commented:

I wanted a positive outcome, that’s why I chose to birth at home. I wanted to be alive myself, I wanted a live baby ... the reason I chose homebirth was I wanted a safe birth for my baby. (FB05)

Another woman explained how freebirth offered her emotional safety:

Because I feel that’s safer and better emotionally for me, and my baby and what’s good for me is good for my baby. It feels safe that way. (FB09)

Another participant described how a *birth outside the system* offered her and her children the all-encompassing safety that she desired:

I want the absolute very best for all of my children, I would not ever, ever endanger them, I don’t want them harmed, I want them to have the very best outcome in terms of their physical health, mental health, emotional health, their complete and utter wellbeing and safety, that is what I want for them. So yeah, so that’s where I was coming from. (FB05)

The participants described what they perceived to be the ideal circumstances required to ensure that their birth was the best and safest it could be. These were, having a natural birth without intervention, having their family close and being respected as the authority. Knowing these desires is important because these women make their birth choices based on which birthing option would best cater to their desires. These desires represent what the women believe to be the best and safest for them and their babies, and birthing options that cannot cater to these desires are discounted because they are perceived to be less safe.
**Having a natural birth without intervention**

For the participants, the intention and ideal was to have a natural birth in which their baby was birthed vaginally without the use of interventions or medications. One woman put it simply: ‘I want a natural birth’ (HB02). A natural birth did not just mean giving birth to a baby vaginally; it also meant avoiding interventions and interruptions in the birth process.

The participants valued and trusted that the birthing process was most successful when left alone and uninterrupted, with one woman explaining, ‘I think the main thing was that I just wanted the process to be left alone’ (FB06). One could assume that these women wanted to be left alone completely throughout their birth, because they said things like ‘I want to be just be left alone to have my baby’ (HB02). However, they did not mean left completely alone, what they wanted was for their body and the birthing process to unfold uninterrupted. Another woman stated, ‘I really just wanted everything to be hands off’ (FB06). The participants believed that many of the routine procedures used to manage birth in hospital interrupted the birth process and were unnecessary. One woman explained:

> The managed third stage ... that was intervention as far as I was concerned and I read quite a bit about if there was no intervention during the birth, there was no need for intervention with the delivery of the placenta. (HB08)

This desire to avoid intervention also applied to their antenatal care, postnatal care and the care of their newborn baby. One woman explained how important it was to her to be uninterrupted from bonding: ‘I just wanted to hold my baby, I didn’t want to be interrupted from that’ (FB07). Another commented on the routine administration of Vitamin K and Hepatitis B vaccines for babies at birth and her desire to avoid these:

> I’d asked immediately for it to be marked on my file that I didn’t want the baby to receive Vitamin K unless it was...
necessary and I didn’t want to baby to receive the Hep B shot, and I had things straight up that I wanted to have clearly marked on my file. (FB06)

These women did not want to be interfered with while birthing their baby, and similarly they did not want the postnatal period with their baby being interrupted by unnecessary activity or intervention. This desire was also informed by the participants’ belief that privacy was essential to ensure that the birth goes well, as will be discussed later. The participants believed that a natural birth without intervention was the best and safest for them and their babies.

**Having my family close**

The participants prioritised sharing their pregnancy, labour, birth and postpartum experience with their family; they therefore made choices that would ensure that the family unit stayed together. For them, this felt the best and safest. Participants reported experiencing an emotional trauma with previous births as a result of separation from their family, and the system’s disrespect for the family unit. The desire to have their family close may have stemmed from wanting to avoid emotional trauma like this again; indeed, it may have been a pre-existing and inherent desire during their earlier birth experiences, causing them distress when this desire was not respected.

The participants expressed the connection they have with their family and their desire to remain close to them as they go through the transformative experience of labour and birth. One woman explained her aversion to adhering to the hospital visiting hours because she wanted to have her family close:

> My husband wasn’t going to be able to stay with me and the nature of our relationship is that we are very close, and I wanted him to be able to be there and to be a part of his first child as well. So he wasn’t going to be able to stay ... I had said early on that if my husband can’t stay, then I don’t want to stay. (FB04)
Another woman explained that her reason for choosing a homebirth was the connection she had with her first child, whom she was still breastfeeding:

My first child was very attached and still breastfeeding, he was only two, or not even two when I fell pregnant and I didn’t want to leave him to go into hospital and then come back with a baby. That was one reason (I birthed at home); I didn’t want to leave him. (HB01)

Another woman explained her priority for the wellbeing of her older son as she considered her birthing options:

At that point I really did not want to leave my other son, I had not spent any time away from him in that whole year and a bit and I didn’t want to have to leave him for a few nights to be in a hospital, to then bring home this other little baby – I just did not want to do that, I didn’t feel like it would be a very good thing for him. (FB07)

When the participants made choices about where they would birth, they also considered the wellbeing of their family. Some women explained that their desire to keep their family close was rooted in their belief that birth is an intimate family experience. One woman explained, ‘I think I really just enjoy my own intimate experience with my family and I just didn’t feel the need to bring too many people into it’ (FB06).

Having their family close was a common desire expressed by the women who chose to birth outside the system. The connection these women felt to their partners and children was a strong motivator to remain at home to birth, where they felt that this desire could be realised. Their previous experiences had taught them that other birthing options could be disrespectful to the family unit, which rendered birthing inside the system an undesirable option. The participants pursued birthing options where they perceived that they would have the best and safest for themselves and their babies; this included having their family in close proximity, something they felt that the mainstream health services could not guarantee.
**Respected as the authority at my birth**

When discussing their desires for the best and safest birth, the desire to be ‘respected as the authority at my birth’ ran as an undercurrent through all of the women’s stories.

When asked to summarise what motivated her choice to *birth outside the system*, one woman said:

> In a nutshell, what motivated me to choose freebirth? The desire to be the authority at my own birth, yeah that’s probably it. (FB08)

Another explained:

> I wanted a birth where I felt autonomous and that I felt empowered and that I was in control of my own decision-making and I think that yeah ideally that was what I meant by best in terms of just ideal circumstances. (FB06)

Here, the women express the central importance to them of retaining authority, autonomy, agency, power and control. This idea of having the freedom to exercise agency and autonomy over their birth was not unique to the women choosing freebirth; women who chose a homebirth also expressed similar sentiments. For example, ‘I feel like I’d have control (if I birthed at home)’ (HB02). The women also commented that to be in control was important to them in other aspects of their lives; they therefore felt entitled to be in control during birth. One woman explained:

> I’m a bit of a control freak, but I think I’m entitled to be because it’s my body and my baby, so me wanting to be in control is slightly more understandable. (HB05)

Part of the desire to be respected as the authority at their birth was not only the longing to have control over the decisions made throughout labour and birth, but also the freedom to have people in their birth space who would respect their ability to make decisions during the birth. The participants made a specific point of choosing care providers and a birth space that afforded respect, and that were supportive of the
woman’s authority. One woman explained, ‘in order to access the type of care I desired, I would have had to relocate or birth at home. I was only looking for privacy, respect and a gentle birth’ (FB10). Another woman noted that in order to regain control over her birth, she would pay for a private midwife who would be respectful of her desires, ‘I’m going to pay for somebody to not touch me the way I don’t want them to’ (HB07). If this desire is not respected and the woman’s autonomy is challenged, women disengaged and pursued other birth options, as will be discussed later. The desire to be respected as autonomous at their birth was a major motivator in the women’s choice of care provider and place of birth.

*Birth outside the system* was perceived to provide the participants with the best and safest birthing option when compared to birth inside the system. It was considered better and safer because the participants felt that it would give them a greater chance to have a vaginal birth without intervention, to keep their family close, and to be respected as the authority at their birth. The participants perceived that birthing at home would provide them with the physical, emotional, social and mental safety that they desired, thus rendering a *birth outside the system* better than a birth inside the system. To better understand how the participants came to believe that birthing outside the system was better than birthing inside the system, we consider their previous birth experiences. After having a suboptimal experience in their previous encounters, participants felt the need to find a better way.

1. Previous birth experiences

For the women in this study, past experiences shaped how they believed their pregnancy and birth would be managed in the system. For the majority of women, their previous birth experiences were traumatic; two participants however did not describe their previous births this way and two participants were primiparous and so had no previous
birthing experience. For the majority of participants, however, it was their previous experiences that contributed to their choice to *birth outside the system*. For the primiparous women in this study, their life experiences and other exposure to the health system informed their choices.

The first participant who chose to *birth outside the system* with her first baby explained how her decision was based on the information she had gathered in the course of her doctoral research, and from other women’s birth stories where she learnt what she could expect from health care providers and the system. She explained:

> Firstly I had been exposed to birth, I was working on a PhD at the time which looked at the medicalisation of childbirth and through that I made contact with what was then a very small group of women recovering from birth trauma and they were very pro – homebirth ... so I had made friends with that community of homebirthers before ... we started trying to conceive, and by that stage I’d already decided that I wanted to freebirth ... I’d heard a lot of birth stories and read a lot of birth stories where the homebirth midwives had been the ones to suggest transfers to hospital and I felt a lot of the time it wasn’t necessary and there were other things, other than the woman’s and the baby’s health that went into that decision-making process, and that concerned me, I felt that I would be very vulnerable. (FB08)

Although this woman had not previously birthed, she had learnt about birth options from other women’s experiences and through her doctoral research. These previous experiences subsequently informed her choice to *birth outside the system*.

The second primiparous woman who birthed outside the system described how she was initially planning a homebirth with a midwife; however, she had felt abandoned by her midwife late in pregnancy, and subsequently decided to freebirth rather than entering the system. She recounted:

> I employed a midwife who worked at the hospital ... everything was cruising along until I got to 28 weeks and started having panic attacks ... because I was having panic
attacks and she worked for the hospital, she said couldn’t support me in a homebirth. She wanted to support me at the hospital, she wanted me to go and birth there ... I was so distraught, and that kind of made life a lot worse for me ... I felt completely dumped ... I was so pissed off with her that I couldn’t possibly entertain the thought of having her with me, I just couldn’t ... for me that was just heart breaking, absolutely devastating ... I’m 32 weeks pregnant, they (the midwives) both came to my house ... and they were trying to kind of talk me around and I was just, I was angry, I felt left alone and betrayed and like what do I do now, what do I do. (FB09)

This woman subsequently had a freebirth, visiting the hospital after the birth to access birth documentation. This was not a good experience, which reinforced her sense that she had made the right decision to birth outside the system. She explained:

They did weigh her, measure her, wanted to check me out which I let them and then someone tried to tell me that I needed stitches and then I asked another midwife – I got her to check me as well and she was like, no you are absolutely fine. But I remember they weren’t very nice, that was the only time where not the right kind of person has touched down there. So my baby got her paperwork and there were some not very happy people there to see us ... thinking back there’s lots of things that would have been great not to have...like, that being dumped by my midwives, that was just huge and that took so much emotionally energy from me. It was absolutely full on, so if that could have never happened that would have been great. But having gone through all of that I, at the end of it all ... I couldn’t have wished for it to be any different. (FB09)

This woman had originally planned a homebirth with a midwife, but was forced to consider freebirth after her midwife ceased to provide her with care. The trauma of feeling abandoned by her midwife was this woman’s experience of the maternity system. After having a positive experience of birth outside the system and then a negative experience in the hospital when she presented following the birth, this woman felt stronger in her resolve that birthing outside the system was a better option than birthing in the system.
This study found that previous experiences with the system shaped women’s perception of the system. They formed the belief that it was not the best and safest option, and they were therefore compelled to find a better way. The majority of participants reported having had a traumatic previous experience, which motivated them to find a better way; two participants however reported previous birth experiences that did not leave them traumatised. Having had a birth that was not traumatic still led the participants down a path in which they aimed to improve on their previous birth experience and find a better way than the one they had already experienced.

One participant who had a previous caesarean for twins, and a vaginal birth in hospital with her third baby, described her choice to birth at home for her fourth baby as being a natural progression from the types of births she had already experienced, as opposed to a response to trauma. She elaborated:

“The thing for me, it really wasn’t about ‘wow I had this magical amazing homebirth experience’ as opposed to these awful hospital experiences, it was just another birth experience in the spectrum ... it was amazing and it was fantastic but so was the other two births for other reasons and so I don’t have that dichotomy that other people have ... I don’t feel that’s why I did it, it wasn’t a reaction to trauma, it was just a progression. (HB08)

Similarly, another participant who had previously experienced two homebirths with a midwife describes them as wonderful experiences that gave her confidence to have a freebirth for her subsequent birth. She describes the decision to freebirth as ‘the improvement’ when compared to her two homebirths, adding:

I just had really wonderful experiences of birth preceding those decisions (to freebirth). I had two really beautiful instinctive births with my first two children and I just really felt that that gave me incredible grounding. I just saw my own capacity and power to give birth and I just saw that the improvement on my experience was to simplify that process for myself and just focus on what was needed and what wasn’t needed and largely my midwife wasn’t needed in both my other births. (FB06)
For these two participants, the choice to *birth outside the system* was not motivated by previous trauma, but rather a desire to improve on their previous birth experiences. The desire to find a better way drove these women to want to move on from previous birth experiences, and to improve upon what they had already experienced.

While these two participants came to *birth outside the system* after having positive previous birth experiences, the majority of women described a previous trauma that they wanted to avoid for subsequent births. Understanding the trauma experienced by the participants’ aids our understanding of why they did not believe the birthing options offered within the system to be safe and why they pursued a *birth outside the system* for their subsequent births.

1a) *Becoming traumatised*

It became obvious early in the research process that a previous traumatic birth experience heavily influenced a woman’s choice to *birth outside the system*. The choice to *birth outside the system* was born out of a desire to avoid particular traumatic aspects, which included, ‘being assaulted,’ ‘being degraded,’ ‘being bullied,’ ‘not being listened to,’ ‘experiencing side effects,’ ‘being separated from family,’ ‘being abandoned by supporters,’ ‘my expectations were not met’ and ‘I had a lot going on in my life.’ Being exposed to these traumatising factors added to the participants’ belief that birthing in the system would not offer them safety. Birthing at home was perceived as a better option than birthing in the system, because it could provide the participants with the emotional, mental, physical and social safety that they did not receive in their previous birth experiences. Below is an explanation of the specific factors that led women to become traumatised by their previous experience. Considering these details allows us to better
understand why the participants believed birth outside the system to be better and safer than their previous experiences.

**Being assaulted**

The participants described incidences where they experienced physical assault by maternity care providers. This assault was characterised as performing medical procedures without the women’s consent, or scenarios where the practitioner performed the procedure by force. The experience of being assaulted at their previous births caused the participants to believe that birthing inside the system was not a physically or emotionally safe birth option. One woman recounts:

> This male doctor and a nurse came in and he was saying, “I’m just going to examine you” ... I was saying “no” and he said “oh it won’t take a minute just slide back” and started, and I was like “stop it, stop it, get out of me: and he was like “just lie still,” and he ended up holding me down and a nurse held me up at the top (points to shoulders) and he held my here (points to hips) while he ‘examined me,’ that was so painful ... in the street, assault is assault, if you’re saying no and there’s a person still continuing doing what they are doing that is assault. (FB01)

This forceful approach was also experienced by other participants, which suggested that this type of treatment was a significant factor in the women’s trauma. Another woman explained:

> My legs are wrenched apart without my consent the registrar forces his hand inside me. I’m offered no explanation and no sedation, I’m gripped by fear, I’m screaming, crying for him to stop what he is doing, I vomit. My husband gets angry: “she told you to stop, what are you doing? She is telling you to stop.” With his arm still inside me, the registrar instructs a nurse to take our son from my husband and remove him from the room. The door is closed, my lover is not allowed back in and our baby is taken to another area ... The registrar continues his search inside of me while the midwife continues wringing out my uterus. I lay there cold and naked, I stare at the ceiling and cry. (FB12)
It was not only the women who went on to freebirth who described these abusive practices; it was also women who went on to choose a homebirth:

Then the doctor came in and he did a vaginal exam that felt like I was being raped, really it was the most horrible experience of my life ... and I would say, “stop just let me breath through this” and I said “you can keep your fingers in there just don’t move them,” but he wouldn’t, he was just like “no I’ve got to get the information I need” ... He was continuing to do it, which to me is kind of like being assaulted. (HB09)

One thing that contributed to a traumatic birth experience was being exposed to a painful procedure, and even more so when this was in the context of being physically assaulted. When asked what she found traumatic about her experience, one participant commented, ‘I think it was just the whole thing, just the pain’ (HB07). If pain was a component of an already unwanted procedure, this increased the woman’s trauma. In enumerating the components of what made a vaginal exam the focal point of her traumatic birth, one woman describes: ‘then every time I’d get a contraction he wouldn’t stop, my back was killing ... it was really horrible and being really painful (HB09).

Having had an experience of physical assault made the participants believe that their previous birthing option was unsafe for them physically, and the emotional trauma that resulted also made it emotionally and mentally unsafe. This informed their belief that their previous birth was the not the best and safest, and their desire for the best and safest motivated them to find a better way for next time. The experience of assault at previous births traumatised women and made them reluctant to enter the hospital for subsequent babies. Experiencing assault at a previous birth represented a threat to the women’s desire for safety in subsequent births, leading them to opt to birth outside the system.
Being degraded

Women also described becoming traumatised when they felt degraded or disregarded during their care in hospital. Being degraded was a threat to the emotional health of the participants, and this made the participants believe that their previous experience had not provided them with emotional safety. Interestingly, the most emotive accounts of ‘being degraded’ were from women who experienced a birth by caesarean section. One woman described how following an emergency caesarean, she enquired about when she could see her baby, only to be met with condescension. She explains:

They were stitching me up and I was saying, when can I see my baby and the guy’s like, “there there dear go to sleep” (uses condescending tone), and they all laughed, and they were talking about their Christmas party and who’d gotten drunk and who slept with who and ... It was horrible, I was so humiliated and so angry and it was just terrible. (FB01)

Another woman described her feelings that the staff performing her caesarean ignored her as a human being and robotically performed their task:

I felt like a piece of diseased meat from which the ‘hero’ surgeon was rescuing my baby from. I was ignored; they talked about cricket or something. The lights were bright. They had the radio on in the background. This was ‘just another day in the office’ to them. Nothing sacred, nothing special. I shook, I was freezing, I felt nauseous. (FB14)

Of her postnatal experience, another participant described the wait to see her baby and how this further contributed to trauma and reinforced the feeling of being degraded:

No one even filled me in, during those three hours, as to how my baby was. I was alone and cold and dizzy, trying to fake good health so I could ‘earn’ my baby back. It was so degrading. (FB14)

Another woman described her experience of caesarean section where she also felt disregarded as a human being, stripped of dignity and degraded:

I was then treated like a piece of meat, my baby was handed to my partner and he was told to leave the theatre,
I was then stripped of all coverings while the staff wandered around theatre cleaning up, I was then told that they were now going to clean my vagina, I was exposed for all to see. I was in such a state of shock by this stage that I was unable to speak, let alone object to what was happening to my body or to ask for my baby. I was stripped of all dignity and totally degraded. (FB15)

Having worked as a private midwife for five years, I have heard many birth stories. My mind travels to a close friend who chose to birth her first baby in a private hospital with an obstetrician. Although her intention was to have a vaginal birth, after an unsuccessful induction, she birthed her baby by caesarean. Although she did not conceptualise this experience as traumatic, she did, like the women above, describe a sense of feeling stripped of dignity during the procedure. She explained how she was happy to pay her anesthetist the money it cost her as a private patient because he covered her up while she was waiting for her caesarean and he said to her, ‘here you go love, have a blanket, they don’t afford you much dignity in here.’ She explained this scenario in detail and stated that she would gladly pay him the fee again just because he cared enough to cover her and preserve her dignity.

The data showed that aspects of maternity care in hospitals can strip women of their dignity and elicit feelings of being degraded. For some women, this degradation and the threat to their emotional and mental safety was sufficiently traumatising to make them avoid birthing in hospital again. For others, they would return to hospital to birth, but as a way of avoiding feeling degraded would gladly pay money in order to have their dignity preserved (as in the aforementioned story of my friend). Either way, women have an emotional response to losing dignity in the birth process, and can feel degraded by the standard of care that is provided to them in hospital. The participants learnt from their previous experiences that they cannot expect to be kept emotionally safe in hospital, and
their desire for the best and safest motivated them to find a better way for subsequent births.

**Being bullied**

The sense of being bullied was a common refrain in the women’s reports of experiencing trauma at birth. The participants described incidents at previous births where they felt bullied into submitting to the suggestions of care providers, even if it was not what they wanted. As explained, the participants wanted the best and safest for themselves and their babies, and made their birthing choices accordingly. To coerce these women into changing their decisions was to offer them a more risky option than the one they had originally chosen. One woman explained:

> It was like all my choices had been totally taken away from me – even though they would say it was informed consent, it was more informed coercion. (FB01)

The participants identified that making a choice that is outside of hospital policy triggers an active attempt by hospital staff to bully them into relinquishing their choice. The participants identified many specific bullying tactics used by hospital staff in an attempt to force compliance. Tactics cited included using fear, being mean and nasty, ganging up on the woman, withdrawing care options and threatening to report to the Department of Community Services (DOCs).

The use of fear tactics to bully women into relinquishing their choices was described by one woman:

> At the time I agreed to it, I don’t think I was terribly reluctant, I agreed to it but I now know the reason I agreed to it was from fear and I realised the fear wasn’t mine, it was fear that was given to me by my obstetrician. (HB05)
The women were also told that their baby could die as a way of scaring them into submission. One participant who was also a midwife explained:

Numerous times I’ve heard doctors say to women, well if you do that your baby will die. What is any mother meant to do, if you are told that your baby is going to die, you are going to do whatever you need to for that baby to live. (FB05)

Another bullying tactic described by the women was staff becoming angry and exhibiting mean and nasty behaviour towards them. The participants described how their reluctance to submit to their care providers’ suggestions elicited anger from their care provider. One woman described a scenario thus:

He [the doctor] was getting really cranky with me because I was sort of not really wanting an induction. I was still talking about homebirth. (HB03)

This woman also explained how the tactic of being mean and nasty was employed by the care providers at her birth:

The rumour was they sent that midwife in because she’s a tough bitch and she’ll sort you out; that was the rumour going around. (HB03)

Another bullying tactic cited was hospital staff ganging up on the women. In describing this tactic, the women explain how all the care providers charged with their care would join forces in a united front and collectively apply pressure to the woman in order to force her submission to their management. One woman described what she had seen done to women during the course of her work as a midwife:

Bullying, coming back at them repetitively, bringing in numerous doctors to talk to them all at the same time ... very much standover tactics and they’ll just push and push and push. (FB05)

Having said this, the women also described how a collaborative approach from care providers was not always needed to force compliance; one woman described how it was
just one person who prompted a change in approach to her care, even though others were happy to cater to her choices:

> It was literally that this new lady came on duty, that the midwives were answering to ... it think she is in charge of both labour ward and the birth centre and she’d just seen the stats and how long I’d been there and where I was at and the fact that I had had a previous caesarean. So up until then, the rest of the staff had been happy to let me keep going; it was just her coming on duty. (HB04)

This sentiment was echoed by another participant, who observed that ‘it’s amazing how one person can wreck it’ (HB03).

Not only did women report that staff members would collaborate and gang up on them in order to apply pressure and have them comply; the women also commented on the hospital staff’s tactics of recruiting the women’s partners to their side. As will be discussed in detail in the next chapter, the participants described having their partner on board as their advocate. Recognising the power of the men to advocate for the women, and how this influences the women’s decision-making processes, hospital staff would try to coax their partners away from their supportive role and use them as a tool. One woman explains how she sees this playing out in her role as a doula:

> And of course the dad wasn’t an important factor and would have been ignored by the midwife til this point but now all of a sudden he’s used as a tool to make the mother agree to having some syntocinon. (HB02)

In this case, the hospital enlists the husband to bully his wife into taking medication she does not want, but that the hospital wishes to administer to her.

Another bullying tactic that women describe was the withdrawal of care options. At its most extreme, women were told that if they declined medical care by choosing to birth outside the system, and then presented to hospital in need of care, it would be refused. One woman explains, ‘the doctors in their meeting had said, if I transferred to the hospital,
they wouldn’t see me’ (FB09). This was done in an attempt to bully women into relinquishing their desire to *birth outside the system*, and instead to compliantly accede to hospital care, because if they did not accept it now, it would not be available later.

Finally, many of the participants reported being threatened with being reported to DOCs as a bullying strategy aimed at subverting their birth choice. One of the participants explained that when her friend presented to the hospital and enquired about the option of homebirth, she was told:

You’ve got to have your baby in hospital, we don’t have homebirth. If you go ahead and do it, we’ll call DOCs. They said there was a lady in the area who went ahead and had a homebirth anyway and we were going to call DOCs on them. So we heard this third-handed bullying information. (FB03)

The perception that they would be bullied into relinquishing their choices in hospital was a motivator to *birth outside the system*. One woman describes why she chose to birth at home as she considered the possibility of this scenario playing itself out:

They weren’t going to be as easy to let me not do those things and I just didn’t want to have those fights ... I didn’t want to be in that position of arguing and combating when I was in pregnancy and labour so that’s the main reason I wanted to do it at home, was to not be in a position of defence. (HB08)

Another explained how she was going to birth her second baby at home after feeling bullied into a caesarean for her first birth:

I’d want to avoid them pressuring me into having a repeat section because they are going to use every scare tactic under the sun. (HB09)

The women explained that avoidance of the hospital system was best and safest for them and their babies, because in the past they had experienced bullying and been subjected to abusive practices. They perceived that these practices had caused them emotional trauma, and thus they wanted to find a better way for subsequent births. These various
experiences of feeling bullied by health providers in the system led women to believe that birth in the system was not the best or safest, compelling them to find a better way.

**Not being listened to**

Another factor in the perception of their births as traumatic was the impression that during their previous births, the women were not listened to. Women explained how, ‘they didn’t listen to me in the hospital’ (FB02) and, ‘I didn’t feel like I was listened to by the staff at all’ (HB05), and ‘they weren’t listening’ (HB03). Not being listened to was traumatising for the women because they felt that they had knowledge about themselves and their babies that could help the staff keep them safe. One woman explains how she felt that something was not right and that her concerns about this were ignored; she stated that not being listened to made her feel like she was now in danger. As she explained:

> No matter how bad this gets and how dangerous this gets, no-one is going to listen anyway, so I started becoming scared of what if my life becomes in danger or what if my baby’s life becomes in danger, because it doesn’t matter what I say and how much noise I make and how much fuss I make, no one is listening anyway. (HB05)

Women reported trying to communicate with staff only to be met with a total lack of interest in what they had to say. ‘I just kept talking to her and she just kept walking off,’ one woman recounted (FB01). Not being listened to was a contributing factor in the trauma felt by some participants; the desire to be listened to was subsequently reported as a reason why women chose to birth outside the system for succeeding births. One participant was asked what she would want differently for her next birth. She responded, ‘I wanted to be able to be listened to’ (HB09). Not being listened to was perceived as creating less safety in their birth experience. For this reason, the hospital came to
represent a more risky choice than birthing outside the system. Not been listened to led women to find a better way that felt safer.

**Experiencing side effects from a birth procedure**

The experience of trauma at birth was not necessarily caused by one upsetting element; rather, it was the compounding of numerous distressing factors that induced an overall sense of trauma. The experience of having side effects from a birth procedure seemed to be one of those distressing incidences that added to the trauma for women. The experience of side effects served as a long-term reminder to the women that things did not go as they had planned. Experiencing side effects also reinforced to the participants that they had not been kept physically, emotionally or socially safe in their previous birth experience.

One woman described how she noticed that due to her caesarean she did not bond with her baby as rapidly or easily as she had with her second baby. She notes, ‘I wouldn’t say there was an instant bond or anything, and my baby and I still have stuff that we are trying to reconnect with’ (FB01). This same woman experienced slow healing of her wound and explained, ‘I had really daggy clothes because of my caesarean scar, because it took a long time to heal’ (FB01). She described these situations of poor bonding and healing in the context of her traumatic birth experience and identified them as distressing elements that intensified her trauma.

Another woman sobbed as she recounted her traumatic caesarean experience, and became even more visibly distressed as she described the impact this had on her child:

> They actually cut her cheek and that was actually from the caesarean. She still has a scar on the side of her face even to this day … that really distressed me. (FB03)
The scar on her child’s face not only added to the trauma of birthing by caesarean, but also served as a constant reminder of the fact that the hospital had not kept her baby physically safe.

Another woman, in the context of listing all the things by which she was distressed, discussed the side effects she experienced from being given pain medication. ‘I was given morphine and I reacted to it really badly ... I was so out of it and itchy and vomiting’ (HB07). While this within itself may not have been sufficient to cause the woman to describe her birth as traumatic, when it was compounded with other factors, it became part of her birth trauma narrative, and also added to her belief that her last experience had not offered her physical safety. The experience of side effects from the birth procedure added to the participants’ dissatisfaction with their previous birth experiences and provided further motivation to find a better way next time.

**Being separated from family**

When the women were asked what aspects of their births they had found traumatising, many discussed the experience of being separated from their family. Being separated from family represented a breakdown in the social support and safety the women wanted during their birth. One woman described how the midwives were encouraging her husband to leave the room for a break, and her emotional distress when this occurred:

> They ended up convincing my husband to go and get something to eat and telling me that I was selfish because he hadn’t eaten all day and he was tired and I was crying asking him not to leave the room. (FB01)

Women also described the separation from their newborns as being similarly distressing:

> The separation from my newborn after the operation gutted me – I remember him being placed up to my face just after he was born, and just smelling him ... trying to inhale him whole because I couldn't touch him or hold him with my hands. It was devastating. (FB11)
Being traumatised due to separation from family is closely linked with wanting the best and the safest. Given that the women pursued birthing options that allowed them to remain with their family, as discussed previously, it is not surprising that they would experience trauma by not being afforded this closeness with their family and newborn. Having previously been exposed to a system that does not prioritise keeping the family unit together, the women in this study subsequently chose an option that would allow them to keep their family close.

**Being abandoned by supporters**

The participants experienced being abandoned by their supporters as an emotional trauma. The abandonment that they describe is not a physical abandonment, but rather a withdrawal and refusal to fulfill their role as the woman’s advocate. Being abandoned was associated with a sense that the women’s supporters were no longer standing up for them; and there was a feeling that the supporters were siding with the hospital. This left the women feeling emotionally abandoned and unsupported, rendering their birth emotionally unsafe.

One woman described how her husband abandoned her after transferring into hospital after their first freebirth. The woman was asking questions of the doctor in an attempt to gather information. She explains how her husband interjected into this conversation:

> So then my husband sort of interrupted and said, “whatever you need to do just do it.” I just felt like thanks, no! He didn’t even say that, he said “I just want you to know that I give my permission for whatever you want to do,” so totally like invalidating all of my concerns, thanks for the support. (FB02)

This woman went on to explain that she still felt angry and bitter about this abandonment and looks back on her birth remembering that he was not there for her at a difficult time.
Another woman expressed a similar experience of her husband’s abandonment, which added to the trauma of her birth:

… somewhat abandoned I suppose. My husband at the time I remember saying to him, you’ve seen me have children before and I wasn’t like this, you should be concerned now, this isn’t normal, what I am doing is not normal, and of course he didn’t know really what to do with me, he was there in a supportive sense in that he was present, but even he didn’t recognise the very big difference in my behaviour from the first time, so I suppose, I felt abandoned a little bit by him as well. (HB05)

Having experienced abandonment by supporters in the past, and its emotional ramifications, made the women feel traumatised by their previous births. As will become apparent later in the next chapter, as a way of avoiding a recurrence of such trauma, the participants prepared for a birth outside the system by ensuring that they have people on their side who would support their choices.

**My expectations were not met**

The participants explained that they had expectations about what their care providers would do or be. One woman explained, ‘I thought he’d [the obstetrician] be really great,’ adding, ‘but in fact he was really old and grumpy and horrible’ (FB01). This constituted a failure to meet her original expectations. For this woman, the approach adopted by her care provider left her feeling traumatised because her expectations were not met; hoping to be met with a sympathetic manner, the woman instead found her carer to be of grumpy demeanour and unreceptive to her desires. ‘I cried after every visit,’ she recounted (FB01). This distress after meeting with her doctor indicated that the care she had chosen was not emotionally safe. This same woman went on to comment that when she chose to birth in a birth centre for her first birth she ‘assumed that the birth centre and everybody there would be totally behind me having a natural birth’ (FB01). After
having a caesarean birth, she concluded that her initial assumptions were obviously incorrect.

While some participants felt betrayed by their antenatal experience, others came to feel betrayed during their actual birth experience. One woman described the moment that she realised that she had been ‘hoodwinked’ by the system:

> Staff started ordering me around; I was in such a deep labour state that I couldn’t work out what was going on, what was real, what was imagined. No one was supporting me. This isn’t what I’d experienced in the past! This made me hysterical, as I felt extremely vulnerable and ‘hoodwinked’ in my weakest moments. (FB14)

For some women, the realisation that they had been betrayed during their birth experience took several years to crystallise. One participant, who had two emergency caesareans with a private obstetrician, researched birthing options for her third pregnancy two years later, and realised that perhaps her two surgical births had not been medically necessary. She also learnt that to induce a woman who has had a previous caesarean was considered dangerous; she then felt betrayed by her obstetrician for inducing her for her second child, because she felt this had put her in danger. She explained how she ‘just assumed that she’d [the obstetrician] do what was in the best interest of my health and safety’ (HB11), and thus she subsequently felt angry and traumatised when she realised that her expectations had been mistaken. The participants wanted the best and safest, and having their expectations of emotional, physical and mental safety betrayed during past birth experiences led the participants to consider birthing outside the system as a way of avoiding a recurrence of disappointment and danger.

**I had a lot going on in my life**

Some participants explained that before having a traumatic birth, their life was already chaotic. One woman described what contributed to her feeling of trauma and said, ‘I
think that because of what else was going on in my life at that time ... it wasn’t just my birth’ (FB01). The tumultuous events had been occurring throughout her pregnancy, set up a scenario that predisposed her to being traumatised by her experience of the birth:

I did put on a lot of weight I was really – looking back, I was depressed. We were a part of this really cultish group that we were sort of getting out of – it had all become crazy, especially toward the end of my pregnancy. I was seven and a half months pregnant and basically got excommunicated from our whole support network. (FB01)

Another woman explained how her life situation also predisposed her to being particularly affected by her birth experience, and how it was also a contributing factor to her subsequent depression:

Well the first one, I had a bit of postnatal depression and mainly because my husband had to go back to work early, I was in a lot of pain still with the infection (from my caesarean) and having to look after a baby, so I was tired, plus in pain, so ... I ended up getting quite depressed and ended up in hospital to change my medication. (HB11)

For these women, becoming traumatised occurred in the context of what were already difficult and complex life situations, which compounded and contributed to the trauma they felt from their birth. Another woman described being traumatised by having been abandoned by her midwife. She describes what her life was like at the time, and how this only intensified her sense of abandonment:

It was a pretty daunting, it was a very uncertain overwhelming time ... and I had a lot going on in my life. I had not long come out of a seven-year relationship and was about to end the other relationship with this baby’s biological father and so it was all really full on ... I was moving around a lot and trying to buy a house before the bank could see I was pregnant ... I had so much going on it was unbelievable. (FB09)

It was in this chaotic context that the additional stress of having been abandoned by her midwife caused her significant emotional trauma; she subsequently chose to eschew the services of another midwife, opting instead for a freebirth.
The experience of a traumatic birth motivates women to find a better and safer way for their next births. Women were further motivated to find a better and safer way once they experienced the life changing effects that birth trauma had on their lives for years to follow.

1 b) Experiencing birth trauma is life changing

Not only does a traumatic experience impact on the actual birth, but it also affected other facets of their lives, with the women reporting the experience of birth trauma as life changing, with a significant impact on their long-term emotional and mental wellbeing. The women felt that the experience of birth trauma contributed to the development of postnatal depression and symptoms of post-traumatic stress disorder. It also impacted on their ability to parent their children and they also spoke of the detrimental effects it had on their relationships and the trauma that their partners experienced.

One implication of having experienced birth trauma is the emotional impact that accompanies the woman throughout her mothering journey. As one woman observed, after her traumatic birth, she ‘had a lot of emotional baggage’ (HB04). Birth trauma is not a single, discrete event that only affects a woman for the duration in which it is experienced. Rather, the participants describe the trauma as being incorporated into their emotional psyche in a longer-term sense. One woman asserts ‘that [first] birth caused myself and my family significant distress and trauma for a long time afterwards’ (FB10). The presence of long-term effects after a traumatic birth left some participants questioning whether they would ever recover, with comments such as ‘I’ve never been the same since’ (HB11) and ‘it would change our family forever’ (FB11). One woman,
having worked through her trauma and reflecting back on the experience of living through it, commented, ‘we just survived’ (FB01).

For some of the participants, the emotional trauma of their birth became the catalyst for the development of pathological behaviours and characteristics after the birth, such as developing addictions and obsessions. One woman reported, ‘all my children know is this obsessively clean control freak who shies away from her partner’s touch’ (FB11). Another woman described her insatiable desire to search the internet for answers to her emotional trauma (FB01). Not only do the women identify changes in their own behaviour, but they can also see how this has affected the behaviour of their children.

One woman explained:

My first baby has anxiety which is genetic, but then with all the psychology sessions we’ve had on this, there was definitely some contributing factors from that whole experience. (HB02)

Some of the participants had pursued clinical diagnoses to help better understand their feelings and changed behaviour. The most frequently mentioned impact on their mental wellbeing after a traumatic birth was the onset of postnatal depression. One woman explained, ‘that experience for me started a lot of years of depression’ (FB01), with another woman becoming so depressed that she required hospitalisation (HB11).

In addition to relaying their experiences of postnatal depression, some women described symptoms that they felt indicated post-traumatic stress disorder. These symptoms included flashbacks, reliving the event in perpetuity and avoidance of the places and people who were part of their traumatic event. Some participants sought medical assistance for these symptoms, and one described:

The psychologist I was referred to was the first person to ever truly listen to me and hear me when I spoke of my first child’s birth, after talking through my symptoms, she diagnosed me with post-traumatic stress disorder. (FB01)
The message portrayed by the women who experienced birth trauma was that it had a lasting effect on their emotional and mental wellbeing, and fundamentally changed the very essence of who they were. As one woman put it, ‘my experience with hospital-based care has been incredibly disappointing, and life changing, but not for the better’ (HB12). This experience of emotional and mental trauma motivated the participants to seek better and safer options for subsequent births.

Another major impact of a traumatic birth experience was the effect it had on a woman’s ability to be a mother. The participants felt that their unstable emotional and mental state engendered a level of absenteeism from their early parenting experience. The participants described the period following their traumatic experience as passing them by; as one woman noted, ‘the first few months of my son’s life were a blur’ (FB11). The women described grieving over the mothering experience they lost for themselves, and they also grieved for their children who missed out on the mother they wished they could have been. One woman explained, ‘seeing what my second baby and I had, and just knowing what my first missed out on, I felt so sad’ (FB01). The participants made specific reference to the inability to properly bond with their child after a traumatic experience; and they saw this as part of the fallout from a traumatic birth. One woman recounts:

I was unable to bond with my child for 5 months and I attribute that to the treatment I received at the hospital and the blatant disregard for my wishes to be carried out at the time of my baby’s birth. (FB11)

Given that the women felt that their previous traumatic birth experiences had impacted deleteriously upon their capacity to function as a parent, they were determined to find a better way next time.

The life-changing effects of a traumatic birth also extended to the women’s capacity for harmonious and positive relationships in general, and in particular with her partner. One
woman revealed that ‘[t]he experience almost killed my relationship, it certainly killed my sex life’ (FB13). Another woman described how amazed she was that throughout the destructive aftermath of her birth trauma, her husband was consistently patient in caring for her as she recovered. She marveled at this, noting that ‘for many other men, I don’t think they could have handled what I went through and stuck by me like he did’ (FB01). Many participants described not only their own trauma, but also that sustained by their partners, and spoke of how this had impacted on the stability and dynamics of their relationship. ‘I remembered him being very traumatised by the whole experience,’ one woman said (HB04). The negative effect of a traumatic birth experience on the women’s partners was an additional strain on their relationships at an already vulnerable time.

This discussion has illustrated how the participants felt that their previous birth experience had failed to provide them with the standard of care that they desired. Emotional, physical, social and mental trauma sustained as a result of previous birthing experiences had led the participants to perceive these previous births as unsafe; the women therefore chose to pursue a better and safer way for their next births. In the next section, I report on the particular perspectives on childbirth and risk that informed the women’s understanding that a birth outside the system could offer them a better way.

2. Perspectives on childbirth

This category considers the participants’ philosophical standpoints on pregnancy, labour, birth and the postpartum period. These philosophical standpoints play a particular role in women’s choice to birth outside the system, because it shapes their perceptions about what will be the best and safest for them and their babies. The participants explained their perspectives on childbirth with reference to the following beliefs: ‘childbirth imprints on one’s life,’ ‘childbirth is a normal process’ and ‘childbirth needs ideal circumstances to
work best.’ Based on these beliefs, the women develop their understanding of what is best and safest for them and their babies.

**2a. Childbirth imprints on one’s life**

The participants held the belief that the process of labour and birth transforms them as people. They believed that childbirth imprints on one’s life and can either contribute to or take away from their wellbeing in the long term. One woman described childbirth as ‘a process that is so fundamental to a woman, to the wellbeing of the woman’ (FB04) and another explained, ‘I think that [birth] is a very strong factor in how you set off in your journey as a mother’ (FB06).

They also believed that what happens to their baby during labour and birth can have a long-term impact upon the baby. One woman felt that ‘the birth imprinting for the baby is lifelong’ (FB06). Another explains how the moments and days following birth will significantly impact the mother and child’s bonding experience – ‘anyone with half a brain knows that those early days are so important for mum and baby for attachment and all that sort of stuff’ (HB01). Although some of these perspectives may have been pre-existing, they would also have developed, changed or crystallised as the participants learnt from their previous birth experiences and subsequently realised the lasting effects that these birthing experiences have had on their lives.

Having this perspective about childbirth made the participants feel very protective towards the experience of childbirth, as they intuited its life-long impact on themselves and their babies. With a greater understanding of the impact of childbirth on a woman’s life, the participants felt renewed determination to protect their subsequent labour and birth experiences. The desire to protect their birth experience also stemmed from the participants’ belief that being in labour opens the woman to new vulnerabilities. The
participants described the experience of labour as going to another world, as being in ‘labour land’ (FB01) or ‘on another planet’ (FB02) and ‘off with the fairies’ (FB02), indicating that being in labour disconnects them from their external environment and transports them into a different zone where the labouring woman is inwardly focused and largely unaware of her surroundings. The participants acknowledged this phenomenon but also recognised the value of it for the labouring woman; indeed they regarded it as a normal part of the labour process. One participant explained, ‘I think it’s really important for a woman to be given that chance when she is birthing to just be in her own zone as much as possible’ (HB06). The participants explained that when they were in this altered zone, interactions with the external environment and those around them became difficult and inhibited: ‘you are in a different zone too, and you’re not sort of thinking at the time’ (HB06).

This state of being in ‘labour land’ rendered them particularly vulnerable to their external environment and those around them, because their ability to communicate became impaired. The women understood that ‘[t]hey already are vulnerable’ (FB05), and this made them vigilant about carefully choosing their birth space and the people around them during labour. A belief that childbirth imprints on one’s life and that being in labour renders a woman vulnerable motivated the women to avoid replicating the circumstances of previous birth experiences in order to avoid a negative impact on their lives. It led them to pursue a better way, a way that would meet their desires for the best and safest, and thus enable the birth to leave a positive imprint on their lives.

2b. **Childbirth is a normal process**

The second aspect of the participants’ philosophical standpoint is that pregnancy, labour, birth, breastfeeding and bonding are normal bodily functions. Built into this perception
is the understanding that these reproductive processes are not an illness and that they do not represent pathology in the female body. Rather, these processes fulfill the woman’s natural, normal purpose. As one participant asserts:

Another thing I learnt after I had my first child was just that birth is not a sickness. During my first pregnancy I was told that all these things can go wrong, and I’m like yeah fine they can, but then the majority of the time it just happens, it’s just like, it’s like breathing it’s like eating it’s like going to the toilet, it’s a normal bodily function it just happens. (HB07)

Another women expressed a similar sentiment:

I don’t think having a baby is being sick, I think it’s a normal, everyday function ... I’m not sick, I’m just having a baby. (FB09)

Given that the participants held the philosophical stance that pregnancy, labour and birth were not illnesses, they failed to see the necessity of birthing in a hospital. A corollary to the women’s belief that birth is a natural process is the perception that hospitals are for the sick. Since the women did not see themselves as sick, they felt no need to position themselves within a hospital context. One participant explained:

Having a baby is a normal thing, you don’t have to be in hospital to have a baby, having a baby is not an illness, it’s not a disease, not something that you need to be in hospital for unless there is a complication. (FB03)

Alongside the belief that normal, uncomplicated birth does not require hospitalisation, and that childbirth is a natural and normal process, the participants felt that childbirth attracts an unnecessary amount of medical attention. They believed childbirth to be a process that had been unnecessarily medicalised. One woman explained:

Sure, there will be a small percentage that still need medical assistance during birth, but there will always be people who need to wear glasses, for example ... But just like we don’t wear glasses if we don’t have a problem, women do not need to have medical assistance during normal birth unless it becomes warranted. (FB14)
The participants felt that the medicalisation of childbirth had become a hegemonic cultural discourse:

> I think we’ve been really well educated by the medical establishment and the media to view birth as something to be feared, something that needs to be controlled and something that is inherently dangerous and I think that if you are exposed to a lot of mainstream media and your only influences are hospital or institutionalised care ... then you would very much believe that it needs an expert and that women’s bodies are generally faulty and that we need to be managed. (FB06)

The women felt that medical management of birth was too rigid in its boundaries, and too prescriptive of what was deemed normal and abnormal. As one participant asserted, ‘birthing just doesn’t go by a textbook’ (HB04). With their views, the women felt that they were setting themselves apart from the commonly held medical perspective on childbirth as having boundaries; the women, conversely, preferred to see birth as relatively boundless. One woman provides the rationale for why she believes there needs to be more diversity in the medical understanding of how birth works:

> A lot of it [hospital practices] is trying to do it by a textbook, and it just doesn’t work that way because we’re humans and humans don’t fit in boxes ... that makes sense to me because we are human, we are individuals, nothing works for everybody, there is not one way ever with anything, that works for everybody. (HB04)

The women provided examples of how pregnancy and birth can encompass numerous variables and different scenarios, all of which may still be described as ‘normal.’ One woman discussed this with reference to gestational length:

> We know that it’s supposed to be a certain amount of time but surely some babies need a bit longer and some that need less, I mean isn’t that the way of nature. (FB04)

By positioning childbirth as a natural process that has been unnecessarily medicalised, and moreover a process that does not comply with normative textbook models, the participants appeared to be simultaneously shunning the medicalised definition of
childbirth as well as the systematised management of birth in hospitals. The women therefore did not maintain the belief that hospitals were the safest and most suitable context for childbirth. Rather, the hospital system was seen to promote the medicalisation of childbirth, which was in fact the antithesis to how the participants thought birth could be managed. Hospitals did not represent the best birthing option for the women, compelling them to pursue a better way.

2c. Childbirth needs ideal circumstances to work best

The participants believe childbirth to be a normal bodily process needing ideal circumstances to work best. The women enumerated the circumstances that they believed to be essential for a positive birth experience and outcome. These included: adequate hormonal function, an optimal environment, relaxation and privacy, active birth positioning and good physical, emotional and mental preparation. From their previous experiences, the women deduced that these elements were most likely to occur in the home environment.

The women demonstrated a detailed understanding about birth physiology and the interplay of hormones required for a successful labour and birth, and made insightful and informed comments about what can happen if these hormones are hindered. They felt that this hindrance was more likely to occur in the hospital setting:

When you move into hospital, ... your labour stops or stalls or goes backward, and part of the reason is that you get this adrenaline in your body and the adrenaline is what slows the process down because your body is anxious. (FB03)

The women felt that the hospital could not facilitate the appropriate hormonal flow required for a successful birth. One woman commented:

The hormones and the changes in a woman’s body in preparation for labour and birth are the same hormones ...
Another participant felt that the ideal birthing environment was a key factor in ensuring a smooth and problem-free birthing experience:

I just really felt like the setting that I began in would really determine how empowered and how safe I would feel through the process ... given the right environment a woman would be able to successfully birth her baby if she was healthy and well and well-informed and I really felt that, aside from good health, the right environment was what was needed. (FB06)

Others commented on the imperative of the mother being relaxed to facilitate a successful labour and birth, ‘just allowing your body to relax and do what it has to do, you just gotta have that almost meditative, just going with it’ (FB02).

Another participant spoke of the importance of using active birth positioning, something that she felt was less likely to occur in hospital:

a change of position to encourage the baby to turn, like leaning over onto the bed ... to try and get gravity to assist ... (in hospital) you end up on the bed lying down. Which is not really conducive to having a comfortable, active labour. (FB03)

Some women discussed the importance of having privacy during labour: ‘[p]rivacy in the birth process ... is a lot more important for women than we really realise,’ (FB04) noted one participant. On the issue of privacy, another woman observed that ‘you have to be very careful with what you invite to your birth experience’ (FB07). One participant expressed her concerns about having strangers at her birth, fearing that they would alter the environment and impact how she would labour:

I really trusted that my body would know how to do it if it was just given the right environment and I think I am just generally quite a private sort of person ... and I also had concerns about, a stranger being in my birth space. (FB06)
Another woman spoke of the importance of good physical, emotional and mental preparation in order to promote normality in labour:

    a birth is already said and done before a woman goes into labour and that is with her nutritional status, her mental status, her emotional status. (FB05)

For the participants, their mental and emotional preparation was just as important as their physical preparation. A good mindset was considered an important factor in a successful birth outcome. One woman spoke of how she blocked out negative birth stories to ensure that they didn’t impact her as she planned to birth her first baby:

    But because I had that mindset of, but that’s their story, I’m not going to worry about … I think that helped me but not all women are in that mindset. (HB03)

Participants believed that there were ideal circumstances that were needed to ensure an optimal birthing experience and good outcomes. Moreover, they believed that the ideal circumstances were not synonymous with the maternity care provided within a hospital setting. This led the women to pursue a birth outside the system as a better and safer way. Just as the participants’ perspectives on childbirth informed their choice to birth outside the system, so too did their perspectives on risk.

3. Perspectives on risk

The participants’ perspectives on risk led them to believe that hospital birthing options would be more risky than out-of-the-system options. The three subcategories found in reference to how the participants perceive risk were: ‘birth always has an element of risk’, where the participants acknowledge and accept the inherent risks involved anytime a woman gives birth. The next was ‘the hospital is not the safest place to have a baby’, where the women described various reasons why they believed the hospital setting would increase the risks already inherent in birth. The final one was, ‘interference is a risk’,
where the participants contend that higher intervention translates to higher risk. For the participants, the environment in which they would most likely be exposed to risky interventions was a hospital. They therefore concluded that birthing in a hospital setting was not the best and safest option for them or their babies.

3a. Birth always has an element of risk

In their discussions about their understanding of birth, the participants were not naive to the potential risks and dangers that birth can pose. They perceived birth to have an element of inherent risk – that may not be influenced by where they chose to birth. As one woman put it, ‘[t]here is always a risk that there might be complications or that something might go wrong’ (FB04). Another echoed this same belief, expanding upon the theme, ‘That is the gamble that you take whether you are in a hospital or at home, things happen, things go wrong at birth’ (HB06).

The participants acknowledged and had considered that not only was there a risk of something going wrong at birth, but that death was also a possibility. They believed death to be a harsh reality of birth that was at times inevitable. One woman remembered how she entertained this possibility as she made decisions about the best place to birth:

I had to go to the worst case scenario too – that either I could die or the baby could die – and that’s real because that’s life and people die. (FB07)

Another woman described how it was not her expectation that her baby would be born alive, because she felt there was no guarantee that this would be the case. However, she also felt that there was no guarantee of having a live baby in hospital either. She held the possibility of death to be an inherent and harsh reality of birth:

I always knew that there was no guarantee that the baby would be born alive or that it would live beyond the birth, but I think there is no guarantee with that in a hospital setting either. (FB06)
These observations further highlight the fact that the participants acknowledged and accepted the risk that birth could go wrong, and that this risk was not dependent on the location of their birth. The women felt that there was no guarantee that things would run smoothly during birth. They believed this to be the case irrespective of setting. The participants believed and understood that birth always has an inherent element of risk.

3b. The hospital is not the safest place to have a baby

Despite the commonly held assumption in our culture that hospitals are a safe place for birth, the participants perceived hospitals to be a less safe birthing environment than the home. The women did not see a hospital birth as a means of mitigating the inherent risks of birth. One participant, who is an experienced midwife working in a hospital, explained her perception about the risks associated with birthing in hospital:

I know my alternative [the hospital] comes with more risk ... I know my other choice isn’t perfect. So whilst being here [at home] mightn’t be considered to other people as being safe, to me going to hospital is even less safe, so I don’t think it’s [homebirth] a less of two evils, because I don’t think it’s the evil choice but, I think it’s the safer option ... I think it’s safer because I know what happens in hospital and I know the risks that are involved there and I’ve seen the outcomes ... I work in a hospital system and I can guarantee you things go wrong there every day and I’ve been part of that, or I’ve witnessed it, I’ve made mistakes myself, I know that it’s not the perfect – it’s not the perfect solution.’ (HB05)

When asked whether she thought that women would still birth in hospital if they were fully informed of the potential risks of this birth choice, she replied:

I think the community would start to realise that the hospital is not the safer option and that staying at home is.

(HB05)

Many participants felt that birthing in hospital carried additional risks on top of the inherent risks of giving birth, making it a less safe place to birth. They believed that the
hospital presented a unique set of risks to which they might not be exposed should they
birthed at home. One participant commented:

   Automatically walking into a hospital I’m exposed to
hospital bugs, that to me is unsafe ... a neonate’s immune
system is not fully developed, I don’t want my babies
exposed to that, I don’t even want myself exposed to that.
So they can’t possibly offer me a safe birth. (FB05)

For many women, their choice to birth at home was motivated by the perception that
home presented them with less risk than the hospital, and therefore represented a safer
birthing choice. One woman commented:

   I thought for me that there was less risk of anything
happening at home than there would have been if I was in
hospital. (HB04)

Having learnt from a previous experience that birth in hospital could threaten her
emotional wellbeing, one participant described how her experience shaped her
perception that birthing outside the system was a better way, because it offered her the
emotional safety that was missing from her previous birth experience:

   In the maternity ward ... the problem wasn’t physical, it
was what I felt was a bullying issue and that’s what I mean
you know emotional safety ... emotional safety is about for
me, having people there with me, like minded, who are
there looking out for my best interests too, they know
what I want and they will help me achieve that as best I
can. (FB04)

Despite the dominant social and biomedical view that hospitals are safe places to have a
baby, the participants perceived hospitals to be a less safe place in which to give birth,
and moreover an environment that presented them with a unique set of physical and
emotional risks that were absent from a home context. This perception led them to
believe that birthing outside the system was a better option.
3c. Interference is a risk

For the participants, the primary risk factor associated with hospitals was the possibility of complications arising out of interventions in the birth process. The participants held a belief that interventions caused more problems than they solved. One participant asserted:

I know that there are some interventions that will save lives but without any shred of doubt they certainly cause more problems than they prevent. (FB05)

Another participant, who chose to have a freebirth for her first baby, explained that the risk to her as a first-time mother was that of intervention. If she went to hospital, she explained, she would need to decline interventions in order to maintain her baby’s safety:

I felt as a first timer, the biggest threat to my safety and my baby’s safety was unnecessary intervention ... and I knew that if went into a hospital I was going to have to fight really hard to get my baby out safely. (FB08)

By staying away from hospital, these women felt that they could minimise the chance of being exposed to risky interventions, and therefore reduce the chance of something going wrong. As one participant put it:

If you can stay away from the hospital system, then you can minimise the amount of interference. I look at interference a bit like risk, like every time someone new comes across you or does something that’s a risk that something goes wrong, every time you get a medication there is a risk it’s the wrong one, every time they do something, there is a risk that flows onto something else, so if no one is doing anything to you or giving you any drugs or performing any unnecessary tests, then there is no risk there. (HB05)

The most common intervention-related risk cited by the participants was that of ‘the cascade of intervention.’ Routine medical interventions were perceived to increase the risk of something going wrong, which then produced a need for further interventions, and so forth. One woman described how she thought that the cascade of intervention was responsible for her ultimately needing to have a caesarean:
They [the hospital staff] made the caesarean necessary by starting the syntocinon and putting me flat on my back ... I seriously feel that if they hadn’t started the syntocinon and just let me do what I needed to do then she would have rotated but the syntocinon forced her into a bad position and just pushed her there and held her there so she couldn’t turn and I ended up with a caesarean. (HB09)

Another commented that:

[t]hey [the hospital staff] interfere so that’s why things happen, they end up with forceps or the vacuum or caesarean because they put up a drip and they just stuff women up. (HB03)

The participants acknowledged and accepted the inherent risks associated with birth. Furthermore, they felt that there were additional risks in a hospital setting that were related to interference and interventions in the birth process. Correspondingly, the women believed that birth outside the system posed fewer risks than those associated with giving birth in hospital. For this reason, birth outside the system becomes a better and safer option.

Having been shaped by their previous experiences, and having formed particular philosophical perspectives on childbirth and risk, the participants formulated a list of what they consider to be the best and safest for themselves and their babies. These desires help guide them in their decision-making, and they ultimately choose to birth outside the system because this provides the best and safest option. Based on their beliefs and previous experiences, the participants concluded that the hospital could not provide the best or safest for themselves or their babies.

4. The hospital can not provide the best or safest

The participants explained that when they investigated or experienced birth options offered by the hospital system, they found that the hospital could not offer the best and
safest. They therefore chose to *birth outside the system* as a better option. The participants reported the following deficits in hospitals: ‘not enough resources to cope with demand,’ ‘it’s not like home,’ ‘it’s like a cattle yard,’ ‘bound by hospital policies,’ ‘they intervene,’ ‘the system fears birth,’ ‘tension around my autonomy’ and ‘hospital management is emotionally unsafe.’

**4a. Not enough resources to cope with demand**

One aspect that contributed to the participants feeling that the hospital could not cater to their desire was their perception that hospital services have insufficient resources to cope with demand. As such, the system lacked the capacity to provide them with the best and safest. One woman commented:

> Maybe it’s a case of underfunding, short staff, not enough beds ... I don’t think that they are an evil corporation trying to deny your life experience, I just think that maybe the system, I feel like the system is really not set up to support the woman but they are working with the resources they have at hand. (HB04)

The participants expressed an understanding and sympathy towards the hospital staff, recognising the high demand for their services that was not being met with the required resources. One participant observed that ‘there are only so many beds and they don’t have all day for you’ (HB02). Despite being sympathetic to this situation, understanding this gap between demand and supply helped the women to develop the perception that the hospital was incapable of catering to their desire for the best and safest birth. One woman commented:

> It’s the volume of women that go through the hospital system, it would be very time-consuming to treat everybody completely individually and holistically with continuity. (HB05)

For some of the participants, the perception that the hospital was unable to cater to their needs due to a shortage of resources was shaped by their previous experiences within the
One woman explained how she could not stay with her sick baby due to a shortage in hospital resources:

“They said that there used to be a facility at the hospital where those kinds of babies could be in the ward with the mother but they don’t have enough money to run it so it’s empty now.” (HB04)

Another described how the hospital was unable to provide her with midwifery at home care due to a shortage in hospital staff and a high demand for the services: “The [midwifery at home postnatal care] program was full, which is where the midwife would have had to come from, so we didn’t have anybody” (FB04).

One participant observed directly how the shortage of resources impacted upon the skill mix offered in a hospital setting, and how this rendered the staff unable to serve the specific needs of the women:

“I watched an assistant nurse give her [another mother] a breastfeeding lesson ... holding the baby, put a dummy in the baby’s mouth and then put the baby next to the mum’s nipple, pull the dummy out and quickly tried to put the baby on the nipple. To trick it into sucking the nipple ... it was an assistant nurse! it wasn’t even a nurse! or midwife, let alone a lactation consultant. Oh it was crazy ... I don’t know if it’s a lack of staff or whatever – but when you’ve got Registered Nurses and assistant nurses trying to teach a first-time mum how to breastfeed, it’s crazy.” (HB01)

The participants had developed an understanding that the hospital has insufficient resources to cope with demand; because of this shortfall, the women suffered. The participants therefore chose to birth outside the system because they wanted a better option than offered to them in hospital. By birthing outside the system, they could access the resources they needed in order to have the best and the safest.
4b. It’s not like home

Due to their philosophy on childbirth, the participants believe the birthing environment to directly impact on the outcome of their birth. The women also appreciated the postnatal benefits of being at home. Many explain in detail the factors that made the hospital environment substandard for them:

I remember at the time ... trying to be in my own zone but ... the bright lights and the looking at the clock and then there is the rolling of the eyes and people coming in and out ... so the first thing is, in your average hospital situation it’s very clinical, it’s the least like home you can possibly imagine, there’s bright lights there’s lots of busy people running around there’s machines that go beep ... there is a tension in the environment which is completely opposite to home. (HB06)

The women felt that a home environment provided the essential elements required to ensure the best possible birth experience and outcome. In contrast, they felt that the hospital could not adequately cater to their needs in labour, birth and afterwards, because the environment was the antithesis of the home context. As one participant observed, ‘there was nothing homely about a hospital’ (FB09).

In their comments about the hospital setting, the women made particular mention of the physical environment in the hospital, how this ‘felt’ and the aspects of the hospital’s physical experience that made it less like home. One woman explained:

Well it was all very beige and very hospital, it was sort of an older hospital, there was no colour, no pictures on the walls, all the medical equipment was just out there in plain sight, it was terrifying. (FB04)

Another commented, ‘I just felt like it was so clinical ... I didn’t want that really sterile clinical feel like when I was giving birth’ (HB03). Another woman, having taken a tour of the hospital in preparation for her hospital birth, explained her distressing response to seeing the place in which she had made plans to birth:
At 38 weeks we have a tour of the hospital, I’m shocked by what I see and cry all the way home, we decide to labour at home as long as we can, then transfer to hospital when I start feeling the urge to push. So for the next few weeks I try to feel comfortable with the idea of birthing in that vile place. (FB12)

The women also made reference to the difficulty they experienced with using the facilities offered by the hospital. They found the hospital facilities did not provide an environment conducive to comfortable labour and birth:

I remember seeing one of those birthing balls, I remember putting it onto the bed to lean onto it while I was standing up, I remember it being very hard, I remember having a big contraction, I remember saying out aloud at that time, ‘oh this is too hard,’ kind of referring to the ball being too hard. (FB03)

Another woman explained the restriction she felt while birthing in hospital:

I just didn’t feel like I had freedom to move around and I remember just being in labour and not knowing where I wanted to be, if I wanted to be on the toilet or on the bed, it felt like I didn’t have an option that felt most comfortable for me and that was a bit frustrating. (FB07)

In addition to not having the facilities and environment for a comfortable labour and birth, one woman explained how the layout of the hospital itself was not conducive to her postnatal healing after she admitted herself to hospital to be with her baby who required admission to special care. As the special care nursery was too far from the postnatal ward, she was unable to rest adequately following the birth:

To be two floors up was absolutely ridiculous, so I was just getting up and walking down stairs every time, so I didn’t rest really the whole week ... I was wrecked, I hadn’t really rested after the birth. (HB04)

The hospital layout, facilities and general atmosphere hindered rather than facilitated comfort and healing. In addition to structural and physical environmental factors, the participants described various sensory aspects of the hospital environment that they found undesirable, including the sounds and smells that confronted them. One woman
explained, ‘it was really noisy and the buzzer was on a loop and it was just horrible’ (FB04).

Finally, the participants commented that the hospital environment makes it too easy for their space to be invaded. They spoke of the challenges that this posed postpartum when they wanted to rest uninterrupted:

Oh I had a lot of visitors, I had just a constant stream of people and even people coming out of the visiting hours and it was quite hard work, juggling all the different people ... all at once, it was really hard, and also wanting to try and feed the baby ... I just felt like I was on show. (FB07)

After having experienced the hospital facilities and environment, the women concluded that the hospital could not provide them with the best and safest. This motivated them to find a better way for next time.

4c. It's like a cattle yard

The participants expressed a belief that the service offered by the hospital system is driven by the desire to move women in and out of their institutions in a timely manner. In their experience of the system, the women felt depersonalised and relegated to a number: ‘The hospitals just really see them [women] as another number’ (FB05). The metaphor most frequently invoked was that of a ‘cattle yard,’ where the hospital’s aim is to ‘keep them moving through like a cattle yard, keep them moving through like a number’ (FB05). One woman reflected on her experience of a hospital birth, noting that if she had her own care provider, her experience would have been more personal and much enriched:

... at least I could have skin-to-skin, at least I would have someone there who knew me, knew the baby, would put my best interests first and I wouldn’t be just another number in the cattle run. (HB09)
The same participant goes on to state this as her primary reason for avoiding the hospital for her next birth:

... that’s what I mean like feeling like you are just another cow in the cattle run, they don’t see you as a person and that’s what I want next time. I want me and my partner and my other child to be seen as a family that has experienced something, not just me and then him tagging along, or me as just a body. (HB09)

This metaphor of the cattle yard is also reflected in descriptions offered by a participant who worked as a midwife in the system. The hospital cannot provide individualised care to women, she stated, because employees are following the process or system that will enable the hospital to run efficiently on the resources available. To maintain productivity, she contends, the treatment of women in hospital has become depersonalised:

There is nothing individual about it, and so staff are, I think, losing the ability to make their own individual choices, they’re just going through the process of what they do every day, they just continue to do every day because that’s what we’ve always done and that’s what works, that’s what gets out 300 women in and out every month. (HB05)

When one woman was asked what could have been done for her at hospital that might have enhanced her experience, she said:

I’m not sure they really could have done anything better for me just because of the mentality ... it’s a revolving door and they’ve got to get this baby out the quickest way possible, whichever way suits us and then get this baby fed, don’t care how just get it fed and then get you out the door. I don’t know if they could have done anything better. (HB07)

These comments reflect the participants’ belief that the hospital could not offer them anything better than what they had experienced in the past. Thus, the hospital could not provide them with the best and safest in the future. Having experienced a system that treated them as a number rather than a person, and having been shuffled through as in a
cattle yard, made the participants believe that the hospital could not cater to their expectations.

4d. Bound by hospital policies

The participants understood that policies and protocols were set up to facilitate the smooth running of the system, and in order to get women and babies through as quickly and safely as possible. By according primacy to productivity, however, the participants felt that hospitals relinquished the possibility of offering individualised and sensitive care to the birthing woman. The focus shifts away from what is best for her and her baby, towards what is best for the system and the institution:

I sort of feel like when you walk in it’s no longer about what you want and what’s important to you, it’s about what works in the system ... you’re put into a category and you do things that suit the whole system ... your induction started at this time because that’s what the policy says and you lay on the bed and you’re monitored because that’s what the policy says and you get fed at these specific times because that’s what the kitchen does and you can’t have a bath because of this, so it’s all very, it’s regimented I suppose. (HB05)

The women felt that the hospital staff were bound by policy, and thus the service that they were able to offer was highly circumscribed and restricted:

They are bound by their protocols ... I think they have them because they believe that is safety and it is also to guide doctors and midwives in their practice, yeah I think they do truly believe it is safety. (FB06)

Although the majority of participants conceded that hospital policies were designed in part to promote safety, one participant who was also a midwife working in the system argued that rigid compliance with policy often led to a diminution of common sense and clinical reasoning. Thus, decisions guided by policy would not necessarily be in the best interests of the individual, but rather would reflect a loyalty and deference to hospital procedure:
I think we’d all like to say that it is for the safety of the woman, but it’s just done in such a roundabout way, there are so many policies and so many procedures that are supposedly in place to keep women safe, that’s what they say, but yet we’ve forgotten that we are keeping women safe, now we are focused on those policies and procedures ... So now we’re more concerned about you know, after 8 hours we should use this drug and after 12 hours we should perform this test and ultimately I’m sure those things were put in place for the safety of the mother, but that’s sort of been a bit forgotten, so there is no common sense anymore. (HB05)

When challenged with the idea that hospitals have high demand and many staff, and thus need policies and protocols to run efficiently and safely, one participant responded, ‘[y]eah I understand that, yep ... I get that there has to be certain systems in place ... there has to be a system – I get that’ (HB04). The women acknowledged that hospitals needed a systematised model of care. They felt, however, that by birthing outside the system, they are finding a better way that is not constrained by policies and procedures. For the participants, birthing outside the system is an option where care is dictated by the needs of the women rather than the needs of the institution. They acknowledge that in the interest of safety and efficiency, the hospital must maintain a system of care, but the women would prefer not to receive this type of care, and therefore choose to birthing outside the system.

Because hospital staff must adhere strictly to policy, the participants felt that the staff could not provide the service that was best and safest for them and their babies. The women acknowledged that their specific desires often fell outside of what was dictated by policy. The women were therefore concerned that their requests would be met with resistance or hostility. Many had formed this impression of hospital services as a result of their previous experiences:

[I was met with] quite a strong message there [in hospital], that was, “we really don’t appreciate you making this more difficult, we have a lot of women here to get through, just be good, just fit in” ... I guess there was a level of threat around anyone that was feeling that the system wasn’t
going to be good enough ... it was just purely a situation of you know, “this is the way we do things and we really don’t have time for you to be trying to ask for any special consideration” ... it was met with quite a bit of resistance and defensiveness and I felt that straight away ... she [the midwife] just basically was indicating to me that she wasn’t interested in any way in looking into that option or giving me that opportunity. (FB06)

Participants perceived there to be no flexibility in the provision of care offered: ‘No, there’s no flexibility, they even said it’ (HB04), and that staff were not open to doing something outside of policy within a hospital setting. One of the women, who also worked as a midwife in a hospital, commented:

I think now we’re putting every woman into the same square, we’ve got one set of policies and procedures for every woman across the whole country, state, whatever. Doesn’t matter what your parity is, where you were born, how old you are, what your risks are, you’re all going to be shoved into the same procedures and policies, so there’s just absolutely nothing individual about it ... for some women, they need that, but for other women there is absolutely no reason why, you couldn’t be more flexible. (HB05)

The participants gave examples of their needs that were unable to be accommodated due to policy restrictions. When one woman was asked what kind of things the hospital was against, she replied, ‘I think just generally anything that was going to interfere with standard protocol’ (FB06). Another woman, when asked why she thought the staff became rude and abrupt when she requested early discharge from hospital, suggested, ‘maybe because it didn’t fall in line with their policies and procedures’ (FB04).

Other participants offered examples of policy interfering with their preferred course of action:

In that hospital, you are not allowed to walk and hold your baby ... you can’t walk or you get in trouble. I was walking and holding my baby and they said “you can’t do that.” (HB01)
As mentioned previously, the participants wanted to have a vaginal birth without intervention; this was also true of the women wishing to have a VBAC. One woman, when asked whether she thought she could achieve a VBAC in hospital, replied, ‘I’d like to, but I think I’d be faced with a lot of opposition’ (HB07). When asked what kind of opposition she thought she would come up against, she responded, ‘oh, just general hospital policy, the mentality of the staff’ (HB07).

In another scenario, a woman chose to freebirth rather than birth in hospital after the hospital was unsupportive of her having a midwife-attended homebirth through their program, even though she had already had a VBAC at home with their program. Due to policy change, however, they would no longer allow her to do this. She recounted:

My second baby was a planned homebirth but it’s a VBAC homebirth and that went all fine and my third baby, I wanted to have a planned homebirth and the policy changed ... therefore I was placed in a high-risk category and they wouldn’t allow me to plan a homebirth ... it’s a strange situation because previously I actually had a homebirth, and this is the ironic part, it was with the same midwife that I had my planned VBAC homebirth and they were under the department of community health and they did a restructure ... and the actual midwifery group practice was reshuffled alongside of acute care instead of being under community health ... then things like VBACs and those other complications couldn’t be dealt with in a homebirth situation, the policies wouldn’t allow for it. (FB03)

Overall, the participants felt that the policies and protocols imposed on them by hospitals were restrictive to their desires and preferences. For the women, this was experienced as an erosion of their choices. Noted one woman: ‘it’s [choice] just taken away from them by protocols and so there isn’t a choice’ (FB05). The participants felt that the hospital would be resistant to any desires that fell outside of policy. This directly conflicted with their wish to be respected as the authority at their birth.
4e. They intervene

The participants also had an understanding that when you enter the hospital to give birth, ‘you are on a timeframe’ (HB02). Of their previous experiences, the women recollected having been expected to conform to the hospital’s timeframe for labour and birth. ‘Like well, you need to be this many centimetres by this time’ (HB03), noted one woman. Another described her experience as ‘the clock was there and there was so much talk about hours and minutes and so many vaginal exams and you’re this many centimetres and blah blah blah’ (FB01). Some women chose to avoid entering the system through fear that they could not satisfy the hospital time limits on labour:

[having had 2 previous caesareans], the overall vibe I got [from the hospital] was that I would probably get about eight hours to labour in the hospital and after that they’d get a bit worried. So I just thought well, if I go in there, with the clock ticking, it’s just not going to happen, I just don’t think I’d be able to do that. (HB04)

Failure to adhere to hospital time limits would result, the women feared, in interventions designed to expedite the processes of labour and birth to ensure that they were contained within the parameters set by the hospital. One woman described this as inevitable if she entered a hospital to give birth, stating, ‘I just can’t imagine having a whole hospital staff caring for me and not intervening in some way’ (FB08). Another woman explained, ‘they [the hospital staff] interfere so much sometimes where they don’t need to interfere, it’s not really needed’ (HB03). As previously discussed, the participants believed that interference and intervention introduce additional risk into the birthing process. Given that the women felt that the system compels the staff to intervene, they saw hospital as a riskier birthing option.

The women gave various reasons for why they believed that they would be exposed to intervention in hospital. When asked why she thought hospitals approach birth in an
interventionist way, one woman responded, ‘because of their fear of litigation’ (FB05).

Another woman who chose freebirth for all her children offered this rationale:

I could see from women’s birth stories and from statistics that intervention rates were just wildly, there was just too many, a ridiculous amount of intervention in birth and birth hasn’t changed a whole lot since we started doing it and so I saw that the medicalisation and the removal of birth from the home as the causes of that. (FB08)

Due to her understanding of how the hospital would manage the birth of her twins, another woman decided to birth at home in order to avoid intervention:

In hospital, at best if I was ‘allowed’ to birth vaginally I would have been pressured to have an induction at 38 weeks, with constant monitoring removing the ability to use my body to its best advantage of an active birth. I would also have been pressured to consent to an epidural and a forceps removal of the second twin. (HB13)

The participants believe that intervening in the birth process increased the risk of something going wrong. Since hospitals represented a higher risk of intervention, the women saw birth outside the system as the safer option.

4f. The system fears birth

As discussed earlier, the participants perceived childbirth to be a normal, natural part of life. Because of this, they did not use the language of fear when describing birth. The participants believed that the system fears birth and thus encapsulates it within a hospital setting where it can be managed. One woman felt that ‘they’re [the hospital staff] looking at the worst-case scenario all the time and coming from fear’ (FB02). The system’s fear of birth sits in direct opposition to the participants’ perceptions of birth, and this creates a philosophical discord.

The participants also felt that the level of their practitioner’s fear of birth was directly proportionate to their tendency to intervene. One woman explained why she believed the hospital staff wanted to use intervention during the birth of her twins:
because of fear from medical practitioners who have no faith in birth being normal and women’s bodies having the innate ability to birth. (HB13)

Further to this idea, another participant cited her doctor’s fear of something ‘going wrong’ as the reason why induction was recommended:

she said to me from 37 weeks when I left, “oh when you’ve had enough just let me know and we’ll go in for an induction” and she says things to me like, “you’re a midwife you know how things can go wrong, you don’t want anything to go wrong in the last week, you don’t want to take your chances.” (HB05)

One participant was asked why she thought the hospital intervened in the birth process and she responded, ‘because they fear that it’s a disease process’ (FB05). The participants’ conceptualisation of birth as a natural and normal process that is best left uninterrupted makes the women reluctant to enter a system that fears birth and dictates its management with intervention. The participants believed that care providers in the system are fearful of childbirth, and that this fear can lead to intervention. By putting themselves in the hands of these care providers, the women felt that they were exposing themselves to an increased risk during birth. This motivates them to avoid birthing inside the system and to find a better way.

4g. Tension around autonomy

The participants expressed a desire to be respected as the authority at their birth, and this felt the best and safest for them and their babies. They assumed that the hospital would not accommodate their desire for autonomy. As such, the hospital did not represent the best and safest place for their birthing experience. One woman explained her early antenatal experience in the hospital and how it motivated her to disengage from their care: ‘there was a real level of tension in my first visit around how much autonomy I would be allowed’ (FB06). She sensed that the hospital expected her to relinquish her autonomy. This was antithetical to her desire: ‘I felt that the experience that I had of the
The hospital was that there was a real expectation to hand over to the experts and that they would take care of it’ (FB06).

The participants were reluctant to return to the system to birth because they felt that by entering hospital, there would be tension around how much choice they would be afforded:

I don’t think that choice is there in hospital. Women might choose to birth in hospital but once they are in the hospital I don’t think they are getting choice. (FB05)

Another woman spoke of arming herself with information in the belief that it would help her to retain autonomy within the hospital setting. In reality, however, this had not been the case. The hospital, for her, was unable to afford the level of agency and choice that she desired:

I’d tried to research it, part of me had thought that you know I have a choice, but at the end of the day I still didn’t feel like I had a choice. (HB07)

For many participants, their previous birthing experiences within the system had taught them that hospital staff would assume control over the woman’s body, ultimately challenging and subverting the woman’s autonomy:

Once we were in the room it was just sort of like, okay now we are in charge and this is what you’ve got to do ... It was just like, okay we are the experts you just do what we tell you to do ... It was sort of disempowering I guess you could call it. (HB06)

The women likened being in hospital to being in school and having to obey an authoritative figure: ‘you feel like you’re a kid and they’re the teacher at school or something that you have to obey their authority’ (FB02). By entering a hospital, a woman lost authority over her body:

In hospital it is very much at times, the midwives’ territory but certainly the doctors’ territory ... so already a woman
just stepping foot into a hospital, she has lost ground. (FB05)

If they entered the system to give birth, the participants feared that there would be tension around how much autonomy they would be allowed. In an attempt to maintain autonomy and thus protect their safety, they chose to *birth outside the system* where they felt their autonomy would be respected.

Embedded in the perception that there would be tension around how much autonomy they would be allowed in hospital is the women’s impression that the system essentially does not trust them. When asked whether she thought that the system trusts that women will make sensible decisions, one woman responded, ‘well it doesn’t trust women at all’ (HB04).

The participants’ consensus was that the hospital did not trust the women’s capacity to make decisions. The participants also felt that hospital staff did not trust women’s bodies to birth. This sat in dramatic contrast to the women’s perception that childbirth was a normal and natural event that only occasionally goes wrong:

> I had a friend that was having her second baby and they told her, “oh look your body’s obviously not able to do this” ... and she’s like “this is my second child I’ve already done it.” So just that implanting into women that they can’t, just because they think they can’t. (FB02)

Another woman correlated the reasons the hospital gave for why they believed her body would not be able to birth vaginally with signifying their mistrust in women:

> They kept saying, “but you are small, your husband’s big,” cause my husband is like 6 foot something and I’m like 5 foot 1 and they are going, oh – and because I was diabetic, shoulder dystocia, you are going to have a big baby, you’re only small, your husband’s big, they were just putting it out there, they were just so negative. (HB03)
Through their experiences within the system, the participants learnt that the system does not trust women to make sensible decisions, and it does not trust their bodies to work effectively. This directly challenges the woman’s desire to be respected as the authority at the birth, and conflicts with her belief that her body is naturally capable of birthing. Being respected as the authority was considered by the participants to be something that would offer them a safe birth. The women felt that the hospital would not afford them autonomy. As such, a hospital setting was not the best and safest, and the women would need to find a better way.

4b. Hospital management is emotionally unsafe

The care provided to the participants in the system did not appear to meet their emotional needs, with women reporting high levels of dissatisfaction with the emotional experience of the care offered by mainstream maternity services:

The hospital doesn’t enter into that, they are flat out looking into the physical side let alone the mental and emotional, I don’t even think they look at the emotional side. (FB05)

The system’s perceived lack of attention to the woman’s emotional needs alienated the participants and motivated them to pursue something better.

The participants described sustaining trauma as a result of the standard of care they received when birthing in a system that does not adequately cater to the emotional needs of women. Throughout this research, some of the most emotionally difficult moments for me were when the women described the violations they endured at the hands of their maternity care providers:

My experience with hospital-based care has been incredibly disappointing, and life changing, but not for the better. The day my first son was born it should have been the best day of my life, instead it has left me scarred, mentally and physically. Part of my treatment in the local
hospital included being assaulted by a midwife as she forcibly held me down while I was in pain so that the doctor could poke around in my vagina without my protest. (FB13)

For another woman, an emotionally traumatic hospital experience was what motivated her to subsequently *birth outside the system*:

> I decided that should I find myself unable to access a midwife, I would birth at home – alone. Nothing that can happen to me or my baby at home could be much worse than what my second baby and I experienced in hospital. I will never subject myself, my baby or my family to such an ugly, traumatic and dehumanising experience again. (FB1)

Another participant described a similar scenario, and her choice to give birth at home to avoid a recurrence of the trauma incurred at her first birth – an experience that she describes as ‘birth rape.’ She explains: ‘I thought home was safer, but for me the real deciding factor was my total and utter fear of going to the hospital again and any of that [abuse] happening to me’ (FB01). From these recollections, we can see that if a woman is exposed to a traumatising event during a birthing experience within the system, this could well predispose her to avoiding the system in the future.

The perception that the hospital cannot offer the best and safest leads the women to discount hospital as a birthing option, and forces them to consider birthing options that fall outside the system:

> Our only other option it seemed, was to birth at the local hospital and not an option we were happy with or willing to choose. So we continued the pregnancy without any antenatal care and birthed our third son at home without medical assistance. (FB10)

Hospital birth presented women with a set of circumstances that they were not willing to accept – circumstances that were not perceived as the best and safest for them and their babies. After being exposed to care that proved not to be the best and safest, the participants sought a better way for their subsequent births. Although the participants
saw no need to birth in hospital, they did make it clear that should complications arise (rendering a birth inside the system as the best and safest option), they would not shun the medical system completely. As one participant observed, ‘[t]here is a need for doctors, [be]cause there are times when things go wrong and they are needed’ (FB02). The participants acknowledged that the time for medical intervention was when things go wrong. One participant explained, ‘obviously I agree, women do need doctors, I’m not saying that women don’t need them, we do need them because there are circumstances where they are needed, you know, they do save some babies’ (HB03). For another woman, ‘they [the obstetricians] absolutely have their worth, I hold obstetricians in high regard but they are there if you have a problem’ (FB03).

The participants felt that the hospital and medical interventions should only be used if really needed, rather than as routine in the context of normal birth. One woman asserted, ‘I will only birth in hospital if proven to be absolutely medically necessary’ (HB13). If medical attention was required to ensure the safety of the mother and baby, this became the best and safest option. Observes one participant, ‘I think the medical system is really fantastic ... it’s awesome that it’s there if we really need it’ (FB04). Another participant (a midwife) believed that the system had its place: ‘certainly, there are times when a hospital is necessary ... with any fetal demise, maternal compromise’ (FB05). For one woman, birthing at home was only appropriate if it would not compromise the safety of the mother and baby, and she explained that the time to move into the system would be:

if there is a problem, if there is a risk, there is something possible that is going to affect the mother or the baby and that’s their only way of getting out a healthy baby, then yeah, that’s the advantage of living in today’s society. (HB04)

The resounding message from the women who choose freebirth, in particular, was that if they perceived a problem during their birth, then the best and safest thing to do for
themselves and their babies would be to transfer to hospital. ‘[I]f I feel like something is wrong, you will not be able to keep me at home,’ stated one woman, ‘I'll be out the door’ (FB08). Another participant described how a complication arose following her birth, and that remaining at home was no longer the best and safest, because it became obvious that they needed more than her midwife and the home environment could provide:

> Even through all its [the hospital’s] gripes, there is still some, I mean we had to go to the hospital with the baby, like there was a point where the care we had wasn’t enough ... so I’m grateful that the hospital was there. (HB04)

One woman did require medical supervision due to her risk factors, and was happy to submit to this, given the circumstances:

> If I’d been what I consider to be low-risk with absolutely no poor history and no medical conditions I would have absolutely no need for an O&G, but I do have things that do need to be monitored, so I’m happy to use her. (HB05)

In conclusion, women in this study *birthed outside the system* because they believe it to be the best and safest for them and their babies. The women judged what was best and safest against three criteria: 1) that their birth is natural without intervention; 2) that they have their family close; and 3) that they are respected as the authority at their birth. If these three criteria cannot be fulfilled by their care provider or chosen birth location, then that setting is not considered to be the best or safest option. The women arrived at their beliefs about what is best and safest after learning from previous birth experiences. These previous experiences helped them to formulate their perceptions about childbirth and what practices they perceive as safe or risky. After having experienced birth within the system, the participants concluded that they had to find a better way, because the system could not offer them the best and safest. The next chapter discusses the basic social process of ‘finding a better way,’ which explains how the women came to the decision to *birth outside the system.*
Chapter Five: The findings – the basic social process

Introduction

The previous chapter examined the core category, ‘wanting the best and safest.’ This discussion revealed that women *birthed outside the system* because they believed this to be the best and safest option for them and their baby. In this chapter, the basic social process of ‘finding a better way,’ is presented. This phrase describes the process by which the women moved through the journey from wanting the best and safest, towards the choice to *birth outside the system*, and finally pursuing this option. The women’s desire for the best and safest leads them to find a better way to birth than what is offered within the system.

The participants in this study described finding a better way by firstly considering all available birth options in order to inform themselves and ultimately choose what they considered to be best and safest for them. Secondly, the participants felt they needed to manage perceived opposition to their choices, and thirdly, they sought to mitigate the risks of birth at home in order to ensure the best and safest birth for them and their babies. ‘Becoming the expert’ was an integral part of the women’s process of finding a better way and was the end result of the women’s pursuit of the best and safest. The women described themselves as different to other women and describe particular character traits that they believe set them apart from other women and facilitated their choice to birth outside the system. These character traits can be described under the following titles: ‘bucking against the system,’ ‘I take responsibility,’ ‘I investigate to make sure I know,’ ‘I have the ability to know,’ ‘entitled to choose,’ and ‘confident in my ability to know.’ Before detailing these findings, a visual representation of this chapter is provided.
### Table 4: The Basic Social Process

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The basic social process – finding a better way

1. Considering birth options

Discussing their choice to *birth outside the system*, the participants described making a considered and informed decision that included first exploring other birthing options available to them. This process followed a typical path, with the women ‘discovering that there are multiple birth options.’ They move on to ‘meet with a variety of care providers’ and then ‘weigh it all up.’ After making the decision to circumvent the system, the women ‘get informed about out-of-the-system birthing options,’ which for some leads to homebirth and for others ‘forces them to consider freebirth.’

1a) Discovering that there are multiple birth options

In the process of trying to find a better way, the women start to explore places and ways to birth that they had formerly not considered. For those who have had a previous birth, it is the pursuit of something better than their previous experience that leads them to explore less common birth options. Women describe their emerging discovery that there are multiple birth options, and that they do not have to be restricted to those that are publicly available and most popular. One woman recounted the moment she discovered that there was an alternative to medically managed birth: ‘I hadn’t had the moment where I realised it could not be medicalised, and meeting those women made me realise, oh wow there is an alternative’ (FB08). For another participant, who was a midwife, it was hearing the birth stories of friends who had experienced homebirths that made her become more receptive to exploring different ways to birth which can result in a positive experience for the mother: ‘where they made you go, oh well there is a different, there is – there can be a different way to birth your baby and it can be a positive experience, it can be a good experience’ (HB03).
In the process of exploring her birthing options, one woman encountered a doula who, after hearing of her struggle to find a midwife, suggested freebirth. As the participant recounted, ‘I spoke to some doulas and one of them said, ‘oh have you thought of like just doing it by yourself?’ and I kind of went ‘oh no, no I hadn’t’” (FB02). As the women investigated and considered birthing options, they discovered many birthing options of which they had hitherto been unaware. In her pursuit of a better way, one participant said, ‘I just became more informed about my other choices ... [and this] just blew open a whole new world for me around another choice’ (HB04). The process of discovering multiple birth options, which is prompted by the motivation to find a better way, is part of a woman’s journey as she makes the choice to birth outside the system.

The discovery of out-of-hospital birthing options was not always an immediate catalyst for women choosing to birth outside the system. Upon first encountering the option of homebirth, the women described feeling unsure and tentative. They were not necessarily initially convinced that it would be the best and safest choice. One woman recalled the moment that homebirth was suggested as the best option if she desired a successful VBAC. She said, ‘that actually freaked me out, because I hadn’t considered it and I was like, ‘oh, I don’t know if I’m a homebirth kind of person,’ and my husband certainly was freaked out by it’ (HB04). Another woman described how she responded when a midwife colleague suggested the option of homebirth to her: ‘I was scared ... I was just going, ‘oh my god, homebirth?!’” (HB03). Such discoveries did not instantly lead women to choose to have a birth outside the system. Rather, their realisation of these options can be understood as an initial stage in their journey to discovering the birth option that they believed would be best and safest for them and their babies. After discovering that there are multiple birthing options, the participants explore these further. This exploration generally entailed meeting with a variety of care providers.
1b) Meeting with a variety of care providers

The participants met with a variety of care providers as a way of further investigating and considering the various birth options that they had discovered. They did not restrict themselves to only meeting with care providers who might facilitate a birth outside a hospital, because they had not yet been convinced that a *birth outside the system* was the best for them. Therefore, they also met with hospital-based care providers and GPs to explore the full gamut of options available. It was felt that this comprehensive approach would allow them to make an informed choice.

Some women described consulting with their GP to discuss birthing options. One participant was told, ‘I’m all for you doing a homebirth, but I want you to fully investigate the options so I want you to go and speak to the hospital as well’ (HB04). This woman went on to visit the hospital and meet with the midwives on staff to discuss her birthing options. Another woman also explained that she ‘went to the hospital and talked to them’ (FB03). The participants reported carefully considering the option of birthing in hospital. In addition to meeting with mainstream care providers, the women also met with care providers who offered services such as private midwifery care and homebirth. One woman described how she ‘decided to investigate it fully, so we met with three or four different midwives’ (HB06).

Meeting with a variety of care providers was one way for the women to gather information about all their options before they could be confident that they were making an informed decision. Through the process of meeting with the care providers, the participants came to realise that the hospital could not offer them the best and safest. Therefore, women who were initially open to considering all possible birthing options grew reluctant to birth in hospital, and began more closely investigating out-of-the-
system birthing options. Along with meeting a variety of care providers and deciding that the hospital could not offer them the best and safest, participants spoke of taking the information they had and ‘weighing it all up.’

1c) Weighing it all up

As the participants investigated their birth options, they also underwent the process of weighing it all up as a way of deciding on the best and safest birth option for them. One woman explained how making a birth choice was not a black and white exercise, but rather a consideration of a complex interplay of components that required careful assessment ‘on a case-by-case basis’ (FB03). When making their birth choices, the women considered their individual circumstances and then made decisions based on what would best suit their particular situation. One woman explained how she reached her decision about who would be best to supervise her breech vaginal birth:

So if you ask any person, who would you go with, someone who has had the experience of seven natural breech births or an obstetrician who is trained in emergency birth situations and has never really witnessed a natural breech birth and all its little idiosyncrasies and what happens, who would you feel more confident with? Well I mean it’s a no brainer for me. (HB06)

In weighing up their options, the women described having a keen interest in understanding the risks involved in each birth choice. There was often a sense of frustration at the lack of comprehensive information available regarding the risk factors of each alternative. One participant who consulted with an obstetrician about breech birth options was apprised of the risks of vaginal breech birth, while the risks of caesarean section were entirely overlooked:

The language also didn’t even cover the risks of caesareans so while he was saying if you birth this baby at home this is what is going to happen to you, not once was it mentioned, these are the risks of a caesarean birth. So to me it was like well you want me to be informed you better
list out everything, all the complications that happen with caesarean too because I want to know. (FB03)

The participants described being keen to understand the risks attached to all birthing options available to them, and then weighing it all up to make the choice that they felt would be best and safest. One woman explained, ‘I think it’s just about looking at the possible risks and weighing those up, just taking on the amount of risk that you are comfortable with’ (HB04).

In weighing up the risk of vaginal birth after caesarean, another woman cited academic research to her hospital care providers in a bid to convince them to allow her to have a midwife-assisted homebirth. This propensity for investigation was a characteristic feature of the participants’ pursuit of a better way to birth:

There was results where they had thousands of documented births that they’d actually included as part of their study and they’d actually found that if you had had a successful VBAC that a subsequent VBAC after that, the risk – because the big risk that they are talking about is this whole, the risk of uterine rupture, and basically the risk of uterine rupture was about 1% ... anywhere between half and 1% ... Interestingly enough it’s about- it’s almost within the same sort of parameters if it’s a first-time mum, and so the thing was that once you’ve had a vaginal birth your risk of uterine rupture decreases and what they had proven statistically was that once you had a VBAC vaginal birth, that subsequent VBACs, the risk of uterine rupture was also decreased and so what I was trying to help them understand was that really I already had proven that I had a VBAC and so I really was at no more risk than at worse a first-time mum. (FB03)

Another participant carried out similar investigatory work as she weighed up her birth options. After discovering the statistical risk of her choice to VBAC, she weighed this up against other risks she takes in life, in order to contextualise and put the risk into perspective. This woman justified her interpretation of the risk of VBAC, explaining:

Then you realise that actually statistically you have more chance of being killed in a car crash on the way home
from hospital and that puts things in perspective somewhat ... you know they can say that it’s whatever it is 0.14% of uterine rupture, I believe them, but when you put that in perspective, it’s just not that great of a risk. (HB04)

When making the choice to birth outside the system, the participants first considered and investigated all their birth options, and weighed up all the information before making their decision. As explained previously, the participants discovered that there were multiple birthing options. They met with care providers and weighed up their options as they came to the conclusion that the system was not the best and safest. Having made the decision to discount a hospital birth, the participants proceeded to educate themselves about the out-of-the-system birthing options available, in their pursuit of a better way.

1d) Investigating birth outside the system

After realising that in-the-system birthing options would not cater to their desire for the best and safest, women set out to investigate out-of-the-system birthing options:

It was at that point that I started talking to people, I got in touch with this mutual friend and she was really fantastic and had some books. She was really great and she just gave me some books and she said well, have some books, this is what I read and so I started looking into it and researching it. (FB04)

At this stage, the women described immersing themselves in information about homebirth and freebirth. ‘I googled everything and anything that I could get my hands on,’ stated one participant, ‘read Ina May Gaskins stuff and yeah so got a lot more informed about the alternatives’ (HB06).

The women reported accessing resources via the internet in their search for out-of-hospital birthing options. One participant ‘had researched on the internet’ (FB02), and found birth stories to be a helpful resource, while another ‘got really into reading
people’s homebirth stories’ (HB04). In addition to this, women sought out homebirth and freebirth communities and tapped into them as a means of gathering information and becoming more informed about the possibility of pursuing a *birth outside the system*.

> I made contact with what was then a very small group of women ... and they were very pro-homebirth ... so I had made friends with that community of homebirkthers. (FB08)

Another woman described her journey from hearing homebirth stories and discovering this as an option, to engaging with the homebirth community, to finally making the decision to pursue a homebirth midwife for herself:

> I had a couple of friends who did actually have homebirths and heard their wonderful stories and decided to join the Home Midwifery Association of Queensland, so I decided to sign up to their membership and I get their magazine sent in the mail, and just reading about their stories and that was how I began my search for a homebirth midwife. (HB06)

The participants came to the decision to *birth outside the system* after considering all their birthing options. Having discounted hospital as a suitable birthplace, they went on to research out-of-the-system birthing options, and sought to investigate these more fully. While many women chose to access a midwife and were satisfied with this choice, the investigation process forced some women to consider freebirth as the best and safest option for them and their babies.

1e) **Forced to consider freebirth**

In their quest to find a better way, some participants came to point where they were forced to consider freebirth. This was because other birthing options became either unavailable or unacceptable to them. All but two participants who freebirthed fit into this category of being ‘forced to consider freebirth’, with the remaining two genuinely coming to the decision through a belief that it was better than having a midwife. The majority of the women who chose freebirth would have preferred to have a midwife, but chose
freebirth because they felt that there was no better option available to them. Women who were unable to source or afford a midwife, for example, fell into this category.

**I would have preferred to have a midwife**

The participants who chose to freebirth were not all initially inclined to make this decision. The majority of the women reported that they ‘would have preferred to have had a registered midwife’ (FB10) at their birth rather than opt for freebirth. As one woman explained, ‘I chose it at that time out of necessity rather than really a real choice, my choice would have been to have an independent midwife at that time’ (FB01). Another woman described her initial intention to secure the services of a midwife to attend her birth, before circumstances changed and she felt pressured to make the decision to freebirth:

> My decision to freebirth was not taken lightly. Previously upon moving to a regional centre we had attempted to employ an independent midwife to support us at home. (FB12)

When asked whether she would have hired a midwife for her birth had the obstacles to accessing one not been an issue, one participant asserted that ‘if there was a midwife close by, I would have had a midwife yeah’ (FB02). The women who choose freebirth do not necessarily do so because they are opposed to having a midwife; in fact, some would have preferred midwifery assistance to the option of freebirth.

Another woman who had birthed her second child at home with a midwife pursued a midwife for her third, and would have been happy to have one had circumstances not intervened and dictated otherwise. She stated that ‘for my third baby I wanted to have a planned homebirth’ (FB03), explaining that had been able to access a private midwife, her third birth would ‘be another homebirth with a midwife present and that would have been nicer’ (FB03). One participant was ‘dumped’ by her midwife late in pregnancy, and
chose to freebirth rather than entering the hospital. In fact, she was so interested in having a midwife assisted homebirth that when pregnant with her second baby, she hired a midwife and planned a homebirth, rather than a freebirth, stating, ‘I’d really like to know that if anything ever did go wrong that there’s someone who knows something there’ (FB09). Women who chose to freebirth did not unanimously cite this as their first or ideal choice; indeed, many stated their preference for a midwife at their homebirth.

Once it became obvious to them that having a midwife was not possible, however, freebirth became the most suitable option.

**There was no other option for us**

To synthesise the above discussions, some of the women who chose freebirth did so because they were forced to consider it. Ultimately they felt it to be the only option acceptable to them. One woman saw freebirth as her only option after a previous traumatic experience in the hospital system, combined with being unable to engage a suitable private midwife:

> There was no other option ... there really wasn’t an option, I just was not going to go to hospital so I was so afraid, I wasn’t one of those women who was like yeah, “I’m gonna have this awesome unassisted birth it’s going to be great,” I was not that woman; I was totally freaking out. (FB01)

Another woman discussed the reasons why she systematically discounted other birth options and finally arrived at the decision to freebirth:

> My first child was born in hospital and the other two were born at home with the assistance of a lay-midwife. I would have preferred to have had a registered midwife at these births but as one was not available, I had to make a decision based on my options. Of which there were very few. I did not want to have another very public and medicalised birth at hospital. In order to access the type of care I desired, I would have had to relocate or birth at home. I was only looking for privacy, respect and a gentle birth. When my third child was born, the maternity services were alternating week about between two local
hospitals. This circumstance helped me to decide that home, even without a midwife, was my best option. (FB10)

Yet another woman describes being traumatised by a previous hospital birth and also discovering that the midwives available to assist with her subsequent birth were unable to cater to her needs:

If we are to ever become pregnant again, we will birth unassisted, because there are no other choices for us. The only local midwives are not able to provide us with the care we need and unless there is an emergency situation, I will not return to birth at the hospital that assaulted me and left me damaged. (FB13)

One participant explained that she chose to freebirth because she was denied access to other options. Freebirth therefore became the next best option:

Yeah, like if that had been available, I would have been quite happy to have the midwife help me in my home have my baby, I never would have considered unassisted ... I mean like I said, I never would have chosen to go down that path had the decision – I kind of felt like the decision was made for me, by denying me that choice. (FB03)

Some of the women, having been unable to access private midwives to attend their homebirths, thought to approach midwives who worked in a hospital and recruit them to attend them at home rather than in hospital. The midwives would be working without the insurance of the hospital and would provide a private midwifery service on the side of their job at the hospital. This approach was adopted by women who desired a midwife-attended homebirth, but discovered that there were no private midwives working in their area.

One woman who had a birth by caesarean for her first baby, and a successful VBAC at home for her second with a publicly funded homebirth program, sought out the same hospital program and midwife during her third pregnancy. In the time between her
babies, however, the hospital policy on VBAC had changed and the program no longer allowed VBAC at home:

Therefore I was placed in a high-risk category and they wouldn’t allow me to plan a homebirth, even though I’d already been through it before and so the choice that we made was too basically labour as long as we could and we would see where that would take us. In the end it ended up being a freebirth. (FB03)

She describes trying to call her midwife to come to her in labour:

We advised the hospital when I went into labour, or the midwife when I went into labour and she at that time she tells me now that she was trying to get permission to come and attend me because the hospital wouldn’t allow her permission to come to me. (FB03)

She went on to explain that:

they didn’t have the freedom to be able to actually attend my birth because they were employed by the hospital and they were under the directive of the hospital, it was kind of like, if you will, their employment under that agreement was held over their heads if they actually attended my birth. (FB03)

Although this woman was determined to avoid the hospital system, she also did not want to freebirth. Rather, her desire was for a midwife to attend to her at home. After the hospital declined this request, the woman opted for a freebirth:

It wasn’t a planned freebirth, so I can’t say that it was a planned freebirth, it was kind of, I mean my husband would probably beg to differ in that he would say yeah I knew we were going to do it all along anyway, but I didn’t intentionally set out, I didn’t say to everybody, you know what I don’t need a midwife I’m going to freebirth, I didn’t say that at all. All I could say to myself was that I didn’t want to go into hospital. (FB03)

Another participant also recruited a hospital midwife to attend her at home. This plan inevitably failed with the woman describing how the hospital management threatened to fire the midwife if she attended a homebirth. This ultimately translated into the midwife’s inability to assist: ‘she couldn’t support me in a homebirth’ (FB09). When asked whether
she had considered a freebirth before her midwife ceased her services, the participant responded that she had not.

Another woman – whose choice to freebirth was documented as part of her submission to the NMR – reported that although she was having antenatal care at the hospital with a midwife who ‘was able to provide all of my antenatal care’ (FB12), the health department ‘would not ‘allow’ her to attend my birth’ (FB12). This refusal of health services to allow midwives to attend women at home resulted in at least three of the women in this study choosing freebirth as an alternative to entering the hospital.

Some of the participants who ultimately had a freebirth described attempting to engage a midwife, as their original intention was to have a midwife-attended homebirth. As will be explained, the women who chose to birth outside the system were strategic in selecting their care providers – they engaged those who supported their choices, and would disengage from those who they felt would not. Participants described choosing freebirth as the next option after being unsuccessful in securing the services of an acceptable midwife:

We were living in a rural area at the time and there was only one midwife up here and she had at that point in time a 75% ditch or transfer rate so she was totally out of the picture for me. (FB01)

As this woman explains, she had only one option for a midwife and that midwife worked in a way that was unacceptable to her. She therefore decided against hiring the midwife, and pursued the only other acceptable option available to her, a freebirth:

I decided not to go with her and then there was no other option and so I started reading a lot about unassisted birth ... there really wasn’t an option, I just was not going to go to hospital. (FB01)

For another participant, the absence of midwives who were sufficiently geographically close, combined with her history of rapid births, meant that hiring a midwife felt futile.
As they all lived too far away to get to her in time for her birth, she felt she would ultimately end up without a midwife anyway:

The midwife I’d had for my previous homebirth had stopped practising and so I was looking around for someone and there was nobody at that time that serviced this area so I tracked down, I asked about four or five different midwives and they basically all said no, [though] two said yes, one was based like a forty-minute drive away, actually they both were but different directions and my previous three births had been really quick and this was my fourth. (FB02)

This woman had desired a homebirth with a midwife as with her previous births. Due to the distance factor, however, she chose to freebirth as the next best option for her. As with the previous woman, she felt she had no other choice given the circumstances:

Well I didn’t really feel like I had much of a choice, like I didn’t think “oh I’m going to have a freebirth.” It was like there was no midwives close by, I had such quick births and yeah like they’d been pretty hands off anyway. And yeah, someone suggested it to me and it wasn’t – like I almost felt like I didn’t have a choice, like if there was a midwife close by I would have had a midwife. (FB02)

Another woman, whose unsuccessful search for a midwife to attend a homebirth led her to consider freebirth, blamed the lack of access to a private midwife on the political climate:

but I couldn’t get a private midwife here because they don’t exist ... The reason why was because of this whole political environment that we’ve got here to do with insurances and stuff like that. (FB03)

This woman felt that the prevailing political climate made midwives reluctant to provide homebirth services, and that this inevitably resulted in more freebirths.

Another woman described her difficulty in accessing a midwife and her refusal to compromise on her choice. For her, if she could not secure the services of a private midwife, the next best option was to freebirth:
Eight months later we found ourselves pregnant again and yet again moving to another regional centre. We quickly set about looking for an independent midwife. Again there were none. This time we were not willing to compromise, the system had failed us catastrophically before and for this not only had my mental health been compromised but also our precious family unit. We felt our only option was to birth at home unassisted. For us at this time only freebirthing could ensure that my body and my baby be respected. (FB12)

For some women, the cost of hiring a midwife was prohibitive, and this was the deciding factor in choosing freebirth. One participant explained, ‘I found out how much it cost ... and I was just like there is no way. I just can’t afford it, so I wanted to have a homebirth but I was ruled out because it cost too much’ (FB02). Another woman had a similar experience:

Looking into options and I just felt really sure and really good about wanting to have a homebirth but as we looked into it again, it was a financial issue, you know you can have a homebirth if you pay for it ... there were midwives that I could have hired to come and help me have my baby in my home but financially we didn’t have the money. (FB04)

Ultimately, many of the participants came to the decision to freebirth after discounting hospital birth and then discovering that private midwives would not be able facilitate the best and safest births for them and their babies for the reasons detailed above. However, two participants fell outside the category of ‘forced to consider freebirth.’ Rather, they felt that ‘women will do even better even without a midwife’ (FB05). One admitted, ‘I felt like deep down I didn’t really want a midwife’ (FB08). For these two women, a midwife represented an interruption or an instigator of intervention that would disrupt the birth process. As one explained, ‘I felt like it would be really hard for a midwife to be hands off’ (FB08). This is in line with the women’s perceptions that interference increases risk. The presence of a midwife translated to potential interference and therefore posed a higher level of risk.
Women are motivated to *birth outside the system* because they want the best and safest for themselves and their babies. They *birth outside the system* because they believe this to be better and safer than birthing inside the system. This perception was based on their previous experiences along with their ideas about childbirth and risk. These ideas then inform their birth preferences, which helps us to understand their perception that the hospital cannot provide them with the best and safest birthing option. Because they want the best and safest for themselves and their babies, the participants prioritise the reduction of risk. If birthing at home represents a risk, they will choose to enter the system to ensure that they have the best and the safest. For this same reason, if they believe a midwife to represent the introduction of risk, they will avoid the midwife and choose to freebirth as a way of ensuring they have what they sense is the best and safest.

The next stage in the women's journey to finding a better way was ‘managing opposition’ that they encountered as they continued to consider their birthing options and ultimately plan a *birth outside the system*.

2. Managing opposition

The participants described the various ways in which they managed opposition as they pursued the best and safest birth. The detailed aspects of managing opposition will be discussed under the following headings: ‘managing opposition is hard work,’ ‘getting informed,’ ‘strategic engagement,’ ‘selective disclosure,’ ‘having people on my side’ and ‘playing the game.’ As discussed previously, the participants had strong beliefs on what they believed was the best and safest for their births. These desires were rooted in their philosophies and beliefs about risk and childbirth, and were desires that they perceived would keep them and their babies safe. The women anticipated that there would be opposition to some if not all of their preferences, and for this reason they anticipated
that they would have to manage opposition. They perceived that this opposition would come from health care providers, maternity care institutions and from friends and family. Furthermore, the women anticipated that managing this opposition would be hard work.

**2a) Managing opposition is hard work**

Not only did the women acknowledge the need to manage opposition, but they also expected this to be difficult. After her homebirth, one participant was asked whether she thought she would have achieved the birth that she wanted in hospital. She replied:

> It’s possible, oh gosh, I don’t know, maybe if you are incredibly staunch and your birth partner is incredibly staunch about exactly how you want it to pan out, and you probably just have to keep repeating that over and over, maybe you can. (HB04)

Her comment that ‘you probably just have to keep repeating that over and over’ is salient insofar as it indicates her belief that she would not only encounter opposition, but that the management thereof would be a challenge.

Women likened managing opposition to a battle scene where they would have to fight in order to win and to have their choices respected. One woman explained, ‘I felt like if I went in there [to hospital], I would be fighting every step of the way’ (HB08).

If women anticipated that their choices or preferences for a particular birth option would be challenged, they would actively avoid that scenario. By birthing in the system, women feared that they would be presented with opposition. In order to avoid conflict and opposition, the women chose to avoid the hospital system altogether: ‘I just don’t want to have to deal with that’ (HB02) noted one participant.

The women anticipated that managing opposition within a hospital setting would be hard work, and they did not want to have face this task while in labour. As one woman put it,
‘I felt like it would be a constant struggle, my partner and I against the hospital staff’ (HB04). Another participant felt that managing opposition ‘seems like a lot of energy’ (HB06). To avoid this situation, the participants avoided the system. One woman explained: ‘I didn’t want to have to spend energy’ (HB08). An unwillingness to fight the system and manage opposition motivated women to avoid this battle scenario altogether and birth outside the system. Knowing that there would be a battle in hospital, they rationalised, ‘I don’t want any of my energy or any of my support people’s energy wasted’ (HB06).

Due to the uncertain nature of pregnancy and birth, where medical assistance is sometimes required, some women found that they did need to engage with the system for part of their care. In these cases, multiple strategies were consciously employed by the women to effectively manage opposition to ensure that their desires were still met. These strategies included: ‘getting informed,’ ‘strategic engagement,’ ‘selective disclosure,’ ‘having people on my side’ and ‘playing the game.’

2b) Getting informed

Getting informed was not only a way for participants to investigate their birth choices; it was also a means of arming themselves for battle should they need to manage opposition. One woman was hoping to have her third birth attended by the same midwife and hospital homebirth program with which she had birthed her second baby as a VBAC. In the interim, however, the hospital policy on VBAC had changed, and they would no longer endorse a homebirth on their program, despite the fact that the woman had experienced an uncomplicated second birth and lived within minutes from the hospital. Desiring a homebirth, the woman met multiple times with hospital management in an effort to be granted ‘special dispensation’ (FB03) so she could have a homebirth with
their midwives in attendance. In order to manage anticipated opposition, the woman prepared by getting informed:

I did a lot of research, I found a lot of papers ... and we’re not talking about like one for two, the results of one or two studies, there was results where they had thousands of documented births ... What I took to him was my full medical records ... I took with me the policy guidelines for the midwifery group practice here, it was set up based on the guidelines for South Australia, so I took the guidelines for South Australia, I took excerpts from his RANZCOG college and I also took with me half a dozen different research papers that were pointing to subsequent VBACs being much more lower risk than first-time VBACs. (FB03)

Other participants describe gathering information from their care providers, as they saw this as an important way to gain information about the system, the policies and practices offered at the hospital:

I’d already asked my obstetrician and in prenatal class, if my waters had broken could I have a bath and they’d said yes. I’d even asked because I’d had a false labour at 35 weeks so I thought I would go early and they said I still could even if I was early. (HB02)

In addition to getting informed, the participants would also actively try to avoid opposition. They thus practised strategic engagement with their care providers as a way of avoiding having to fight for the best and safest.

2c) Strategic engagement

The women in this study described strategically and selectively engaging or disengaging with care providers who they felt would or would not cater to their particular needs and desires. If the participants anticipated that their care provider would not cater to their desire for the best and safest, or if the care provider explicitly voiced opposition, the women then disengaged from this care provider and subsequently avoided discussing their preferences with them. One woman who was gathering information on her options
for VBAC recounted a consultation with her GP, and his directives for the information she should present at the hospital:

He said something like, “oh well tell them you’ve had two caesareans, they’ll probably put you in a high-risk group and they’ll probably want you to have another one,” so I thought, I’m not discussing anything with you. (HB04)

This woman then sought the services of a different GP who ‘might be willing to be a bit more sympathetic’ (HB04). This scenario of disengaging from care providers also played itself out at the time of labour. One woman discussed her previous labour, and the fact that she disliked the midwife’s approach. In an attempt to disengage from her, the woman instructed her birth support team to ‘keep her away from me, I don’t want to see her again’ (HB06).

Participants will therefore disengage from care providers who do not cater to their desires or share their philosophy or vision for their pregnancy, birth and postnatal experience. Conversely, they will actively engage with those who they feel will help facilitate their desires and who will not be in opposition to them. One woman describes having found a GP with whom she was pleased, and how upset she was that he would soon be unavailable to her:

There was a doctor up here who used to be a homebirth doctor in the ’70s and his children and grandchild were born at home and I just luckily got to see him in his last two weeks of practice, he was moving, I was so upset I was like can’t you just stay here for six more months. (HB06)

As this demonstrates, when mainstream health care providers are prepared to work with women and help to meet their needs, women will engage with the system. Conversely, where care providers are perceived to be in opposition, the women will disengage.
If a woman has already entered a hospital, the way that they manage opposition and selectively disengage is commonly to discharge themselves if they are confident that the hospital cannot or will not give them the best and safest care. Women reported futile attempts to negotiate with hospital staff, followed by signing oneself out of hospital:

So there was a bit of an argument that happened there but then I just said yeah I can sign myself out or whatever, I’m going. (HB08)

In the same way as women selectively engage and disengage from care providers, they will also practise selective disclosure of information as a way of managing opposition.

2d) Selective disclosure

As previously discussed, women will disengage with care providers or the system if it becomes apparent that they will face opposition to their desires and preferences. In the same way, if women anticipate or sense that care providers or other people around them will oppose their birth choices, they will be selective about what information they disclose about their birth plans. One woman described this as ‘picking my words very carefully’ (HB07) when interacting with people. By being judicious, the women did not need to defend or explain their choices; selective disclosure was used as a form of self-preservation and a way to manage opposition without being confrontational:

I guess there were certain people that we decided, like we didn’t kind of advertise the fact that we were having a homebirth because we just didn’t want to hear people’s ... They were just, there’s not point in even having that conversation really. So I kind of played it down to a lot of people. (HB04)

Women who birth outside the system would rather not have to fight. Rather, they elect to avoid opposition. Thus, they employ the strategy of selective disclosure of information. When one woman was asked why she chose her words carefully, she responded:

Just not having to argue, I’m not a fighter, if I can take the easy way I will, like in general life, I was just like oh I don’t want to fight with you, I don’t want to deal with your lack
of experience and your narrow mindedness and so that’s why I picked my words. (HB07)

Other women described withholding information from their care providers as a way of preserving the integrity of their care provider, as well as protecting their birth plans. One participant who was choosing a freebirth was also attending a local hospital for antenatal care, and describes how she chose not to disclose her plans to her midwife because she did not want her midwife to have to be complicit in her plan or to be in a position where she felt obliged to report the woman to her superiors. While considering the position and responsibilities of the midwife, the woman chose not to disclose the information so as not to draw attention to her plans and create further opposition. By selectively withholding information, this woman was managing opposition, while ensuring that she would get the birth she desired:

We were very conscious about not actually saying to the midwife, we didn’t want to put her in a position where she had to report me ... we didn’t want to say to her, look we are actually planning a homebirth anyway, because we didn’t want to put her in a position where she had to say, oh no, panic panic hit the alarm button, so that’s why we didn’t tell her. (FB03)

Other participants describe being selective in disclosing information about their bodies and what was occurring to them during labour. They did this as a way of managing opposition and subverting the system in a bid to have their birth choices met. One woman’s midwife said to her, ‘don’t let them know, don’t let them see you push’ (HB03) in an attempt to stave off hospital staff who may otherwise feel compelled to perform a vaginal exam to diagnose full dilation. This woman and her midwife knew that once full dilation was determined, the clock would be ticking and the birth of the baby would be expected within the timeframe set by the hospital. In a bid to subvert this standardised practice, the woman and her midwife collusively practised selective disclosure as a way to manage opposition.
Another participant recounted her previous hospital birth, where the midwives were screaming at her to push during a contraction, even though she did not have an urge to do so. As this was in opposition to her natural inclination to wait until she had an urge to push, she ‘wouldn’t tell them [she] was having a contraction’ (HB02). By withholding this information, this woman was managing opposition and subsequently getting what she had wanted for her birth.

Reporting that managing opposition was hard work, the participants sought to share this burden by recruiting people to assist them. Having people on their side was a strategy employed by the participants to help manage opposition.

2e) Having people on my side

Within the context of women anticipating managing opposition as hard work that requires considerable energy, they worked to get people on their side. This was done to transfer the effort of managing opposition away from themselves and onto someone else, so that they could concentrate on birthing. One woman explained how a midwife in the system was on her side, and how this meant she did not have to do the hard work of fighting for what she wanted: ‘with my second, I didn’t have to fight anything because I had this wonderful midwife who’d come in to bat for me’ (HB02). Another participant was transferred into hospital for care where she was approached by a supportive midwife who ‘was so great, she was like, I’ll fight for you, I’ll do whatever you want to do’ (HB03).

Women could not always be sure that the hospital staff would be on their side, so they avoided making assumptions. Rather, they made conscious choices to recruit birth
supporters who would act as their advocates. One woman described how she ‘had the people with me on my side looking out for me’ (HB08). These people were sometimes family, professional birth supporters and often partners.

The participants frequently reported calling on their husbands or partners to defend their choices. One woman described the role of her husband, saying ‘he was totally my advocate, he was ready for a fight if anybody did anything to me at the hospital’ (FB01).

The women described how their partners gave them power to orchestrate a better way. One woman’s husband played a crucial supporting role as she attempted – in the face of opposition – to discharge herself early from hospital:

They were using threatening tactics and I felt quite bullied by that and fortunately my husband was there for that and he said look, they can’t make us stay, if you don’t want to stay, then we are going to go. He’s there for me, he said if you want to go, then we are going to go home, and so we did. (FB04)

The women described how having their partners on their side benefited them as they managed opposition: ‘he was there, he was the father of my baby, he was there to protect me’ (FB06). Having people on their side helped the participants better manage any opposition to their preferences, and thus helped them to orchestrate a better and safer way for them and their babies.

2f) Playing the game

The final strategy employed by women to manage opposition to their choices was to play the game. As described earlier, the participants acknowledged that there were certain rules and regulations that govern hospital practices. If entering the system, the women felt that they needed to ‘play the game’ in order to obtain the best and safest for themselves and their babies. Because of this, the women changed their management strategy in an attempt to adapt routine hospital management better to suit their desires.
As discussed earlier, the women realised that birthing in hospital entailed having timeframes imposed upon the process. Knowing this, women attempted to buy more time, to beat the clock to avoid hospital interventions. One woman explained how she adapted the management of her induced labour to better cater to her desire for the best and safest. She stated, ‘I chose to have it at 6 pm; they would have done it at 10 am’ (HB03). This afforded her several more hours to allow her body to go into labour naturally (after the hospital artificially ruptured her membranes), thus increasing her chances of a natural birth or successful induction. Aiming to avoid a caesarean for slow progression of labour, another participant disclosed how she employed the strategy of buying time:

I’d say, “oh please can I have another two hours,” so when you look at those notes it says, “suggested a caesarean to the client she would like to wait another two hours” and then two hours later it would say, “suggested to the client a caesarean she’d like to wait another two hours.” (HB04)

Another strategy employed by the women when playing the game was picking their battles. The women seemed to come to terms with the possibility that they would not get everything they wanted in hospital, and were thus willing to relinquish certain things that were deemed less important, in order to hold onto the things that they really wanted. One woman reported that a hospital midwife actually suggested this as a strategy to help her get what she wanted: ‘Play the game a little bit, just give them a little bit’ (HB03).

This same woman described how she acquiesced to monitoring, in order to appease the hospital staff and render them more amenable to her refusal of an induction: ‘I said I would come back in three days for the CTG, but I wasn’t going to be induced’ (HB03).

If the participants were not successful in playing the game, they then attempted to manage opposition by withholding their consent to hospital management. The
withholding of consent was a strategy that the women knew would work due to their understanding that the hospital could only provide them with care to which they consented. As one participant said, ‘you have the right to refuse’ (HB01), and the women exercised this right as a management strategy to combat opposition to their choices.

After undertaking the hard work of managing opposition on their journey to finding a better way, the participants described doing all they could to ensure that their birth outside the system was the best and safest that it could be. This meant doing everything within their power to mitigate the risks of birth at home, and to therefore experience the best and safest birth for themselves and their babies.

3. Mitigating the risks of birth at home

Managing risk and maintaining the safety of women and their babies is considered to be the job of experts such as doctors and midwives. In taking responsibility to mitigate the risks of birth at home, the participants subverted this model by appropriating the role of expert. Women who chose freebirth prepared slightly differently than those who were hiring a midwife; however, all participants’ actions can be explained under three headings: ‘getting mentally and physically prepared,’ ‘gathering knowledge, skills and supplies’ and ‘planning for all possibilities.’ The participants saw these steps as the optimal way to prepare for their birth outside the system, and to mitigate the risks of their birth option.

3a) Getting mentally and physically prepared

Irrespective of whether or not their plans to birth incorporated the presence of a midwife, all participants described preparing mentally and physically for the birth. Women who chose to birth outside the system prioritised their physical health because they believed that in doing so, they would achieve a more favourable birth outcome:
I really feel like setting the scene for the freebirth for me was all about taking good care of myself and I invest a lot of time and money into having really good health care and I take really good care of myself. (FB06)

Another woman described her lifestyle choices and the steps she took to physically prepare for her birth at home:

My diet is good, it’s strong it’s healthy, I know that my level of exercise is good and strong and healthy ... my lifestyle is, you know we did preconception care, both of us, we were doing everything we possibly could for every single baby to ensure their health ... no alcohol, caffeine, nothing, it was very clean ... even within my environment, natural cleaning products, so I had minimal contact with chemicals, any way that I could help to benefit my child, anything I possibly could do, I did ... I'm sort of always watching my body and watching for wellness and looking at my symptoms and you know doing self-diagnosis, I know if I have particular symptoms that I need to take more of a particular mineral so I was always tweaking and always self-medicating and I also ... had an acupuncturist and she supported me, my health through the pregnancy, she wasn’t providing antenatal care but she was providing really good holistic health care to support my wellness. (FB07)

Women who chose to homebirth with risk factors also physically prepared for their birth choice. Their physical preparation centred on ways to reduce the impact of the specific existing risk factors for themselves and their babies. One participant, for example, spoke of the techniques she used to manage her insulin-dependent gestational diabetes:

By 36 weeks I really started to meditate ... and after that, you know my sugars started to really come down, I could start eating more ... I pretty much did that nearly every day from about 36 weeks, my blood pressure started to come down as well and my sugars started to come down. (HB03)

As with the women who had chosen freebirth, those having a homebirth with risk factors took comfort in knowing that by preparing physically and by taking active steps towards mitigating their risk factors, they were making their birth at home safer.
In addition to physically preparing for their birth, all participants made it a priority to prepare mentally. Those choosing to freebirth spoke of confronting their fears about birth as an essential step in their mental preparation:

I was totally freaked out, I was so fearful that whole pregnancy, though, I think what happened was, anytime I had a fear about something happening like shoulder dystocia, I would research it. I would talk to people about it ... I confronted my fear; I confronted everything. (FB01)

This process of confronting fears was not evident with the women who were hiring a midwife to be at their birth. Instead, they focused on familiarising themselves with relaxation techniques that could be applied during labour, such as ‘calmbirth,’ ‘hypnobirth’ and ‘powerbirth.’ These women felt that such strategies would increase their chances of having a problem-free homebirth. One woman explained her rationale for preparing in this way: ‘[t]hey were showing that if you did her class, you had a more likely chance of having a natural birth’ (HB02). These courses also aimed to increase a woman’s trust in her own body, and instill confidence in her capacity to birth. This was an element of mental preparation, however, that the women who chose freebirth did not mention.

The women who were choosing freebirth also discussed dealing with emotional issues that arose throughout the course of their pregnancy. Confronting and processing issues as they emerged was a way of preventing them from escalating and potentially hindering their birth process: ‘it was also a lot of emotional support throughout the pregnancy, a lot of addressing emotional issues that might come up in the labour’ (FB05). The women who had hired a midwife, however, did not discuss the strategy of addressing emotional issues during the pregnancy.
In addition to physical, mental and emotional preparation, the participants gathered knowledge, skills and supplies that they perceived would mitigate the risks of birth at home and increase their chances of having the best and safest birth for themselves and their babies.

3b) Gathering knowledge, skills and supplies

The next thing that the women did to prepare for their birth outside the system was to gather knowledge, skills and supplies that they believed would prepare for the birth and mitigate risk. Women who freebirthed gathered knowledge, skills and supplies differently to the women who were hiring a midwife. Women who freebirthed, for instance, took it upon themselves to gather supplies that they felt were required for their birth. They read about what they might need – as one participant noted, ‘we did a lot of research into what we would need to have the birth at home’ (FB01). Women who freebirthed collected equipment for resuscitation – ‘we had the little resus [resuscitation] kit’ (FB01) – and also equipment that would be required for an uncomplicated birth, ‘like sterilised scissors’ (FB05) to cut the cord after the birth and ‘[h]aving a net to take out any bits of poo’ (FB06) from the birth pool.

While women who had hired a midwife did not make mention of specific items that they gathered in preparation for their homebirth, the women who freebirthed felt obliged to gather this equipment since they were taking full responsibility over what supplies would be available to them for their birth. Women who had a midwife, conversely, could be reassured that the midwife would supply the requisite clinical equipment.

Another preparatory activity that was undertaken by the women who chose freebirth was the gathering of knowledge and skills required to manage birth. Women discussed first
learning about the physiology of ‘how birth works’ (FB08), and then progressing to researching ways in which to deal with potential complications. The women who were planning to freebirth were aware that if they or their baby required clinical assistance, no trained professional would be available to provide it. Because of this, the women actively sought out information and acquired skills that they and their support people could apply during the birthing experience. In this way, the women felt that they could act as an effective replacement for a trained health professional. One participant describes researching the potential problems that could occur at birth:

Anything that came into my mind that I thought could be a problem I would just research it and I had textbooks.

(FB01)

The women then took steps to gather the skills required to manage these problems:

I’d read all about it, you know I read all about the Gaskin Manoeuvre, I knew about everything I could do. (FB01)

Women who chose freebirth also encouraged their birth supporters and partners to acquire skills in emergency care. Explains one participant, ‘I studied infant resuscitation and my husband had as well and also my friend had as well’ (FB01).

In addition to learning how to manage complications at birth, the women who chose freebirth took it upon themselves to acquire the skills necessary to assess antenatal wellbeing. In so doing, they became their own caregiver. They learnt, for instance, how to palpate the position of their baby. A participant explained, ‘I certainly felt very confident by my third and fourth pregnancy that I’d be able to locate the position of my baby and know when it was head down or bottom down’ (FB06). The women also learnt how to measure fundal height: ‘I knew how to check fundal height and the baby was growing perfectly’ (FB06). Participants described this learning process as being ‘a progressive experience of feeling more confident the more skilled up I felt as time passed’ (FB06).
Women who had hired a midwife, conversely, took no active steps towards providing their own clinical care. They did, however, endeavour to ‘gather knowledge, skills and supplies’ that were required to mitigate the risks of birth at home. One particular women, for example, hired a second midwife who possessed the requisite skills to manage her particular risk factor. The hiring of a specialised midwife introduced new knowledge, a specific skill set and extra supplies into their birth space. The women orchestrated this as a way of preparing for their birth and mitigating risk. One woman whose baby was in a breech position explained that her chosen midwife was not confident in attending her at home due to her lack of skill in assisting with breech birth:

I’m in contact with another midwife and I’m willing to bring her on at my own expense, she’s had a lot of experience with breech birth at home ... and it made my midwife so much more comfortable with things as well and she had always wanted to work with that midwife so it was just a great professional opportunity for her as well. (HB06)

By seeking out a second midwife who was confident and experienced in breech birth, the woman gathered skills and knowledge around her as a way of preparing for her birth and mitigating her specific risk factors. This made her choice to birth at home better and safer, which is in line with the participants’ pursuit of a better way. For another participant to confidently birth her twins at home, she stated, ‘I needed to find two midwives’ (HB13). For her, hiring a second midwife was an effective and practical way to gather skills and knowledge to assist her to birth at home. One woman with a history of postpartum hemorrhage (PPH) became aware that her selected midwife felt under-skilled should emergency care be required. The woman therefore recruited a second midwife as a means of mitigating the risk of a poor outcome:

We had another midwife as a backup. The plan that worked for both the midwife and I was that the other midwife came as back up because she could do cannulas,
so she was there as the backup if a PPH happened and she was going to give me a cannula and that would deliver three times the amount of syntocinon. (HB06)

The participants took responsibility to orchestrate the best and safest birth that they could. As part of this, they considered a variety of scenarios and planned for all possibilities as a way of finding a better and safer way.

3c) Planning for all possibilities

The final action taken by the participants to mitigate the risks of homebirth was to plan for all possibilities. The women who had chosen to freebirth gave much more attention to this than the women who hired a midwife. Those who chose to freebirth were far from flippant or blasé about their choice; indeed, they described how they ‘had so much planning in place for it’ (FB08) to ensure they were prepared for all possibilities. Women who hired a midwife, however, made no mention of any plans that they had formulated and would implement if various scenarios became a reality.

One of the potential outcomes anticipated by the women was the development of complications during labour or birth that would warrant transfer to hospital. The freebirth participants made lists of scenarios that they believed would justify transfer to hospital, and these women made their birth supporters aware of this list. One participant, for example, had prepared for:

... everything from, if my waters break and there is staining in the meconium we are off to hospital, if you know, if I’m feeling unwell – you know we went through a – I listed all the situations with my husband and I sort of said if this happens, then we need to transfer to hospital, if that happens then we need to transfer to hospital. (FB08)

The women choosing freebirth made detailed plans of how to execute a transfer from home to hospital, and gave explicit instructions to their birth supporters about what they should do. Reports one woman:
I said to my husband if a transfer is necessary, then this is what you need to do in the car and things like that, we’d even talked about all that sort of stuff and you know what we have to do with kids and this and that and the other to make sure that, and I had a bag packed in case we need to transfer to hospital. (FB06)

Women not only made plans for when they would transfer, but also how they would transfer and how they would continue to maintain control over their birth in hospital. One woman explained that ‘we were ready to transfer, we had ambulance cover, we had hospital birth plans as well as homebirth plans ... one [plan] for transfer and doing one for home’ (FB08).

In their pursuit of a better way, the participants considered all their options, managed opposition and mitigated the risks of birth at home in order to orchestrate the best and safest birth for themselves and their babies. As they went about their task of finding a better way, the participants assumed responsibility for the safety of themselves and their babies. While pursuing the best and safest, the participants also simultaneously became the experts. Becoming the expert was integral to finding a better way; without gathering expertise, the participants could not have orchestrated a better way or have been sure that birthing outside the system was the best and safest for them and their babies. Becoming the expert was also a result or by-product of the participants’ pursuit of a better way.

4. Becoming the expert

Becoming the expert was an integral part of the women’s process of finding a better way; it was also the logical result of the women’s pursuit of the best and safest. Here, the participants describe their relative naiveté during the birth of their first baby. Having learnt through research and experience, however, the women subsequently perceived themselves as more knowledgeable. They discussed how their level of expertise set them
apart as different to other women, whom they saw as naive and ignorant. The participants also gave insight into the character traits they possessed that helped to facilitate their movement from being a novice to an expert. Without these traits, the women felt that the acquisition of expertise would not have occurred.

The participants ultimately position themselves as the experts in their decision-making process about the best and safest way to birth. They had not always seen themselves in this role; however, by the time they decided to *birth outside the system*, they felt confident in positioning themselves as the expert. The women described their evolution from novice to expert as they progressed through their decision-making process about birthing options. In this way, becoming the expert is part of the basic social process that occurs as the participants, motivated by wanting the best, seek to find a better way.

In their evolution from novice to expert, the participants were able to retrospectively understand their former selves as somewhat naive as they started out on their mothering journey. One woman explained:

> I just think that I was just naive that I just didn’t understand, I didn’t know what it was that I had no idea about. I didn’t know what I didn’t know. (FB03)

When the women spoke of their initial experiences of pregnancy, birth and parenting, they painted a less confident picture than with subsequent experiences. Participants described ‘not knowing’ the first time around. One woman commented, ‘I didn’t know what a labour was’ (HB04). The participants also recollected their naiveté about care provider options for their first babies:

> At that time I didn’t know that I could have a private midwife attend me ... I just didn’t know beyond what was normal, normal as in, available to me in my local community. (HB10)
Another participant looked back on her first two birth experiences, both of which ended in emergency caesareans, and attributed these outcomes to her lack of knowledge. She retrospectively expressed regret at not knowing better:

I wish I’d known the higher risk of having a private doctor – like how they like intervention. I wish I’d known about induction and how most of the time it fails if you are not ready. That some women don’t progress 1cm every hour ... I wish I’d done more reading on it and been more assertive in what I want and not assume the doctors always right. I didn’t know any different for my first and I 100% trusted that what the doctor was doing was in my best interest. (HB11)

As a first-time mother, this woman felt that she had not engaged in enough research. She did not know any better and had failed to question care providers as she would now. Another participant expresses similar sentiments. She explains, ‘as a first-time mum, I hadn’t researched it terribly, I didn’t question it, I just thought oh she’s breech, I have to have the caesarean’ (HB04). One woman spoke of embarking on her first pregnancy journey, ‘not knowing any better, not ever having researching it and thinking that pregnancy and childbirth and motherhood would just come naturally to me’ (HB07).

As they reflected back on their early pregnancy and birth experiences, the participants positioned themselves as ‘not knowing.’ This was contrasted against how they subsequently perceived themselves as ‘experts,’ having gained confidence and acquired knowledge from their experiences. Now, they felt that they ‘know’ better than they did in the past. They are now thus sufficiently informed to be able to make different and better choices to those made previously. As one participant observed, ‘you get a lot more confident the more births [you have] I guess’ (HB01).

Another woman spoke of how her previous birth experiences had turned her into an expert. If she had been instructed to have a caesarean for her first birth – a breech baby
– she would have unquestioningly complied. Having since gained confidence and expertise through her previous birth experiences, she felt confident to birth her breech baby vaginally at home:

It was my third birth. I think that is a big factor. If it was my first birth, I probably would have listened to the obstetrician and just gone for the elective caesarean out of fear, so again I was very comfortable with birthing babies by this stage, very confident in my own ability. (HB06)

Another woman explained how having gained knowledge and confidence through her initial birthing experiences, she felt she could trust her own abilities for her subsequent births. This stance motivated her to freebirth:

I could put it, that trust, in nature and I could put that trust in myself because I know my own ability and capability so that’s probably why for my first birth I did have someone there, in that, I didn’t know how I would labour, but I did know I could do it. Then after that I didn’t want anyone else there. (FB05)

One woman described the progressive nature of becoming an expert; the evolution from her status as novice to her repositioning as expert:

I felt empowered to be able to take a certain amount of control over my own care ... I think really largely for me, it’s really been a progressive experience of feeling more confident the more skilled up as time passed. (FB06)

Although many of the participants moved from being a novice to an expert by giving birth, it was not always birth experiences that turned women into experts. Some participants described how life’s challenges taught them independence and how to trust their own knowledge. These life circumstances impacted on how they approached their births, and predisposed them to making choices that fell outside of the normative model. For one woman, the lessons she learnt from past experiences equipped her to take charge of her birth choices and position herself as the expert in her decision-making:

Some of the challenges that I’ve been faced with maybe have caused me to question things more rather than just going with the flow, you know life lessons if you like. I’ve
learnt that the best things for me are the things that I decide; nobody else knows what’s best for me other than me. (FB04)

4a. Reframing medical discourse

In line with their perception of themselves as the expert, the participants appear to shun the knowledge of those who are culturally positioned as birthing experts (doctors and midwives). The rejection of modern day medical knowledge about birth, combined with their own perceived expertise, led the participants to reframe medical discourse. This process of reframing will be discussed under the headings ‘failure to progress’ and ‘defining necessary.’ As this discussion will demonstrate, in the process of finding a better way, the participants become the experts. Thus, their reframing of medical discourse is an expression of their expertise. In their role as expert, the women set about redefining the discourse around birth while simultaneously disavowing the medical knowledge offered by ‘the experts.’

Failure to progress

The commonly used medical phrase ‘failure to progress’ denotes a situation where a woman’s body has ceased to progress in labour. This cessation is usually accompanied by contractions that do not intensify in length or strength, combined with a slow or no change in cervical dilation. The standard medical phraseology – ‘failure to progress’ – carries the pejorative connotation that somehow the woman’s body is deficient and has failed to perform as expected. The participants set about to reframe this medical discourse. Rather than allowing the blame for the lack of progression to be apportioned to themselves, they subvert the meaning by redirecting the blame towards the hospital:

When you move into hospital ... your labour stops or stalls or goes backward, and part of the reason is you get this adrenaline in your body and the adrenaline is what slows the process down because your body is so anxious ... you feel like you’re bad, like you’ve done something wrong because you’ve stopped the process but in actual fact to
look at it the other way around is to turn around and say that your body is so efficient and so strong that it can do this. (FB03)

Here, the woman blames the anxiety-provoking hospital environment for causing her body to stall in labour. She also praises her body’s ability to pause the labour and hold her baby in rather than give birth in a place that makes her fearful.

Another woman reframed medical discourse about failure to progress in a slightly different way. Rather than blaming the woman’s body for failing to progress, she accuses the care providers of ‘failure to wait’ (FB08). One participant retrospectively questioned the necessity of her caesarean, which had been attributed at the time to her ‘failure to progress.’ ‘According to research and several midwives I’ve spoken to,’ she stated, ‘my diagnosis of failure to progress was more of failure just to be convenient’ (HB11). She thus suggests the diagnosis of ‘failure to progress’ to be an excuse to justify her caesarean. Upon reflection, this woman felt that her obstetrician gave her a caesarean based on convenience to herself and not necessarily in the best interests of her patient. Adds the woman: ‘two of my friends who have been through her as well were classed as failure to progress around about the same time I was, in the early evening, that it just makes me think that its more convenience’ (HB11). As with the other participants, this woman reframes medical discourse, shifting the blame onto the establishment and their clinical management. Referring to her diagnosis of ‘failure to progress’ as a ‘failed induction,’ (HB11), she apportions failure and blame to the act of medical intervention, rather than to her body and its capacity to birth.

**Defining ‘necessary’**

One of the key roles of being the expert is to define and decide what is necessary and unnecessary. Although many of their care providers had defined interventions as
'necessary,' the participants felt that many of the interventions offered at hospital were actually ‘unnecessary.’ When asked whether intervention could ever be justified, one woman replied:

Yeah of course ... almost every intervention has a place, I’m still not convinced that episiotomy is one of them though, I just can’t imagine that ever being necessary, but most of the others I’m sure there are rare cases for ... other unnecessary things would be if the baby is breech having a caesarean and for me I believe that using drugs for pain relief is unnecessary. (FB08)

Along similar lines, another woman explained her decision to decline prophylactic antibiotics for prolonged ruptured membranes:

Well, I didn’t have an infection for starters, so why fill me full of antibiotics if I don’t have an infection and why do that to the baby, there’s no infection. (FB02)

Her perception that antibiotics are only necessary when there is an existing infection informed her decision to decline them.

According to the women’s definition and understanding of necessity and the place of intervention in birth, they report only being willing to accept intervention if it is medically indicated and is for the best; that is, if their or their baby’s life is in immediate danger. Conversely, the participants were reluctant to accept prophylactic intervention, because they felt that it carried a risk of entailing further interventions. In line with the participants wanting the best and safest, anything that was seen to compromise the safety of their birth was avoided. One woman explains why she declined special care admission for her baby due to her being an insulin-dependent diabetic:

I didn’t think it was necessary. For me I didn’t see the point, if he was sick I could understand completely, but if he’s not sick, why does he have to be in special care and be monitored away from me. (HB03)
Another participant contends that her caesarean was unnecessary given that there were no medical indications listed in her notes:

The midwife was actually happy for me to keep going, they didn’t have any concerns and if you read the notes there’s nothing medical that – no medical reason. (HB04)

Women who choose to birth outside the system arrive at the decision to do so because they assume the role of the expert and take responsibility for finding a better way for themselves and their babies. As the expert, they make decisions about what is best and safest for them. Positioning themselves as the expert in their decision-making process sets these women apart as different to other women.

4b. Different to other women

In positioning themselves as the experts, the participants felt that they were different to other women in society. They commented that they ‘don’t understand them [other women]’ (HB01), because their approach to making birth choices was so different to their own. The ways in which they believe they differ and are somewhat superior to most other women include that they ‘know’ and have expertise. Conversely, they perceived other women to be comparatively naive and uninformed. As one participant explained:

... you look at the research, they have found that women who choose to birth at home tend to be more highly educated and more informed than women that birth in hospital. (FB05)

According to the participants, other women were relatively ignorant. ‘I guess it’s just their lack of knowledge about the whole thing ... what’s that saying, ignorance is bliss. That’s what I think it is’ noted one women (HB02). Others stated bluntly that ‘women don’t know’ (HB03) and ‘they are ignorant’ (HB01).

The participants took responsibility and made their own choices rather than uncritically following the directives of the medical establishment. This made them different to other
women, who they believed were too willing to relinquish their agency and allow the
‘experts’ to make decisions on their behalf. Frequently, the participants appeared to
regard other women somewhat derisively:

I think there’s a big proportion of people that just don’t
question the doctors, the expert, and you just give over
your responsibility to them, they just trust that they know
what they’re doing and they don’t engage in it for
themselves. (FB02)

For the participants, any woman who willingly submits to the system is essentially a
victim of social propaganda, indoctrinated by the prevailing medical paradigm:

They just let go of whatever power they have or any say
that they have in hospital. They just listen and go well ‘he
[the obstetrician] would know,’ they just take that on, they
believe that and it’s a misconception, it’s such a
misconception about the safety of hospital childbirth and
it’s indoctrinated into our society, so women go with it.
(HB01)

The participants saw their decision to birth outside the as correlating to their high level of
expertise and knowledge. They felt that other women did not consider their birth options
as carefully as they did. This disparity, they believed, set them apart as different to other
women.

The participants described the specific character traits that they possessed that enabled
them to move from novice to expert, and to confidently apply their expertise as they
made informed decisions. These traits include: ‘always bucking against the system,’ ‘I take
responsibility,’ ‘I like to investigate,’ ‘confident in my ability to know,’ ‘entitled to choose’
and ‘confident in my ability to birth.’

**Always bucking against the system**

The participants described how they had a general tendency to buck against the system.
One participant explained how this was a mainstay of her early years: ‘I had dealt with a
lot growing up as well, like I was always bucking against the system and always getting in trouble for it’ (FB01). For another woman, bucking against the system was similarly a lifelong trait: ‘I think I’ve always had a problem with being told what to do too, I think that needs to be worked on, I don’t know, I’ve always felt like I don’t like to be told’ (FB07).

The participants believed that their tendency to buck against the system was rooted in their attitude to authority; many described themselves as rebelling against authority. One woman confessed, ‘I do have issues with authority’ (FB08), and another described her reflex to rebel against what she has been told to do: ‘Yeah I am a bit of, a little bit of a, like if somebody tells me to do something I sort of turn around and do the opposite, there is a little bit of that’ (HB06). Another woman explained her rebellion against medical authorities in particular: ‘I kind of had a bit of an attitude that I didn’t believe what the medical people said ... I knew that my tendency was to react and go against medical suggestions’ (HB08).

This tendency to buck against the system, and the rebellious streak noted in the participant group, might make the choice to birth outside the system a more reasonable option for them compared to women who were attitudinally more inclined towards compliance and adherence to normative social models.

I take responsibility

The participants emphasised that it was in their nature to ‘take responsibility’ for life decisions. Rather than relinquishing control to an external source, these women exhibited a sense of personal agency over decisions and actions that affected them. Exercising volition was a mainstay in the women’s behaviours as they sought out a better way and took responsibility for planning the best and safest birth for themselves and their babies.
In discussing her approach to decision-making, one woman explained, ‘I think there’s a desire to be the one that’s responsible’ (FB02). Another participant describes what taking responsibility looks like in her life:

I like to do whatever I can towards finding a solution because I feel that if I put in some effort and do what I can, even if it doesn’t end up solving the problem, it’s kind of creating some momentum in the universe ... and an answer will present itself to me provided I get off my bum and make an effort as well. (FB04)

The participants described the taking of responsibility as a character trait that permeated all of their decision-making processes, and not just those around the choice to birth outside the system. While this tendency to take responsibility was inherent for some women, others described having acquiring it through life experiences:

I just kind of figured out over time that you just have to take responsibility for what you do and not just go along with the system because everybody else does it. Just figure it out, figure out why and just take responsibility for your own actions. (FB03)

For another woman, the birth of her first child was the catalyst for her learning to take responsibility:

I think that’s the greatest thing that I learnt after I had my first child, was that it was my responsibility to educate myself, it wouldn’t just come to me, like you know if I wanted or had a certain expectation of the way things would happen, then I would have to prepare myself.’ (HB07)

One participant was asked about what made a birth outside the system right for her. She responded, ‘I was in control, I was responsible and I was empowered’ (FB08). Their desire to take responsibility significantly impacted on choices made by the participants regarding their birthing options.
I investigate to make sure I ‘know’

Linked closely to the desire to take responsibility is the participants’ tendency to investigate and undertake research to ensure that they make the best possible choice.

This trait was evident in their diligent and extensive research into birthing options, and in the active steps they took to find a better way for themselves and their babies. One woman explained:

I like to investigate, make sure I know, and I might come to the same decision that the majority of society comes to in other areas of my life, but I want to know for myself that this is the optimal choice for me. (FB05)

This tendency to investigate did not only inform the women’s decision to birth outside the system, but was also a demonstrated characteristic in other areas of life. One woman noted her propensity to take it upon herself to investigate: ‘Yeah, I mean I’m pretty much a big home researcher’ (HB06). For all participants, a commitment to research and investigation allowed them to make educated decisions in their daily lives:

I like to make an informed choice about anything we do, in terms of our lives, our health ... I do make alternative choices but the reason is not so that I’m alternative, I make them as an informed choice. I make sure I know what’s going in my mouth, what’s going in my children’s mouth, what their bodies are coming into contact with, what influences they have around them emotionally. (FB05)

Another woman explained that her birth choices were rooted in what she learnt through investigating her options. By being informed, she was able to make her own decisions: ‘We were informed and that’s why we were making choices ... and I believe it was an educated decision, it was an educated choice’ (HB01). For women who birthed outside the system, investigating their birth options was a natural inclination because of their inclination to investigate and become informed about their options throughout life.
I have the ability to ‘know’

The participants had an inherent belief and confidence in their personal capacity and ability to ‘know.’ As one woman put it, ‘I knew for my own body what was best’ (FB05).

This knowledge was not always acquired in a conventional manner; rather, the women were confident in their intuitive knowledge about their bodies and babies:

I will know if there is something wrong and ... I was really adamant that I would know and I was really confident in that side of my nature, to really trust that ... I was quite sure that everything was going to be fine. I think I would have known, I was pretty sure I would have known in advance if there was going to be a problem, again its that intuitive side of me. (FB04)

This confidence in their intuitive knowledge spurred them on to pursue a birth outside the system because they felt they possessed an innate way of ‘knowing’ that was not reliant on another person. One woman spoke of her intuitive understanding, and how she felt confident that this would provide adequate indication of whether she needed to transfer to hospital. ‘I did truly believe that if anything was wrong, I would know early enough within myself to transfer,’ she stated (FB01). Another participant, while reflecting on the choices she made for her hospital birth, retrospectively expressed her regret at not listening to what her intuition was telling her at the time:

I just, intuition, like I should’ve listened to myself, I just knew he was fine ... I just knew it, I just thought, there is nothing wrong with him, it’s me, it’s just me. For some reason I’ve got diabetes and it’s me, it’s not him, it’s not affecting – I just never thought it was affecting him ... I’ll know if my baby is not right. (HB03)

After seeing that her baby was unaffected by her diabetes, she felt that in future she could trust her intuition. Through the experience of her first birth, she learnt to trust in her ability to ‘know.’

Participants also spoke of having an intimate knowledge and understanding of their bodies in general, as explained by one woman:
I know exactly the day I conceived, because I said I’m that regular and I know I can actually I can feel when it ovulates, I get like a low ache and I said so I can tell you exactly which date it was. (FB03)

In addition to being confident in their intuitive knowledge and the knowledge of their bodies, the participants also emphasised the fact that as intelligent beings, women were capable of making decisions about their birth. The participants were confident in their ability to know intellectually as well as intuitively. One woman asserted that ‘the government should recognise that women are intelligent enough to make decisions about their own bodies’ (FB14). The participants felt that their cognitive and intuitive knowledge allowed them to choose a birth outside the system. Without this knowledge, they may not have made the same choice. Moreover, participants stated that they would not suggest birthing outside the system to women who were not confident that they ‘know.’ As one woman remarked, ‘I wouldn’t by no means suggest to other women that they do that [homebirth], it’s just that I’ve been in the situation before ... it’s not like I would suggest anyone else do that in that situation because they don’t have the same knowledge’ (HB02). The participants had faith in their capacity to choose where to birth, because they were confident in their ability to know. For them, this was an important factor in making the choice to birth outside the system.

Entitled to choose

The participants felt that they were entitled to choose for themselves rather than deferring to the advice of maternity care providers or others around them. This sense of entitlement stems not only from a personal confidence in themselves as discussed above, but also from a feeling of ownership over their bodies and their babies. One woman explained, ‘this is something that’s happening to me and I want to have a say in how it happens’ (FB02). Another participant made reference to the way in which her doctor wanted to have control over what would happen at her birth. She also expressed her
conviction that she is entitled to have control over choices around the ownership of her body and that of her baby:

I think I’m entitled to be because it’s my body and my baby, so me wanting to be in control is slightly more understandable. (HB05)

The women’s sense of entitlement made them more likely to reject any care provider suggestions that were not aligned with their own choices. Similarly, they did not allow their partners to sway their choices. Instead, they maintained their entitlement to choose even if their partners were unsupportive:

So with my first pregnancy, I knew before I was pregnant that I wanted a homebirth, I had briefly discussed that with my husband before, he was fearful initially and I told him well, it was my body and so I would do things how I wanted to do it ... but ultimately it’s my body and I was going to birth where I wanted to birth, not where someone else wanted me to birth, even if it was my husband. (FB05)

**Confident in my ability to birth**

The participants conveyed a confidence in their ability to birth their babies. This confidence arose partly out of their past experiences, but also from their perception of childbirth as a normal, natural event. One woman explained how, as she developed her birthing expertise through experience, she also built confidence in her body’s ability to birth and cope with the birthing process:

I knew I could do it without drugs, because I’d done it twice already, and I was confident that I’d be able to trust my body and that it would all happen ... because I’d had two good births I was like, yeah, this is how my body does it itself. (FB02)

For another woman, her confidence was linked not only to the fact that she had birthed before, but also that her mother had birthed, so she could too:

I just had this really strong instinctive expectation that my body would take care of it and that my mum had done it twice ... I really trusted that my body would know how to
do it... and so I guess I gained confidence from the birth experience ... you know I’d done it twice by now, I felt pretty confident it was going to be okay. (FB06)

This confidence in their ability to birth became a factor in their choice to birth outside the system. When asked why the risks of a breech birth at home were not enough to scare her off choosing this option, one woman cited her confidence in her body’s ability to birth as a factor in her choice to birth at home:

Well, it was my third birth, I think that is a big factor; if it was my first birth I probably would have listened to the obstetrician and just gone for the elective caesarean out of fear, so again I was very comfortable with birthing babies by this stage, very confident in my own ability. (HB06)

Women who birth outside the system do so because they perceive a birth outside the system to offer them the best and the safest when they compare it to other birthing options. The participants learnt from experience that birthing inside the system was not the best and the safest, because it had proved to be an unsafe option in the past. The participants thus sought to find a better way for their subsequent pregnancies. On their journey to finding a better way, they became the experts in order to get the best and the safest for themselves and their babies. This chapter has explained the findings of this research. The following chapter presents a discussion of these findings, grouped under seven headings: ‘concepts of safety,’ ‘safety in social and biomedical birthing models,’ ‘risk and risk management,’ ‘trauma in childbirth,’ ‘maternal choice, control and autonomy’ and ‘authoritative knowledge.’
Chapter Six: Discussion chapter

Introduction

The aim of this study was to explore what motivates women to *birth outside the system*. The core category (discussed in Chapter Four) was ‘wanting the best and safest’ and is supported by four subcategories: ‘previous birth experience,’ ‘perspectives on childbirth,’ ‘perspectives on risk’ and ‘the hospital can’t provide the best or the safest.’ I theorise that women *birth outside the system* because they seek the best and safest birthing option for themselves and their baby. The basic social process (discussed in Chapter Five) was ‘finding a better way,’ which explains how women come to *birth outside the system* after ‘considering birth options,’ ‘managing opposition,’ ‘mitigating the risks of homebirth’ and ‘becoming the expert.’

In this chapter, I discuss several key areas that emerged from this study. Under the heading ‘concepts of safety,’ I discuss how women choose what they believe is best and safest for themselves and their baby. Their beliefs about what is best and safest are rooted in their previous experiences and their philosophical views on childbirth and risk. The women in this study saw safety as encompassing emotional, social, cultural, spiritual and physical safety. Secondly, ‘safety within social and biomedical birthing models’ is discussed with particular reference to how each model caters to, or does not cater to, women’s physical, emotional, social, cultural and spiritual safety. The participants preferred the social model of care as it best fit with their understanding of safety. Thirdly, ‘risk and risk management in childbirth’ is discussed with particular reference to how the participant group perceived risk differently to mainstream biomedical discourse. Because of their differing beliefs, the participants chose to manage risk differently to medical expectations of risk management. Fourthly, the topic of ‘trauma in childbirth’ is considered, since birth trauma was a common occurrence amongst the participants. The
long-term impact of previous trauma figured prominently in the women’s decision to
*birth outside the system*. The participants made particular reference to how their care
providers were often the perpetrators in the events that left them traumatised. Following
this, the topic of ‘maternal control, choice and autonomy’ is explored. In this section,
*birth outside the system* is framed as the women’s attempt to reclaim control of their birth
and open up their birth options, which are limited within the system. The participants’
lack of fear of the birth process, combined with their philosophical stance on childbirth,
enhanced their confidence to take control of their own birthing decisions and to be
autonomous. Finally, the process whereby the participants became the experts of their
own births will be discussed alongside the concept of authoritative knowledge. As the
participants embarked on their journey to find a better way, they became the expert, and
ultimately became their own authority rather than submitting to the authority and
knowledge of medical maternity care providers.

**Concepts of safety**

Women seek to give birth where they feel safe and protected (Wick & Hassan, 2012).
However, concepts of safety differ vastly depending on beliefs, culture and the context in
which a woman is giving birth (Capelli, 2011; Donnellan-Fernandez, 2011). For women
in resource-poor countries, safety may be constructed as having access to birth
technologies, skilled attendants and health care facilities (Spector, Reisman, Lipsitz, Desai,
& Gawande, 2013). In zones of war and conflict, safety may mean accessing a safe space
in which to give birth without being injured or killed (Wick & Hassan, 2012). For the
participants in this study, safety was perceived as having a natural birth without
intervention, keeping their family close and being respected as the authority at their birth.
Maternity care and childbirth is more than a biomedical event (Wick & Hassan, 2012); it
occurs for each woman in a unique context. In this study, the context surrounding the
women’s choice to *birth outside the system* included a previous traumatic birth experience, a belief that childbirth is a normal life event, differing perspectives on risk, and the perception that hospital services do not adequately provide the best and safest. It is through this interpretative prism that these women perceive what would be best and safest for them and their baby.

Using a broad concept of safety, which is philosophically different to mainstream beliefs and medical discourse, the women in this study felt that the highest level of safety would be achieved by avoiding a medically managed birth in a hospital. The women’s previous experiences had taught them that the staff at these institutions could not adequately keep them emotionally, mentally, socially, culturally and physically safe.

**Choosing the safest birth option**

The majority of women prioritise the health and wellbeing of their baby and avoid dangers that might impact negatively on this (Fisher, Hauck, & Fenwick, 2006). Therefore, the decisions most women make during pregnancy and birth are underpinned by a desire to have a healthy baby while remaining healthy themselves. There is often a negative focus in the media and from greater society on women who make ‘alternative choices,’ with their motives for eschewing biomedical discourse often questioned.

Conversely, women who make other decisions, such as those choosing elective caesarean section without a medical indication, are less criticised because caesareans are in line with biomedical constructs of risk and safety (Chadwick & Foster, 2014). Research shows that caesarean section performed without medical indication confers few health benefits on women and neonates; indeed, it is associated with an increase in some health risks, compared with vaginal birth (Dahlke et al., 2013; Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Grivell & Dodd, 2011; Silver, Landon, Rouse, Leveno, & Network, 2006; Villar et al., 2006). Despite this, Fenwick et al (2010) found that some first-time mothers
elected to have a caesarean section with no medical indication because they believed that it was a safe and responsible decision (Fenwick, et al., 2010). A similar sentiment was expressed by the women in Chadwick and Fosters’ 2014 study (Chadwick & Foster, 2014). Faisal et al (2013) also found that participants feared the process of vaginal birth as it held the risk of perineal tearing, pelvic floor damage and brain trauma to the infant (Faisal, Matinnia, & Khodakarami, 2013). Such fears compelled women to opt for a caesarean section as it was perceived as the safer option. Chadwick and Foster (2014) explain that women choosing caesarean section constructed their choice as a form of risk management (Chadwick & Foster, 2014), which ironically (given the vastly different media and cultural constructions of each choice) is the same perception of women who choose to birth outside the system. Both groups of women are invested in reducing the perceived risks in their births.

Despite the fact that many complications occur at a greater rate in a caesarean section compared to vaginal birth for low-risk women (Liu et al., 2007), women who opt for caesarean section believe it to be the best and safest for themselves and their baby. Women who elect to have a non-medically indicated caesarean section are labeled as ‘too posh to push,’ (Arnold, 2013; Sharp, 2013; Song, 2004). The criticism of their choice, however, does not centre on the increased danger or risk, and nor are they labeled as ‘ignorant,’ ‘risk takers’ or ‘irresponsible,’ all of which are criticisms leveled at women who choose freebirth or high-risk homebirth (Devine, 2009; Devine, 2011). In industrialised societies, the medical management of labour and birth is marketed as the safer option (Murphy-Lawless, 1998), designating an elective caesarean without medical indication as a ‘legitimate’ birth choice (Chadwick & Foster, 2014). Conversely, to birth outside the system is a choice that explicitly contravenes the medicalised and valorised model of birth that
dominates western medicine. Birth decisions made outside of the biomedical framework are thus classified as unsafe and less acceptable. Nonetheless, the participants in this study rejected biomedical authority and felt confident deciding for themselves what would be best and safest.

Fear of the perceived dangers of vaginal birth led the women in the Fenwick et al (2010) study, for example, to choose caesarean section, as they felt this would offer them protection. The participants in my study feared what they might encounter if they entered the system. In this context, the basis of their choice to birth outside the system can be seen as comparable to the fears underpinning the choice for elective caesarean for the women in the Fenwick et al study. In other words, women will choose the birth option that they feel is the safest, in order to mitigate or avoid the perceived danger for themselves and their babies.

A broad concept of safety

The participants in this study had a broad concept of safety that accorded equal status and importance to physical, emotional, social, spiritual, cultural and mental safety. This valuing of multiple aspects of safety comes into conflict with biomedical models of care (Lothian, 2012). The biomedical model prioritises the physical wellbeing of the mother and baby, and equates reducing physical risks with increasing safety. However, safety for women and babies is more complex than merely reducing physical risk (Edwards, 1997). From a medical perspective, safety is thought to be achievable by minimising perceived risks during pregnancy and then giving birth in a hospital (Lothian, 2012). While the participants in this study wanted to reduce risks, they did not perceive birthing in hospital to be the best way to do this. The women believed that what occurred during their birth could have long-term positive or negative consequences. They were thus interested in both immediate and long-term safety. In her study on the reasons why women choose
homebirth, Edwards discovered that the long-term physical and emotional wellbeing of
the women, their babies and their relationships were central to the decisions they made
around their birthing options (Edwards, 1997).

**Differing philosophical frameworks around safety**

A biomedical framework assumes that a refusal of intervention is synonymous with
welcoming danger into the birthing process. From this vantage point, women’s choice to
*birth outside the system* is seen as risky and reckless. Yet for the women who make the
decision to *birth outside the system*, they do so because they feel it is the best and safest
option for themselves and their babies. With such divergent philosophical positions, each
side finds it difficult to rationalise the beliefs of the other. For women to enter into a
system that cannot understand their perspective seems counterintuitive to them
experiencing the best and safest birth, so they choose to *birth outside the system*.

The women in this study believed that biomedical practices prioritised the health of the
baby while sacrificing other aspects of safety, such as the wellbeing of the mother.
Dahlen and Homer (2013) make reference to these differing philosophical standpoints in
their research on what women discuss in blogs on VBAC. Dahlen and Homer (2013)
describe the ‘childbirth’ philosophy as one where the baby’s wellbeing is prioritised over
the mother’s, with the mother being sacrificed for the good of the baby. Alternatively,
they describe the ‘motherbirth’ framework as one where ‘giving birth matters to the
woman and a happy healthy mother is a happy healthy baby’ (Dahlen & Homer, 2013, p.
167), which is a configuration in which the mother and baby are accorded equal priority
(Dahlen & Homer, 2013). Women who chose to *birth outside the system* expressed these
same sentiments. A philosophy of ‘motherbirth’ led the participants to pursue a birth
choice that would facilitate the best and safest circumstances for both mother and baby.
This was not seen as possible in a hospital setting, and so *birth outside the system* provided
the best and safest option. Alternatively, Chadwick and Foster (2014) explain that women who made the choice to birth by caesarean section believed that the wellbeing of the baby was more important than the birth process, which was merely regarded as a means to an end (Chadwick & Foster, 2014). This correlates with Dahlen and Homer’s (2013) study that shows the ‘childbirth’ framework to sit comfortably within biomedical philosophies about birth. Thus, women who birth outside the system hold philosophically divergent beliefs to the prevailing biomedical context in Australia.

**Avoiding the cascade of intervention**

For the women in this study, one way of minimising danger was to avoid unnecessary interventions, which they assumed would introduce risk into the birthing process. This echoes the findings of other studies where women chose to birth at home to avoid the perceived dangers of unnecessary interventions (Boucher, Bennet, McFarlin, & Freeze, 2009; Hildingsson, Waldenstrom, & Radestad, 2003). There is a significant body of research demonstrating that ‘it is dangerous to interfere in the normal, physiological process of birth without a clear medical indication’ (Lothian, 2012, p. 45). Women’s concerns regarding routine interventions in hospital are therefore corroborated by a considerable body of work (Sandall, Morton, & Bick, 2010), indicating that their fears about going to hospital are not completely unfounded. For example, Alfirevic et al found that, despite widespread use in Australian hospitals, continuous cardiotocography (CTG) during the labours of low-risk women did nothing to change infant outcomes, but it did increase the use of caesarean section and instrumental vaginal births (Alfirevic, Devane, & Gyte, 2013). Similarly, an admission CTG, which is routinely performed on most women who present to hospital in labour, provides no benefit and appears to increase caesarean section rates by up to 20% (Devane, Lalor, Daly, McGuire, & Smith, 2012). Amniotomy, where a woman’s membranes are artificially ruptured with a hook-like tool,
is reported to be one of the most commonly performed procedures in modern birth settings. However, its use is not supported by evidence and can lead to complications such as cord prolapse and fetal heart rate anomalies (Smyth, Alldred, & Markham, 2007), resulting in the need for further intervention. Furthermore, despite evidence that mobility and being upright during labour and birth benefits the mother and baby and reduces the need to intervene in birth (Gupta, Hofmeyr, & Shehmar, 2012; Lawrence, Lewis, Hofmeyr, & Styles, 2013), the majority of women birthing in hospital will do so in a semi-recumbent position (Priddis, Dahlen, & Schmied, 2011). Despite its routine use in hospitals, coached versus physiological pushing for the second stage of labour does little to expedite the birth of the baby and shows no benefit to the baby, but can adversely impact on maternal bladder function (Bloom, Casey, Joseph, McIntire, & Leveno, 2006). Forceful valsala bearing down efforts, which accompany coached pushing, have been shown to unnaturally deoxygenate the baby (Roberts & Hanson, 2007), leading to poorer neonatal outcomes, making physiological pushing the safer approach. The women in this study cited all of these interventions and expressed their avid desire to avoid them in order to guarantee the best and safest for themselves and their babies. Avoiding unnecessary intervention was therefore a major motivator behind their choice to birth outside the system.

**Previous negative experiences inform concepts of safety**

In this study, previous negative birth experiences impacted on women’s beliefs about the risks and safety of birthing in hospital. Smythe (2010) notes that the feeling of ‘being safe’ is an interpretative act that comes from lived experiences (Smythe, 2010). Thus, if women experience an event that has made them feel unsafe, regardless of the intention of the care provider, the care will be interpreted as unsafe (Smythe, 2010). The participants in this study expected to be listened to and for their decisions to be
respected. Some made particular reference to not being listened to, resulting in them feeling unsafe because their choices and knowledge about themselves and their babies was being ignored and disregarded. Smythe (2010) found this same phenomenon in her research, noting that ‘[w]hen women do not feel heard, or understood, when they sense they are being misinterpreted, safety is lost’ (Smythe, 2010, p. 1479). At some point in their experience with the system, each of the women in this study was made to feel unsafe. Therefore, regardless of the message of safety propagated by mainstream maternity services, women’s own experiences became more influential. Notably, as their trust in the hospital system diminished, their confidence in their own decision-making abilities correspondingly increased.

**Women expect to be kept safe by their care providers**

Women expect to be kept safe by their care providers. For the majority of women in my study, these expectations were not met, and trauma, anger and dissatisfaction ensued. The participants in this study reported being traumatised by undignified care during childbirth; many of them described feelings of being degraded and assaulted. Women expect to be treated with dignity during childbirth (Lubic, 1972; Records & Wilson, 2010) and when this expectation is not met, trauma and dissatisfaction can result. Elmir et al found that women experienced trauma when they were not treated humanely by health professionals (Elmir, Schmied, Wilkes, & Jackson, 2010). When women were treated as just ‘another number’ in the ‘cattle run,’ as the participants of my study described it, they are placed in an emotionally unsafe space. Bowers (2002) explains that women expect their care providers to meet their emotional and physical needs (Bowers, 2002). When these needs are not met, the effects on the woman are deleterious. Judging by the findings of this and other studies, the principle of treating women with dignity and respect seems to be lacking in some institutions in Australia. Goodman et al (2004)
found that women who had their labour expectations met were more satisfied with their overall experience (Goodman, Mackey, & Tavakoli, 2004).

In summary, women will choose to birth in a way that they believe is best and safest. The women in this study believed that birth outside the system was the best and safest option. This option allowed them to have their explicit expectations of safety met. Their perceptions about safety were broad and multi-factorial, encompassing many aspects of health and wellbeing. The women’s beliefs sat in stark contrast to the biomedical model, in which physical safety was prioritised. The women perceived birthing at home to be better and safer, because it catered to their beliefs about safety in a way that a hospital birth could not. The women rejected the medical management of birth and the use of interventions because they felt that these threatened the safety of themselves and their babies. Interventions were seen as adding risk to the birth process and creating a slippery slope of complexity. Birth at home was better and safer because it was removed from unwanted and routine interventions often used in hospitals. The women expected to be kept safe by their care providers; however, their previous experiences had taught them that this expectation might not be met in hospital.

It is obvious that the women in this study have differing perspectives on safety than those that underpin the biomedical birth discourse. The women are coming from a philosophical framework that favours social birthing models, whereas mainstream discourse valorises biomedical birthing models.

**Safety in social and biomedical birthing models**

Each country, culture and subculture has its own context and understanding of pregnancy and birth (Odent, 2001; Walsh, 2010). This research on women who birth
outside the system was conducted in Australia where birth is predominantly believed to be a medical event and the pregnant woman and her birthing process is viewed through a biomedical paradigm (Maher, 2003; Murphy-Lawless, 1998). However, there is a conflict between two paradigms, a social model of care and a biomedical, technocratic model of care. Biomedicine proposes that the focus in childbirth should be on the physical wellbeing of the mother and baby (Chamberlain & Barclay, 2000), while social models consider the holistic needs of the mother and her family (Kitzinger, 2012; Kirkham, 2003). Wagner suggests that the difference between a biomedical and ‘humanised’ approach (exhibited in social models) is whether or not the woman giving birth retains control (Wagner, 2001, p. 26). Essentially, then, the struggle between the two paradigms centres on who should hold the power during childbirth.

The biomedical model

Western medicine sits within a biomedical framework, where birth is set apart from the rest of women’s lives (Benoit, Zadoroznyi, Hallgrimsdottir, Treloar, & Taylor, 2010; Kitzinger, 2006). Biomedical birthing models are usually played out in hospitals and clinical settings, in an environment that is foreign to the woman, attended by individuals who are relatively unknown to her, and alongside multiple routine procedures designed to control the birth process (Kitzinger, 2012; Wagner, 2001). In western culture, the biomedical birth model is considered superior to a social model (Benoit, et al., 2010; Kitzinger, 2012; Wagner, 2001). This is partly because a biomedical model utilises highly technological equipment that is believed to enhance safety (Jordan, 1987; Mansfeild, 2008). Furthermore, a philosophical hallmark of biomedicine is that of ‘Cartesian dualism’, which describes how medicine perceives the body and mind to be separate entities, not connected or influenced by each other (Mendel, 2003). It is this philosophical standpoint that leads its detractors to disparage the biomedical model as
reductionist and mechanistic (Mendel, 2003).

The move from seeing birth as a social event to one that is managed in hospital is considered a hallmark of the medicalisation of childbirth (a concept described earlier in this thesis). Medicalisation relies on defining a problem or event in medical terms and then using a medical intervention to treat or manage it (Conrad, 1992). The result of medicalisation is that the medical profession gains power through their expertise in and authority over this knowledge. In the arena of childbirth, this allows the professionals to take control of the woman and her birth process. Biomedicine has come to define and control what constitutes health and illness, and to redefine what is considered normal and abnormal (Ballard & Elston, 2005; Benoit, et al., 2010; Murphy-Lawless, 1998; Rose, 2007). Within a biomedical context, medicalised knowledge becomes authoritative and legitimised. Hausman (2005) summarises the conflict between medical and physiological frameworks for childbirth, explaining that ‘as long as physicians are trained to see childbirth as a medical management issue as well as a set of risks that must be managed by technological progress and manipulation, mothers will always be seen as sick patients whose choices must be carefully circumscribed by the framing of childbirth risk within medical language and understanding’ (Hausman, 2005, p. 35). Although it is indisputable that human intervention and control over the birth process can at times be life saving for mother and baby (Davis-Floyd, Barclay, Daviss, & Tritten, 2009; Wagner, 2001), the women in this study nevertheless felt that interventions used to manage birth are overused, leading to related morbidity. Intervention should be reserved for abnormal labour, the participants felt, rather than used routinely on healthy women and babies. Critics of biomedical birthing practices likewise question whether a medical model of maternity care is sufficient to understand or cater to the complexities of childbirth, and to allow for the provision of high-quality care (Waldenstrom, 1996). It is suggested that
the technologies and procedures used within this model of care to help improve safety may not necessarily be advantageous from a psychological standpoint (Waldenstrom, 1996). The participants in this study reject the medicalisation of childbirth and see the philosophical standpoint of biomedicine as different to their own understandings of birth.

The rhetoric of medically managed birth contends that interventions are designed to enhance safety (Davis-Floyd, 1992; Murphy-Lawless, 1998). There is concern from other researchers, however, that interventions in birth create iatrogenic risk (Davis-Floyd, 1992), and that women sustain psychological and emotional trauma as a result of being subjected to such treatment (Kitzinger, 2006b). Critics suggest that intervening in birth can cause more problems than it solves, increasing the risk and complexity of birth beyond what would otherwise occur (Davis-Floyd, Barclay, Daviss, & Tritten, 2009; Kitzinger, 2006b). Other authors note that while there are some advantages to modern obstetrics, the price in both monetary terms (Tracy & Tracy, 2003) and the collateral damage to the mother and baby is increasingly high (Davis-Floyd, Barclay, Daviss, & Tritten, 2009).

Medically managed birth relies on screening, surveillance and intervention, leading some authors to liken technocratic management to institutionalised violence, where the women feel like they are products who are managed rather than human beings who are cared for (Ayers, 2004; Kitzinger, 2006b; Thomson & Downe, 2008). Davis-Floyd et al contend that the biomedical care of birthing women does not work, because it creates unnecessary iatrogenic physical, social and emotional damage (Davis-Floyd, Barclay, Daviss, & Tritten, 2009). Some women refer to their birth as ‘traumatic’ and ‘birth rape,’ indicating that they experienced a sense of violation (Kitzinger, 2006b). This is further supported by observations of birthing practices in anthropological studies, where it is
found that in a technocratic setting, it is not the woman who holds the power, but rather the keepers and users of the technology. This places the woman’s care providers in an authoritative position, increasing her vulnerability and opening her up to feelings of powerlessness (Davis-Floyd & Sargent, 1997; Kitzinger, 2006b). In these instances, the care provider has control over what is done to the woman, and she is relegated to a position of passivity. Lack of control has been demonstrated to be a risk factor for a negative or traumatic birth experience (Thomson & Downe, 2008). In situations of power imbalance where women feel that things were done to them without consent, these are experienced as acts of assault (Kitzinger, 2006b). Furthermore, technocratic birth has been posited as a psychologically and emotionally damaging management approach (Beck, 2004; Kitzinger, 2006b). Kitzinger (2006) suggests that ‘women are traumatised by being treated like they are at constant risk of breaking down. They are traumatised by feeling that they are sucked into a medical system that deprives them of any control over what is happening to them’ (Kitzinger, 2006b, p. 2). Kitzinger further suggests that the development of trauma symptoms is an understandable reaction to insensitive care, where a woman has ‘no choices and no means of escape’ (p. 3). This dynamic, she contends, is inherent to the technocratic birthing model.

In the technocratic approach to birth, the mother and baby are seen as separate entities and the baby is often prioritised over the mother (Wagner, 1994). In this way, technocratic birth management presents carers with a dilemma as to which ‘patient,’ the mother or the child, should be accorded primacy when making clinical decisions. Because technocratic birth relies upon the actions, decisions and choices of the care providers, they must also decide where their allegiances lie – with the mother or with the baby. This creates a conflicting paradigm causing a dichotomy between the mother and her child (Wagner, 1994). While the mother-baby dyad once favoured the preservation of
the woman, it now appears to have shifted to give priority to the baby (Murphy-Lawless, 1998).

Despite being trained to perform clinical tasks upon the mother, obstetricians consider the welfare of the baby to be their primary concern when making care decisions (Ballard & Elston, 2005; Richard, et al., 2002). Thus, when an obstetrician’s decisions conflict with the wishes of the mother, the doctor feels it is his/her role to protect the unborn baby from its mother. This dichotomising of mother and baby is a further extension of the biomedical approach to medicine, which conceptualises the body as a machine with disconnected parts that can be managed and repaired in isolation to each other (Davis-Floyd, 1992).

**Social models**

The participants in this study found safety in social birthing models rather than biomedical ones. Social birthing models are often adopted in out-of-hospital settings, including in the home or in freestanding birth centres. Within these models, the nurturing of relationships between the woman, her family, her care providers and the community are key (Homer, et al., 2009; Kitzinger, 2012). Hunter et al (2008) explain that forming and maintaining relationships is a fundamental element of quality maternity care. They note ‘how rarely relationships are overtly identified as causal factors, particularly in macro-level discussions of maternity care’ (Hunter, Berg, Lundgren, Olasdottir, & Kirkham, 2008, p.132). The researchers further observe that relationships are not only important in the provision of humanised care, but are also integral to maintaining clinical and physical safety (Hunter, et al., 2008). The management of birth in social birth models does not rely on sophisticated technology; rather, the focus is on facilitating the physiological process of birth with minimal interruption (Davis-Floyd, et
Social birthing models are considered to reflect how birth would be managed in traditional villages and tribal situations, with womenfolk and family in attendance to give support (Kitzinger, 2012). Social birthing models place importance on maintaining the social fabric of the woman’s life. It is this fundamental emphasis that makes these models attractive to some women. Hunter et al concur, suggesting that birth can be the focus for building social capital, ‘not least because supportive social networks make such a difference to the health and social wellbeing of new mothers’ (Hunter, et al., 2008, p. 134).

Birth was a social act long before it was governed by medicine (Kitzinger, 2012), and the participants in this study value the social aspects of birth and have resisted the redefinition of birth within biomedical discourse. By wanting to keep their family close, the participants seek to preserve the social nature of the birthing experience. Perceiving birth to be an important part of their families’ life, the women felt that it should be shared. The arrival of a newborn does not only impact the mother; it affects the whole family unit. In this way, the participants want the best not only for themselves, but also for their family. This informs their birthing decisions. As Mansfield (2008) notes, the ‘nature society’ worldview held by women who prefer natural childbirth (p. 1085) also entails an active rejection of the medical model. This is in part interpreted as an attempt by the women to return to traditional birthing methods (Mansfield, 2008). In this study, the participants’ rejection of biomedical management predisposed them to make alternative birth choices and to ultimately elect to birth outside the system.

**All-inclusive safety**

For the women in this study, the feeling of safety came not from being in a low-risk category, as defined by biomedical discourse. Rather, they elevated other meanings of safety, including social, emotional, cultural and spiritual safety, to have high priority and
were critical about biomedical beliefs as they ignored these aspects. The women had therefore formulated their own alternative schema in terms of safety. While biomedical models of birth are concerned with reducing the physical risk for the woman and her baby (Jomeen, 2012), the participants were equally focused on reducing their emotional, mental, social and cultural risks. Keeping their family close was an integral part of doing this. Conversely, hospitals strictly govern who is present during childbirth and postnatally, and this restriction represented a complete rejection of the social and familial values held by the women in this study. Not being able to keep their family close led the women to believe that hospital services were unsafe and could not accommodate their all-inclusive constructions of safety.

The women in this study can be defined as a subculture of women in Australia. The accepted contemporary definition of ‘culture’ involves the shared meanings, values, attitudes and beliefs of a group (Kruske, Kildea, & Barclay, 2006). The idea of all-inclusive safety is not restricted to white, western women who chose to birth at home. In Australian Aboriginal culture, birth is considered an emotional, physical and cultural experience (Dietsch et al., 2011). For the Canadian Inuits, for example, health is considered more than the absence of disease; it also encompasses the individual’s physical, mental, social and spiritual wellbeing, in addition to the health of the family and community as a whole (Van Wagner, Epoo, Nastapoka, & Harney, 2007). To help understand the importance of maintaining socially appropriate birthing practices, some comparisons can be made with women’s desire to keep their family close, and the desire of the Australian and Canadian Indigenous populations to ‘birth on country.’

Birth on country is the term used to describe women giving birth where they live, close to their family and community. In Australian Aboriginal society giving birth on
country holds significant cultural value and is linked to the child’s connection to the land, and his or her responsibilities to the community later in life (Anonymous, 2011; Kruske, et al., 2006). Indeed, the place of birth becomes incorporated into one’s overall identity (Dietsch, et al., 2011). In Australia, women living in remote areas are transported out of their rural and remote communities, without family or support people, to large urban birthing units where they wait for labour to start (Dietsch, et al., 2011; Ireland, Narjic, Belton, & Kildea, 2011; Kruske, et al., 2006). Many of these women are Aborigines and Torres Strait Islanders (Shah, Zao, Al-wassia, & Shah, 2011), and removing them from their community is considered culturally inappropriate and unsafe (Dietsch, et al., 2011; Kruske, et al., 2006; Wardaguga & Kildea, 2004). Transporting the women to centralised birthing units has done little to improve outcomes for Indigenous mothers and babies in Australia (Dietsch, et al., 2011), and has instead led to adverse outcomes by contributing to non-compliance in attending antenatal care from Indigenous women (Dietsch, et al., 2011). This indicates that services that fail to meet the needs of the consumer will be avoided. Similarly, the participants in this study found current mainstream maternity services unacceptable, because they did not cater for emotional, social, mental or cultural safety. The women therefore avoided these services by birthing outside the system.

Removing Indigenous women from their support network renders their birthing experience devoid of cultural, social and emotional significance, reducing it to a biological event (Kruske, et al., 2006). This approach is incongruent to the way Indigenous women want to birth. It removes all that they value from the birthing process, and makes the women feel trapped, lonely, frightened, traumatised and unsafe (Dietsch, et al., 2011; Ireland, et al., 2011). This renders their birthing experiences negative and unenjoyable, compelling the women to avoid these services in the future. Parallels can be drawn between this and the experiences of the participants in my study, who found
previous birth experiences traumatic and were thus determined to control the circumstances of subsequent births.

Medical opinion dictates that birthing away from hospital without technological care presents unnecessary danger to women (Murphy-Lawless, 1998; Wagner, 2001). However, humanising birth and handing control over it back to women can actually produce equivalent physical benefits while providing a better psychosocial experience for the women. This has been shown by the Canadian Inuit initiative which trained local midwives to attend local women at local facilities (Van Wagner, et al., 2007). Since the practice of bringing birth back to the Inuit community began in 1986, the region has experienced improved maternal and infant outcomes when compared to air evacuation, even though the former involves birthing in remote communities far from tertiary care (Van Wagner, et al., 2007). Jusapie Padlayat, a Canadian Inuit Saulluit elder, says of birthing in community, ‘I can understand that some of you may think that birth in remote areas is dangerous. And we have made it clear what it means for our women to birth in our communities. And you must know that a life without meaning is much more dangerous’ (Epoo, Nastapoka, & Stonier, 2005, p. 1). This Inuit initiative demonstrates that where there is emotional, social and cultural safety, there is also the possibility of achieving physical safety. Moreover, in some cultural contexts, there are elements that are even more important than physical safety alone.

**Risk and risk management in childbirth**

There is a distinct lack of research exploring women’s constructions of risk and childbirth (Chadwick & Foster, 2014), and my study goes some way towards filling this gap. The participants in this study challenged mainstream medical understandings of risk in pregnancy and childbirth. Their rejection of medical definitions of risk contributed to their decision to *birth outside the system*, which they perceived to be a less risky option than
birthing in hospital. This section will begin with a commentary on the concept of risk in general, followed by a consideration of the participants’ understanding and acceptance of the risks inherent in childbirth. As will be demonstrated, the participants carefully weighed up their own individual risks as they deliberated over how to best mitigate both the risks inherent in birth, and their own unique set of risks. While going against dominant beliefs about risk and risk management, the participants simultaneously took responsibility for defining risk as they saw it.

**Understanding Risk**

Freebirth and high-risk homebirth are considered taboo because of the perceived risk associated with these two birthing options. However, risk itself is poorly defined and open to a wide range of interpretations (Bryers & Teijlingen, 2010; Smith, Devane, & Murphy-Lawless, 2012). The commonplace notion of risk suggests that it is statistically measurable and linked to the doctrine of probability, and can thus be used to predict outcomes (Murphy-Lawless, 1998). However, risk is not objective, and it takes on different meanings for different individuals (Smith, et al., 2012). Smith et al (2012) analysed the concept of risk in maternity care, concluding that it is variegated, diverse and dynamic: ‘What constitutes risk today may not necessarily be viewed in the same light tomorrow’ (Smith, et al., 2012, p.130). They suggested that there is no universally accepted definition of risk, and that the concept of risk itself is not stable. Generally accepted definitions of risk are predicated on the concepts of statistics and probability; therefore risk is merely an abstraction reliant upon the interpretation of statistical data (Smith, et al., 2012). For Smith et al (2012), the problem in computing risk is compounded by the lack of consensus about what constitutes risk in maternity care (Smith, et al., 2012). Given that risk minimisation has come to dominate the reasoning behind many maternity care practices, if the definition of risk is different between
individuals, then so too is the belief of how risk should be managed (Bryers & Teijlingen, 2010; Smith, et al., 2012).

Smith et al (2012) identified three approaches to understanding risk. The ‘realist approach’ (p. 130), where risk is viewed as an objective and calculable entity that relies on scientific and biomedical data to explain it. Within this approach, science and technology define what constitutes risk, and then govern the process of reducing or eliminating that risk. This approach dominates in the medical management of pregnancy and childbirth. Secondly, the ‘weak constructionist approach’ (p. 131) sees risk as a product of social and cultural processes, whereby individuals construct and produce what they believe is risky based on their social or cultural circumstance; this may be the case within homebirth communities (Smith, et al., 2012). Lastly, the ‘strong constructionist approach’ (p. 131) considers risk to be a result of external, rather than individual, social and cultural processes. Smith et al (2012) argue that individuals, groups or populations are shaped and moulded by expert knowledge, surveillance and monitoring to see risk a certain way. Thus a person’s beliefs are the result of an active attempt by the ‘expert’ to regulate and control how society perceives risk (Smith, et al., 2012). Some authors argue that the generation of risk and fear around birth has been an ideological tool deployed to elicit compliance from women and compel them to accept obstetric care (Murphy-Lawless, 1998). The use of fear, danger and risk discourse around childbirth could be viewed as a way of obstetric experts employing a ‘strong constructionist’ approach to risk. Smith et al (2012) go on to describe the linguistic principle where risk perception is influenced by an individual’s knowledge, training, personal values and past experiences. For example, a midwife working in a high-acuity setting, where birth is often accompanied by pathology and complexity, would see birth as inherently more risky than a midwife working in a lower acuity setting. Similarly, for obstetricians, who may rarely witness the unfolding of
a normal birth, birth is perceived as more risky than for a midwife who frequently attests uncomplicated normal births. For women, the linguistic principle means that they will rely on their personal exploration, research and past experience to shape how they view risk during pregnancy and birth. Some women, influenced primarily by mainstream or dominant risk discourse, will come to see birth as risky and fear that it might go wrong, especially if these fears were realised in previous experiences. Others may choose to disengage from this discourse and subscribe to a belief that childbirth is a natural, normal event. As Smith et al (2012) observe, the latter group of women may also come to perceive a medical model of childbirth as more risky than a homebirth model of care. Finally, Smith et al (2012) describe the logical principle, which explores the concept of risk with reference to related concepts such as safety.

The difficulty in defining accessory terms to risk, such as safety, adds further ambiguity as we attempt to understand risk. In an industrialised, western context, hospitals are marketed as the ‘safe’ place to birth because they offer the comfort of close access to monitoring and technology. This is seen to minimise or manage the risks of childbirth (Smith, et al., 2012). However, in the instance where these technologies are considered to present the woman with risk, the woman may perceive the hospital as not safe. The concept of safety, then, is equally as ambiguous and broad as the concept of risk in maternity care. Given the ambiguity in the meaning of risk and safety in childbirth, Smith et al (2012) conclude that, enmeshed within the concept of risk is a level of vagueness. They ultimately determine that, despite a review of the literature, the definition of risk in maternity care remains elusive and lacks integrity (Smith, et al., 2012).

In her work on ordering risk in Australian maternity care policies, Lane (2012) elucidates Beck’s theory of ‘risk society.’ For Beck, risk can be defined as the ‘anticipation of
catastrophe’ (Lane, 2012, p.25). This ‘anticipation’ shapes the individual’s expectations and guides their actions until their actions transform the world into a ‘world risk society’ (Beck, 1992, 1999). From the perspective of medical risk discourse, there is always the anticipation that something will go wrong during birth. To avert impending catastrophe, maternity care providers therefore act in an interventionist and preemptive way.

Lane (2012) also refers to Crook, who proposes that different kinds of societies use different risk mechanisms to govern their populace. Crook believes risk to be generated by paternalistic, enterprising governments or opportunistic groups. In this sense, the threat of risk is deployed as a mechanism of control (Lane, 2012). For Crook, practices or events are not intrinsically ‘risky.’ Rather, they must be semantically conceptualised as risky; in this context, risk is created rather then a reality. Different regimes, be it from governments or other groups such as medical organisations, produce different kinds of risk. The parties that advance these constructions of risk will benefit from their agenda, assuming that they are successful in promoting their newly configured construction of risk to the point where it is recognised as incontrovertible truth. Murphy-Lawless argues that obstetrics is guilty of this production of false risk for their benefit (Murphy-Lawless, 1998). Similarly, Lane contends that obstetrics sees the pregnant female body as risk-laden and bound for failure. These doctrines sit in diametrical opposition to a model where birth is seen as a low-risk natural process, and where midwives have faith in the woman’s ability to birth her baby (Lane, 2012). These differing perspectives on the risk of the pregnant female body and the process of giving birth inevitably influence the belief systems of care providers. In a 2012 radio interview on ‘Life Matters’ Australian obstetrician Gino Pecoraro referred to interventions in birth as ‘treatments,’ reflecting the prevailing obstetric view in Australia that birth is an illness that needs treating (Life Matters, 2012).
Bryers and Teijlingen (2010) provide a critical analysis of the concept of risk and explore the ways in which maternity services have moved from a social to a medical model. They suggest that the risk agenda was an integral part of this movement (Bryers & Teijlingen, 2010). They argue that the assessment of risk depends on human judgement and decision-making; thus, objective and subjective risk cannot be separated (Bryers & Teijlingen, 2010). The authors describe three major risk theories. Firstly, the perspective of ‘risk society and reflexive modernity’ (p. 489) contends that the ongoing modernisation of society is accompanied by an over-monitoring, which generates yet more information and knowledge. As the authors observe, this has propagated increasing anxiety over danger and risk, making way for the creation and definition of new risks that will subsequently need to be remedied (Bryers & Teijlingen, 2010). Secondly, ‘social and cultural construction of risk’ (p. 489), which describes how the elements of life are all socially constructed, allowing for different groups to view or do things differently all-the-while still considering it normative within their personal and cultural context (Bryers & Teijlingen, 2010). The same is true for the construction of risk and safety. Finally, Bryers and Teijlingen (2010) describe the category of ‘governmentality and self-surveillance’ (p. 490), whereby perceptions of risk are based on the assumption that populations or communities require measurement, management and protection in order to maximise productivity, health and welfare (Bryers & Teijlingen, 2010). Within this third framework, the surveillance and regulation of childbirth is seen to benefit the individual and society alike.

The medical paradigm tends to define every aspect of labour and birth as risky in an attempt to predict all possible eventualities (Hausman, 2005; Murphy-Lawless, 1998). Therefore, the labouring body is positioned as risk-laden, with the possibilities for something going wrong proliferating. The field of obstetrics has convinced women to
submit to medical management as a way of making birth safer and less risky (Murphy-Lawless, 1998). Through defining what is ‘normal’ and ‘abnormal,’ obstetrics has been able to identify and frame their perspective on risk (Murphy-Lawless, 1998). Thus, from an obstetric perspective, a low-risk or ‘normal’ state carries within it the potential to become an ‘abnormal,’ high-risk state. Obstetricians are positioned as the knowing professionals responsible for managing this probability and reducing the risk of ‘abnormal’ (Chadwick & Foster, 2014; Murphy-Lawless, 1998). However, Murphy-Lawless (1998) asserts that, ‘normal is never clear cut nor even especially stable’ (p. 169).

Much like the variegated definitions of ‘risk’ and ‘safety,’ the concepts of ‘normal’ and ‘abnormal’ are ill-defined and open to interpretation. The lack of linguistic and semantic fixity for the term ‘risk’ has become obvious throughout this study. Furthermore, it has been demonstrated that the women’s definitions of risk sat in marked opposition to those upheld within the mainstream biomedical discourse.

By developing a conceptual difference between abnormal and normal, the medical profession have secured a large and growing market for their services in perpetuity. This has been achieved via the cultural construction of false needs, and then the provision of services to cater to these newly perceived needs (Ballard & Elston, 2005). If childbirth can be marketed and accepted as risky, then more women will submit to medical management in the hope that risk can be avoided. In this sense, women’s perceptions of the risks of childbirth have been moulded through history by shifts in the management of childbirth from social female-dominated contexts to the medical model of hospital obstetric practices in industrialised western nations. This transformation has produced new kinds of risks, and new ways to approach and manage these risks (Hausman, 2005). Thus by creating risk and redefining natural life events as risky, obstetrics has gained
control over managing birth (De Vries, 1993). In an obstetric setting women are organised into risk categories and managed or treated accordingly; those assigned a ‘high-risk’ label inevitably become the women who are most readily the focus of obstetric intervention (Murphy-Lawless, 1998). By apportioning ‘risk labels,’ obstetrics legitimised their professional power over the processes of pregnancy and birth (Lane, 2012), while collectively laying claim to the sole ability to predict and manage risks (Murphy-Lawless, 1998).

Such social structures can be explained by Foucault’s theory of biopower, whereby whoever claims responsibility over defining or predicting risk is also responsible for the outcomes (Lane, 2012). It is perhaps this perspective on risk that has allowed for the medicalisation that governs childbirth management in Australia today. The women in this study saw risk differently when contrasted against biomedical philosophy and wholeheartedly reject biomedical discourse about risk. Nonetheless, the women did, however, understand and accept that birth will always carry an element of risk, irrespective of where they choose to birth.

**Accepting risk**

Death in birth, for women and for babies, can and does occur. Neither obstetrics, anxious to defend its reputation, nor women, anxious to exercise control over their lives, can deny this reality. (Murphy-Lawless, 1998, p. 243)

The women in this study understood that death and disability were a possible outcome of giving birth. This acceptance and acknowledgement of risks associated with birth was not unique to these participants. In other studies, women have similarly acknowledged that their babies could encounter problems during childbirth at home (Lindgren, Hildingsson, & Radestad, 2006; Lindgren, et al., 2010). This suggests that women who choose freebirth or high-risk homebirth are not unaware of the problems that could
ensue. Obstetrics perceives childbirth and the risk of catastrophe as interconnected (Johanson, Newburn, & Macfarlane, 2002; Murphy-Lawless, 1998), maintaining that there is always the possibility that a woman or her baby may die during childbirth. Within this biomedical discourse, there is an assumption that women who choose homebirth do not fully understand the risks of childbirth (Devine, 2009; Elder, 2009; Squires, 2011). However, the findings of this study refute this assumption. As discussed in Chapter Two, Symon et al (2010) examined 15 instances of perinatal death that occurred with independent midwives in the UK (Symon, et al., 2010). They found that in 13 cases where homebirth was attempted, significant antenatal risk factors were present. There was a strong desire by the women to avoid mainstream maternity services, and the authors concluded that ‘the women in this review had reportedly accepted the potential consequences of their high-risk situations. If reality is to match rhetoric about patient autonomy, such decision-making in high-risk situations must be accepted’ (Symon, et al., 2010, p. 280). Although Symon et al (2010) did not actually interview any women, my study did. It was evident that the participants in my study understood their individual circumstances and acknowledged the risks associated with them.

**Weighing up and mitigating the risks of birthing at home**

The participants in this study described undergoing a process of ‘weighing it all up’ as they considered their birth options and decided how to manage the risks. The weighing up of risk and benefits is considered to be a central feature of having choice and making decisions (Jomeen, 2012). For the women in this study, the process of weighing up their risks included pursuing a detailed understanding of their own personal and unique risk status. By understanding their personal risks, the participants created a body of information on which they could base their risk management decisions. Similarly, McClain (1983) observes that women choosing homebirth undergo a risk-benefit analysis...
of home versus hospital settings before making their final choice (McClain, 1983).

Likewise in my study, the weighing up process resulted in the women making the choice that they perceived to be the less risky for them and their baby. Lindgren et al (2006) also described how their participants weighed the risks and benefits of their birth choices both intellectually and emotionally (Lindgren, et al., 2006), and not just based on improving physical outcomes for their baby.

It is thought by some that women who choose to birth outside the system are ignoring or underestimating the risk of giving birth at home (Devine, 2011; Wolfson, 1986).

However, it was apparent in this study that women gave serious consideration to risk, and placed the iatrogenic risks of giving birth in a hospital under intense scrutiny. They also challenged implicitly agreed assumptions that hospital birth must be safer and exposing risks that are often simply accepted as part of birth. One in ten people entering hospital experience an adverse event, with around half of these being preventable (WHO, 2008). In light of this, some researchers argue that the debate around safety in maternity care often focuses too heavily on the ‘aberrant’ behaviours and characteristics of women, while failing to acknowledge harmful activities of health providers and health care organisations (Dahlen, 2011; Sandal, Morton, & Bick, 2010). Given the WHO statistics, it is not unreasonable that the participants might expect to be exposed to iatrogenic risk if they choose to birth in hospital. In accordance with the participants’ perception that hospital risk management procedures may not actually promote safety, but rather introduce unnecessary risk, Wagner comments:

... to be appropriate, both the benefit and the safety of technology must be assessed by those on whom it is used. Scientists can measure the efficacy ... and the risks ... but the person taking these chances [the patient] is the only one who can legitimately decide whether one chance outweighs the other. It is thus inappropriate and dangerous for a doctor to tell a patient that something is ‘safe.’ (Wagner, 1994, p. 37).
For Wagner, it is perfectly reasonable that the women, as potential recipients of the intervention, should be the ones to decide and interpret what they believe to be safe or risky, based on the information they have. Furthermore, he argues that the concept of safety is more of a value judgement than a fact (Wagner, 1994). Clearly, obstetric care providers manage and perceive risk differently to the participants in this study. Moreover, each cohort would have difficulty understanding the view and approach of the other group, given the vast fundamental and ideological differences in their perspectives.

Despite mainstream maternity discourse encouraging women to respond to the potential risks of childbirth by submitting to obstetric management and interventions in a hospital, the participants in this study respond to the risk of birth differently. Boucher et al (2009) also found that women who choose to give birth at home equated medical intervention with reduced safety (Boucher, Bennet, McFarlin, & Freeze, 2009; Schneider, 1986). The participants in this study believed that interference and interruption in the process of labour and birth would be both hormonally and psychosocially disruptive and deleterious, and would lead to increased risk. The women consequently rejected the biomedical idea that interventions are a required aspect of risk management in maternity care.

**Going against dominant beliefs about risk**

Tension exists between the biomedical model of risk and the contemporary discourse of low-risk birth as a normal process (Jomeen, 2012). Similarly, the women in this study trusted and elevated their own perceptions of risk and rejected the biomedical authority. They went against dominant perceptions of risk and birth. Such a stance frequently exposes the women to ridicule. As Jordan (1997) states, ‘those who espouse alternative knowledge systems tend to be seen as backward, ignorant or naive trouble makers’ (Jordan, 1997, p. 152). Women’s agency through the choice of homebirth is a rejection of
the established agenda and therefore becomes a threat to well-established and implicitly agreed beliefs (Dahlen, 2011). This positions the women as a ready target for derision, judgement and misunderstanding. While the participants acknowledged that all birth entails an element of risk, they did not subscribe to the obstetric rhetoric that dictates that the hospital is the only way to manage this risk.

Chadwick and Foster (2014) explain that women who choose homebirth believe the birthing woman should be the centre of the birth process. This configuration contrasts sharply with biomedical models of childbirth, where the woman becomes a passive recipient of treatment from experts who are charged with managing risk (Chadwick & Foster, 2014). Women who do not buy into the western risk discourse of birth are seen to challenge obstetrical calculations of risk (Freeze, 2008). Thus the phenomenon of freebirth and high-risk homebirth may be understood as an effort to escape the hegemony of the western risk culture and to redefine acceptable boundaries of risk and safety. By choosing to prioritise their own understandings of risk over those expressed by dominant biomedical discourse, these women simultaneously place their own knowledge as higher authority and reject the medicalised definitions of birth as risky. Their belief system thus represents a countercultural perspective about birth in western society, marking these women as different.

**Taking responsibility**

The women in this study rejected the obstetric claim of responsibility over the management of risk in birth. Instead, the women took responsibility for defining their own risk status. In so doing, they reclaimed jurisdiction and control over risk management and the subsequent outcomes of their pregnancy and birth. Chadwick and Foster (2014) similarly found that women choosing homebirth constructed an alternative
approach to childbirth that destabilised biomedical definitions of risk and allowed the women to construct their own interpretation of risk (Chadwick & Foster, 2014).

The idea of taking personal responsibility was not isolated to women who birth outside the system, but was characteristic of women who choose homebirth in general. Lindgren et al (2006) report that women who choose homebirth avoided hospitals because they feared their responsibility would be taken away. The women were willing to accept the consequences of their own decisions, and moreover to avoid the risk of being unable to make decisions autonomously (Lindgren, et al., 2006). Entering a hospital to give birth threatens a woman’s autonomy because ‘obstetrics demands compliance and is not prepared to deal with the woman who asserts her own authority as anything other than a grossly irresponsible risk-taker, a non-compliant patient, a source of potential disaster’ (Murphy-Lawless, 1998, p. 237).

The participants in this study feared entering hospital where there would be tension around their autonomy. As Murphy-Lawless (1998) argues, ‘when women engage with obstetric medicine, they jeopardise their chances to exercise control over their situation because of the demands that the scientific discourse on risk makes’ (p. 233). The women in this study felt that their birth would be the best and the safest if their autonomy and authority were preserved and respected. To hand this autonomy (and responsibility) to maternity care providers represented a less safe option.

**Trauma in childbirth**

This research makes a unique contribution to the literature on trauma in childbirth. Much of the existing literature centres on the trauma engendered by difficult, painful or complex births. There is scant research, however, considering how care providers can
actually be the instigators of traumatic events. To date, the events of the birth itself have been the predominant focus of why women feel traumatised. This research turns the spotlight on care providers and examines how their behavior contributes to trauma.

Current strategies to manage how women feel about their birth experiences have focused on influencing the behaviour of the woman rather than that of the care providers; for example, reducing her pain using epidural analgesia and helping her to cope with labour by offering antenatal education and providing a homelike environment (Waldenstrom, Hildingsson, Rubertsson, & Radestad, 2004).

In this section, I discuss how a previous traumatic birth experience was one of the major contributing factors for women who decide to birth outside the system. Trauma following childbirth is not isolated to women who eventually choose to birth outside the system, but is an increasing problem within maternity care in general (Gamble, Creedy, & Moyle, 2004). It has been identified in this study that loss of control during birth can lead to feelings of trauma after childbirth. A sense of disempowerment also led women to become traumatised. The participants in this study found the resulting trauma to be life changing. They pursued a birth outside the system in the hope that by giving birth in an environment that allowed them to maintain power and control, they could heal and be positively transformed. The women attributed their previous traumatic experience, in part, to care providers within a hospital setting. By avoiding this setting and its staff for subsequent birthing experiences, the women hoped to also avoid a repeat of trauma.

**Previous birth experiences as traumatic**

For the women in this study, trauma sustained with a previous birth experience was a major contributing factor in their decision to birth outside the system. The women perceived their previous birthing experiences to be emotionally, mentally, socially, culturally and
physically unsafe. The choice to *birth outside the system* came from a desire to avoid particular traumatic aspects, including ‘being assaulted,’ ‘being degraded,’ ‘being bullied,’ ‘not being listened to,’ ‘experiencing side effects,’ ‘being separated from family,’ ‘being abandoned by supporters’ and not having their expectations met. Most participants in this study were multiparous, and their perceptions of risk were shaped by their previous birthing experiences.

In another recent study, women reported that feeling unsafe in their previous hospital birth experience was a major motivator behind their choice to homebirth (Lindgren, et al., 2010). Previous experience had taught these women that despite claims that hospital-managed birth enhances safety and reduces risk, the reality was very different. The women’s trust in mainstream maternity services to provide safe care had been eroded. Vissainen (2001) found that a decision to birth at home was related to a specific event in the woman’s past, most often ‘an unpleasant and traumatic experience of giving birth in hospital’ (Vissainen, 2001, p. 1114). This motivation was also evident in the study by Boucher et al (2009), where approximately a quarter of respondents cited a previous negative hospital experience as the reason they chose to birth at home (Boucher, et al., 2009). Similarly, 58.6% of the respondents in an Australian study in 1993 reported dissatisfaction with a previous hospital birth as their reason for planning a homebirth (Bastian, 1993). The importance of prioritising the emotional and mental wellbeing of the mother during labour and birth is being increasingly identified throughout the literature. Austin et al (2007) cite the findings from the last three reports on maternal deaths in Australia (from 1994 to 2002) and suggest that maternal psychiatric illness is one of the leading causes of maternal death (Paule Austin, Kildea, & Sullivan, 2007) This finding is also mirrored in other more recent research (Thornton, Schmied, Dennis, Barnett, & Dahlen, 2013). This suggests that the mother’s postpartum emotional and mental state
has a large bearing on the maternal morbidity and mortality rates for Australian women. Thus it is plausible that if women experience a traumatic birth, followed by a sequelae of mental health concerns, they are at increased risk of subsequent ill-health or self-harm.

**Trauma following birth a common issue**

The experience of birth trauma is not isolated to women who choose to birth outside the system. A recent Australian study published in 2010, for example, found that up to 45.5% of women felt traumatised after their birth experience (Alcorn, O'Donovan, Patrick, & Devilly, 2010). Other studies suggest that between 20% and 48% of women rate their childbirth experience as traumatic (Harris & Ayers, 2012). Predictors of trauma include caesarean deliveries, a high level of medical intervention, long and painful labours, feeling powerless, lack of information, negative interactions with medical personnel and a disparity between expectations and the actual childbirth event (Beck, 2006). Creedy et al (2000) examined the incidence of acute trauma symptoms following birth by screening 499 women for postnatal trauma symptoms. One in three of the participants reported a stressful birthing event and expressed three or more trauma symptoms, with twenty-nine participants meeting the diagnostic criteria for acute post-traumatic stress disorder (Creedy, Shochet, & Horsfall, 2000).

The development of post-traumatic stress disorder (PTSD) after childbirth is being increasingly reported, with some studies finding that up to 6% of women demonstrate symptoms following childbirth (Beck, 2006; Boorman, Devilly, Gamble, Creedy, & Fenwick, 2013; Harris & Ayers, 2012). Post-traumatic stress disorder is defined by the DSM-IV as a disorder arising from exposure (either discrete or ongoing) to a stressor that involves actual or threatened death or serious injury, or damage to self or others, whereby the person’s response involves intense fear, helplessness or horror. The
symptoms of acute PTSD include persistent re-experiencing of the traumatic event and persistent avoidance of stimuli associated with the event (Creedy, et al., 2000).

Although only one woman in this study actually pursued a formal diagnosis of PTSD, it is possible that the avoidance of hospital (the place at which the original trauma occurred) is an indication that many more participants experienced symptoms of PTSD after their births, but had not been formally diagnosed. One seemingly natural response to birth trauma is to avoid the place at which the trauma occurred (Creedy, et al., 2000; Harris & Ayers, 2012). Thus, if women are impacted by birth trauma and wish to have more babies, they must either overcome their trauma and re-enter mainstream services, or select an alternative birthing location. It would appear that the participants in this study pursued the latter. In this context, *birth outside the system* is less of an active choice and more a case of being ‘backed into a corner’ given their previous trauma. The choice to *birth outside the system*, then, is motivated not solely by the participants’ birthing philosophy or desires. Rather, it is also a direct result of the poor treatment, limited choices and birth management they experienced at previous births.

**The contribution of health providers to emotional trauma**

It has been suggested that when women have clear ideas for their birth preferences, they may be more prone to disappointment and trauma if their birth does not go as they had hoped (Goodman, et al., 2004). Suggestions like these focus on the predisposition of the woman to feeling traumatised. My study’s findings, however, reveal that the feeling of trauma has less to do with the woman and more to do with the treatment she received from care providers.

While physical safety is important to women, the things that can make them feel most unsafe and traumatised are emotional and interpersonal events. Harris and Ayres (2012)
found that the main incidents that were identified as ‘hotspots’ for having caused PTSD were ‘interpersonal difficulties,’ with the most frequent subcategory of ‘being ignored’ (Harris & Ayers, 2012). This points to the central role that health care providers play in a woman’s experience of birth. Women also identified lack of support, poor communication, being abandoned and being put under pressure as circumstances that contributed to their birth traumas (Harris & Ayers, 2012). Elmir et al (2010) explain that women felt traumatised when they felt invisible and out of control, where health care professionals ignored their opinions and made decisions about their care without consulting them (Elmir, et al., 2010). While physical events in labour may be traumatic, many women are similarly traumatised by the personal and emotional treatment they received from their care providers. Interestingly, a study by Chadwick and Fosters (2014) found the maintenance of dignity and bodily integrity to be a primary motivator for choosing to birth at home and also to elect for caesarean. This suggests that birth outside the system and the avoidance of vaginal birth in hospital may both be choices women make to avoid a traumatic or disempowered birth experience.

Kitzinger (2012) contends that distress and/or the onset of PTSD after childbirth is a result of a disempowering birth experience where the woman is exposed to obstetric management with frequent interventions, lack of emotional support and rigid timelines. Indeed, for many women, giving birth is an experience comparable to rape (Kitzinger, 2012). Numerous women in my study also expressed this feeling of having been raped, with the term ‘birth rape’ invoked by some as they recounted their traumatic birth experiences. This terminology is not new; other scholars have encountered women speaking of their birth experience as rape (Beck, 2009, 2011; Goldbort, 2009; Kitzinger, 2006a; Thomson & Downe, 2008). This also suggests that the use of the terminology is not restricted to the homebirth community.
A major cause of trauma for the participants in my study was the feeling of having been assaulted when interventions were performed on them without their consent. Women described not being listened to when they asked their care providers to stop. The women reported feeling stripped of any volition over what was happening to their bodies. The loss of control over what might happen to oneself is recognised as an identifiable risk factor for women’s dissatisfaction with their birth experience (Waldenstrom, et al., 2004). Creedy et al (2000) also found that a high level of intervention and dissatisfaction with intrapartum care strongly correlated with the development of acute trauma symptoms. The literature indicates that the level of satisfaction a woman feels with her birth experience is commensurate with the amount of control she felt throughout her birth (Goodman, et al., 2004). When procedures are performed on women without their consent, this effectively wrests control, and predisposes the women to view their birth experience as incredibly dissatisfying and, in the circumstances discussed in this study, traumatising. It is becoming increasingly obvious that seeking consent from women to perform interventions is not always undertaken by care providers. Thompson and Miller (2014) found that the number of women who are provided with information and at least consulted in decision-making is considerably lower than optimal for procedures such as ultrasound scans, blood tests, vaginal examinations, fetal monitoring and episiotomy (Thompson & Miller, 2014).

There is scant literature that focuses on how health providers may contribute to the trauma some women feel as a result of their birth. One study by Beck (2004), however, has singled out aspects of care that contribute to women’s trauma. Using the theme ‘to care for me: was that too much to ask?’ Beck reports the participants’ descriptions of feeling raped, abandoned and stripped of dignity by their care providers. One woman spoke of being ‘hurt deep in my soul’ (p. 32). Similarly in my study, women recounted
the failure of hospital staff to keep them safe. On the contrary, the care providers had actually been the perpetrators of traumatising events. The second theme in Beck’s (2004) study was ‘communicate with me: why was this neglected?’ In this section, a lack of communication was experienced by the women as traumatic, with one woman explaining, ‘my soul was in agony’ (p. 33). The words of the women are emotive and heartfelt, expressing their anguish and trauma at not being kept emotionally and physically safe during childbirth. Other literature has found that providing support in labour and listening to women are underestimated strategies for reducing the incidence of negative birth experiences (Waldenstrom, et al., 2004). Furthermore, O’Hare and Fallon explain that eight of the nine participants in their study felt most out of control and most dissatisfied with their birth experience when they felt they were spoken at, rather than communicated with (O’Hare & Fallon, 2011).

Communication is a key predictor of women’s sense of control. In turn, maintaining control is an important contributing factor to women’s levels of satisfaction. Thus, poor communication can result in a disappointing birth experience. The third theme identified by Beck (2004) was ‘to provide safe care: you betrayed my trust and I felt powerless’ (p. 33). This theme parallels one of the major reasons why the participants in my study chose to birth outside the system. In Beck’s study, the women described expecting to be kept safe, and subsequently having their expectations betrayed. Similarly, the participants in my study also expressed a sense of betrayal of expectations. Once women learnt that they could not expect safety in the hospital, they lost trust in the system and chose to pursue birth outside the system as a better and safer option. The final theme identified by Beck (2004) was ‘the end justifies the means: at whose expense? At what price?’ (Beck, 2004). This section touches on the themes of ‘motherbirth’ and ‘childbirth’ discussed previously from Dahlen et al’s study (Dahlen & Homer, 2013). Here the women discuss how their
experience did not seem to matter, with the medical focus exclusively on the baby during their birth and afterwards. Similar experiences were relayed by the women in my study, who perceived hospital as unsafe because both mother and baby could not be cared for equally.

In a recent publication, Dahlen (2011) asks, ‘why are we not asking what is wrong with our mainstream maternity care that makes the fear of entering it worse than the fear of losing one’s baby or life? These women don’t love their babies less– they fear mainstream care more. This is an indictment on what we offer women’ (Dahlen, 2011, p. 20). In 2005, the WHO challenged practitioners not to ask, ‘why women do not accept the service that we offer?’ but rather, ‘why do we not offer a service that women will accept?’(WHO, 2005). While women in my study accepted responsibility for their decisions, they also challenged the assumption that a hospital birth was a better option for them. The fact that 16 of the 20 women in this study who had had their first baby in a delivery ward or birth centre pursued a completely different option for subsequent births makes one question the impact of current maternity care on these decisions.

**Trauma is life changing**

Traumatic birth, where the woman is disempowered by harsh and humiliating treatment, leaves women feeling violated and their dignity denigrated (Forssen, 2012). Fearing another traumatising experience, the participants in this study felt that they must do something different for subsequent births. They believed the events of birth to be an important factor in how they and their baby would move forward and develop through life. Forssen (2012) found that the traumatic experiences of childbirth can remain with women for a lifetime and alter their experience and perception of motherhood (Forssen, 2012).
The women in this study recognised a direct link between their labour and birthing experience and their mothering and emotional experience in the immediate and long-term postnatal periods. For these women, the choice to birth at home, assisted or not, was fuelled by a desire to avoid the risk of having another traumatic birth experience. The participants of this study considered the emotional wellbeing of them and their babies to be of primary importance throughout the birth process. Any risk or threat to this was actively avoided by planning to birth outside the system. The women identified that their experience of a traumatic birth in the past had impacted upon their mothering and their relationship with their child. This negative impact on the mother-baby relationship has also been noted in other studies as a side effect of a traumatic birth (Ayers, Wright, & Wells, 2007; Nicholls & Ayers, 2007; Reid, 2011). In order to enhance the quality of their mothering and bonding experience, the women felt they needed to avoid hospital-managed birth. A woman’s satisfaction with her birth has been linked to subsequent positive feelings towards motherhood and her infant (Elmir, et al., 2010; Simkin, 1991, 1992). However, a traumatic experience can affect a woman’s ability to bond with her children, and can induce feelings of rejection towards the baby (Ayers, Eagle, & Waring, 2006; Elmir, et al., 2010). The detrimental consequences that can be suffered in the aftermath of a traumatic birth highlight the importance of prioritising emotional and psychosocial wellbeing for birthing mothers.

The participants in this study also discussed how their traumatic birth disrupted the lives of their family and impacted on their relationship with their partner. This phenomenon was also noted by Catherall (1998) who observed that the milieu of the family is disturbed and destabilised in the wake of a traumatic birth (Catherall, 1998). Furthermore, women who experienced childbirth-related PTSD described a negative impact on their
relationship with their partner – they avoided sex, their communication was impaired and the relationship became infused with negativity (Ayers, et al., 2006; Nicholls & Ayers, 2007). The participants in this study therefore chose to birth outside the system to avoid the socially destructive nature of birth in hospital that they had experienced in the past.

**Giving birth again**

Current literature shows that a traumatic birth experience predisposes some women to either avoid having subsequent children (Beck & Watson, 2010) or to request caesarean section for subsequent births (Ryding, 1991, 1993). Other studies, however, have focused on women’s perceptions of a positive birth following a traumatic hospital or operative birth (Cheyne, 2008; Fenwick, Gamble, & Mawson, 2003; Thomson & Downe, 2010). Thomson and Downe (2010) found that an experience of joy following trauma led women to reframe and reintegrate their perceptions and beliefs surrounding a traumatic birth. The authors described this as ‘redemptive,’ explaining that women were transformed by a positive birth experience. In this study, I found that even the women who had experienced an adverse event during their birth outside the system still viewed it as healing and empowering, because they had regained the control and autonomy that was previously denied. Beck and Watson (2010) also report that a positive childbirth can serve to re-empower a traumatised woman and help her to reclaim her life (Beck & Watson, 2010). A redemptive and healing birth was characterised by women reclaiming their bodies and experiencing a strong sense of control (Beck & Watson, 2010). The redemptive nature of birthing outside the system reinforced to the women that they had made the best and safest choice for themselves and their baby.

**Maternal choice, control and autonomy**

A major cause of birth trauma is the sense of disempowerment and loss of control felt by the birthing woman. Being respected as the authority at their birth was an aspect cited by
the participants as central to their definition of the best and safest. This section addresses aspects of this autonomy and what this looked like in practice. Maternal choice, control and autonomy will be discussed in this section with reference to women reclaiming the control that they felt was lost in previous birth experiences. *Birthing outside the system* as a strategy to open up birthing options that are unavailable to women in the system will also be discussed. The confidence to be autonomous and take control derives in part from the woman’s belief in birth as a natural process. The participants did not fear the birth process and so had confidence to take control and be autonomous, rather than relinquish the management of their birth to external parties.

**Taking back control**

The participants reported wanting to be respected as the authority at their birth and to have control over their birthing circumstances and environment. Control in childbirth is poorly defined. However, across multiple contexts and cultures, women express a desire for control during births (Meyer, 2012). Meyer (2012) identified four attributes of control in labour and birth: having an active and lead role in decision-making, having access to information, the feeling of personal security through a humanised approach to care (which came from being listened to, respected and supported by care providers) and finally, having control over their physical functioning, such as what would happen to their bodies, and strategies for the management of pain (Meyer, 2012). For the participants in my study, control and autonomy occurred when they could freely choose their place of birth, who would be there, and what would or would not be done to their body and baby and if and when they would engage with the maternity care system. If they entered the system, the participants felt that their autonomy would be challenged and that access to these elements of control would be limited. It appears that the participants desired what Vandevusse (1999) refers to as ‘external control,’ which
denotes control of the environment, procedures, the actions of care providers and the
decision-making processes that take place (Vandevusse, 1999). The participants aimed to
improve on their previous birth experiences by maintaining a high level of personal
control and autonomy – a circumstance made possible by avoiding the system. Edwards
(2013) rightly comments that choice within a hospital system is limited by a
‘predetermined obstetric menu’ (p. 214) so if women desire something that is not on the
‘menu’ they must seek birth models that are not provided in a hospital setting. Women
birth outside the system to take control over what options and choices will be available
to them.

The participants felt entitled to choose what was best and safest. Indeed, part of their
dissatisfaction with the system was the exertion of control over them by hospital staff.
Part of the women’s concept of safety was ‘being the authority at my birth,’ which meant
being able to control their birthing circumstances without being subjected to external
resistance. It is well documented that the feeling of being in control is a significant factor
in women perceiving their birth experience as satisfying and positive (Goodman, et al.,
2004; Meyer, 2012). Having a sense of control over the birth process induces a feeling of
accomplishment. This provides the self-confidence to enjoy and thrive in their parenting
role, a benefit that continues to play out in future pregnancies (Green & Baston, 2003;
Meyer, 2012). A common cultural misconception is that women actually do have control
over what is done to them in hospital, simply because the institution is obliged to obtain
consent from patients. As Lothian notes, however, ‘[i]t’s an illusion. No matter what
anybody tells you in prenatal classes, or what your friends say, or what you read in books,
the bottom line is, you will follow the rules of the hospital, and you will do what your
doctor wants you to do’ (Block, 2007; p. 166). For Lothian, the possibility of choice
within a hospital setting is a myth, and the reality is that the maternity care system
severely circumscribes a woman’s autonomy (Lothian, 2008). This aligns with the critiques of the maternity care system offered by the participants in my study, who chose to *birth outside the system* in order to preserve their autonomy.

The avoidance of hospitals is not a new strategy in the pursuit of autonomy during childbirth. Wagner (2001) argues that hospitals are essentially doctors’ territory, with all power and control therein remaining resolutely theirs. Wagner therefore suggests that if a woman wishes to control and humanise her birth, she must move outside of the hospital (Wagner, 2001). Schneider (1986) similarly reports that births in the home meet the expectations of women who seek to partake in decision-making and who wish to retain control over their birth experiences (Schneider, 1986). More recently, Dahlen et al (2010) (Dahlen, Barclay, & Homer, 2010). With no assurance that they could maintain control and autonomy within the hospital system, the women in my study chose the birth place that met their expectations and provided the best and safest option.

**Opening up birth options**

For some participants, the presence of risk factors limited their birthing options within the system. For example, in some cases, the local hospitals did not offer VBAC, and some did not accept high-risk clients at all. The women who were considered ‘high-risk’ had no access to most midwifery continuity of care models, birthing centres or publicly funded homebirth. Therefore, they had little option but to submit to obstetric medical care in a hospital. Similarly, Bryant et al (2007) found that in the presence of risk factors or perceived risk, obstetricians believed that women would have immediate withdrawal of choice because there was no option but to intervene. An interventionist approach was thought to be the only way to ensure a positive outcome (Bryant, Porter, Tracy, & Sullivan, 2007). In medically risky circumstances, the desires of the mother were undermined, while medical preferences were accorded primacy. As Bryant et al (2007)
explain, if there was a perceived medical risk, then the option of no or low intervention was assumed void. Instead, the woman is presented with an interventionist approach as the only valid option (Bryant, et al., 2007). The participants of this study refused to have their birthing choices limited by their risk status, and they felt that the only way that their choice would be allowed or respected was to *birth outside the system*. From an authoritative medical stance, it would seem that women’s free choice and self determination are paralleled by the obligation to choose the perceived less risky option (Beck-Gernsheim, 1996).

The women in this study opened up their birth options by exhibiting what Gofen (2012) refers to as ‘the entrepreneurial exit response’ (Gofen, 2012). This response refers to the actions of citizens who, out of dissatisfaction with public services and a lack of other viable options, exit public services by creating an alternative viable option themselves (Gofen, 2012). In this context, to *birth outside the system* is an active and entrepreneurial decision to leave a service that is deemed unsatisfactory, and to create a viable alternative that services the women’s needs. The participants in my study chose to exercise their autonomy and to free themselves from being under the gaze of medical authority so they could choose for themselves what risks they were willing to take. Whether or not their choices are the safest is irrelevant, as explained by Wagner: ‘Doctors are human; birthing women are human. To err is human. Women have the right to have any errors committed during their birthing be their own and not someone else’s’ (Wagner, 2001, p. 26).

**Authoritative knowledge**

This section will discuss the concept of authoritative knowledge and how the participants disregarded obstetric authoritative knowledge around childbirth and elevated their own knowledge, according it the highest status. In this way, the participants valued their own
expertise above that of the socially accepted experts of birth, and they used this expertise
to make their own choices. The participants also used their expertise to strip obstetric
discourse of its power to define birth. For example, they substituted the term ‘failure to
progress’ with ‘failure to wait,’ essentially shifting the allotment of blame from
themselves onto their care providers.

Between the 1920s and 1970s, western medicine enjoyed a golden age of dominance over
pregnancy and childbirth, with its hegemony remaining relatively unchallenged (Willis,
2006). From the 1970s onwards, however, there was an increase in awareness of the
social, emotional and spiritual dimensions of health and wellbeing. Alongside this sat a
corresponding diminution of trust in medical authority (Benoit, et al., 2010). This cultural
shift also found expression in the consumer birth movement, which advocated for
natural birth methods and challenged the need for a doctor at every birth (Benoit, et al.,
2010). No longer cast as passive players, birthing women were reconfigured as active,
thoughtful and reflexive consumers (Zadoroznyi, 2001). This represented a move away
from the authoritative knowledge that had dominated childbirth for the majority of the
century.

Authoritative knowledge can be defined as ‘the knowledge that participants agree counts
in a particular situation, that they see as consequential, on the basis of which they make
decisions and provide justifications for their course of action’ (Jordan, 1997, p. 58).
Although authoritative knowledge is essentially subjective and thus not necessarily
correct, its power is that it counts (Jordan, 1997). In a medicalised context, ‘ownership’
(p.61) of the artifacts to manage labour displays who possesses the authoritative
knowledge, and consequently who holds the legitimate decision-making power (Jordan,
1997).
When the authoritative knowledge about birth rests with the medical establishment, the birthing woman turns to her caregivers for information about her wellbeing and that of her baby (Kitzinger, 2000). The woman defers to their expert knowledge to inform her about whether she and her baby are well and healthy. The mother’s reliance upon medical knowledge to determine her baby’s wellbeing negates and overshadows her own intuitive ability to know her baby (Kitzinger, 2000). Thus, the mother’s intuitive knowledge of her baby is diminished or rendered illegitimate by the medical establishment’s authority (Fleuriet, 2009). Unlike in clinical settings where medical practitioners are considered to have authoritative knowledge, in a social birthing context, the woman and her attendants are considered to be the authorities (Fleuriet, 2009).

Fleuriet (2009) contrasted conceptualisations of authoritative knowledge between U.S. midwives and their immigrant clients at a religious birthing centre in Texas. The midwives acknowledged that ‘pregnant women’s intuitions can be as powerful as, sometimes even more powerful than, information derived from medical technology.’ (Fleuriet, 2009, p. 219). Although medical knowledge has been legitimised as the source of power and authority, this is not the only way of knowing.

The ‘medical gaze’ was most prominently recognised in the work of Foucault, where certain conditions or behaviours are perceived through the prism of this gaze and that physicians may legitimately lay claim to all activities concerning the condition (Conrad, 1992). Under the medical gaze, certain cohorts within society are designated as either compliant or deviant, exhibiting good or bad behaviour. From a Foucauldian perspective, conformity to the medically defined norm is seen as good behaviour (Ballard & Elston, 2005). The decision to birth outside the system can be understood as a way of escaping the medical gaze. By rejecting the medical arena, the women can protect themselves from surveillance and control as they undertake what they perceive to be a normal
physiological bodily function. In the paradigm proposed by Foucault, escaping the medical gaze would categorise these women as social deviants. Nibbs (2011) argues that compliance with authoritative knowledge produces the good citizen (Nibbs, 2011), and therefore the repudiation of this knowledge designates citizens as deviant. Writing about deviance, Miller (2012) refers to women who freebirth as ‘doubly deviant’ – firstly because they have chosen homebirth, and secondly because it is unassisted (Miller, 2012). Women who choose freebirth, contends Miller, must reckon with multiple layers of stigma: not only are they assigned to an already deviant group, but by choosing homebirth, they are designated as further deviant within this group because they reject midwives as appropriate care providers. Argues Miller, this goes against the broader ethos of homebirth (Miller, 2012). The concept of double deviance also became apparent in my study, where some of the participants choosing to birth at home with risk factors explained that they could not understand the choice to freebirth as it seemed to them a more extreme level of birthing at home. This to them was unreasonable.

While the majority of western women are convinced that highly technical, hospital-controlled births will increase the likelihood of an optimal outcome (Records & Wilson, 2010), the participants in this study diverge from this mainstream view, and in fact believe the opposite. These women set themselves apart from the majority of women and see themselves as different because they refuse to buy into the messages of safety that are marketed about hospitals. The participants believe the safety of hospitals to be overstated and often false. Cohain (2012) states that ‘the belief that hospital birth for low-risk pregnancies has better outcomes than planned, attended homebirth is an urban legend. The choice of low-risk women to deliver in hospital is a result of the dominant and irrational human propensities to gossip, to follow the crowd and to cling to irrational hope’ (Cohain, 2012; p. 467). These viewpoints challenge and subvert western culture’s
authoritative knowledge about birth. The decision to shun medical management of birth constitutes a counter-cultural approach to decision-making.

When birthing outside of the system, women are not exposed to the medical gaze and may not have access to the socially acceptable expert who is seen to possess the authoritative knowledge about birth. As explained earlier, the participants of this study have avoided medicalised care for their births. They have therefore essentially shunned the prevailing authoritative knowledge on what is considered best and safest for themselves and their babies. As a result, the participants became the experts and considered their own knowledge to be authoritative. Indeed, the participants’ confidence in their own expertise may also have played an integral role in their decision to shun medicalised birth practices in the first place.

This research found that through the process of ‘finding a better way’ to birth, the participants simultaneously became the expert. Their expertise facilitated a reframing of medical discourse, stripping medical experts of the authority to label and define certain aspects of birth. The participants felt that becoming their own expert was outside the norm, and in doing so they were different to other women. They described themselves as ‘always bucking against the system,’ ‘taking responsibility,’ ‘investigating to make sure they know,’ ‘having the ability to know,’ ‘being entitled to choose’ and ‘being confident in their own ability to birth.’ These attributes were reified by the participants, who felt that many women lacked insight, knowledge and expertise around the issue of birth and birthing options. Because of this, the participants felt that they were different from the majority of women.
The concept of entrepreneurial exit was mentioned previously and described the process by which the women in this study demonstrated initiative to seek other options for birth. Gofen (2012) argues that an entrepreneurial exit embodies a transformation of the layman into a provider of a professional service, or what I have termed ‘the expert.’ Through this process, contends Gofen, the superiority and authority of hierarchical professional services are undermined (Gofen, 2012). Thus, in the context of birth outside the system, the choice to disengage with mainstream maternity services represents an entrepreneurial exit response that relies on the transformation of the woman into the expert, which simultaneously elevates her to an authoritative position.

Part of being the expert is using one’s authority to define terms. Correspondingly, the participants of this study challenged medical definitions of normal, believing them to be overly prescriptive and rigid. For example, a systematised approach to birth management describes an overly-long labour as ‘failure to progress.’ This phraseology pathologises the situation and indicates it for medical intervention (Maher, 2003). The women in this study challenged and reframed medical discourse about duration in labour and birth; rather than accepting the medical diagnosis of ‘failure to progress’ as a failure of their own bodies, they reframed this discourse to apportion blame to the hospital setting and its interventions. In this reframing, rather than expediting the process of labour, the clinical setting was seen to delay or stall it. The women also placed the blame for perceived unnecessary interventions on care providers, with one woman attributing her caesarean to her care providers’ ‘failure to wait’ (HB11).

**Conclusion**

In summary, the women in this study had a broad concept of safety that encompassed emotional, social, mental, spiritual and physical wellbeing. This concept differs from the
prevailing biomedical discourse about safety, which predominately focuses on maintaining physical safety. The women in this study chose to birth outside the system because, like most other birthing women, they wanted the best and safest for themselves and their babies. The women believed birth outside the system to be better and safer because it enabled them to avoid routine interventions, thus minimising the risk of a traumatic or unsatisfactory experience. In a medicalised context, birth outside the system is perceived as more risky than birthing in a hospital. The women’s perceptions represented a complete departure from this. They reported understanding the risks inherent in the labour and birth process and accepted that there was always a possibility that something could go wrong, regardless of where they chose to give birth. Believing that birth in hospital and at home carried their own unique sets of risks, the women carefully weighed these up as they considered their birthing options. Having chosen to birth outside the system, the women then took steps to mitigate the risks of birthing at home, remaining aware that they may need to transfer to hospital. The women understood that their beliefs about risk went against dominant societal and biomedical risk discourse; however, they chose to prioritise their own understandings of risk as they considered their birthing options.

Experiencing previous trauma or dissatisfaction during labour and birth was a predisposing factor that motivated women to consider birth outside the system. The experience of a traumatic birth experience is a growing problem in Australia, and feelings of disempowerment at birth contribute to this trauma. The women in this study reported that the experience of trauma is life changing, forcing them to make informed and considered choices for subsequent births. The women in this study chose to birth outside the system to avoid or heal from their previous traumatic experiences. Birth outside the system was attractive because many of the women believed that the behaviour of their care providers was the source of their trauma. By birthing at home, the women could select
who would care for them, thus avoiding further trauma. Birthing outside the system allowed the women to reclaim the control and autonomy that they felt was lost in their previous birth experiences. This decision was also a manifestation of the women’s confidence in their knowledge and ability to ‘know.’ Although birth outside the system is perceived to be an unreasonable option in broader cultural terms, the women in this study held their own beliefs and experiences as authoritative, and thus disregarded the dominant biomedical discourse about risk and safety.

The following chapter is the conclusion to this thesis. Implications for the future, recommendations for change, research limitations and recommendations for future research are all addressed.
Chapter Seven: Conclusion

In Australia today, women have very little choice but to birth in hospitals, where the process is managed as a medical event and interventions are routine. According to a recent study in 2012, even amongst the low-risk cohort, only 15% of first-time mothers in private hospitals and 34% in public hospitals in New South Wales had a normal vaginal birth without intervention (Dahlen, et al., 2012). For low-risk women, the options of publicly funded homebirth or midwifery-led continuity of care models are possible but very scarce, and the majority of women do not have access to these. Women with risk factors have little choice but to accept obstetric care as most hospitals do not have midwifery-led models for women of all-risk. There are very few options for women who wish to have a physiological birth and avoid unnecessarily intervention. Approximately 97% of Australian women birth in hospitals, so while the majority may be accepting of a medical approach to birth, there are a small number who are not. It is the experiences of women who seek to birth outside the system that I have explored in this study.

Homebirth and private practice midwifery are not well supported in Australia, not by society, hospitals, the media, policy makers, industry bodies or government. The politics around homebirth in Australia is complex, and is becoming more so as the legislative and regulatory parameters that dictate private midwifery practices become stricter and more difficult to navigate (Wilkes, et al., 2009). It is feared that the growing regulation around private practice midwifery and homebirth will deter midwives from practising or even registering (South Australian coroner, 2012). If fewer midwives continue to assist with homebirth, it is feared that more women will seek freebirth (Newman, 2008). The exact number of women who choose to freebirth is unknown, as these data are not captured by any existing data collection methods. Women who birth outside the system represent a
minority group, of which little is known in the academic literature and the reasoning behind the rejection of mainstream maternity practices has been poorly understood to date. This study goes some way towards filling this gap in the literature, moving us towards an understanding that women *birth outside the system* because they believe it is the best and safest for themselves and their babies when compared to other birthing options.

As demonstrated by the core category, women in this study chose to *birth outside the system* because they believe that this was the best and safest for themselves and their babies. A significant motivator to *birth outside the system* included a previous negative or traumatic birth experience in hospital. The women spoke of feeling assaulted, degraded, bullied and not listened to by their care providers. Women reported preferring *birth outside the system* because they saw it as a way to safeguard themselves from being traumatised again. Birth at home was perceived as offering all the elements of safety (physical, mental, emotional and social) that the participants valued, including a natural birth without intervention, keeping their family close and maintaining their autonomy.

Women who chose to *birth outside the system* are different to most women giving birth in Australia. The main differences lie in their philosophical perspective on birth and risk. From their perspective, birth is a normal event that requires the ideal circumstance. These are available in a home environment. Furthermore, birth is seen as a special event for the entire family that imprints on one’s life. This differs from mainstream perspectives, where birth is constructed as a medical event that should occur in hospital and be managed to enhance safety. Mainstream biomedical discourse around risk would suggest that interventions enhance safety in birth; however, the women in this study saw interventions as risky. They *birthed outside the system* as a way of avoiding this risk.
For many women, *birth outside the system* was not their first choice, but it became the best and safest choice when they discovered what their other options might be. The majority of women who chose freebirth in this study did so due to the limited options available in mainstream services. Most of the women did not actively choose freebirth, but rather were forced to consider it due to the absence of more acceptable birth options. This raises questions about the perceived standard of care provided to some women within the Australian maternity care system, and also the accessibility of midwife-attended homebirth.

The shortfalls in the Australian maternity care system were major contributing factors to women’s choice to *birth outside the system*, and to consolidating their belief that this was their best and safest option. It can be said that *birth outside the system* is an iatrogenic consequence of a maternity care system that does not adequately cater to the needs of some women (Dahlen, Jackson, et al., 2011). What is even more concerning is that these women consider birth in hospitals as dangerous to their own and their babies’ wellbeing. They believe they are taking less of a risk *birthing outside the system* than within it.

This group of women were not only highly educated, but also took their decision to *birth outside the system* very seriously. The women described the process of finding a better way as starting with a careful consideration of all of their birth options. They spoke of discovering a range of options that they had not thought possible. After investigating and weighing up all options, the women decided that *birth outside the system* would be the best and safest option for them and their baby. The women were aware that this choice was outside of the norm, and anticipated that they would need to manage the opposition that they would encounter.
The basic social process ‘finding a better way’ led women to become the expert of their own bodies, babies and birthing experience. This expertise developed inadvertently as the women investigated and planned for their birth outside the system. The women became so confident in their expertise that they began to perceive the authoritative knowledge of mainstream birth experts such as doctors as inferior to their own.

The women in this study understood safety as incorporating physical, mental, emotional and social dimensions. Accordingly, they felt that a social model of care facilitated these aspects of safety better than a biomedical model. They believed that birthing in hospital would increase their exposure to risks. They were aware that this belief system goes against the prevailing modern medical discourse. Despite this, the women accepted and weighed up the risks of their choice and took responsibility for the outcomes. The women developed their differing beliefs and perspectives largely as a result of their previous experiences with the system, which for the most part were disappointing or traumatising. In particular, participants wished to avoid care providers in the system, since care providers had perpetrated some of the past events that left these women traumatised. The choice to birth outside the system represented the reclamation of control, choice and autonomy that was lost in previous birth experiences. The women took it upon themselves to open up birth options that would facilitate their autonomy.

**Implications for the future and recommendations for change**

If the Australian maternity system does not change to better cater to the individual needs of women and provide evidence-based care, women will continue to birth outside the system. Government and political approaches that seek to limit women’s access to homebirth will only serve to further push many women out of the system. If the aim is to encourage women to be more accepting of existing maternity services, then maternity services need
to deliver a more satisfactory and acceptable service. A key to successful management of maternity care services is to satisfy consumers’ needs and expectations (Gofen, 2012). Efforts to humanise care, expand birth options and monitor freebirth statistics are therefore urgently required.

**Humanise maternity care**

Past experience of traumatising and disrespectful care was one of the major motivators for women choosing to *birth outside the system*. Therefore, humanising maternity care and providing respectful woman-centred care is needed to enhance women’s satisfaction with existing maternity care options. A move towards humane care is a move away from biomedical models of care. Moreover, humane care valorises the midwifery profession and prioritises social models of birth (Rattner, Abreu, Araujo, & Santos, 2009). The provision of humane care would require some maternity care providers to effect a complete philosophical shift in how they care for women (Rattner, Abreu, Araujo, & Santos, 2009). The 2014 National Institute for Health and Clinical Excellence (NICE) recommendations suggest that all care providers should create a culture of respect for each woman as she undergoes ‘a significant and emotionally intense life experience’ (p. 38), and to ensure that she is listened to, in control and cared for with compassion (NICE, 2014). If women are provided with a dignifying and compassionate experience in the system, they may be less inclined to choose *birth outside the system* for subsequent births.

Components of humane care include non-invasive practices, respect for women’s autonomy, providing evidence-based care, the valuing of family-friendly environments, a focus on relationships between the woman and her care providers, respecting the privacy of women and ensuring that they have adequate birth support (Rattner, Abreu, Araujo, & Santos, 2009). Humane care is thought to be key to preventing complications and emergencies during pregnancy and childbirth (Rattner, Abreu, Araujo, & Santos, 2009).
Humanising birth can be achieved in a number of ways, including the use of one-to-one midwifery care during labour and birth, women-centred care and reducing the use of routine interventions.

**One-to-one midwifery care during labour and birth**

Continuous care by a known provider has been shown to improve rates of spontaneous vaginal birth, reduce the use of pharmacological analgesia and improve infant outcomes. It also increases the likelihood of women reporting a satisfying birth experience (Hodnett, Gates, Hofmeyr, & Sakala, 2013). Implementing continuous care models will reduce the levels of disappointment and trauma associated with the birth experience. This in turn will likely minimise the need for women to consider *birthing outside the system*. The 2014 UK NICE guidelines for intrapartum care recommend that women in established labour be provided with one-to-one care and not be left on their own except for short periods with the woman’s consent (NICE 2014).

**Woman-centred care**

Allowing women autonomy in their birth choices and supporting them to have the birth that they believe is best and safest may help to protect the safety of women who choose high-risk homebirth or freebirth. One way to promote autonomy for birthing women is for practitioners to provide woman-centred care, which prioritises treating each woman as an individual and respecting her wishes (Brass, 2012). Woman-centred care in childbirth is a process in which the woman is actively involved, makes choices and has control over her care (Maputle & Donavon, 2013). If women can be provided with woman-centred care, they may have a more satisfying first birth, preventing them from considering *birthing outside the system* for subsequent births. In addition, if a woman who has chosen to *birthing outside the system* knows she will receive woman-centred care while
attending her GP or local hospital, she may choose to access timely and necessary medical care when needed. Providing this type of care means that maternity care providers cater to the woman’s needs and desires by respecting and facilitating her choices. This may also require providers to exercise a certain flexibility and latitude in relation to hospital policy and procedures. The 2014 NICE recommendations suggest that care providers ensure that the woman is involved and in control of what is happening to her (NICE, 2014). Key aspects of woman-centred care include providing education to promote informed consent (Maputle & Donavon, 2013), while also allowing space for informed refusal as an acceptable option.

**Reduction in routine interventions**

A major source of dissatisfaction identified by the women in this study was the number of interventions used in hospitals to manage birth. The women were opposed to the use of unnecessary interventions, and many chose to *birth outside the system* in order to avoid them. Davis-Floyd et al. (2009) argue that the overuse of intervention is a hallmark of birth models that do not work (Davis-Floyd, Barclay, Daviss, & Tritten, 2009). Bringing hospital-based maternity services into line with current evidence may serve to make hospital birth more acceptable and reduce the number of interventions women and their babies experience during labour and birth (Davis-Floyd, Barclay, Daviss, & Tritten, 2009). Major interventions that are unsubstantiated by evidence include routine vaginal exams (Downe, Gyte, Dahlen, & Singata, 2013), continuous CTG where there are no risk factors (Alfirevic, et al., 2013; NICE, 2014), the use of supine birth positions (Gupta, et al., 2012; Priddis H, et al., 2011), repeat caesarean for VBAC (Dodd, Crowther, Huertas, Guise, & Horey, 2013), restricting maternal food and water (Davis-Floyd, Barclay, Daviss, & Tritten, 2009) and early cord clamping (McDonald, Middleton, Dowswell, & Morris, 2013). Basing hospital policy on evidence, and undertaking regular audits of compliance,
may reduce the number of interventions used. Providing more access to homebirth with a midwife and the option of midwife-led units would also be an effective way of reducing unnecessary interventions (Birthplace in England Collaborative Group, 2011).

**Expand birth options**

The women in this study found mainstream maternity care in hospitals to be unsatisfactory; however, not all of the participants wished to *birth outside the system*. Some explained that if they had access to midwifery-led birth centres, publicly funded homebirth, a private midwife or continuity of care with a midwife, they might have chosen one of these options instead. In order for women to access the model of care and location that they believe is best for them and their baby, service providers need to offer a wide variety of options within the system so women are not forced to *birth outside the system*. There are a number of birthing options that are safe and evidence-based and do not require women to birth in hospitals (Birthplace in England Collaborative Group, 2011; Hodnett, Downe, & Walsh, 2012).

**Publicly funded homebirth**

In Australia, the prevailing belief is that homebirth (even in the most ideal circumstances) is more dangerous than hospital birth. This is not supported by research. For example, the 2014 NICE guidelines have provided advice that it is safe for low-risk multiparous women to give birth in a midwifery led unit (free standing or along side) or choose homebirth, since these options offer fewer interventions and present no difference in perinatal mortality and morbidity (NICE, 2014). According to these guidelines homebirth may carry slightly more risk than midwifery led units (particularly for primiparous women), however, is still considered a suitable and safe birth choice.

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2 The NICE guidelines were still in the draft phase and were out for consultation at the time of this thesis being written.
Although publicly funded homebirth is available in some states and territories in Australia, to date there are only 12 such services across the country. There is a need for this option to be expanded so women are able to access homebirth that is affordable and where midwives can be adequately insured. The submissions to the 2009 National Maternity Review (NMR) also mirrored women’s desire for funded homebirth, either through the private sector, covered under Medicare, or publicly funded homebirth services through hospitals. The submissions suggested that by allocating funding to these options, women would more readily take them up, as cost would no longer be prohibitive (Dahlen, Schmied, et al., 2011). In addition, recent research into outcomes of Australia’s existing homebirth programs has been encouraging (Catling-Paull, et al., 2013), so expanding this option may be feasible and beneficial in the Australian context. New Zealand provides free maternity care to women choosing midwives, even if they choose to birth at home. Given the high levels of satisfaction expressed by the women who utilise these services, this is a model that Australia could emulate (Grigg & Tracy 2013). Furthermore, the Dutch maternity care system has shown that providing homebirth on a large scale is safe and feasible, with around 20% of the births in the study occurring at home and with good outcomes (De Vries, Wiegers, Smulders, & Teijlingen, 2009)

**Birth in standalone or alongside midwifery units**

Some women in this study had previously given birth in birth centres because they saw this option as a middle ground between homebirth and hospital birth. Although they were initially open to this as a suitable option, after their experiences they chose not to return. Most birth centres in Australia are annexed to or inside a hospital, with very few standalone birthing units run by midwives. Walsh (2009) suggests that the small-scale approach to birth provided by birth centres and smaller midwifery units, provide women with a reprieve from the production line mentality of larger birthing units. Furthermore,
such units also allow midwives to provide care that facilitates the involvement of family (Walsh, 2009). Similarly, the NICE guidelines recommend that women plan to give birth in midwifery-led units (standalone or alongside a hospital) because they will experience fewer interventions, and because outcomes are no different than if they birth in obstetric units (NICE, 2014). Hodnett et al (2012) also concluded that birth centres are associated with lower rates of intervention and higher levels of satisfaction, with no increased risk to either mothers or babies (Hodnett, et al., 2012), making them an attractive alternative to obstetric hospital care.

**Midwifery-led continuity of care**

As detailed in the background section of this thesis, midwifery-led continuity of care has better outcomes for mother and baby compared to standard fragmented care in hospitals (Sandall, 2012). Under midwifery-led continuity of care, women experience fewer interventions, greater satisfaction, positive birth outcomes and a heightened sense of confidence and achievement (Fahy, et al., 2008; Homer, et al., 2008; Leap, et al., 2010; Sandall, et al., 2013). Continuity of midwifery care is also cost effective (Tracy, et al., 2014), and it has been successfully expanded in New Zealand (Grigg & Tracy 2013). Models of care that maximise partnership and relationship-based care need to urgently be expanded in Australia.

**Midwifery care for high-risk women**

A major problem in Australia is that women with risk factors have little choice but to birth in a high-acuity setting under obstetric care, or else birth at home with the assistance of a midwife who risks being reported to the regulatory body if an adverse event occurs. Providing other options – such as continuity of midwifery care – for
women with risk factors will broaden the possibilities, and lessen the sense that women are faced with an either/or quandary.

An Australian study published in 2013 reinforced the benefits of a midwifery continuity of care model for women of all-risk levels (provided that a collaborative approach to care is prioritised). The randomised controlled trial included all-risk pregnant women, who were randomised to either standard care or caseload midwifery care (under a continuity model) (Tracy, et al., 2013). The authors concluded that ‘for women of any risk, caseload midwifery is safe and cost effective’ (p. 1723). The authors encourage other maternity care providers to consider adopting this collaborative model, as it would allow higher-risk women to have access to midwife-led care (Beasley, Ford, Tracey, & Welsh, 2012).

**Access to VBAC**

Access to VBAC was a significant contributing factor to women’s choice to birth outside the system. Some women birthed outside the system because their local hospital did not offer the option of VBAC. Women who did not want a repeat caesarean section had no choice but to travel the distance to a hospital that would provide the option of a VBAC, choose a private midwife to attend them at home, or opt for freebirth. Furthermore, policy restrictions around VBAC in hospital, such as requirements for continuous electronic fetal monitoring and venous access, deterred some women from giving birth in hospital. If more women were offered the option of VBAC, and if policies regarding care during labour were rendered more flexible, women may be more willing to accept mainstream maternity care.

**Enhanced support for private practice midwifery and private homebirth**

The majority of women who chose to freebirth explained that they felt backed into a corner and forced into this situation by the fact that there were no other acceptable
options. One way to cater to these women would be to ensure that women have greater access to privately practising midwives (Newman, 2008). Australia needs to make practising as a private midwife less daunting, encouraging more midwives to pursue this professional path. Currently, there is a great deal of cultural and medical hostility towards, and political unrest around, private midwifery practice. As a result, midwives are giving up practicing. Therefore, women who want a midwife at their birth are experiencing difficulty locating an appropriate person. Furthermore, vexatious reporting of private midwives (by other maternity care providers) to legislative authorities is making midwives scared to refer complex cases, rendering the practice of private midwifery less safe for women. Policymakers, regulators and government should be making private practice a more welcoming option for midwives by, creating a supportive environment, facilitating access to hospitals, providing adequate professional indemnity insurance and offering adequate medicare funding.

Encouraging women to birth inside the system cannot be achieved by a heavy-handed approach. Rather, providing women with what they believe is the best and safest (in this context, trained registered midwives to attend them at home) will reduce the numbers of women who choose to birth outside the system.

Monitor freebirth statistics

Freebirth rates are not captured easily in current data sources. In the future, it would be ideal to record the numbers of women having freebirths. This would allow monitoring of variability across geographical regions, and to determine whether rates are changing over time. If birth outside the system is an indication of women’s dissatisfaction with mainstream maternity care options, then perhaps as maternity care evolves in a positive direction, the
number of women planning freebirth will reduce. Currently, however, there is no way to assess this due to the lack of accurate data.

**Research limitations**

The limitations of this research include the fact that it was undertaken in Australia so may not be generalisable to other countries. The Australian context differs from some other countries, as homebirth and private practice midwifery are poorly supported by the Australian health care system and transfers to hospital often met with hostility. Aboriginal and Torres Strait Islander women were not interviewed for this study and are a faction known to avoid mainstream services.

Women who chose to *birth outside the system* and experienced poor perinatal outcomes were not included in this study. As all the participants had a live and overall healthy baby, this study is unable to provide insight into the thoughts of women who experienced adverse outcomes. Ultimately, it was the aim of this research to discover what motivated women to choose to *birth outside the system*. Therefore, the actual outcome was not the focus. However, interviewing women who had experienced a poor outcome due to their choice to *birth outside the system* may have added depth to the findings.

**Recommendations for future research**

This research on *birth outside the system* has produced an overall theory of why women in Australia choose a homebirth with risk factors or a freebirth. Further investigation into why women with particular risk factors such as VBAC choose to *birth outside the system* should be prioritised in the future. Understanding which interventions women are wanting to avoid most and why would also be useful in helping service providers better cater to women and to deliver care that is more acceptable.
There is little research into outcomes for women and babies following high-risk homebirths or freebirths. The current understanding around this issue is that women should be low risk when planning a homebirth, as this has been shown to facilitate good outcomes. However, what is not known is which risk factors, if present during a homebirth, produce poorer outcomes then if the birth was to occur in hospital.

As already discussed, women whose babies had died during their birth outside the system were not included in this study. Several of these women were identified during the research process, as these cases are often highly publicised. However, including these women in a research project is complex due to the their vulnerability, which raises ethical concerns. There is also the fact that these women may be identifiable. A study including women who have had an adverse event would add further depth to our understanding of birth outside the system. It would be helpful to investigate, for example, whether women’s views were shaped by the loss of a baby in these situations.

An epilogue – my birth outside the system

In the third year of my doctoral candidature, and soon after presenting my research at a conference in July 2012, my husband and I set off on a two-week holiday to celebrate our tenth wedding anniversary. The relaxation must have done me good because soon after our return, we discovered we were pregnant. Being a homebirth midwife, it was an easy decision for me to choose a homebirth. I set about hiring a private midwife to look out for me and my little ‘Charlie,’ but mostly, I worked hard at looking after myself. I believe that being as healthy and as low-risk as possible bodes well when planning a homebirth. I personally felt that homebirth would allow me to be cared for in the best way possible, because I would be able to decide what monitoring I may or may not want,
and I would not have the mental or emotional burden of dealing with care providers who
did not see things my way. I loved that when I made an appointment with my midwife,
she saw me at the time we planned and made me a cup of tea. There was always easily
accessible parking and her times were flexible to accommodate our family’s work
schedule.

Despite some nausea, tiredness, ligament pain, early spotting and persistent thrush, my
pregnancy progressed well with only minor complaints. I consulted frequently with an
osteopath to keep my body well and balanced, and religiously took my supplements. I
went off coffee and sweet foods. I ate well and felt no regrets about how diligently I was
caring for myself and my baby. My education as a naturopath and midwife informed my
approach to pregnancy care. I started ‘showing’ very early and my midwife thought I
might have twins. I decided not to have any early scans, fearing what it might do to my
baby, and decided to wait until twenty weeks gestation to discover what exactly was
going on in there (but I really knew I wasn’t having twins!). I felt an intuitive connection
to my baby, and a few days after discovering I was pregnant, I confidently told my
husband that ‘we are having a boy and his name is Charlie, because it’s a fun name and I
can already tell that this little guy is going to be crazy.’ At seven weeks, I started
experiencing a little bit of spotting which cleared after a weekend of rest. I started
spotting again at 15 weeks, and after three days decided it would be nice to know what
was going on in there. I reluctantly took myself off for a scan to determine the source of
the bleeding, but was also a little relieved because I would know for sure whether or not
I needed to be worried. Deep down I knew that my baby was ok, I really did, I could
already feel him kicking, but the midwife in me could not stand the ambiguity of waiting–
I needed to know if this bleeding was serious, or nothing at all. I also wanted to put my
mental energy into directing my body to stop the bleeding, but I didn’t know what to tell
it to do without knowing the source of the bleeding. In the end, the scan showed no known reason for the bleeding and our lovely baby and placenta were fine. I declined a speculum to assess my cervix, feeling that it was an unnecessary risk to start aggravating my cervix if I was already bleeding. I suppose it was at this second bleed that my ‘high-risk’ journey started, since I had engaged with the system to evaluate a complication in the pregnancy. Additionally, although some might say that my low body mass index (18), short stature and history of polycystic ovarian syndrome also put me into a higher-risk category, I didn’t see these as risk factors at all.

I had a feeling all along that my little Charlie boy would be born early, right from the beginning I was telling him to ‘stay inside till you are ready, don’t come too early.’ At 16 weeks, one of my midwifery colleagues shared with me a story of one of her clients whose waters broke at 16 weeks. Hearing this had a strong effect on me; I felt so paranoid that the same thing might happen to me. I kept telling Charlie, ‘don’t break your waters, stay inside little one.’ After an uneventful second and third trimester (despite a scare with a client who had an active CMV infection), my husband and I moved into our very nearly finished new home when I was 35 weeks pregnant. I was adamant that we needed to move before 36 weeks, because I knew that our little one would be born early, so I was persistently pushing the builders to finish more quickly. I spent the week unpacking and feeling very tired and pregnant. I had been experiencing tightenings since very early in my pregnancy, although they were never painful. At about 36 weeks and 2 days, I started getting some slightly painful tightenings, and this made me think that maybe labour wasn’t too far away. Amidst the madness of moving house, however, I didn’t really have much time to dwell on it. At 36 weeks and 4 days, I awoke at 2.30 am with painful tightenings, I thought not much of it and went back to sleep, but they continued to come so I decided to time them – regularly every 10 minutes and pretty
soon, every 5 minutes. My husband went off to the gym at 5.30 am and I asked that he keep his phone close. At 6.30 am, I called him and asked him to come home because things were heating up. I texted my midwives to tell them what was happening and reminded them that I was 36 weeks and 4 days (pre-term), and asked how they felt about persisting with a homebirth. They both commented that it was fine with them so long as it was fine with me. It was totally fine with me; I always knew that he would be ready to be born early – I knew he was ready and I knew he was fine. Birthing a pre-term baby at home would have also placed me in a high-risk category.

My labour proceeded for another 37 hours, with many peaks and troughs including eight hours without contractions when I was fully dilated (this would have most certainly placed me in a high-risk category in hospital). During my labour, I had thoughts of what might happen if the contractions didn’t start again. I couldn’t go to the hospital, not after such a long labour with a pre-term baby, and having had none of the screening they would have normally expected of me. I was worried about what would happen to me if I didn’t start contracting some more. I mentally went through the scenarios in my head, and I also thought through what might happen if I presented at hospital. The best-case scenario would be that they gladly agree to augment me with a bit of syntocinon, and that soon after, I would push my baby out and go home. But then I took myself to the worst case scenario – when I arrive at hospital, they will probably freak out because I did not do a GBS swab or a glucose tolerance test or follow-up blood tests; they will give me grief over the vaginal exam and admission CTG that I would most certainly decline when I arrived, and that they may be somewhat concerned with the length of time I had been labouring with a pre-term baby, and may or may not decline to give me an augment and suggest a caesarean section instead ... Nope, I most certainly was not going to hospital. I knew that my baby would be born small, and that they would whisk him away from me
immediately for observation in special care. He would have a nasogastric tube and blood sugar tests, they would give him vitamin K and not allow me to cuddle him through fear that it might make him cold or tired and mess up the readings on their heart rate and oxygen monitors. Nope, I was not going to hospital! I couldn’t, it felt the wrong thing for my baby – I had other plans, better plans. I was going to push him out of my vagina, feed him regularly, have uninterrupted skin-to-skin and kangaroo care for at least a week, and he would be sleeping with me. So, what was I going to do, since I had virtually no contractions?

By midday, I was fully dilated with no contractions or urge to push. I had been in labour for about 31 hours. My little baby was doing fine, I was doing fine, my membranes were intact and all of our observations were perfect – there was no need for a hospital transfer but my midwife told me, ‘you need to have this baby soon, Mel,’ I knew I did too. She suggested a walk, so I reluctantly allowed my support people to get me dressed and do my hair ... I climbed the 25 stairs to access the road from my house and walked for an hour through the lovely sunny streets of the Blue Mountains, but didn’t get one contraction! It was at this time that we decided to call an acupuncturist, and long story short, within three hours I had my baby in my arms. My tiny, perfect, 2.3 kg baby was finally here. By way of protocol, my midwife informed me that had I birthed in hospital, my baby would have been admitted to special care nursery. We smirked at each other and I politely declined transferring to hospital. He slept with me and I watched him through the night. I fed him hourly, giving some expressed breast milk via a syringe to keep his blood sugar stable. For the next three weeks, I kept him skin-to-skin with me and his daddy in a wrap, and didn’t get him out for anyone. He gained 350 g a week and thrived. He got jaundice, but we managed this with sunlight and regular feeds.
As a midwife, I believe in low-risk women having homebirths. Before starting this research, I felt I had nothing in common with the women I would be interviewing, and I had no idea what to expect as I interviewed them. By the end of the research process, I understood their perspective and could see the logic behind their decision. Hearing their stories, however, had no bearing on my decision to birth outside the system and have a ‘high-risk’ homebirth. Rather, I genuinely felt that I knew what was best for me and my baby, and that birthing at home would be the safest for us both. I can now say that while I gained an understanding of the participants’ perspectives and philosophies through the research process, after having my own baby I can feel their experiences also. I felt the fierce protective instinct for my baby, I trusted my intuitive knowledge about the health of my baby, I felt the fear of the unknown if I went in to hospital and what they might do to me, I experienced what it was like to have respectful, empowering care and the amazing freedom of being in control of my birth.

I am so glad that I birthed outside the system, it was the best and safest for me and my baby, and also for my husband who loves, nurtures and cherishes our son with the most blissful joy. Knowing what I know as a mother, a homebirth midwife and a researcher, I can cite thousands of reasons why my birth outside the system was the best and safest for me and my baby. Even though the findings for this research were complete before I had my baby and I was confident then that the findings were accurate, now I know with true certainty that women birth outside the system because they want the best and safest for themselves and their baby.
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Appendices

1. The Participants – a summary of their stories

Summaries of the stories of the women who were interviewed have been provided here. The stories are a representation of their experiences and have been slightly altered to protect the confidentiality of the women who participated. The maternity review submissions have not been included as these are public documents and consent to reproduce them in this thesis has not been sought by the women who submitted to the NMR. Their stories have however been used and analysed as data.

High-risk Homebirth 1

This participant had three children at the time of her interview, the first born in a birth centre which was an uncomplicated birth but she was disappointed by the midwife who was grumpy and distracted from her job and who had her birth on her back using coached pushing; she reported that she didn’t feel listened to. Wanting something different next time and not wanting to leave her first child she pursued homebirth for her second child. Her risk factors started at 35 weeks with premature rupture of membranes. She declined care offered by the hospital and pursued natural therapies to avoid ascending infection. She went into labour at 36 weeks and 2 days and planned to birth her pre-term baby at home. Knowing her baby might be born prematurely, this woman researched and made preparations to provide kangaroo care at home. When questioned about her risk status she commented that regardless of birth place, being born early is a risk and the thought of interventions at birth, the baby going to special care and leaving her other child at home felt more dangerous to her than the option of homebirth. With reference to premature rupture of membranes she decided to stay home where she felt her risk of infection was less. Her baby was born at home without complication but ended up in hospital a few days after the birth with Jaundice. Her time
at hospital was described as a horrible experience as she battled with the conflicting approach to care offered to her and her baby. Despite her second baby going to special care, she also chose to birth her third baby at home.

**What motivated you to birth outside the system?**

Instincts and lack of interference and I believe it was an educated decision, it was an educated choice and my education went against the hospital’s protocol, what I’d learnt went against their protocol.

**High-risk Homebirth 2**

At the time of interview this woman was 36 weeks pregnant with her 3rd baby and had been getting irregular contractions since 32 weeks. Her risk factors were history of anemia, asthma, severe vulval varicosities and previous pre-term births. At the time of interview she was planning to have her third (potentially pre-term birth) at home. Her two previous babies were born prematurely in a private hospital under the care of an obstetrician, the first spending 4 weeks in special care after an emotionally traumatic birth. This woman described not being listened to and belittled during labour and not having control over what was done to her baby afterwards. She experienced severe depression following this experience. She had her second baby in hospital after being unable to convince her then-husband to agree to a homebirth and after a similarly disappointing experience decided to birth her third baby at home, even in the event of prematurity.

**What motivated you to birth outside the system**

Before I was pregnant the reason would be that I just didn’t want to have to argue with anyone while I was in labour again ... I couldn’t do it again ... I just want to be left alone, pretty much that’s my main reason ... you just have so much more support and control at home and its, it’s not like I would suggest anyone else do that in that situation because they don’t have the same knowledge, yeah its just, I want that choice myself, given my
circumstances and my knowledge. And its all and individual thing.

High-risk homebirth 3

This participant worked in a hospital as a midwife and hired a private midwife to help her have her first baby at home. After developing gestational diabetes and being heavily pressured and bullied by the hospital she worked at, she relented and went in for an induction, as per the protocol for women in her circumstance. After a traumatic experience in the hospital and being abused by the hospital staff, this woman decided her second baby would be born at home. She regretted not listening to her instincts and staying at home as she knew her baby was fine, and he was. This woman was so negatively impacted by her birth that she sobbed through much of the interview.

What motivated you to birth outside the system?

I just wanted to have a nice birth at home, just, it just appealed to me, it was natural, and I guess I never really saw myself as having a problem.

High-risk homebirth 4

This participant was considered high-risk because she had two previous caesareans, which she now believes weren’t medically necessary, she had one for breech and the other after a long labour and ‘slow progress.’ In order to prevent a repeat caesarean section, which is what the hospital offered her, she hired a midwife to assist her to birth at home, feeling that this would be her best chance of having a vaginal birth. At the time of the interview she had birthed her third baby vaginally at home and required transfer to hospital soon after for respiratory distress in the baby. The experience she had in hospital with the special care nursery reiterated to her why she had chosen to birth at home in the first place as they did not feel they were treated well and were not confident that the hospital properly cared for the needs of their baby or the mother adequately. She expressed no regret at her choice even though she transferred.
What motivated you to birth outside the system?

To avoid another caesarean. Yep, that was the big, well to avoid an unnecessary caesarean, I would have done it if I’d had to, but yeah.

High-risk Homebirth 5

This participant was pregnant with her fourth child at the time of the interview – she was approximately 40 weeks pregnant and planning a homebirth with a midwife friend of hers. She was also seeing an obstetrician to manage her clotting disorder, which had caused her a previous fetal death in utero. This participant was a midwife herself and acknowledged that her risk factor required her to have specialist care during pregnancy. One of her previous children had been an induction, a procedure which traumatised this woman due to its intensity and poor treatment from maternity care providers. She chose to birth at home due to her previous disappointing experience.

What motivated you to birth outside the system?

I think it was wanting to be in control of my own birth and delivery, and I think a big part of being in control was feeling safe. So in an effort to want to make my own choices and to be in control and to feel safe, and like the decisions were truly mine and the decisions that are the best for not just you and not just your baby, not just your husband, but just the whole picture. It’s what’s best for me and this baby and my other children and my husband, its wanting the best and to get the best I feel like I need to be in control and for me to be in control and to be safe means I need to be at home, well it seems to me to be the most logical place to be is home, where I can control who comes and goes and what decisions I make.

High-risk Homebirth 6

At the time of interview this woman had birthed her third baby at home after two previous hospital births. Her homebirth was high-risk because her baby was presenting breech. Her first birth was uncomplicated but due to pressure from staff she took pain medication, which she didn’t really want and she felt like she was treated as an inconvenience. Her second birth at a birth centre with continuity of care which was a
very positive experience. This gave her confidence to pursue a homebirth for her third. After discovering that the baby was breech, and that her local hospital would only offer her an elective caesarean, she decided to persist with a breech birth at home and did so.

**In a nutshell what motivated you to birth outside the system?**

Well prior experience, like having two births before, feeling very confident that I could easily birth this baby, being informed through all the relevant research that breech is really, while it is deemed by hospitals to be high-risk, it's actually just a different version of normal and complete confidence in my carers and my midwives and my support team.

**High-risk homebirth 7**

This participant was pregnant with her third child at the time of interview and was planning a homebirth after two previous caesareans. Her two previous experiences, she explains, made her lose faith in the hospital system and she was going to pay for someone to not touch her in a way she didn’t want to be touched for her third birth. She felt confident to birth at home because she perceived the risks of VBAC to be lower than the hospital perceived them to be.

**In a nutshell what motivated you to birth outside the system?**

To have a better experience and to encourage a healthier after birth experience, to lessen the risk of anybody getting sick.

**High-risk homebirth 8**

At the time of interview this woman had had her fifth baby at home and was considered high-risk because of a previous caesarean for twins, two previous post partum haemhorrages, low platelets and GBS positive for her homebirth pregnancy. She had had previously positive births but when she approached the birth centre where she had her last baby to care for her again for this pregnancy she was disappointed with the amount of conditions put on her care so changed her mind and chose to birth at home instead.
where she could make the decisions and be in control of what was done to her.

**In a nutshell what motivated you to birth outside the system?**

I didn’t consider the risks as high as they did. The risks and the research I’d done, the information I had and the doctors I’d seen or one doctor I’d seen, I wasn’t high-risk...so it felt like the right thing to do. I wasn’t trying to prove a point it just felt like the right thing to do considering everything we’ve talked about and the family and where we live and I did want to have that experience of being just in my own space with labour.

**High-risk homebirth 9**

At the time of interview this woman, who was also a midwife had birthed her first baby in hospital and had a disappointing and traumatizing experience which ended in a caesarean section. She was included in this study because she reported that she wanted to birth her next baby at home and have a VBAC. At her first birth she felt she was not listened to, didn’t have control and was a victim of a cascade of intervention.

**In a nutshell what motivated you to birth outside the system?**

Well it was the past trauma – and I fully feel like it was trauma

**Homebirth 10**

This woman was interviewed while heavily pregnant with her second child. She didn’t specifically fit the criteria of being high-risk but defected from a hospital homebirth program to an independent midwife through fear that if she developed risk factors she would be booted off the program and stuck having a hospital birth. Furthermore, she wished to decline some antenatal screening tests which she knew would see her ineligible for a homebirth through the hospital program. Due to the strict criteria of hospital homebirth programs this woman (although initially accepted to the program) decided to birth outside the system because she didn’t trust that the hospital would still provide her with their service on her terms.
High-risk homebirth 11

This participant was not pregnant at the time of interview but stated that if she should become pregnant with her third she would like to have a homebirth. Her two previous births were with a private obstetrician which both ended in caesareans which she now feels were unnecessary. The second pregnancy was induced despite being a VBAC, which this woman now feels put her at increased risk. Both caesareans caused her long term side effects and discomfort with reoccurring wound infections and postnatal depression which she attributes to her birth and postnatal experiences. This woman was traumatised by her previous two experiences and sobbed through much of her interview. She wanted a homebirth next time to avoid having such a negative experience again and is very angry with her obstetrician for the events that unfolded at her last births.

In a nutshell what motivated you to birth outside the system?

Because I want to experience, I want to deliver a baby naturally, beside from experience, but also because I don’t want the after pain, I would rather have the pain there and then, and maybe have stitches but I don’t want the stomach pain like I went through with the caesarean with the infection and the UTIs and all that. I also want to be mobile and be able to pick up my other child. I couldn’t do that for six weeks, I want to be able to drive, I want all the freedom after the birth. Yeah I don’t want the intervention of any doctor, I don’t want a doctor anywhere near me unless it was absolutely necessary. Yeah I just want to be in my own home and going to sleep in my own bed, their beds are not very comfortable. Yeah, I just want everything to be available that I need and just be more happy.

Freebirth 1

This participant had chosen to birth her first baby in a birth centre and experienced which she described was a truly traumatic experience which left her with post-traumatic stress symptoms. As a direct result of this birth and the resulting caesarean section she decided that she could not return to hospital to birth her subsequent babies. In the absence of any suitable midwives in her locality that would attend her at home, she
decided that her next best option was to freebirth with a doula. Her first freebirth occurred in a relatively uncomplicated manner, her second resulted in a severe postpartum haemorrhage which required transfer to hospital. Her hospital experience was marked by respect from the staff to her requests and she felt very much in control of what was done to her. This experience was healing for her and seemed to reverse the trauma of her first birth where her wishes were not respected.

**In a nutshell what motivated you to birth outside the system?**

Disempowerment and re-empowerment, that’s pretty much it for me, that, going from such a traumatic experience and the impact it had on me as a mother and my ability to care for my child was so greatly disabled that I had to find a better way. And knowledge, like once I started reading about what birth could be like, and you know learning about all the hormones and the physiology and the way the body works and everything, it just, that, I just feel like there wasn’t – you know, birthing at home as a high-risk person, that was for me, learning and then there was really not another choice I could have made. And because they also weren’t allowing VBACs at my local hospital when I was pregnant.

**Freebirth 2**

This participant birthed her third baby with a midwife at home, when pregnant again she found that she could not access a midwife in her area and would be unable to afford one anyway. She also felt that she would likely birth before the midwife arrived and so felt forced to freebirth given her circumstances. Birthing in hospital was not an option in her mind based on her birthing philosophy and having already birthed in a birth centre for her first two. Her first two births were too interventionist for her liking which is what led her to homebirth in the first place. After then not being able to access a homebirth midwife, freebirth felt like her next best option.

**In a nutshell what motivated you to birth outside the system?**

I think it was the lack of homebirth midwives that kind of forced me to consider it and then when I considered it I embraced it.
Freebirth 3

This participant had had three babies at the time of interview. Her first was a caesarean section due to fetal distress from an induction of labour. She is not fully convinced that the baby was really in distress. Her second was a homebirth through her local hospital homebirth program which at the time was allowing VBACs at home. This was uncomplicated and went very well according to the woman. At the time of her third pregnancy this woman returned to the hospital homebirth program to book in with the same midwives who had attended her second birth. She was turned away from the program on the basis of her first caesarean as they were no longer allowing VBACs. Knowing there were no private midwives who serviced her area she fought with the hospital to allow her to have care by their midwives but they would not allow it. Based on the success of her last homebirth she decided she would freebirth her third baby. She felt confident to do this because she lived 2 minutes from the hospital. In labour she called her previous midwives to see if they would come and attend her. They told her that the hospital would not give them permission to come and they would lose their jobs if they attended. They suggested that she call them once the baby was born and then they could come because that would count as a postnatal visit. Her baby was born healthy and well at a freebirth, with a midwife present to supervise the birth of the placenta.

In a nutshell, what motivated you to birth outside the system?

Because we couldn’t, in a sense we were backed into a corner, because really the – I wasn’t allowed to choose, and I guess really what I was doing was exercising my right to choose, because the thing was is that we were backed into a corner, basically the obstetrician and the hospital said, no, you are a VBAC you will come to hospital and I guess, not that we said it but I guess in a way what I was saying was, no, I’m not a VBAC, I’ve had my VBAC, I’ve already proven that I can birth vaginally, I’m lower risk, I’ve had a healthy normal pregnancy.

Freebirth 4
This participant birthed her first baby in a birth centre. This experience was disappointing for her after a difficult postnatal experience where she was very disappointed with the postnatal care, hospital facilities and services and the attitude of the staff. After reporting that her hospital experience made her feel emotionally unsafe, she opted for a homebirth for her next birth. After looking into homebirth she realised that this would not be an option for her because she could not afford a private midwife and the local hospitals did not have homebirth programs. She decided to have antenatal care at the hospital and then birth at home unassisted as the next best option to having a midwife attended birth.

**In a nutshell, what motivated you to birth outside the system?**

My body, my baby. My experience. My choice. It was the right place to be, it was the right place for me to be. Can I just say that following the birth at home and in the water I felt so empowered, it was night and day, it was just so amazing, I was just, I just felt so incredible and we’ve got some photo’s of me like after having him, just a few minutes old and I just look, the photo’s are just so joyful, it’s just beautiful and it was so the right thing for us to do, the right thing for me to do, for my baby.

**Freebirth 5**

This participant is a midwife and had very strong feelings that the hospital system is not the ideal place to have a baby and felt strongly that many of their routine practices are dangerous. This participant had a homebirth for her first baby and then went on to have three freebirths. This woman reported that her homebirth was wonderful and therefore she felt no need to hire a midwife for the subsequent pregnancies and commented that she now feels women do better without a midwife present.

**In a nutshell what motivated you to birth outside the system?**

Um just my own empowerment, completely and utterly in my own power as a woman, as a birthing goddess I don’t need someone else there to tell me if it’s okay or not, because it is okay, we’ve got an innate ability to birth, I don’t need someone to help me do it.
Freebirth 6
This participant had originally planned to have her first baby in a birth centre but quickly opted out of this service as she realised they were not willing to be flexible with how she would like her birth to be managed. She then hired two midwives to attend her homebirth. After a positive first experience she also hired a midwife for her second birth. This second birth occurred quickly before the midwives arrived and gave this woman confidence to pursue freebirth for her next two births.

In a nutshell, what motivated you to birth outside the system?

I just had really wonderful experiences of birth preceding those decisions. I had two really beautiful instinctive births with my first two children and I just really felt that that gave me incredible grounding and I just saw my own capacity and power to give birth and I just saw that the improvement on my experience was to simplify that process for myself and just focus on what was needed and what wasn’t needed and largely my midwife wasn’t needed in both my other births… I think it was just a progression… I just took care of it myself with my family and everything was well and birth – I think we were just very fortunate to just experience birth as simply as it can be, I think we complicate the whole situation to be honest and I think we have a large investment in life and that’s what makes people, you know the guarantee of life vs any risk of death and I think that’s what really motivates people decision around care and employing people and I think our spiritual outlook is that we know there is no guarantee and we strive to move beyond that fear and have an experience that’s more satisfying than that.

Freebirth 7
This participant had her first baby in hospital and found the experience to be physically and emotionally overwhelming. This birth ended in the baby being extracted with a vacuum which made this woman feel guilt about what had happened to her baby at birth and she reports feeling like she had failed to keep her baby safe. Becoming pregnant, her birth experience and a difficult postnatal experience with mastitis sent this woman on a transformative journey. For her subsequent pregnancies, she reported wanting to perfect her experience and also heal from the last birth experience. She birthed in hospital for
her second child as well after being unable to convince her husband to have a homebirth. This birth experience went well but was unfulfilling and still not ‘perfect,’ this sent her on a journey to find something better for her next births. She chose to homebirth with a midwife for her third baby which still wasn’t quite what she wanted. After some spiritual searching she came to realize that freebirth was what would be best for her.

In a nutshell what motivated you to birth outside the system?

in a nutshell it was an inner drive, in a nutshell it didn’t feel like just my decision, it was my babies decision also, it, I’m sure past experiences added to me making that decision but it wasn’t consciously based on those past experiences, it was really, you know I followed where I was led.

Freebirth 8

This participant had done her PhD on the medicalisation of fertility treatment and subsequently went on to look at the medicalisation of birth. This positioned her to want to avoid birthing in hospital. She also met with some women who were part of the freebirthing community which made her inclined to choose to freebirth. She chose to birth her first and second babies at home. This decision was based on what she knew of the hospital from her research and the influence of the women around her who had freebirthed. This woman was very much guided by her philosophy.

In a nutshell what motivated you to birth outside the system?

The desire to be the authority at my own birth, yeah that’s probably it.

Freebirth 9

At the time of interview this woman was pregnant with her second baby and was under the care of midwives so she could have an attended homebirth. Her first birth had been a freebirth after she felt forced to consider this option after being ‘dumped’ by the midwives she had hired to attend her at home the first time. She didn’t want to birth in hospital and so felt freebirth was her next best option but would have preferred a
midwife to attend her.

**In a nutshell what motivated you to birth outside the system?**

because I feel that’s safer and better emotionally for me, and my baby and what’s good for me is good for my baby. It feels safe that way, yeah, I feel, yeah safe and supported and yeah, no foreigners. I think that’s what it comes down to, nothing foreign in general, no people, no places, no smells, no nothing, just everything that I just know.
‘Birthing outside the system’

Melanie Jackson, a PhD student from The University of Western Sydney and Independent Midwife is looking for women who would be interested in being interviewed for her PhD project entitled, ‘Birthing outside the System’

This study aims to discover why women from all over Australia choose to birth unattended by a registered midwife (Freebirth) or have a homebirth with a midwife, despite being told they are considered ‘high-risk.’ It is hoped that this research will ultimately influence maternity health care provisions in Australia

If you have chosen one of these options in the past or intend on choosing one of these options in the future, Melanie would love to hear your story.

Please contact her for more information and to express your interest

Thankyou

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3. Participant information sheet (women)

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Birthing outside the System

Participant Information sheet

Thank you for your interest in my PhD research project. This project commenced in 2010 and is expected to be completed by 2013. Please find below detailed information about the research that is to be undertaken and what it is hoped will be discovered.

What is this research about?
A PhD is a University degree which is done independently by a student researcher. The researcher develops a research question and then sets about to answer it. It is expected that the research project will contribute positively to a pool of knowledge and have a benefit to society. Melanie Jackson will be undertaking a PhD and seeking to answer the question, ‘why do Australian women choose to birth outside the system.’ ‘The System’ refers to mainstream/supported options for birthing in Australia (Public or Private Hospital, birth centres, ‘low-risk’ homebirth provided by a hospital). The women she is particularly interested in discussing this with are women who have chosen to birth at home unassisted by a midwife or who have been told they have a ‘high-risk’ pregnancy and choose to birth at home anyway, assisted by a midwife. Women who have had a homebirth assisted by a midwife and considered ‘low-risk’ are not the focus of this project as substantial amounts of research is available about this.

Who is conducting this study?
I (Melanie Jackson) am the primary researcher for this research and will be working under the supervision of Associate Professors Hannah Dahlen and Virginia Schmied of the School of Nursing and Midwifery at The University of Western Sydney. Previous to undertaking this research project I studied Remedial Massage, Naturopathy, Nursing and Midwifery and currently work as a Privately Practicing Naturopathic Midwife and as a Research Assistant at the University of Western Sydney.

Who is funding this study?
This study is yet to attract internal or external funding and there are no funding bodies that have an interest in the outcome of this research project.

Who can participate in this research?
it is anticipated that participants are women and fit one of the following criteria:

- Have had an unassisted homebirth in the past
- Are pregnant and are planning an unassisted homebirth
- Are intending to have an unassisted homebirth in the future
- Participants can be included in this study if their intention was to birth unassisted and then required assistance or transfer during the pregnancy or at the time of labour and birth
- Have had what would be considered by ‘the system’ a high-risk homebirth in the past
- Are presently experiencing what would be considered by ‘the system’ a high-risk pregnancy and are planning a homebirth
- Are aware that future pregnancies will be considered high-risk and are intending on planning a homebirth in the future
- Participants can be included in this study if their original intention and plan was to birth at home yet required transfer during pregnancy or at the time of labour and birth

What does participation in this research involve?
Participation in this project is voluntary and participants are welcome decline or withdraw participation at anytime without ramification. In order to answer the research question it is intended that women and mothers who choose to participate will be asked to participate in a one-on-one interview with Melanie Jackson to discuss why they are choosing or have chosen to birth at home unassisted or assisted. It is anticipated that the interview will be conducted in an informal manner and will be tape recorded to make collecting information more efficient. Participants have the freedom to elect the location of the interview and can choose to conduct it in their home. As the research project develops Melanie may contact you for a second interview to discuss interesting information that is arising from other interviews and to ask further questions about your experience. Participants will also be asked to fill out a short demographic form which will help Melanie describe the general characteristics of the participants who chose to part-take in this research. Participants may also be asked if they know anyone else who may be interested in taking-part in this research and if there are websites, books or information they feel would be helpful to this research.

Will the information I give be confidential?
Yes, everything you disclose to Melanie about your personal information and birthing choices will be confidential and at no time in the research process or at the time the findings are published will you be identified as having taken part in this research. All care will be taken when reporting the findings of this study and where case studies are used and stories are quoted the researcher intends to maintain the confidentiality of the participants, however, some stories may have been portrayed in mainstream media in the past and be known amongst the homebirthing and freebirthing community and thus may be recognisable. If you are concerned about this, consider it when making a decision about whether to participate or not. The only people who will be aware of your participation are Melanie Jackson and her Supervisors Hannah Dahlen and Virginia Schmied who will have access to the information you provide for this project.

Are there any risks or disadvantages to participating?
There are no foreseeable risks involved in participating in this research. If at any time throughout participation in this project you experience emotional discomfort or distress you will not be pressured into divulging further and will be invited to cease the interview. You are free to continue or cease the interview at anytime if you feel uncomfortable or upset. Melanie Jackson can provide information for services which may provide assistance if this should occur.
- Anglicare Counselling services – 13 26 22 ([http://www.anglicare.org.au](http://www.anglicare.org.au))
- Salvation Army Counselling services – contact details for your area can be found at [www.salvationarmy.org.au](http://www.salvationarmy.org.au)

**Are there any benefits?**
While I cannot guarantee there will be any direct benefits to you in the short term, it is intended that what is discovered in this research project will highlight shortfalls in the current maternity care options and improve the quality of the care women receive and have access to during their parenting journey.

**What will happen when this project is complete?**
At the completion of the data collection and analysis process and throughout the research process, the findings of this project will be written and published in Midwifery, Medical and Academic Journals. The findings will also be presented by Melanie at professional conferences in Australia and Overseas. Ultimately, at the end of this project a PhD thesis will be produced by Melanie Jackson and be submitted to be examined by external markers. Throughout the publication and dissemination process your identity will remain confidential and no published material will include any information identifying individual participants.

**What if I have a complaint?**
This study has been approved by the University of Western Sydney Human Research Ethics Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Human Ethics Officer, nominated as Complaint Officer (phone (02) 4736 0883 or email humanethics@uws.edu.au). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you require further information or have questions about any aspect of the research project or what participation involves, please do not hesitate to contact me.

**Melanie Jackson**
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M.Jackson@uws.edu.au
0425 280 682
02 8807 7859
PO BOX 4122 Werrington NSW 2747
4. Participant consent form (women)

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Melanie Jackson
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13464758@student.uws.edu.au
0425 280 682
02 8807 7859
PO BOX 4122 Werrington NSW 2747

Birthing outside the System

Participant Consent form

I, ___________________________________________ (name)
____________________________________________________ (Address)

Have read and understood the information for participants on the above named research study and have discussed the study with Melanie Jackson (the principle researcher)

I have been made aware of the procedures involved in the study, including any known advantages or disadvantages to participating in this study.

I freely choose to participate in this study and understand that I can withdraw at any time

I also understand that the research is strictly confidential

I understand that interactions with the researcher will be tape recorded

I agree to being contacted in the event that the researcher requests additional information

I understand that the information I provide for this research project will become part of publications including but not limited to journal submissions, PhD thesis, books and conference presentations.

Name: ___________________________________________

Signature_________________________________________ Date: ________________

Contact phone number_________________________ e-mail ____________________
5. Participant demographic form

**Birthing outside the System**

Please take a few minutes to answer the following questions. This information will be used to describe the women who have taken part in this research. All responses will be de-identified for confidentiality.

**How old are you? ________**

**In which country were you born?**

________________________

**Are you of Aboriginal or Torres Strait Islander Origin?**

________________________

**How many children do you have?__________**

**Are you employed?____________________**

**What is the highest qualification you have completed?**

- € No formal qualifications
- € School certificate (Yr 10)
- € Higher School Certificate (Yr 12)
- € Trade/Apprenticeship
- € Certificate/diploma
- € University degree
- € Postgraduate degree

**What is your present marital/relationship status?**

- € Married
- € Defacto
- € Separated
- € Divorced
- € Widowed
- € Never Married
- € Not in a relationship

**What choice did you make/are you making about where to birth your last/next baby?**

- € Planned homebirth without a midwife
- € Planned homebirth with a midwife
- € Other __________________________

**Who provided/who will provide antenatal care for this pregnancy?**

- € Me/Myself
- € Doula
- € Friend
- € Lay Midwife
- € Registered Midwife
- € GP
- € Hospital Midwife clinic
- € Obstetrician
- € Other

**Have you birthed any of your children in a hospital or birth centre? YES / NO**

If YES, can you briefly list at which hospital/birth centre you had each of your children

________________________

________________________

________________________

________________________

If NO, can you briefly list the birth place of all your previous births and who attended these (if anyone)

________________________

________________________

________________________

________________________

________________________

**In what state do you live? ________________**

**In what city do you live? ________________**

Approximately how far do you live from the closest hospital providing maternity care (please include approximate kilometres and travel time)

________________________

Thank you for your time and generosity.
Birthing outside the system: Perceptions of risk amongst Australian women who have freebirths and high risk homebirths

Melanie Jackson, Research Midwife RN, RM, B.Nat, M (Nurs), Grad.Dip (Mid) (PhD Candidate)*. Hannah Dahlen, RN, RM, BN (Hons), M (CommN), PhD (Associate Professor of Midwifery), Virginia Schmied, RN, RM, PhD (Professor of Midwifery)

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Abstract

Background: homebirth for low risk women attended by competent midwives who are networked within a responsive maternity care service is supported by research as safe. Concerns exist over the safety of homebirths which are unattended by trained health professionals, or for women with medically defined risk factors. Both these birth choices are unsupported by mainstream maternity care options in Australia and therefore represent birth choices considered to be ‘outside the system’.

Aim: to explore the perceptions of risk held by women who choose to have a freebirth (birth at home intentionally unattended by a trained birth attendant) or a ‘high-risk’ homebirth (professionally attended home birth where a mother or baby has medically defined risk factors). Both of these choices are considered to be ‘outside the system’.

Methods: twenty women were interviewed about their choice to ‘birth outside the system’, nine choosing freebirth and 11 choosing to have an attended homebirth despite the presence of medically defined risk factors; three were primiparous and seventeen were multiparous. Women intending to have, or having had a freebirth or high risk homebirth, were interviewed using semi-structured interviews. Interviews were transcribed and analysed using thematic analysis.

Findings: the three main themes about perceptions of risk that were evident in this study were: ‘Birth always has an element of risk’, ‘The hospital is not the safest place to have a baby’; and ‘interference is a risk’.

Discussion: the participants acknowledge that birth is a time in life that carries an element of risk. They perceive that hospital represents a more risky place to give birth than at home and that interventions and interruptions during labour and birth increase risk. Women who birth outside the system perceive the risks of birth in hospital differently to most women. These women feel that by birthing outside the system they are making a choice that protects them and their babies from the risks associated with birthing in hospital and thus provides them with the best and safest birthing option.

Conclusion: in pursuing the best for themselves and their babies, women who birth outside the system spent a lot of time and energy considering the risks and weighing these up. For them birth in hospital is considered less safe than birth at home.

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that one reason women choose to freebirth or have high risk homebirths is a general dissatisfaction with the birthing options offered within the mainstream maternity care system (Dahlen et al., 2011). Some recent high profile cases in the Australian media indicate that outcomes can be adverse (Dahlen, 2009; Dahlen, 2010) but there is inadequate population based data to determine the numbers of women making this choice or the outcomes associated with it. In Australia, in the latest available statistics more women had a birth in a location other than a hospital than had planned homebirths (Laws et al., 2010). It is unclear how many of these women did so intentionally.

Trevathan (1996) suggests historically that women developed a sense of vulnerability and reliance upon a birthing assistant due to the fact the baby is born facing away from the mother and the diameters of the mother’s pelvis changed over time. With this dependence came a shift of control from the mother to the birth attendant (Trevathan, 1996). Freebirth and high risk homebirth may both represent women’s wrestling of control back from the birth attendant.

With regard to the safety of freebirth, it has been argued that data on babies who are ‘born before arrival’ (to hospital) provides evidence that freebirth poses unnecessary dangers to babies, as outcomes for babies born before arrival are poorer than for babies born in hospital. Research by Turton (2007) has challenged this assumption around the safety of freebirth describing why it is possible that outcomes for babies accidentally ‘born before arrival’ could actually be worse than an intentional freebirth. Therefore, data on babies ‘born before arrival’ is an inaccurate way of determining the safety or danger of freebirth. Mothers who freebirth have planned to do so and are more prepared and educated, which Turton argues, affords them greater safety at birth than women who birth outside of hospital unexpectedly (Turton, 2007). The reality, however, is there is very little evidence available to examine the outcomes from freebirth as it continues to be undertaken outside the gaze of mainstream maternity care, only coming to attention when sensational cases hit the media headlines (Dahlen, 2009).

In relation to ‘high-risk’ homebirth, the current literature shows that there is evidence that high-risk homebirths cannot expect as good outcomes as low-risk ones, in particular twin and breech births (Bastian et al., 1998; Symon et al., 2009; Kennare et al., 2010). No studies have specifically focused on expected outcomes for high risk homebirths so the exact ‘risk’ associated with birthing at home with specific risk factors is yet to be accurately determined and is unlikely to be so in the future.

The aim of this study was to explore how women who make the choice to birth outside of the mainstream birthing system perceive the risks associated with birth and place of birth. This study is part of a larger study on what influences and motivates a mother’s choice to ‘birth outside the system’.

Method

Design

A qualitative interpretive study was undertaken of women who choose to have freebirths or high risk homebirths in Australia. Ethics approval was obtained from the University of Western Sydney Ethics Committee (protocol number H8248).

Sample

Twenty women were interviewed from four different states in Australia. Nine participants had chosen to freebirth and 11 chose to have an attended homebirth despite the presence of medically defined risk factors. Three were primiparous and 17 were multiparous. The average age of participants was 34 years. Nine were employed, 14 had university degrees and all lived within 30 mins of a hospital able to provide emergency maternity care (Fig. 1). Participants were included in the study if they had previously planned or were planning to have a freebirth or a homebirth in the presence of medically defined risk factors. ‘High risk’ was deemed to be any factor, which would have excluded the participant from using a birth centre or publically funded homebirth. Women under the age of 18 were excluded from this study. Recruitment of participants was done initially as a call for interest at an Australian Homebirth conference followed by a snowball technique.

Data collection

Women participated in semi-structured interviews using open ended questions. Interviews ranged from 45 mins to two and a half hours and were conducted both face to face in a location of the woman’s choice or over the phone if they lived at a long distance from the researcher. Seven interviews were conducted by phone. The participants were asked to start by sharing their birth story, which then allowed for more specific questioning. Specific questions about the participants’ perceptions of risk included, ‘when you developed that risk factor, how did that change your perception of your pregnancy?’ and, ‘what things do you see as increasing the risk of birth?’ and ‘why do you think the doctor thought you were high-risk?’ and ‘what risks did you perceive to be associated with your birth choice?’ Interviews were digitally recorded and transcribed by the first author. Participants were de-identified during the transcription phase. Demographic data about the participants was also collected using a standardised form completed by the participants themselves.

Data analysis

The 20 interviews were transcribed and analysed using thematic analysis. Using an iterative process, transcripts were read and re-read to identify the emerging themes (Liamputtong and Douglas, 2005). Through this preliminary analysis, concepts such as ‘risk’, ‘danger’ and ‘death’ were noted to occur in almost all transcripts. This provided a rationale for further exploration into the emerging concepts related to the perceptions of risk among the study participants. All data coded within the broad theme ‘perceptions of risk’ was extracted and analysed in further detail. Three preliminary sub themes were identified and to confirm that we had extracted all the data related to this theme a key word search of all the interview transcripts was undertaken for the key words, ‘risk’, ‘danger’, ‘death’, ‘die’, ‘wrong’ and ‘safe’. Further coding of the data in each theme then occurred along with identification of linkages and relationships between themes (Liamputtong and Douglas, 2005).

Findings

The demographic information collected from the participants indicated that they were a highly educated group of participants, with 14 out of the 20 having a bachelor degree or higher; 8 of these were at postgraduate level with 1 participant having a doctoral degree. This means 70% of the participants had a tertiary qualification. This is a significant finding as the 2010 statistics for percentage of Australian population between 25 and 64 years old to have a degree. This means 70% of the participants had a tertiary qualification. This is a significant finding as the 2010 statistics for percentage of Australian population between 25 and 64 years old to have a bachelor degree or higher is 26.9% (Australian Bureau of Statistics, 2011), around three times less than the study cohort. Another significant finding is that of the 20 participants interviewed, four were midwives working within a hospital who chose to freebirth or birth at home despite having risk factors. Seventeen of the
participants had more than one baby, which may have been a factor in the average age of participants being 34 years of age. Interestingly, all the participants lived within 30 mins from a hospital, which would be able to provide them with emergency care if this became necessary (Fig. 1). None of the women in this study were living in a rural setting, which may have impacted their perception of how ‘risky’ or ‘safe’ their choice to freebirth or have a high risk homebirth was, considering they knew that medical care could be accessed in a timely manner if it should be needed.

Three main themes found were: ‘Birth always has an element of risk’, ‘The hospital is not the safest place to have a baby’, and ‘interference is a risk’.

Birth always has an element of risk

The participants in this study perceived birth to always have an element of inherent risk. In their descriptions about their philosophical understandings and beliefs about birth, they were
not naive to the potential risks and dangers that birth can pose. They explain:

“There is always a risk that there might be complications or that something might go wrong. (Freebirth 04)

That is the gamble that you take whether you are in a hospital or at home, things happen, go wrong at birth”. (Homebirth 06)

The participants acknowledged and had considered that not only was there a risk of something going wrong at birth, but that death was also a possibility. They believed death to be a harsh reality of birth that can sometimes not be avoided:

“I had to go to the worst case scenario too that either I could die or the baby could die- and that’s real because that’s life and people die”. (Freebirth 07)

“I always knew that there was no guarantee that the baby would be born alive or that it would live beyond the birth, but I think there is no guarantee with that in a hospital setting either”. (Freebirth 06)

The hospital is not the safest place to have a baby

Despite the common assumption that hospitals present a safe birth option, the participants in this study perceived hospitals as a less safe birthing environment than birth at home. The women in this study didn’t perceive a hospital birth to be the answer to mitigating the risks of birth and hospital was not seen as the safer option when compared to homebirth (with or without a trained attendant).

One participant who is an experienced midwife working in a hospital and chose to have a ‘high-risk’ homebirth explains her perception about the risks associated with birthing in hospital:

“I know my alternative [the hospital] comes with more risk… I know my other choice isn’t perfect. So whilst being here at home mightn’t be considered to other people as being safe, to me going to hospital is even less safe, so I don’t think it’s [homebirth] a less of two evils, because I don’t think it’s the evil choice but, I think it’s the safer option. I don’t know whether you can say one is safe and one isn’t, but I think it’s safer because I know what happens in hospital and I know the risks that are involved there and I’ve seen the outcomes… I work in a hospital system and I can guarantee you things go wrong there every day and I’ve been part of that, or I’ve witnessed it, I’ve made mistakes myself, I know that it’s not the perfect- it’s not the perfect solution”. (Homebirth 05)

When asked if she thought women would still birth in hospital if they were fully informed of the potential risks of this birth choice she responded:

(Laughs) “I think the community would start to realise that the hospital is not the safer option and that staying at home is; it’s just that we don’t talk about it, we don’t talk about all the things that go wrong in hospital, or terrible mistakes happen”. (Homebirth 05)

Many of the participants expressed their belief that birthing in hospital carried inherent risks that added to the risks of birth itself, making it a less safe place to birth:

“I would also say that it [freebirth] is about safety because I don’t think hospitals are safe places to have babies and I don’t think some midwives are safe people to have babies with”. (Freebirth 08)

“Automatically walking into a hospital I’m exposed to hospital bugs, no, that to me is unsafe, I don’t need- as you know a neonates immune system is not fully developed, I don’t want my babies exposed to that, I don’t even want myself exposed to that. So they can’t possibly offer me a safe birth”. (Freebirth 05)

For many participants their choice to birth at home was motivated by the perception that home presented them with less risk to their physical, emotional and mental well-being than the hospital would and therefore represented a safer birthing choice:

“I thought for me that there was less risk of anything happening at home than there would have been if I was in hospital”. (Homebirth 04)

“We had the classic experience up in the maternity ward and it was, the problem wasn’t physical it was what I felt was a bullying issue and that’s what I mean you know emotional safety… emotional safety is about for me, it’s about having people there with me, like minded, who are there looking out for my best interests too, they know what I want and they will help me achieve that as best I can”. (Freebirth 04)

Despite the dominant social and biomedical view that hospitals are safe places to have a baby, the participants of this study perceived that hospitals were less safe places to give birth in than home and perceived the hospital to present them with a unique set of physical and emotional risks that they would otherwise not be exposed to at home.

Interference is a risk

The main risk factor women who ‘birth outside the system’ associate with hospital birth is the risk of complications produced by intervention and interruption in the birth process:

“I know that there are some interventions that will save lives but without any shred of doubt they certainly cause more problems than they prevent”. [Freebirth 05]

“I felt as a first timer [primiparous woman] that the biggest threat to my safety and my baby’s safety was unnecessary intervention and you know, I was young and I knew I was healthy and I knew that if went into a hospital I was going to have to fight really hard to get my baby out safely”. (Freebirth 08)

These women felt that by staying away from hospital they could minimise the chance of being exposed to risky interventions and therefore reduce the chance of something going wrong:

“If you can stay away from the hospital system then you can minimise the amount of interference. I look at interference a bit like risk, like every time someone new comes across you or does something that’s a risk that something goes wrong, every time you get a medication there is a risk it’s the wrong one, every time they do something there is a risk that flows on to something else, so if no-one is doing anything to you or giving you any drugs or performing any unnecessary tests, then there is no risk there”. (Homebirth 05)

Women in this study perceived risk to be associated with medical intervention and interruptions that could potentially create poorer outcomes for both the mother and baby. Many of the women had developed this perception due to previous experiences:

“I seriously feel that if they hadn’t started the syntocinon and just let me do what I needed to do then she would have rotated but the syntocinon forced her into a bad position and just pushed her there and held her there so she couldn’t turn and I ended up with a caesarean”. (Homebirth 09)
The main risk related to interventions and interruptions used during birth and labour mentioned by the study participants, was the risks of ‘the cascade of intervention’. Routine medical interventions used at hospital were perceived to increase the risk of something going wrong, which then produced a need for further interventions:

“They made the caesarean necessary by starting the syntocinon and putting me flat on my back.” (Homebirth 09)

“They interfere so that’s why things happen, they end up with forceps or the vacuum or caesarean because they put up a drip and they just stuff women up.” (Homebirth 03)

“When I read up things about the cascade of intervention, so I just like ye! I so agree with that.” (Homebirth 07)

Discussion

Risk has been described as having two components – probability and severity, and it has been argued that women who choose to birth outside the system ignore or underestimate the risk of giving birth at home (Wolfson, 1986). However, it was apparent in this study that the women considered risk seriously but placed the iatrogenic risks of giving birth in a hospital under intense scrutiny, challenging implicitly agreed assumptions that hospital birth must be safer and exposing risks that are often simply accepted as part of birth. Despite one in ten people entering hospital experiencing an adverse event, and around half of these being preventable (WHO, 2008), researchers argue that the debate around safety in maternity care often does not focus on the harmful activities of health providers and health-care organisations but on the behaviours and characteristics of women (Dahlen, in press; Sandall et al., 2010).

Women who choose homebirth, regardless of risk status or whether there is a professional in attendance or not, have been labelled in the Australian media as uninformed, ‘gullible’ risk-takers (Devine, 2009). The group of women interviewed for this study, however, were highly educated compared to the general population disrupting common images portrayed about these women in the media and by health professionals. In addition, Most of these women had read extensively around the rationale and ramifications of their birth choices and prepared for these accordingly. Some undertook, or had their partner undertake, education and training in neonatal resuscitation and obstetric emergencies, using formalised training pathways or by reading midwifery and obstetric textbooks. They also planned extensively around what they would do if things ‘went wrong’ and discussed with their partners and care providers strategies and pathways they would like to put in place to allow for flexibility in the management of their birth if complications should arise.

The majority of these women had had a previous birth and their perceptions of risk were shaped by these experiences. Some felt that they were put at unnecessary risk by care providers whom they trusted to keep them safe and thus concluded that they would be safer avoiding them for their next birth. Others felt that by returning to hospital for subsequent births they would put themselves at risk of having a repeat traumatic or dissatisfying experience that would impact upon their mothering ability and experience, a risk they were unwilling to take.

Four of the 20 participants in this study were midwives; one choosing freebirth and three choosing homebirth with risk factors. This adds an interesting dimension, as these women had insider knowledge of mainstream maternity services and chose to shun these and opt for a birth that they perceived would be safer. These women felt their choice of birth place gave them greater control of external factors during their pregnancy and birth, thus presenting them with fewer possible risks at birth. These participants cited many reasons for avoiding the hospital due to the greater risk they perceived it would pose to them and their babies.

Researchers such as Vissainen (2001) found that a decision to birth at home was related to a specific event in the woman’s past, most often ‘an unpleasant and traumatic experience of giving birth in hospital’ (Vissainen, 2001, p. 1114). This motivation also came up in the Boucher et al.’s (2009) study, where approximately a quarter of respondents cited a previous negative hospital experience as the reason they chose to birth at home (Boucher et al., 2009). Similarly, 58.6% of the respondents in an Australian study said that dissatisfaction with a previous hospital birth was their reason for planning a homebirth (Rastian, 1993). Other studies have focused on women’s perceptions of a positive birth following a hospital or operative birth (Fenwick et al., 2003; Cheyne, 2008; Thomson and Downe, 2010). Thomson and Downe (2010) found that an experience of joy following trauma led women to reframe and re-integrate their perceptions and beliefs surrounding a traumatic birth. They described this as ‘redemptive’ and that women were transformed by a positive birth experience. In the study we undertook we found women who even experienced what we would consider as an adverse event saw their birth outside the system as healing and empowering.

The women in this study recognise a direct link between their labour and birthing experience and their mothering and emotional experience in the immediate and long term postnatal periods. Many of the participants had what they would describe as a ‘traumatic’ or ‘horrible’ previous hospital birth experience. For these women the choice to birth at home, assisted or not, was fuelled by a desire to avoid the risk of having another traumatic birth experience. The participants of this study considered their and their baby’s emotional well-being to be a priority throughout the birth process and any risk or threat to this was actively avoided by planning to ‘birth outside the system’.

The importance of prioritising the emotional and mental well-being of the mother during labour and birth is being increasingly identified in the literature. Paule Austin et al. (2007) report that, findings from the last three reports on maternal deaths in Australia (covering the period during 1994–2002) suggests that maternal psychiatric illness is one of the leading causes of maternal death (Paule Austin et al., 2007). This suggests that the mother’s postpartum emotional and mental state has a large bearing on the maternal morbidity and mortality for Australian women and the factors contributing to this should be closely examined.

A medical model of care often focuses on the physical well-being of mother and baby, however, women’s concept of safety is more complex (Edwards, 1997). Edwards (1997) describes that within their concept of safety women explain that, ‘the long term physical and emotional well-being of themselves, their babies and their relationships were central’ (Edwards, 1997, p. 10). Women in this study identified the duplicity in the arguments put forward by medical professionals and provided a strong counter argument to the generally accepted belief that hospital birth and easy access to medical expertise and technology is a positive thing. Their choice to birthing outside the confines of medical supervision of birth is fuelled by their fundamental belief that birth is a natural, every day event and not an illness.

A philosophical belief that birth is a non-medical event leads some women to want to avoid interventions during labour and birth at all costs. Interventions and hospital procedures are seen as disrupting the flow and forces of nature, and avoidance of these is a motivating factor for women to avoid the most likely place these would occur, the hospital (Schneider, 1986; Boucher et al., 2009). Boucher et al. (2009) found that women who choose to
give birth at home equated medical intervention with reduced safety. It is their belief that interference and interruption in the process of labour and birth will disrupt the hormones required to labour and birth effectively and will therefore increase the risk of something going wrong at their birth. The participants of this study defined things such as lack of privacy, bright lights, noise, having strangers at birth, feeling cold, being spoken to, being separated from their baby, strong smells and being medically monitored as interfering in the natural labour, birth and bonding process. They perceived that these interrupting occurrences would be most likely experienced in hospital and chose to birth at home to avoid the risk of this happening and cascading into disruption of the birth process.

Women who birth outside the system go against dominant perceptions of risk and birth, which inevitably exposes them to ridicule. Jordan (1997) stated that, ‘those who expose alternative knowledge systems tend to be seen as backward, ignorant or naive trouble makers’ (Jordan, 1997, p. 152). Based on the findings from this study, women who birth outside the system valued their own perceptions of risk and thus reject the authority of biomedical knowledge when considering the risks of their birth choices. Women’s agency through the choice of homebirth is a rejection of the established agenda and therefore becomes a threat to well established and implicitly agreed beliefs (Dahlen, in press, p. 20) making them a ready target of judgment and misunderstanding.

There is very little literature specifically discussing why women with risk factors would choose to birth at home. Symon et al. (2010) examined 15 instances of perinatal death that occurred at term with independent midwives (Symon et al., 2010). The study found that in the three cases that occurred in hospitals, women were most likely to experience labour and birth as being too fast, having a difficult birth or having interruptions to the birth process. They believed that these were factors that would result in a traumatic birth for both the mother and baby. In contrast, when the same midwives conducted home births, women who had high-risk pregnancies were more likely to have a completion of a natural birth process, with the birth being seen as a positive experience.

In 2005 the WHO challenged practitioners not to ask, ‘why women do not accept the service that we offer?’ but to ask ‘why do we not offer a service that women want and accept?’ (WHO, 2005). While women in this study also accepted responsibility for their decision they challenged the assumption that a hospital birth would have been a better option for them and also questioned the kind of care they would receive in hospital. The fact that 16 of the 20 women in this study who had had their first baby in a delivery ward or birth centre pursued a completely different option for subsequent births makes one question the impact of current maternity care on these decisions.

There are several limitations with this study. The participants were obtained through a word of mouth and snowball technique increasing the chance that women with similar views were interviewed. The small number of women interviewed means the findings cannot be generalised and their experiences may not be relevant to women who ‘birth outside the system’ in other countries.

Future research is needed into how to maximise safety and choice for women who choose to ‘birth outside the system’. The fact that we don’t really know how many women intentionally freebirth each year in Australia is concerning as it is difficult to monitor trends and outcomes without the data. More attention needs to be paid to this issue and maternity service providers need to consider their roles and responsibilities in providing services that meet all women’s needs.

Conclusion

In this study women who birthed outside the system were pursuing the best for themselves and their babies by choosing the least risky birth options and they perceive the birth itself to carry an inherent risk regardless of the place of birth. They perceive that hospitals are not the safest place to give birth as they carry a unique set of additional risks to the mother and baby when compared to birthing at home. Hospitals were viewed as the most likely places women would be exposed to interventions and interruptions to the birth process compared to homebirth, and interventions in labour and birth are perceived by these women to be risky and therefore pose a potential danger to themselves and their baby. In pursuing the best for themselves and their babies the women spent a lot of time and energy considering the risks and weighing these up. For them birth in hospital was eventually deemed less safe than birth at home.

References


Catling-Paull, C., Homer, C., Dahlen, H. Multiparous women’s confidence to have a publicly funded homebirth: a qualitative study. Women and Birth, submitted for publication.


