

**An Exploration of Women's Expectations
of and Preferences for Childbirth
Experiences.**

A Mixed Methods Study.

**Thesis submitted in fulfilment of the requirement
for the Degree of Doctor of Philosophy at the
University Of Dublin Trinity College.**

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Declaration

I hereby declare that I conducted all the work represented in this thesis and composed its presentation. The thesis has not been previously submitted to this or any other University.

I agree that the Library of Trinity College Dublin may lend or copy the thesis on request.

Patricia Larkin
October 2009.

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Summary

Childbirth experiences are important for women, their families, health professionals, and society. Outcomes for childbirth often reflect a biomedical appraisal focusing on statistical measures rather than women's own assessment of their experiences. Maternity policies are influenced by the biomedical approach because current methods of research fail to produce data that also integrates women's views. This study is a response to the marginalisation of women's childbirth experiences and their diminution due to a consistent emphasis on quantitative and reductionist forms of evidence. The research was carried out within a framework of feminist research with the particular approach of standpoint theory. The approach enabled a unique insight of women's worldviews and a critical analysis of the influences that shaped their experiences. The research design is a sequential mixed method approach which combined women's views from a qualitative perspective as a basis for the development of a quantitative instrument. The subsequent quantitative analysis added a statistical dimension, revealing the six core attributes that are important for women's childbirth experiences. The integration of the data from both phases of the study uncovered original contextually rich insights, suggesting that in the context of busy hospital settings most women value the technological help that interventions can bring, in addition to emotionally supportive care. The research revealed that interventions have become a normalised part of childbirth experiences. Most women have a medicalised belief system about childbirth and have had little exposure to models of care other than a hospital based one. Women expressed uncertainty about their own birthing abilities and embraced technology to enhance their feelings of control and safety, to alleviate pain, and to gain acceptance within the system wherein they gave birth. Other influences such as societal, social, and cultural norms influenced women's perceptions of pain technology, and intervention.

List of abbreviations

ASC Alternate specific constant

ANFGI Antenatal Focus Group Interview

DCE Discrete choice experiment

DCERI Discrete choice experiment research instrument

DOMINO Domiciliary in and out

FGI Focus Group Interview

KPMG Independent professional auditor firm

PNFGI Postnatal Focus Group Interview

SD Standard Deviation

Glossary

Alternate Specific Constant is a parameter for a particular alternative that is used to represent the role of unobserved sources of utility.

Attribute is the key characteristics of services or goods

Attribute level is a specific value taken by an attribute experimental designs require that each attribute take on two or more levels that may be quantitative or qualitative

Androcentric a term used to explain a situation centered or focused on men, often to the neglect or exclusion of women

Cascade of intervention where interventions introduced early in labour are more likely to result in further interventions, e.g. augmentation of labour leads to more painful labour, followed by an epidural and operative delivery, hence one intervention necessitates another leading to a 'cascade' of interventions.

Choice set is the of alternatives over which a respondents makes a choice

Coefficient a scalar value by which a particular element in a model is multiplied in the estimation process

Cognitive burden is the level of difficulty faced by a respondent in considering a set of choices

Discrete choice the selection of one alternative among a set of mutually exclusive alternatives

Discrete choice experiment is a subset of a broader experimental technique of conjoint analysis.

Doula is a woman experienced in childbirth who provides advice, information, emotional support, and physical comfort to a mother before, during, and just after childbirth

Dummy coding denoting the existence of a particular attribute with a one and its absence with a zero

Essentialism is a doctrine that certain traditional concepts, ideals, and skills are essential to society and should be taught methodically to all students, regardless of individual ability, or need

Feminist theorists seek to understand the nature of inequality and focus on gender power relations and politics. The basis of feminist ideology is that society is organised by a patriarchal system where men have an advantage over women.

Full factorial design a design in which all possible treatment combinations are enumerated

Hegemony is broadly understood as power that maintains and naturalizes existing social structures

Homebirth a birth which takes place in the mother's home outside of the hospital setting

Independent Midwife a midwife who works independently of the HSE who offers a service of antenatal, intrapartum and postnatal care usually in the woman's home

Main effect is the direct independent effect of each factor upon a response variable

Marginal rate of substitution The amount of a particular item that must be given to an agent in order to exactly compensate that agent for the loss of one unit of another item

Marginal utility the increase in utility due to an incremental increase of an attribute

p value represents the probability of an erroneous finding in terms of accepting the conclusion drawn from a test conducted on a sample as being valid, or representative of the population

Private Maternity Care this means that women have an identified consultant obstetric consultant who is paid a fee. Women see their consultant each antenatal visit either in the hospital or in the consultant private rooms. After the birth the woman may be able to avail of a private room if it is available.

Public maternity care is free to all women; it includes all antenatal care, all care during labour and childbirth, and all postnatal care. It covers all hospital accommodation costs

Semi-private Care can mean different things in different hospitals. Women are seen by their own consultant but the doctor that is on duty attends the birth. Some hospitals have 'semiprivate' clinics and someone from the team will be there for the birth. Semiprivate facilities are available for the mother if available.

Utility how desirable one finds a commodity or the attributes of a commodity

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Chapter 1

Introduction

1.0 Introduction

Childbirth experiences can have positive or negative outcomes on the health of the woman and her family. With over 64,000 women giving birth annually (ESRI and Department of Health and Children 2008), childbirth experiences affect a great number of people in Ireland. Understanding women's childbirth experiences is seen as an indicator of the quality of maternity care, and can be used in making decisions about the organisation and provision of services (McCrea and Wright 1999). Investigating women's childbirth experiences is therefore relevant to maternity care providers, policy makers, and administrators (Hodnett 2002). The traditional means of involving women in shaping the direction of maternity services has been through satisfaction surveys (Hundley and Ryan 2004). The methodological limitations of such approaches and the complexity of measuring the multidimensional concept of satisfaction is under debate (Turris 2005). When considered in isolation evaluations of success that have focused on narrow medically defined objective definitions such as morbidity and mortality, or limited to satisfaction studies, provide little insight into the important elements of childbirth experiences.

In an Irish context further uncertainties are derived from the lack of congruence between high levels of satisfaction with confirmatory quantitative clinical measures (Geary *et al.* 1997, McKenna and Matthews 2003), and reports of poor childbirth experiences from qualitative studies (McCann 2000, Durkin 2007). High rates of dissatisfaction with maternity services have also been reported in the media (Regan 2006). Although there have been some changes in the provision of maternity services in Ireland since the 1970s, when a policy of delivering all babies in hospitals staffed by consultants on the grounds of safety was

instituted (Comhairle na n-Ospidéal 1976), a hospital based consultant led model persists. A recent plan for maternity and gynaecological services in Ireland produced by the Institute of Obstetrics and Gynaecology (2006) maintains:

"We reflect a long tradition of advocacy for the highest standard of care in women's health...and the world wide reputation for excellence" "It is from such beginnings of proactivity in woman's health that the Institute wishes to encourage policy makers.....to ensure the highest standards of care" (p.1)

It is not clear how and where the 'world wide reputation' is expressed nor is it evident where there is evidence of 'proactivity'. Over the past thirty years maternity services have become more centralised with the closure of smaller maternity units, reaffirming the benefits of consultant led hospital based maternity services (O'Connor 2006). In Ireland a 'medicalised' maternity care system prevails (Devane *et al.* 2007), with increasing intervention and caesarean section rates (Kennedy 2002). Changes in the delivery of services has been extremely slow although in recent times Midwifery Led Units have been instituted (Devane *et al.* 2007), but the consultant led model prevails. A recent review of Dublin maternity hospitals cites; 'well-recognised optimal clinical outcomes' as the rationale for maternity services being relocated within acute adult services (KPMG 2008). 'Optimal' clinical outcomes relate to 'safety' and 'convenience', with expert physicians at hand if needed. The recommendations are made despite evidence from the United Kingdom that the evolution of their services to large centralised maternity units are less 'women friendly', and support for women is more difficult to provide and access (Page *et al.* 2006).

Although clinical outcome measures of childbirth are important they provide little information about the impact or the significance of the childbirth experience for women and their families. From a sociological perspective the 'biomedical' or 'technocratic' view of childbirth has emerged from a positivist tradition regarding childbirth as pathological, best assessed by scientific knowledge and measurable outcomes.

Statistical measures are generally unquestioned as the best, most efficient, most legitimate sources of information with the added value of being objective and value-free (Oakley 2005, Brubaker and Dillaway 2009). Although biomedicine has undoubtedly contributed to saving lives its purpose in improving health care is subject to much debate (Brubaker and Dillaway 2009), whilst its role in childbirth can be potentially harmful (Murphy-Lawless 1998).

There is little research about what women in Ireland want from their childbirth experiences hence there are significant gaps in our knowledge to refute claims of the benefits of centralisation and institutionalisation. A recent study of priorities for midwifery research in Ireland found that women centered care was ranked highly as an important area for investigation (Butler *et al.* 2009). The challenge for midwives therefore, is to accumulate convincing evidence about what is likely to be effective care (Page *et al.* 2006). The review of Dublin maternity hospitals (KPMG 2008) acknowledged women's preferences for a midwifery 'more social' model of care. Its guarded recommendations about the possible benefits of such a model for labouring women are couched by the caveat: '*if well practiced by experienced midwives,*' (my emphasis) (KPMG 2008:69). The review continues to recommend midwifery leadership of: 'non-complex pregnancies and labour, with clear escalation policy where complications arise' (KPMG 2008:69). The recommendations of the report appear to take a biomedical stance of a 'risk' approach where positivist paradigms predominate. Pregnancy and birth are perceived as pathological requiring vigilant monitoring, with a potential for crises that may need active intervention at any time. In Ireland the medical frame of reference has been accepted and expert medical knowledge reinforced thereby maintaining the status quo albeit with some cautious stipulations. Such recommendations continue to cast the obstetrician as the childbirth expert, and by emphasising birth as inherently 'risky' legitimise the need for interventions (Zadoroznyj 1999). The landscape for maternity care, particularly in Dublin, seems to point towards a perpetuation of the biomedical imperative, compounded by the

continuation of maternity policies that render women and their experiences invisible (Begley and Devane 2003). On the important question of women's childbirth experiences there is a resounding silence.

This study is an original piece of research that contributes to the knowledge gap that exists about women's preferences for childbirth experiences. The aim of the study is to explore women's expectations of and preferences for childbirth in the Republic of Ireland. The study seeks to identify women's views through using an innovative mixed method approach incorporating a discrete choice experiment from the discipline of health economics. The evidence from the study provides valuable insights into a previously unexplored area and presents an original contribution to understanding women's experiences of childbirth in Ireland.

The study ought to be read in the context of my midwifery clinical and teaching background considering the midwifery model and philosophical milieu within which I am situated. I have practised midwifery in different countries and within different organisational frameworks over the past twenty years, which has offered me different perspectives on childbirth. I became aware of the differences in the societal, policy, and organisational contexts that influence women's care during childbirth in addition to the profound effect that childbirth can have for women. I also reflected on the paucity of published research about childbirth in Ireland particularly by midwives. I found that the medicalised approach to childbirth is difficult to challenge, with subtle and not so subtle undermining of any other model of care. I discovered that the dominant medical model is reiterated by health policy and organisation of care but is also reflective of Irish society. The accepted wisdom in Ireland appears to conform to the 'they know best' attitude to medical knowledge yet there are some glaring contradictions between what women experience and what is thought to be best for them (McCann 2000, Durkin 2007).

1.1 Outline of Thesis

The thesis is organised into ten chapters. The next chapter consists of a literature review and concept analysis of childbirth experiences, and their significance and impact for women, their families and society.

In Chapter Three I discuss the research design. I explore the rationale for choosing the methodology that best facilitates the research process centered on the research question. Feminist standpoint theory provides a framework for the study, challenging the biomedical strategy of marginalising women's experiences by positioning women as experts at all stages of the research. The use of a sequential mixed method approach challenges the notion of a singular reality, instead, generates a complexity of evidence that eludes binary compartmentalisation.

In chapter four, and five, the qualitative phase of the exploratory sequential mixed method approach is explained, initiated and analysed. The chapter includes the recruitment and involvement of participants, ethical considerations, the research processes, frameworks used for analysis, and the rigour of the research study. Five antenatal and five postnatal focus groups are employed to identify the important elements of childbirth experiences. The antenatal and postnatal FGIS also provide information about the influences brought to bear on women in setting their priorities for childbirth.

In Chapter six strand one, I discuss the development of the research instrument incorporating the DCE from the discipline of economics. The development includes data from the concept analysis, FGIs and contemporary literature. Phase two strand two of the research is described in chapter seven including the theoretical foundation, piloting, recruitment and distribution of the DCE research instrument (DCERI).

In Chapter eight, the results of the quantitative data from the DCERI are presented. Firstly, the descriptive data to provide background statistical information is presented. In chapter nine the results of the logistic

regression and coefficients that establish women's preferences for elements of the childbirth experiences are presented, and examined in relation to demographic characteristics of the participants. The integration of the data from the open questions and the DCE follows, whilst also referring to the focus group interview data. The integration of both qualitative and quantitative data helps to provide a contextual understanding of the factors that contributed to women's preferences for their childbirth experiences.

The final chapter presents the research question alongside the conclusions and discussion of the study. Feminist standpoint theory provides a background for the analysis of the wider socio-political issues that may account for women's priorities for childbirth experiences. Recommendations from the findings are advanced in the areas of research, policy, and professional practice.

Chapter 2

Literature Review

2.0 Introduction

The following literature review places the study in the context of the contemporary research in relation to childbirth experiences. The significance of childbirth experiences are outlined followed by a concept analysis of childbirth experiences. The concept analysis clarifies the attributes of childbirth experiences, identifying the scope and limitations about what is known. The multidisciplinary literature in relation to the topic reveals a myriad of research and literature. An extensive literature review was carried out and the most appropriate studies are reviewed. ¹

2.1 Background

Birth experiences are critical events in women's lives and have been the subject of discussion within a range of disciplines for many years. A seminal work by Cartwright (1979), established that women's perceptions of what professionals thought of as innocuous 'routine interventions' often negatively impacted on their birth experience. Three decades later experiences of childbirth are recognised as having wide ranging impacts not only for the individual, family, and community, but also on societal and economic outcomes (Murphy-Lawless 1998, Bailham and Joseph 2003). Women's perceptions of the 'meaning' and 'success' of childbirth may differ and what professionals consider 'normal' can be perceived as traumatic (Beck 2004), yet childbirth is often evaluated within narrow scientific parameters obscuring emotional and psychological dimensions.

¹ A paper arising from this chapter has been published see Appendix 1.

2.2 Significance of Childbirth

Many women have come to see the experience of childbirth as a critical moment of 'self affirmation' (Murphy-Lawless 1998), central to maternal psychological wellbeing (Bailham and Joseph 2003). Positive birth experiences are associated with long lasting benefits (Beech and Phipps 2004), an affirmative relationship with the newborn (Green *et al.* 1990) and a positive attitude towards motherhood that contributes to the woman's self esteem and feelings of accomplishment (Simkin 1991). Psychological morbidity following childbirth including anxiety, post natal depression, and traumatic stress disorder (Allen 1998), has become a focus of concern due to the consequent effects on the mother and her family. Consequences can include difficulties with infant attachment (Ballard *et al.* 1995) and life-long psychological effects for both the mother and her family (Crompton 2003). A negative birth experience may define or alter future pregnancies by affecting a woman's future reproductive decisions (Waldenstrom *et al.* 2004a), including, for some, a preference for a caesarean section for future births (Ryding 1993).

Childbirth represents a physical and psychological challenge, a process from which women can derive profound feelings of empowerment and achievement (Waldenstrom 1996a), or conversely feelings of anger, guilt, violation and depression (Bailham and Joseph 2003, Mazingo 2002). In Ireland the emotional and psychological consequences of labour and birth has received little attention despite international recognition of the centrality of childbirth experiences to women's psychological well being (Simkin 1991, Bailham and Joseph 2003, Walsh 2007). Childbirth experiences both positive and negative have been shown to affect the whole family, with memories extending beyond the puerperium, sometimes lasting a lifetime (Simkin 1991). Although postnatal emotional and psychological health have been related to symptoms of depression, a relatively newly recognised 'category of distress' has emerged entitled post traumatic stress disorder (PTSD) (Ballard, 1995). Women who negatively appraise their childbirth experiences have reported symptoms of traumatic distress evoking feelings of helplessness, intense alarm, and horror, because they feared

death or serious injury during labour and birth (Czarnocka and Slade, 2000). PTSD can have a sustained effect on women's psychological well being (Allen 1998) reinforcing the importance of women's perceptions of their experiences.

It is increasingly recognised that women's appraisals of their experiences as distressing, negative, or disappointing may differ from that of the professionals who are caring for them. Women who have seemingly 'normal' births may perceive them as traumatic and suffer from severe and lasting symptoms of PTSD (Wijma 1997, Allen 1998, Czarnocka and Slade 2000, Beck, 2004). Whatever diagnostic criteria are attached to the distress women may feel following adverse childbirth experiences, and the possible overlaps between depression and trauma symptoms, clearly there is a psychological and emotional dimension within the childbirth experiences that is important to women's wellbeing. The experiential element of birth is often ignored or marginalised because of the emphasis on physical outcomes that may be more obvious and easier to identify and quantify.

Beck (2004) found such dissonance leading her to deduce that the focus for clinicians is often solely related to clinical efficiency and a live healthy baby, to the exclusion of and seemingly oblivious to the women's feelings about their experiences. Although clearly identified in international literature, in Ireland there are significant gaps in our knowledge as to whether or not maternity services are meeting women's needs and priorities in relation to birth experiences. To date much of the research in Ireland has focused on the maternity services through the use of 'satisfaction' studies or related to the presentation of statistical rates of interventions, caesarean section rates, mortality, and morbidity. Walsh (2007), using his extensive experience of practice and research within a variety of U.K. childbirth environments and organisations, concludes that focusing on fixed clinical measures is inadequate to explain the complexity of human experiences, particularly childbirth. Sackett et al (1996) over a decade earlier similarly point out that evidence based practice is related to a trio of supports, consisting of

research, clinical expertise, and 'patients'' preferences. More recently the National Institute of Clinical Excellence (NICE) stipulates in its guidelines that interventions should not only be evidence based but should also be acceptable to women (NICE 2008). Walsh (2007) concludes that evidence has concentrated on the research element at the expense of women's preferences which have been marginalised.

2.2.2 Irish Context

In Ireland the evidence paradigm consistently referred to is one of mortality and morbidity with an emphasis on clinical measures. There is a paucity of research about women's views of existing maternity services. One of the few published studies investigating women's attitudes towards amniotomy in an Irish setting concluded that women wanted 'shorter' labours and did not mind interventions to help achieve it (Impey 1999). The presumption of a linear effect in the study between a choice of limited options and vague outcome has limited utility when evaluating the nuances of childbirth experiences. It is difficult to draw plausible conclusions about childbirth experiences by studying one aspect without relevant contextual knowledge. Conflicting data from in depth qualitative studies in Irish hospitals, found that women were distressed by interventions such as amniotomy, with a consequent negative perception of their birth experiences (McCann 2000, Durkin 2007). Similar to Cartwright's (1979) seminal research in the United Kingdom, what was regarded by many practitioners as 'routine' could be perceived as traumatic for women.

In 2006 a national survey of over 600 women published in the Irish Examiner found that 63% of women were dissatisfied with Irish maternity services (Regan 2006). A wide spectrum of concerns was expressed by women ranging from clinic waiting times, to privacy levels and interventions during labour and birth (Regan 2006). The report also highlighted that women who availed of private maternity care were happier with the amount of information they received about labour and birth, had more choice about birthing positions, and felt much more supported by midwives (Regan 2006). In the absence of any research

about what women want from childbirth experiences in Ireland it seems that an assumption is made that effective and safe outcomes for mother and baby will suffice. However, when women are consulted about maternity services they stress the experiential elements of the childbirth such as attention to women's preferences alongside clinical outcomes. Two policy documents relating to maternity services sought women's views about the organisation of maternity care, found that birth experiences were highlighted by women as an area of concern (DOHC 1997b, DOHC 2001). Submissions by women for The Report of the Maternity and Infant Care Scheme Review Group (DOHC 1997b) showed that the emotional and psychological dimensions of birth were important to women who said they would seek home births to ameliorate previous negative experiences in hospitals. The report found that women were unhappy about their childbirth experiences in hospital due to their; 'perception of an unfriendly atmosphere...lack of control ... procedures carried out without adequate informed consent and removal of dignity and autonomy' (DoHC 1997b:21). The report alludes to the women's voices 'being lost' in a hospital organisation and suggests ways in which they can be heard, stressing 'informed choice' and the treatment of woman with 'respect and kindness' (DOHC 1997b:28). The recommendations arising from the disquiet expressed by women about their childbirth experiences suggested that hospital accommodation should be 'set aside' with a more 'homely atmosphere where women can walk around and partners and children are welcome', whilst those who 'insist' on wanting to birth at home 'despite professional advice' alternative arrangements such as DOMINO services were suggested (DOHC 2007b:21). Despite women's expressed preferences for increased choice and autonomy, at the heart of the recommendations there appears to be a lack of understanding about the complexity of childbirth experiences. It appears that the policy makers believe that transplanting a homely environment to hospital would automatically address the concerns raised by women in relation to dignity, autonomy, and control. The changes in maternity services that emerged from this report centered on the setting up of 'pilot' domiciliary services, with the core of the maternity services remaining in hospitals with consultant led

care. A further consultation (DOHC 2001) to inform the health strategy 'Quality and Fairness' (DOHC 2001) suggested that significant improvements of maternity services needed to be made, including more choice and continuity for women. The report suggests that "A plan to provide responsive, high quality maternity care will be drawn up", the objectives of the plan being to ensure that maternity care is women centered, equitable across all parts of the country, accessible to all, safe and accountable (DOHC 2001). No such plan has been initiated and, although maternity policies have made some progress in recent years (Devane 2007), changes are however confined to portions of the service rather than an overall transformation.

The majority of women continue to access maternity services as outlined in Appendix 11 following a predominantly hospital-based model of care (KPMG 2008). The hospital-based model of care is often justified on the grounds of 'safety' based on a seemingly intractable belief that any other model of care might jeopardise the low maternal mortality rates. A substantial body of evidence has established that other models of care such as birth centres, and midwifery-led units, have been proven to be 'as safe' in terms of mortality and morbidity with additional advantages of improving women's assessments of their experiences (Walsh 2007, Begley et al 2009).

In Ireland significant reductions in maternal mortality and a corresponding decline in perinatal, neonatal, and infant mortality have mirrored international improvements (KPMG 2008). However, the concentration on quantitative clinical outcomes has been at the expense of gaining a better understanding of the social and psychological impacts of maternity services using different types of evidence such as the opinions of its users.

Although internationally organisations have moved from hospital to community based models of maternity care, in Ireland there appears to be a reluctance to move away from hospital based consultant led care. Alternative models of care in Ireland such as DOMINO care and Midwifery-Led Units have been initiated in some areas but their dispersal

is disjointed and inequitable with varying levels of services available depending on a woman's geographical location. The present predominantly hospital-based model is 'contrary to currently recognised best practice that promotes primary and community care models managed by midwives with medical intervention by obstetricians reserved for high risk pregnancies and births' (KPMG 2008:52). In the United Kingdom, community based models have been shown to influence the way women perceive pregnancy (i.e. it is not an illness therefore hospital is not necessary), and improve childbirth experiences (Walsh 1999).

The KPMG report draws attention to alternative models of care in the Netherlands and New Zealand that have similar clinical outcomes to hospital-based ones, although they include a stronger primary care and community focus with an increased midwifery input (KPMG 2008). Internationally more attention has also been placed on the psychological and social impacts of the birth experience and the reconceptualising of safety as a psychological and emotional event in addition to the physiological process (Walsh 2007). Despite international evidence about the benefits of community based care, and declarations by policy makers to aspire to women-centered care (DOHC 2001) maternity care provision in Ireland has become more hospital and technology focussed (Kennedy 2000). There is little awareness or attention given to the potential psychosocial sequelae of birth experiences, both positive and negative. Women respond positively to measures of satisfaction because they think they have received the best care available (Van Teijlingen *et al* 2003). Women and health providers especially in the maternity services may have different views and interpretations of the meaning of 'success' (Graham and Oakley 1981), consequently aspects of experiences such as psychological safety may be underestimated (Walsh 2007).

2.3 Competing Ideologies

The differing frames of reference about childbirth are construed as 'competing ideologies' (van Teijlingen 2005, Graham and Oakley 1981) (Appendix 111). The social model considers childbirth as a 'life event' imbued with personal social and cultural meaning, whereas the medical model regards childbirth as an intrinsically dangerous medical event. The social model encompasses elements of childbirth experiences in addition to the medical positivist paradigm of a live mother and baby. Feminists are concerned about medical claims of 'authoritative knowledge' because it disempowers and undermines women's 'inferior' knowledge about childbirth (Oakley 1980, Rothman 1991). Other critiques of the dominant medical knowledge have been made from a variety of perspectives and disciplines. Criticism from doctors (Johanson *et al.* 2002) question obstetric involvement in normal birth. Tew (1995) suggests that medical misrepresentation and statistical misinformation has led to obscuring evidence that birth is: 'safer the less the process is interfered with' (Tew 1995: vii). Feminists (Oakley 1980, Murphy-Lawless 1998) criticise the biomedical preoccupation with numbers, the systematic exclusion of women's knowledge, combined with a political agenda to support dominant practices and norms through a process of patriarchal privilege. Anthropological analysis augments the censure of the dominant biomedical/technocratic discourse suggesting a pervasive hegemonic culture that functions as: 'a powerful agent of social control, shaping and channelling individual values, beliefs and behaviours' (Davis-Floyd 1994:1125). Midwives (Begley and Devane 2003, Walsh 2007) and consumer groups (Newburn 2007) argue against medicalisation as a distortion of a complex multidimensional but fundamentally natural process, whilst proposing an alternative social or midwifery model of childbirth. Despite their diverse backgrounds a common theme is the extent to which childbirth in Western society has been medicalised by defining childbirth as an inherently dangerous event requiring close monitoring and intervention, rather than a 'natural' or 'social' process.

Childbirth according to some authors (Rothman, 1991, Leavitt, 1986; Davis-Floyd and Sargent, 1997; Oakley, 2000) encompasses a complex layering of cultural, political, and gendered significance where a dominant science-oriented perspective persists. Hence, solutions and improvements are based on measurements of outcome through mortality and morbidity statistics (van Teijlingen 2005). Concerns about such scientific measures and statistical aggregates emphasise deficits of a purely reductionist approach. There are doubts about their accuracy due to variances in routine recording (Said *et al.* 2006), ascertainment differences (Zhang *et al.* 2005), and producing partial knowledge thereby masking other physical and emotional problems (Cartwright 1979, Salmon 1999). Although labour is a universal physiological process, the more tenuous interrelated psychological and emotional elements that women experience are often ignored in favour of more tangible components such as quality of care, interventions and mortality and morbidity measures (Oakley 1993, Baker *et al.* 2005). Oakley (2000) adds that the complexity of childbirth is such that one method of inquiry such as a purely positivist approach, is insufficient to answer any in-depth questions about it.

The evolvment and dominance of medical knowledge has implications for the way in which childbirth is defined, valued and organised, (van Teijlingen 2005) and how society and women perceive the childbirth experience. Murphy-Lawless (1998) and Oakley (1981), suggest that medicalisation marginalises women's childbirth experiences in a society circumscribed by a dominant group rooted in a patriarchal model that has become entrenched within the fabric of society. According to some authors there is evidence that there is a reduction in the monopolisation of medical authoritative knowledge (Zadoroznyj 2001, Brubaker and Dillaway 2009), increasingly challenged by a variety of groups and individuals including professionals, semi-professionals and 'lay experts'. As reflected by Zadoroznyj (2001), some women are moving from being passive recipients of medicalisation to actively shaping their own experiences. Van Teijlingen (2005) in his analysis of the medical model stipulates that both ideologies are not static but are being continually

redefined. In an Irish context, however, medicalisation seems to persist and remains a dominant force (Murphy-Lawless 1998) shaping both policy and organisation of maternity services (O'Connor 2006), with a consequent impact on women's childbirth experiences.

Childbirth experiences are individual and generalisations are difficult to make. Newburn (2007) has established that the agenda about women's needs during childbirth is limited and determined by what is already provided or what has never been experienced. The concept of evidence underpinning midwifery practice has become an underlining feature of the maternity services, but due to the individuality of childbirth experiences there is little consensus about the important elements of that experience. Investigating women's experiences of childbirth has a number of acknowledged problems including the apparent ambivalence of some of the research findings (Walsh 1999). Women may receive the care that they want or alternatively what they expect, as previous experience can mediate choice. Women are reluctant to criticise maternity services and their carers, and tend to evaluate their experiences positively (Walsh 1999, Hodnett 2002), compounded by a belief that the mainstream services they receive are the best possible (van Teijlingen *et al.* 2003). Women may not be aware of the possibilities of a service based on women-centered care and therefore couch their expectations within the medicalised framework they have experienced and have come to expect. If women are not aware of the potential for different services they will not aspire to them and will assess present services positively. Consequently there are difficulties establishing whether services actually meet women's needs, and in establishing clear preferences to inform evidence based practice.

In order to establish the important aspects of childbirth experiences requires an acknowledgement of the effects of care on women's experiences. Furthermore, Page *et al* (2006) stipulate a need to establish more complex indicators that encompass the reality of childbirth rather than simple physical 'events'. There are multiple methodological challenges in researching childbirth experiences, and in

developing the existing complexity of evidence. Despite agreement across disciplines regarding the significance of childbirth experiences, there is little consensus on a conceptual definition. To clarify some of the elements of childbirth experiences a concept analysis was undertaken, and the following section describes this process.

2.4 Concept Analysis

Concepts such as experiences are shaped and developed by a variety of forces including contextual factors such as their use in daily life and in the development of a disciplinary knowledge base (Rodgers and Knafl 2000). Concepts are an essential structural component of theory development (Chinn and Kramer 1999), and are a significant form of enquiry that expands and develops nursing knowledge (Hupcey and Penrod 2005). Such developments are also important contributors to midwifery knowledge by enhancing the theoretical foundations of research and practice. Morse (1995) considers that the most urgent area for methodological development is that of conceptual inquiry. The evolutionary method involved is based on the primary activities outlined by Rodgers (2000) (Table 1).

Table 1 Steps in evolutionary concept analysis

- Identify the concept of interest
 - Identify surrogate terms and relevant uses of the concept
 - Identify and select an appropriate realm for data collection
- Collect data relevant to identify the:
- (a) attributes of the concept and
 - (b) the contextual basis of the concept including interdisciplinary socio cultural and temporal variations.
- Analyze data regarding the above characteristics of the concepts
 - Identify implications hypotheses and implications for further development of the concept. (Rodgers 2000:85)

An evolutionary view of concept analysis is appropriate to the experience of childbirth as it espouses a view of reality and of human beings as comprised of many interrelated and overlapping elements (Rodgers 2000). Within the evolutionary model, attributes are not a fixed set of necessary conditions; instead the cluster of attributes that constitutes the concept may unfold over time (Rodgers 2000). The aim of the analysis is for the researcher to identify a current consensus of the 'state of the art' that will provide a foundation for further development and enquiry (Rodgers 2000).

The concept of childbirth experiences has received increasing attention from a variety of disciplines over the last two decades. Historically, midwives borrowed heavily from knowledge generated from and within a medical model. Since the middle of the 20th century, however, perspectives from psychology, social and behavioural sciences, interest groups, and midwives themselves have influenced the knowledge base of the midwifery profession, and contributed to a more informed understanding of childbirth as a cultural, social, and psychological phenomenon as well as a physiological one (Oakley 1993, Hunt and Symonds 1995). Nevertheless, the extent to which knowledge integrates women's 'ways of knowing' (Oakley 1993) is open to debate as is the influence of prevailing epistemologies on research interests and what is viewed as 'data' (McCourt 2005).

The concept of childbirth experiences is therefore culturally framed and often mediated through professional interpretations. The midwifery interpretation of the childbirth experience relates to the social model of childbirth as a life event. Midwifery care involves holistic women-centered perspectives, which incorporate multiple ways of knowing such as intuition and experience in addition to knowledge (Davis Floyd and Sargent 1997).

This review is not impervious to limitations of different interpretation but attempts to analyse the concept of women's experience of labour and birth by identifying its attributes, antecedents and consequences.

The experience of labour and birth is complex, multidimensional and subjective, relating to both the outcome i.e. the safe birth of the baby and the process i.e. the physical and cognitive processes of labour and birth experienced by individual women. For the purpose of this analysis childbirth refers to the experience of labour and birth but excludes experiences of elective caesarean section, as the research focuses on the process of labour and birth which differs from an elective surgical process.

2.4.1 Search Methods

An extensive search was carried out in computerised databases CINAHL, MEDLINE, and PsycINFO. The initial search identified over 9,000 citations related to 'childbirth'. The search was limited to those published from 1990 to 2005, as I felt that this period takes into account the recent changes toward recognising the importance of the childbirth experience to the woman and her family. In order to focus on the element of childbirth experience the addition of 'experience,' 'labour',' and 'birth', combined with the 'and' and 'or' Boolean operands as appropriate limited the sample to 2,200. The MIDIRS database identified a specific search related to 'women's experience of labour' (L54) with 197 citations. Manual searches of online journals were also undertaken to ensure that characteristics associated with the concept of experience of labour and birth were included in search terms. Once duplications, non-English literature, and papers extraneous to the concept were excluded, 1,500 abstracts were read. A total of 300 articles tentatively met the sampling criteria of primary research that would elucidate the concept of women's experiences of labour and birth. The sample was further reduced by excluding childbirth experiences that merit specific consideration such as stillbirths, particular client groups, post traumatic stress disorder, and organisational issues.

The majority of research was published in interdisciplinary journals, encompassing multidisciplinary approaches, which precluded the comparison of disciplinary perspectives as suggested by Rodgers (2000).

Research conducted by consumer groups and childbirth educators was included as it added to the development of the concept. The literature was therefore classified according to the theoretical foundations of the research, identifying areas of consensus to substantiate the conclusions of the work as suggested by Rodgers (2000).

The papers were divided into two groups, one representative of the subjective experiences of women as identified in studies that explored the childbirth experience from a qualitative perspective. The second group was representative of studies that were broadly quantitative in nature. A random sample of 60 studies, 30 from each paradigm, was identified using a table of random numbers. As suggested by Rodgers (2000), a purposive sample of two works that were frequently cited, Green *et al.* (1990) and Simkin (1991) were included, giving a final sample size of 62 papers for detailed analysis.

2.4.2 Methodological Approaches

Methodological issues and the complexity of 'measuring' the childbirth experience have been discussed in the literature (Bramadat and Driedger 1993, Brown and Lumley 1997, van Teijlingen *et al.* 2003), and is evidenced by the multiplicity of approaches and designs. The range of broadly positivist approaches included surveys, correlation and longitudinal studies, and randomised controlled trials. The focus of the research related to measures of concepts such as self efficacy, satisfaction, and attitudes encompassing elements of childbirth experiences deemed to be important to women.

Green *et al.* (1990), for example, employed three questionnaires, two before and one after birth, including objective and subjective aspects of birth and four indices of psychological outcome. Psychological theories, e.g. 'self-efficacy,' were used to underpin the work of some researchers such as that of Larsen *et al.* (2001), and Lowe (2000). Survey approaches have used multivariate analysis or multiple regression analysis (Goodman *et al.* 2004) in an attempt to identify independent explanatory variables for satisfaction. Some authors combined open

questions following each section (Brown and Lumley 1994) or at the end of the questionnaires (Fowles 1998, Lavender *et al.* 1999). Research has shifted from identifying variables related to the childbirth experience to developing tools to measure them (Bramadat and Driedger 1993). The literature reviewed included a proliferation of research instruments including a multidimensional satisfaction survey instrument (Johnson *et al.* 2002), and the development of a taxonomy of patient satisfaction (Howell and Concato 2004). Harvey *et al.* (2002) combined the Labour And Delivery Satisfaction Index (LADSI) and the Attitudes about Labour and Delivery Experience (ADLE) with a Six Simple Questions (SSQ) questionnaire, administering the questionnaire at 36 weeks gestation, 48 hours, two and six weeks postpartum. Goodman *et al.* (2004) used a combination of the Labour Agency Scale, McGill Pain Questionnaire, and the Mackey Childbirth Satisfaction Rating Scale, to assess satisfaction. Proctor (1999) investigating women's responses to maternity care deliberately omitted the term 'satisfaction' from her study, because women in the developmental focus groups felt strongly that it was "too lukewarm a term" to describe their feelings about their birth (Proctor 1999:495).

Studies guided by a qualitative paradigm explored a deeper and more contextual understanding of women's experience of childbirth, and its emotional impact including the complex and sometimes contradictory feelings that childbirth evoked. Data collection methods used included focus group interviews (Di Matteo *et al.* 1993) but the majority involved individual interviews. Interview studies mostly adopted a phenomenological approach and identified descriptions of the affective process of childbirth or employed the use of metaphors e.g. 'Releasing and Relieving Encounters' (Lundgren 2004) and 'Birth as a journey' (Halldorsdottir and Karlsdottir 1996). The sample of women in some studies were from a range of social backgrounds (Bluff and Holloway 1994, Fraser 1999), while in others women were identified as being 'white middle class' (Miller 2005) or 'mostly middle class' (Di Matteo *et al.* 1993) with little ethnic or city deprivation variation (Hall and Holloway 1998, VandeVusse 1999). Although qualitative research does

not purport to be representative, the studies in this sample may be the voices of a particularly articulate group of women who are confident in expressing themselves.

Participants were recruited through antenatal classes (Mozingo *et al.* 2002, Larsen *et al.* 2001), or via the woman's General Practitioner (Ogden *et al.* 1998). Studies were conducted in a variety of settings including doctors' waiting rooms (Di Matteo *et al.* 1993), birth centres (Lundgren and Dahlberg 1998), midwifery led units (Hall and Holloway 1998), participants' homes (Ogden *et al.* 1998), in hospitals (Bluff and Holloway 1994) and in both home and hospital (Fraser 1999). Debates continue on the effects of timing of postnatal research, the context in which it is carried out and by whom it is undertaken.

It is clear from the literature reviewed that childbirth experiences are difficult to measure. 'Success' means different things to individuals and care providers. Traditional indices may not capture contextual meanings. Despite the multidimensional nature of satisfaction, the difficulty for women identifying their experience on the positive or negative continuum by means of a Likert scale e.g. (LADSI), is that components of the experience, such as 'control', (e.g. LAS), are not always present or absent, but rather may be part of an ebb and flow that shifts during labour (Lundgren and Dahlberg 1998). Similarly, other pre-coded dimensions of surveys such as 'success' of pain relief, 'helpfulness', 'kindness' of caregivers are difficult to assess in terms of 'very', 'partly' or 'not at all' (Brown and Lumley 1998). Women's perceptions of 'normality' may differ; they may avail of a variety of pain relief measures, have had care from a number of caregivers, and can require from them different interactions at different times during the course of labour. The limitations of the studies in this sample are consistent with the limitations of most satisfaction studies in that they restrict the range and complexity of responses, and seldom identify the relative importance or value that individual women place on different aspects of childbirth (Bramadat and Driedger 1993).

2.4.3 Timing of Research

Studies selected were mostly retrospective and varied in timing from during labour (Larsen *et al.* 2001), to 24-72 hours, (Bluff and Holloway 1994, Salmon *et al.* 1990), three to six months (Di Matteo *et al.* 1993), two years (Lundgren 2005), three to five years (Ogden *et al.* 1998) and 16-22 years (Simkin 1991), following the birth. Eliciting women's experiences while they remain in hospital at a time when they may feel physically and emotionally vulnerable can be problematic. Women may have difficulties in discussing negative aspects of birth in the early postnatal period especially if the baby is healthy (Soet *et al.* 2003). Women could be susceptible to a 'halo effect,' where initial relief and euphoria means that women are less likely to be negative about their experiences (Waldenstrom *et al.* 1996) or, conversely, that a negative experience that did not meet expectations may cause a grieving process of which the first stage is denial (Bramadat and Driedger 1993:27).

2.4.4 Data Analysis

A combination of iteration and thematic analysis identified recurrent variables, words, or phrases related to the attributes, antecedents and consequences of the experience of childbirth. Although the analysis focused on manifest (surface) content, latent (underlying) content was also used to describe occasions where themes were implicit (Joffe and Yardley 2004). Methodological issues such as timing of the research, methodological approaches, sampling frames, in addition to contextual features, were also noted. The research was conducted within a variety of models of maternity care with the majority of the research being carried out in the United Kingdom (22) North America (13) Sweden (9) and Australia (7). In the process of analysis, the characteristics of the concept and surrogate terms were identified and the related concepts, antecedents and consequences were documented.

2.5 Findings

2.5.1 Characteristics of the Concept

The essential characteristics of the concept should be applicable to any situation in which the concept is present (Morse 1995). Notwithstanding the methodological difficulties and the inherent limitations of researching such a complex phenomenon, there was evidence of consensus on the attributes of the concept of the labour and birth experience. The attributes identified were: individual, complex, process and life event.

2.5.2 Individual

The terms 'unique' and 'special' are encompassed in this attribute. Although childbirth is a universal phenomenon, women's experiences are subjective, personal, and particular. The broader social, moral, and cultural contexts of childbirth are experienced by women in different ways (Miller 2005). Authors describe the experience as unique, universal, individual and idiosyncratic (Halldorsdottir and Karlsdottir 1996), or unique and special (Proctor 1999). Many aspects of the experience such as pain and control are perceived by individual women in different ways, both positively and negatively. Women themselves have expressed the uniqueness of the childbirth experience (Halldorsdottir and Karlsdottir 1996) and a need to be related to as an individual during the process (Berg *et al.* 1996, Fraser 1999, Lundgren 2004). The specific blend of individual experiences differ, affected by interrelating factors and contexts such as the dynamics of the relationship with the carer, the amount of perceived pain, perceived control, the nature of support received, previous experience, and the outcome and process of labour.

2.5.3 Complex

The experience of childbirth is described as complex (Lavender *et al.* 1999) or complex and multidimensional (Waldenstrom *et al.* 1996). The tapestry of the concept (Hupcey and Penrod 2005) is demonstrated by the intricacies of dimensions such as 'control' and 'pain' and the affinity between 'support' and outcomes. In addition, the plethora of tools

developed in an attempt to evaluate dimensions of the experience is a further demonstration of its complexity. Studies stemming from both qualitative and quantitative traditions identify the most important features of the experience such as 'feeling in control' and 'support'; however, their meanings to women in labour are often conceptualised differently. For many women, knowing that they are being cared for by experts and letting them make decisions, allows them to feel in control (Bluff and Holloway 1994) thus, these women may not question decisions made (Halldorsdottir and Karlsdottir 1996, Blix-Lindstrom *et al.* 2004). It is the belief that the woman could have made a different choice, which enhances her sense of control, and abdicating decision-making responsibility can be part of this (Green *et al.* 1990). Women identify a synergy between physical and psychological processes (Lundgren 2005) whilst Parrat and Fahy (2003) suggest that some women experience a struggle between mind and body, and that relinquishing mind control releases the body progressively throughout labour in the context of a trusting relationship with the midwife. Furthermore, feelings during labour are not static entities, but may involve contradictory positive and negative feelings (Waldenstrom *et al.* 1996), and perceptions of being in control and loss of control, taking command of oneself or letting go (Lundgren 2005).

2.5.4 Process

The process of the experience of childbirth is characterised by the beginning, labour, with the movement or activity towards a goal, that of giving birth, and a transformative process to motherhood (Miller 2005). This idea echoes the progressive and sequential physiological processes of normal labour, which involves a productive effort or 'work' (Gould 2000), and an unpredictable journey (Halldorsdottir and Karlsdottir 1996). Childbirth, and hence the experience of it, is a process with a dynamic and temporal nature (Drummond and Rickwood 1997). Due to the dynamic nature of childbirth, physical and psychological processes fluctuate during the experience and are in turn affected by the outcome, i.e. women feel more positive about the experience when the baby is healthy (Halldorsdottir and Karlsdottir 1996), or can feel more negative

about a birth if they perceive labour as being prolonged (Nystedt *et al.* 2005).

2.5.5 A Life Event

The childbirth experience is variously described as one of profound significance for women (VandeVusse 1999), a significant landmark in women's life (Andrews 2004), an important life experience (Lundgren 2005), and a pivotal life event (Matthews and Callister 2004). The experience is variously described as critical and reflexive, contributing to a change in lived identity, developing women's knowledge (Zadoroznyj 1999), or as rite of passage with complex psychological and social processes and outcomes (Di Matteo *et al.* 1993). Women have described the experience as an: 'intense powerful life experience, naturally magnificent, awe inspiring' (Halldorsdottir and Karlsdottir 1996:56) or may feel betrayed or violated by the experience (Mozingo *et al.* 2002). Although discussion about life events (Holmes and Rahe 1967) is beyond the scope of this analysis, the experience of childbirth can have profound effects that may be positive, but may also be stressful (Knapp 1996), disappointing (Mozingo *et al.* 2002, Lavender *et al.* 1999), and associated with a loss of identity subsumed within a new identity as a mother (Miller 2005).

2.6 Surrogate Terms

Surrogate terms are means of expressing the concept other than the word or expression selected by the researcher to focus the study (Rodgers 2000). The term 'experience' was interchanged with a variety of surrogate terms such as 'satisfaction' (Howell and Concato 2004, Goodman *et al.* 2004), and 'satisfaction with care' (Harvey *et al.* 2002). However, the use of satisfaction is an ambiguous, ill defined health care phenomenon (McCrea 1993), and the subject of much analysis and debate (Bramadat and Driedger 1993). In the absence of alternatives, satisfaction indices continue to be used in researching women's experiences of labour and birth. Women's experiences have also been explored within a range of dimensions or variables related to the experience, which are identified as related concepts.

2.6.1 Related Concepts

Related concepts are based on the idea that every concept exists as part of a network of concepts that provide a background to, and help to impart significance to, the concept of interest (Rodgers 2000). The most commonly identified elements in the sample of papers reviewed relating to childbirth experiences were control, support, relationship with caregiver, and pain. Although considered separately, there are affinities between concepts such as 'control', and 'relationships with professionals', (Green *et al.* 1990, Brown and Lumley 1997).

2.6.2 Control

Control is identified as a key factor that can enhance or diminish the experience of childbirth, but is not always conceptualised in the same way (Green and Baston 2003). Women's perception of 'control' as a subjective experience may not be a static entity throughout labour with some women wanting to relinquish control to others (Bluff and Holloway 1994) yet remain actively involved in the labour, whilst others felt that negotiating support from caregivers was a significant dimension of control (Hall and Holloway 1998). 'Control', as a key component of the childbirth experience, is highlighted through women's narratives (Simkin 1991), phenomenological perspectives (Hallsdorsdottir and Karlsdottir 1996, Gibbins and Thomson 2001), grounded theory analysis (Hall and Holloway 1998), feminist constructivist perspectives (Parratt and Fahy 2003), satisfaction studies (Slade *et al.* 1993, Brown and Lumley 1994), psychological indices (Ayers and Pickering 2005) and as an explanatory variable in relation to overall experience (Goodman *et al.* 2004). Feeling in control can contribute significantly to women's satisfaction with the labour experience (Knapp 1996), and with feelings of fulfilment and postnatal emotional wellbeing (Gibbins and Thomson 2001, Green and Baston 2003).

Control was also related to the birth environment (Proctor 1999), and, from a sociological perspective, to societal changes and organisational shifts. Miller (2005) suggests that hospital is now culturally accepted as

the 'natural' place to give birth, although this is likely a 'developed country' perspective. Miller points to possible tensions between policy concerns and the personal private experience of childbirth. Whilst childbirth is life changing for individuals at a societal level mothering has also changed within a 'changing and increasingly diverse social and familial circumstances' (Miller 2005: 111). Zadoroznyj (1999) proposes that natural childbirth models also involve control that is more 'internalised' i.e. disciplinary power over the self. Women, in an attempt to increase their feeling of control during labour and birth, have chosen particular birth environments including labouring in water (Hall and Holloway 1998), home birth (Andrews 2004), birth centres (Berg *et al.* 1996) and, in some cases, to avoid the experience of labour and birth by opting for a caesarean section (Ryding 1993).

2.6.3 Support

Intrapartum support appears to have a number of benefits for mothers and their babies, with a pivotal influence on the childbirth experience (Callister 1993, Halldorsdottir and Karlsdottir 1996, Ogden *et al.* 1998) that may protect women from long-lasting negative experiences (Lundgren 2005), and can be related to feeling in control (Gibbins and Thomson 2001). Support was generally identified by women as caring, providing emotional support, having a presence (MacKinnon *et al.* 2003), treating women as individuals (Fraser 1999, Lundgren 2004), encompassing elements of comfort, privacy, (Ogden *et al.* 1998) and dignity (Matthews and Callister 2004).

2.6.4 Relationship with Caregiver

The presence of a caregiver who is supportive, sensitive to a woman's needs and who communicates information appropriately during labour contributes to women's satisfaction with the childbirth experience and to a woman's feeling of participation (Green *et al.* 1990, Waldenstrom *et al.* 1996, Brown and Lumley 1998). The interpersonal skills of carers can enhance the experience of labour and transcend other attributes such as pain relief (Corbett and Callister 2000), and knowing the caregiver can contribute to feeling in control (Homer *et al.* 2002). The potential to

influence decisions during childbirth can contribute to feelings of control (VandeVusse 1999) and can impact profoundly on the birth experience (Slade *et al.* 1993, Bramadat and Driedger 1993). A caregiver who is knowledgeable, intuitive and flexible and who understands the contextual nature of women's individual concerns (MacKinnon *et al.* 2003) involving women in decision making can therefore enhance the birth experience.

2.6.5 Pain

The experience of pain during childbirth is a complex phenomenon that can impact negatively on women's experience (Slade *et al.* 1993, Lavender *et al.* 1999) but can also lead to feelings of fulfilment and achievement (Salmon *et al.* 1990, Waldenstrom *et al.* 1996, McCrea and Wright 1999). The elimination of pain is seen by obstetric practice as the primary factor in providing a positive childbirth experience (Stern 1997). However, for some women, pain is an essential component of the childbirth experience, bestowing meaning to the transition to motherhood (Lundgren and Dahlberg 1998), whilst its absence may contribute to a woman's perceived loss of control of the process of labour and birth (Stern 1997). Pain is influenced by other factors such as personal control (McCrea and Wright 1999), and confidence in oneself and in carers (Lundgren and Dahlberg 1998). The importance of pain as a contributor to the experience of birth is individual, with a multiplicity of physiological and psychological mediating factors, but it is a woman's ability to manage pain that can influence her perception of the labour experience (Lowe 2000).

2.7 Antecedents

Antecedents are situations preceding an instance of the concept; the physical antecedents to the experience of childbirth are pregnancy and the event of labour. The affective antecedent to the experience of birth identified in the literature is that of expectancy. Women's expectations can be coloured by societal expectations which influences their sense of what is appropriate behaviour during labour (VandeVusse 1999). Women

develop their expectations over time (Beaton and Gupton 1990), and they may incite hope and happiness, or provoke anxiety and fear (Melender 2002, Saisto 2003). Many of the theories of satisfaction are based on fulfilment or discrepancy models, but psychological antecedents are not a feature of this model (Bramadat and Driedger 1993). A woman's confidence in her ability to cope with labour has been identified as a predictor of a positive childbirth experience and has been investigated using psychological scales that seek to measure their 'self efficacy' (Drummond and Rickwood 1997). All women develop detailed individual expectations for their birth experience (Gibbins and Thomson 2001), which relate to analgesia, pain, (Beaton and Gupton 1990), in addition to interventions, control, involvement in decision making and support from their caregivers (Green and Baston 2003). Women's perception of 'not coping' and succumbing to pain relief has been associated with a sense of 'personal failure' (Stern 1997). The literature indicates that incongruence between maternal childbirth expectations and the reality of the actual experience of childbirth has a negative impact on women's perceptions of their experiences (Mozingo *et al.* 2002, Waldenstrom *et al.* 2004a, Lundgren 2005).

2.8 Consequences

The transition to becoming a mother requires complex cognitive, affective and behaviour changes (Fowles 1998). A mother's feelings about her labour can affect her maternal role attainment and her self concept (Callister 1993). What is considered a 'successful' birth by professionals may not always correspond with the woman's criteria of 'success' (Lavender *et al.* 1999). The consequences of the experience of childbirth can lead to increased self confidence (Simkin 1991), acquisition of skills and knowledge (Halldorsdottir and Karlsdottir 1996), or can result in feelings of guilt and disappointment (Stern 1997). The development of a new identity and the establishment of the mother in a new role in society can be a source of stress for many women (Miller 2005). Negative birth experiences have resulted in women avoiding further pregnancies, choosing to terminate pregnancies, and demanding caesarean sections (Ryding 1993).

2.9 Discussion

The experience of childbirth and the experience of care are considered as a whole (Waldenstrom *et al.* 1996). Future concept development may consider if this is the case and, if not, might attempt to further disentangle these as separate entities. The interrelationship between related concepts such as 'control', and 'relationships with professionals', highlight areas for future consideration. The predominantly professionally mediated nature of research and the literature has already been acknowledged. The data could possibly have been enriched, by selecting literature from other perspectives to incorporate cultural and spiritual aspects of the experience.

Childbirth has undergone a change in its cultural meaning from a private to a public event. Childbirth has been given a public recognition by medicalising the 'natural' event into an event which is potentially 'unnatural' and places childbirth within the medical and scientific realm (Murphy-Lawless 1998). Childbirth has therefore been converted from private and mysterious to a subject for open discussion which has assimilated a different set of meanings, and has become a focus of technical intervention and scientific application (Hunt and Symonds 1995). An important evolutionary aspect of the experience of childbirth is that the focus on the 'birth experience' has come about once the fears about mortality of the mother and baby became less likely (Murphy-Lawless 1998). Important attributes of the childbirth experience are consistently and historically identified in the literature. Supportive behaviour from caregivers has been alluded to from Biblical times and in English manuals of midwifery in the 17th and 18th Century (Tew 1995). Supportive care still has a profound effect on childbirth experiences but is contingent on the birth environment, type of provider, timing of onset and organisational policies (Hodnett *et al.* 2003). Although the importance of the childbirth experience is acknowledged, there is little agreement on the type and timing of interventions that may be warranted, or the preventative measures carers, policy makers and organisations can adopt prior to, during and after labour. In reviewing

the literature over fifteen years, studies of childbirth continue to move from objective investigations examining the role of interventions and identifying outcomes, and from a dichotomous evaluation of experiences as positive or negative. Subjective exploratory studies now investigate and report women's experiences, elucidating various affective dimensions from a variety of perspectives. The childbirth experience has been studied in the broader context of health policy, organisational and professional philosophies and societal changes. Turriss (2005) in her feminist critique of satisfaction theories suggests that the concurrent focus on consumerism and accountability is forcing health care providers finally to attempt to address the experiences of those for whom they provide care. These challenges require inventive and creative research approaches (Hundley *et al.* 2001), drawing on evidence of women's experiences and opinions (Sackett *et al.* 1996), and integrating methods (Creswell 2003). A cyclical approach to knowledge development (McCourt 2005) involving interdisciplinary approaches will increase our understanding and ability to improve women's birth experiences.

The attributes of the concept identified labouring women as unique individuals undergoing a transformative life changing process, incorporating interrelated physiological and psychological elements. These attributes and the related concepts of control, support and other dimensions of the childbirth experience are embraced within a social rather than medical model of childbirth (Murphy-Lawless 1998, Walsh 2007). A social model of care is one that society recognises as consistent with both its' values and diversity (Manero and Turner 2003). Such a model embodies the concept of being 'with woman,' i.e. the provision of individual, emotional, physical, spiritual and psychological presence/support by the caregiver (Hunter 2002) and embraces the 'normality' of childbirth. It is difficult for midwives to maintain these ideals within the prevailing bio-medical model of maternity care, a context from which much of the literature in the sample was derived. Alternatives such as Birth Centres, where the concept of midwifery is at the heart of a social model of care are characterised by a recognition of childbirth as a life changing event with implications for both individuals

and society as a whole (Manero and Turner 2003). Midwifery models of care promote the strength of women and their own power and skills but care for women is often dominated by the medicalised model of care (Walsh 2007). For woman to access such models of care and for midwives to provide them require a congruent organisational, policy and cultural environment (Hunter 2004) and a change in societal perspectives that are often entrenched by and into a bio-medical model of childbirth.

2.10 Conclusions

Advancing an understanding of women's experiences of childbirth has both practical and political relevance in current health care systems to guide practice, policy formulation, and research. Further development of the concept is warranted to understand more clearly related concepts such as 'support' and 'control'. Greater understanding of these concepts may be an effective way to prepare and support women and their partners and to identify effective, timely supports. The present concept analysis is a broad framework of a complex subject and provides a foundation from which further research may be broached and the concept further analysed.

2.11 Summary

Acknowledging that women's views about what happens to them during labour and birth is important is a relatively new concept. Cartwright (1979) exposed a gap in practitioners' knowledge when initiating interventions: 'without taking into account mothers views and preferences' (Cartwright 1979:136). Asking women what they want around the time of birth remains a topic that warrants further research (Newburn 2007). It is evident from the literature review that childbirth experiences are often obscured from much of the biomedical research. Although attempts have been made by various disciplines, existing means of evaluating experiences have been found to be of limited use in health care settings (Turriss 2005) and are particularly adverse in evaluating childbirth experiences. 'Satisfaction' for example is hard to define and difficult for women to verbalise in relation to childbirth

(Bramadat and Driedger 1993). The involvement of health professionals can also influence the methodologies and methods used, and the aspects of childbirth studied may be those that are the professional priorities whilst women's experiences may be marginalised (Walsh 2000).

Individual and personal experiences are important to our understanding of childbirth experiences and have provided us with relevant and important information but are inherently confined. Oakley (1999b), a committed feminist sociologist, points out that phenomenological individual experiences are self limiting, because the subjectivity of the researcher as in all sciences is a potential influence on the knowledge claims made (Oakley 1999b). Her stance suggests that rather than adopting exclusionary and exclusive veracity claims a range of research methods will enhance and expand our knowledge. A total rejection of biomedical research serves only to limit our knowledge base and our potential to influence policy decisions. Oakley (1993), and Patton (2006), remind us that different questions require different research methods and the ability to speak in the rhetoric of scientific inquiry is sometimes necessary to effect change in women's lives. Women's experiences of childbirth including those whose needs may not be met by routine care, must be considered and research conducted in such a way that women can express those views but also should be amenable to policy makers to influence policy decisions.

This chapter provided the background to the interview question, and has established the important concepts of childbirth experiences. In Ireland, policy makers and service providers have to date focused on issues relating to risk and convenience (O'Connor 2006), to the detriment of considering women's experiences in any meaningful way. The following section addresses the rationale for the research design and outlines the feminist framework within which it is situated.

Chapter 3

Research Design

3.0 Introduction

This chapter explains the research objectives, and justifies the design of the study. The chapter outlines the inherent limitations of the dominant medical model of childbirth incorporating criticisms of objective inquiry and authoritative knowledge. The challenges to the development of midwifery knowledge are explained with a brief account of feminist epistemologies and their commitment to understand and make visible women's experiences. Paradigm issues and mixed methods are discussed as a means of exploring the complexity of women's experiences of childbirth and to support feminist assumptions of multiple realities. The rationale and framework for the research design is outlined in the context of the research question.

3.1 Aim of the Study

The aim of the study is: To explore women's expectations of and preferences for childbirth experiences.

Objectives:

1. To determine women's expectations for childbirth experiences.
2. To identify the components or attributes of childbirth that are important to women.
3. To determine the relative value or utility that women assign to elements of their experiences.
4. To investigate the associations between women's preferences regarding childbirth experiences, and variables such as parity, age, and model of maternity care.

Achievement of the first two objectives occurred in the initial qualitative phase of the research whilst the second two objectives were addressed in the subsequent quantitative phase.

The research design is based on a sequential exploratory design (Creswell and Plano Clark 2007), with the intent of developing and testing the DCE research instrument. The DCE was developed through a rigorous set of procedures based on previous recommendations arising from DCE studies (Hundley et al 2001, Coast and Horrocks 2007) and guidelines related to mixed methods (Creswell and Plano Clark (2007)). The phases of the design are incorporated into a plan of the overall procedures to demonstrate the stages for the instrument development as outlined in Figure 1. The design will be discussed in detail later in the Chapter.

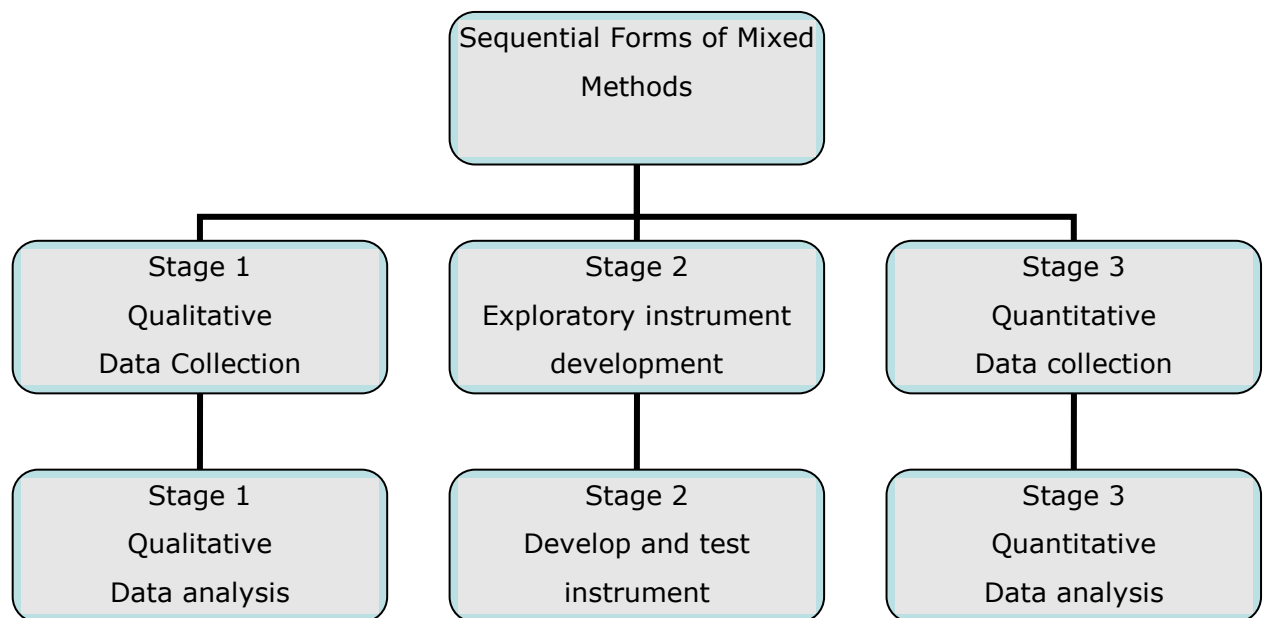


Figure 1: Sequential forms of Mixed Methods Data Collection (Creswell and Plano Clark 2007).

3.1.1 Feminism and Childbirth

The thesis has considered childbirth as a complex personal experience that also has implications for the family, community and society. Childbirth is considered by feminists to have cultural and political dimensions that are rooted in and have consequences for gender relations (Oakley 1981, Davis-Floyd 1992). There are many rich blends of feminism that defy any conclusive definition, however a distinguishing

feature of feminist research is the inclusion of women's experiences, encompassing a shared principle that women's lives are important (Reinharz 1992, Ramazanoglu 2002). I consider validating women's experiences of childbirth and regarding them as an important source of knowledge is central to midwifery and feminist thinking.

Historically, childbirth has been dominated by an androcentric dynamic where a patriarchal group dominates a predominantly female professional group that shares the same 'turf' (Walsh 2004:59). Disputes between doctors and midwives in Ireland are gendered in that most obstetricians are male and most midwives are female (O'Connor 2006). As alluded to in the introduction, policy and plans for service delivery continue to exert a patriarchal control over women who use and provide maternity services. Midwives are supposedly experts in 'normal births' (An Bord Altranais 2001), however, recent plans for maternity and gynaecological services suggest that this terrain remains firmly in the doctor's domain:

"Consultant obstetricians and gynaecologists should continue to contribute to the care of all pregnant women'...'The training in, and practice of, obstetrics and gynaecology requires expertise in, and ongoing exposure to, normal pregnancies".

(The Institute of Obstetrics and Gynaecology 2006:34)

It is in the interest of maintaining their expertise that women should be cared for by doctors – therefore services will be provided (in part at least) from institutional settings. The report expresses a wish to influence policy makers to provide the highest standard of care 'close to home', yet the recommendations reiterate the 1976 policy of 100% consultant led hospital births (Comhairle na n-Ospidéal 1976) albeit for a different rationale. The Institute stipulates that pregnant women should be 'counselled' in favour of birth within a maternity unit ...'given the current infrastructure available' (The Institute of Obstetrics and Gynaecology 2006:36). The report does suggest the expansion of DOMINO services, however the dominant institutionalised medical model of care is clearly emphasised.

The male domination of the obstetric profession has resulted in a mechanised view of childbirth that has to be ordered and controlled (Murphy-Lawless 1998, Oakley 2000), with little regard given to women's experiences. The masculinist emphasis on the physiological event dis-empowers women by subsuming their individual experiences. Midwives subscribe to an alternative more fluid idea of childbirth by normalising the uniqueness of women's experiences rather than maintaining rigid boundaries and expectations by which many women will 'fail' (Crabtree 2004).

3.1.2 Feminism and Midwifery

Midwives profess to be 'women centered' reflecting the Anglo-Saxon origin of the word midwife meaning 'with woman' (Pairman 2006), therefore have a great deal in common with feminism. Elizabeth Davis asks "what could be more feminist than the practice of midwifery"? (Davis 1987:5), because midwives embrace the concept of being 'with woman' to define their role. Despite the relationship between feminist theory and midwifery (McCool and McCool 1989) and affinities between feminist thinking and midwifery research (Mander 1999); there is a paucity of feminist midwifery research. One of the difficulties in adopting this type of approach may be that feminism is conceived as a direct challenge to traditional research or perhaps the myriad of feminist frameworks may cause misunderstandings and misconceptions (McLoughlin 1997).

I consider that a feminist theoretical framework is intrinsic to the research undertaken and aligned to my professional and philosophical position that acknowledges the legitimacy of women's experiences with multiple realities rather than a single objective truth. There are continuing debates about whether experiences in fact constitute reality and about the validity of knowledge that transpires when connecting such knowledge and experience (Ramazanoglu 2002). Whilst feminists do not have any intellectual, moral or other authority to decide for others what experience really is (Ramazanoglu 2002), and despite the

challenges researching women's experiences, feminists contend that: "females are worth examining as individuals and as people whose experience is interwoven with other women" (Reinharz 1992:241). The research undertaken attempts to respond to the devaluing and disparaging of feminist knowledge by producing and justifying 'better knowledge'. The following section presents a critique of the biomedical knowledge claims about childbirth that undermine other forms of knowledge.

3.2 Contested Knowledge

Authoritative knowledge is an interactionally grounded notion where a community produces and reproduces its own 'brand' of knowledge and where some authorities wield more power than others (Jordan 1997). Jordan views knowledge in the context of power relations where certain types of knowledge 'count' more than others because they are affiliated to a stronger power base. This is of concern to women, feminists, and midwives because powerful authoritative knowledge forms the basis for policy and practice, thereby subjugating other forms of knowledge that could potentially enhance women's childbirth experiences.

Much of the authoritative knowledge in relation to childbirth relies on scientific androcentric evidence supposedly derived from rational thinking and deductive reasoning (Oakley 2000). The scientific knowledge produced is more easily explained and replicated therefore culturally accepted and supported (Davis-Floyd 1992, Murphy-Lawless 1998). Alternatively midwives tend to rely on intuition as a source of authoritative knowledge, but any challenges to medical knowledge is hindered because intuitive knowledge is difficult to explain and communicate (Davis-Floyd and Davis 1997). The more subtle, intangible components of midwifery knowledge are therefore often disregarded because they are complex, and difficult to make explicit. Many midwives have therefore been forced to abandon their own knowledge of clinical experience and intuition and replace it with the scientific approach adopted by doctors (Lorber 1997, Davis-Floyd and Davis 1997). Midwives' views of childbirth as a normal physiological event rather than

a risky medical one, therefore has to attune to a political climate of medicalised childbirth.

The genesis of scientific knowledge is seen as a political endeavour emerging from a background of competing ideological, social and economic agendas (Oakley 2000, Wickham 2004). Feminists suggest that the 'masculinisation' of science has evolved from the methodological paradigm divisions of Cartesian Dualism mind/body division. Davis-Floyd and Davis (1997) challenge the Cartesian mechanistic model when imposed on childbirth, suggesting that technology displaces the physical and emotional intimacy of the holistic model of birth. Oakley (2000) maintains that methodology is 'gendered' where positivism is viewed as masculine, and hence more powerful than the interpretist feminine less powerful approach. Her feminist analysis concludes that the cultivation of science as an authoritative form of knowledge has developed within a patriarchal society and gendered structures within which they are entrenched (Oakley 2000). She asserts that the dualistic view of childbirth as a medical event introduces the element of human control to the birth process, which mirrors the social control and male dominance in society. Davis-Floyd and Davis (1997) agree with Oakley's contention that scientific knowledge in relation to childbirth is a reflection of patriarchal values that are embedded in Western societies. They maintain a broader influence of society's belief in science and technology systematically undermines women's knowledge of their own bodies. The success of the historically and culturally rooted medical model of childbirth owes much of its success to what Murphy-Lawless (1998) calls 'shroud waving'. By labelling childbirth as 'risky' and potentially life threatening and by promulgating medical monitoring, supervision and care as the safest option, the medical priorities of physical safety can render women's subjective experiences of lesser importance.

In an Irish context, midwifery knowledge has become aligned and often subsumed within an androcentric, institutionalised medical model that values scientific knowledge and technological practices. Women's views are similarly defined and moulded by scientific knowledge and their own

innate knowledge is ignored. Actively managed birth is one of the prevailing practices of Irish maternity care (O'Connor 2006). Midwives practising in obstetric units can be placed in conflict with their own holistic philosophy, their knowledge and practice submerged within a medicalised, hierarchical, and patriarchal environment (Keating and Fleming 2008). Although interventions can be midwife initiated advocating for women who espouse a holistic philosophy can prove difficult for both women and midwives within medicalised institutions. Medical claims for labour interventions are instigated in the name of clinical indications; midwives, however, suggest that they are often instituted because of individual preferences of obstetricians, for convenience, because of staff shortages, or because the woman is a private patient (Hyde and Roche-Reid 2004). With almost 50% of women having private health insurance (O'Connor 2006), midwives may be placed in invidious situations where they are providing care through a public health care system with a particular ideology of care whilst the 'private patient' has a contractual arrangement with the consultant obstetrician espousing a different ideology. Private maternity fees are worth an average of €500,000 per annum to consultant obstetricians and any challenge to their domination in practice has been met with resistance (O'Connor 2006).

Midwives find that their skills are not valued within the medicalised system and that their knowledge is devalued in favour of technology (Hyde and Roche-Reid, 2004; Keating and Fleming, 2008). The dominance of medical knowledge and authority is validated by managers, institutionalised norms, and legislation with little reference to midwives and women's views (Keating and Fleming 2008). When women express decisive views choosing for example to give birth at home, obstetricians have used coercive strategies to prevent them (O'Connor 2006).

3.2.1 Policy Influence

In the policy arena, although there is some commitment to incorporate women's views in planning maternity services (Department of Health

1997b, Department of Health and Children 2001, KPMG 2008), recommendations reiterate and sustain the medical model of institutionalised birth, hence authoritative medical knowledge continues to be reproduced. Although purporting to be 'multidisciplinary', obstetricians dominate policy formulation with ensuing recommendations that are seen as 'increasingly authoritarian and repressive' (O'Connor 2006:114). Although there are some exceptions (Devane *et al.* 2007), midwives far from being recognised as autonomous practitioners and a source of knowledge are mostly relegated to obstetric supports. Although the KPMG recommendations support the setting up of Midwifery Led Units, midwives are recommended to: 'play a more prominent role in obstetrics' (KPMG 2008:120).

Midwives' practice is limited, restricted by maternity services policy which prioritises hospital based maternity care under obstetric supervision. As previously identified there is an underlying implication that, although there is evidence that less medicalised holistic systems provide good outcomes in other contexts, a particularly risky environment prevails in Ireland due to the lack of appropriately experienced midwives (McKenna and Matthews 2003, KPMG 2008). McKenna and Matthews (2003) for example cited one of the reasons for an excessively higher morbidity rate for home births, (data that were later discredited (O'Connor 2006), was lack of midwifery 'expertise'.

Midwives who subscribe to the 'normality' of birth have difficulties in resisting medicalisation, compounded by lack of support and consequent feelings of helplessness when interventions are instigated at the whim of obstetricians (Hyde and Roche-Reid 2004). Midwives have also found little support from colleagues when they espouse midwifery philosophies which do not conform to the medical model of birth (Keating and Fleming 2008). Midwives have been criticised and disciplined by their own professional bodies, particularly independent midwives who dare to work outside obstetric control (O'Connor 2006).

Midwives therefore have little opportunity to develop their skills and knowledge outside institutionalised settings and consequently continue to practise within and draw upon well expressed and published scientific medical discourses. In Ireland, midwives seem to have difficulty in articulating and making visible their contribution to a distinctive midwifery knowledge base. Butler *et al.* (2009) suggest that despite an impetus to develop a research culture among nurses and midwives in Ireland the attempts to date have been uncontained and poorly coordinated. In the process of researching women's experiences of childbirth I accessed over ten Masters Dissertations relating to women and childbirth in Ireland that would have contributed a substantial body of work yet much of this research remains unpublished. In the context of these difficulties, safety issues, and increasing medicalisation of birth with pre-eminence given to authoritative medical knowledge and practice endorsed by institutions and policy makers, midwifery knowledge about childbirth in Ireland remains largely undervalued, underdeveloped and almost invisible.

In order to develop midwifery knowledge it appears that feminist epistemology has much to offer. Feminists challenge received wisdom regarding scientific knowledge as a symbol of the incompleteness of our understanding by omitting certain truths (Wickham 2004). Feminist epistemology and methodology attempts to do what medical research has not, - by involving women and their experiences, with women as expert sources of knowledge (Trego 2005). Feminist methodologies incorporate the idea that women have agency with legitimate subjective views of what they want from the experience of childbirth that contribute to a more realistic view of the world. In challenging the adequacy of knowledge produced by authoritative voices of medical discourse, feminists have developed their own alternative authoritative knowledge of women's lives (Ramazanoglu 2002). In order to challenge, mediate, or perhaps complement medical knowledge it is incumbent on midwives to develop and contribute a distinctive 'brand' of authoritative knowledge.

3.2.2 Reflexivity

Reflexivity is a cornerstone of feminist research with an understanding of the importance of the influence of one's own reality such as gender, race, socio economic group, and experience. Feminist researchers, in rejecting notions of objectivity, acknowledge that the research process from the topics chosen through to the theories and methods favoured and the meanings from the data, are "deeply and reciprocally connected" to our own values and self interest (Crawford and Kimmel 1999:3). Reflexivity in practice means that researchers show an awareness of, and appropriate responses to, relationships between researchers and participants (Ramazanoglu 2002). As a midwife, my ontological and epistemological position has been influenced by my practical experience and professional philosophy (An Bord Altranais 2001), which asserts a holistic, woman-centered approach to childbirth. My practical experience has been in the context discussed in the previous section. My views of women's experience of childbirth in Ireland have been influenced by my work in other contexts of maternity care in addition to my experience in education and policy formation. Childbirth in Ireland is medicalised,(Devane *et al.* 2007), influenced by a linear mechanistic approach to labour and birth, with strict parameters and time limits, where intervention is the norm (Murphy-Lawless 1998), and there is little room for intuition to understand individual experiences. I was conscious of significant divergences between midwifery services in the UK and Ireland where over half of women who give birth in Ireland choose a private obstetrician for their care. There is little opportunity for women to experience continuity of midwifery care, and community midwifery is not seen as an essential part of maternity services. Women may therefore be unaware of alternative models outside consultant led care. As in other countries, safety has become the dominant rationality in childbirth thereby emphasising the physical above and beyond any other aspect of the woman or baby's experience (Wickham 2004).

3.2.3 Feminist Epistemology

Different feminist epistemologies offer different rules on what constitutes legitimate knowledge (Ramazanoglu 2002). Feminism is seen as a

perspective not a method (Reinharz 1992), with the potential to draw on a spectrum of ontological, epistemic positions and research techniques that question the nature and authority of science (Ramazanoglu 2002). The emancipatory nature of feminist research rejects claims of a relationship between bias free objective knowledge and the implication that subjectivity contaminates the quest for truth (Ramazanoglu 2002); instead it actively seeks and promotes research including subjective experiences with the intention of improving women's lives.

The complexity and uniqueness of the childbirth experience as outlined in the literature review underlines the importance of seeing and hearing women as individuals with varying needs of support and care, located within a particular socio-political and cultural context. Research about childbirth in Ireland has been evaluated almost exclusively through quantitative, statistical means, with an emphasis on objective physiological outcomes. In Ireland there are few challenges to the authoritative knowledge of obstetricians about childbirth. Women's experiences are thereby subjugated as inferior, offering only limited truths. This study seeks to challenge one dimensional scientific knowledge about childbirth experiences within the tenets of feminist thinking.

There are disputes about categorising feminist epistemology (Longino 1994, Baber 1994). Harding (1991) suggests three feminist philosophically-based epistemologies that respond to the dominant scientific modes of knowledge seeking, and ways of being in the world: feminist empiricism, feminist standpoint theory and feminist post-modernity. A brief outline of feminist epistemologies follows.

3.2.4 Feminist Empiricism

Feminist empiricism retains the existing rules and principles of the sciences, arguing that androcentric biases can be eliminated by reforming, extending, and improving existing positivistically-construed norms of scientific inquiry to women (Harding 1991). It is a foundationalist approach suggesting that the traditional scientific

methods, including the neutral objective nature of biomedical research, are fundamentally sound but that they need to be used more appropriately. Feminist empiricists attempt to address how feminist values can inform empirical enquiry and how 'bad science' can be improved in light of feminist critiques of androcentrism and social bias in previous biomedical and positivist inquiry. Feminist empiricists are criticised on a number of issues, but also hold some appeal. Harding (1991) views the justificatory strategy of feminist empiricism as having some strength because many of the claims emerging from feminist biology and social sciences such as the underrepresentation of women are in fact true. She supports some strategies adopted by feminist empiricists stressing the efficacy of feminist empiricist theory in explaining the successes of feminist-inspired research to: 'certain important audiences' (Harding 1991:114). A pragmatic appeal of feminist empiricists is that by adopting conventional language and epistemologies they enable dialogue, encounter less resistance, and can strategically critique 'from within,' enabling research that is more in touch with the prevailing discursive and political context of knowledge building. However merely 'adding' feminist claims to those that they have previously challenged and where previous tensions and contradiction applied is problematic (Harding 1991:113). The positivist orientations of feminist empiricism concludes that the world is accessible and understandable with discoverable objective truths, however this is contrary to feminist's beliefs about the complexity and diversity of women's experiences. Empiricists claim that connections can be made between experience and reality by establishing testable connections between them (Longino 1994). The previous literature review has outlined how incomplete knowledge claims espoused by positivist biomedical research about childbirth may omit certain dimensions of childbirth sequelae. Barber (1994) stipulates that advocates of feminist epistemology would have to make a case for the benefit to women of their theories of knowledge. Although it does hold some appeal, in this regard feminist empiricism to my mind falls short. It appears to discount the association between science and politics, blinding proponents to inherent power dimensions. Allegiances to the superiority of 'factual'

knowledge from 'objective' biomedical sources deny the potential harm to women by marginalizing, ignoring, and devaluing their experiences as adjuncts to 'real' research.

3.2.5 Feminist Standpoint Theory

Standpoint theory originates from Marxist Hegelian theories of the slave/master relationship suggesting that distorted knowledge claims arise from the dominant position of white middle class males. Feminist standpoint theorists maintain that knowledge grounded in women's experiences provides for a more comprehensive, unique and different point of view. Feminist standpoint theorists argue that women not only experience the world in a different way to men but that as an oppressed group women develop a dual perspective, their own, based on their experiences of being oppressed, and that of the dominant group. Standpoint theorists describe the development of a "double vision" or "double consciousness" arising from either women's compliance with socially determined roles as wives or mothers or adopted to ensure their own and their family's survival (Brooks 2007:64). Women therefore may have differing ideas about what they would like from their childbirth experience, yet with most dominant insitutionalised régimes they have to adapt and comply with the 'maelstrom' of safety issues, prevailing culture, practices, and organisation that stifle choice, silencing and obscuring the importance of their experiences in order to survive. Women therefore tend not to question their care, they want to believe that 'doctor knows best' because they are extremely vulnerable and need to trust their carers (Klein *et al.* 2006).

Standpoint theory has been both 'deconstructive in exposing the androcentricity of the theory and practice of the sciences and reconstructive in offering alternative explanations of the world informed by women's experiences and activities' (Ho and Schraner 2004:3). Feminist Standpoint theorists argue that the lives of marginalised groups such as women provide for a privileged, radically different vantage point of reality that challenges mainstream androcentric understandings of nature and society (Ho and Schraner 2004).

Within the medical model, childbirth is framed as a potentially dangerous event. In evaluating risk the scientific paradigm predominates whilst narratives 'do not count' (Symon 2006:7). The dominant model dictates where birth should happen, the parameters of what is to be expected throughout the trajectory of childbirth and the criteria for success and failure. Women meanwhile may have different assessments of risk, success, and failure. Similar to other feminists' beliefs about the way in which childbirth is represented and evaluated, standpoint theorists argue that positivist claims to 'objectivity' and value-neutrality camouflage an androcentric bias that constructs meanings that are 'not only sexist but also racist, classist, and culturally coercive' (Harding 1986:9) thereby devaluing and neglecting women's experiences.

Standpoint theorists such as Sprague (2001) extend the empiricists' notion of 'bad science' to criticise a deliberate, selective scientific endeavour and representation: 'Hidden behind the veil of the "important", the "interesting", and the "rigorous" are systematic selection patterns that reflect the evaluators' stakes within the existing network of prestige and their own experiences of social life and their own class-, race-, and gender-based interests in how social life is organized' (Sprague 2001:532). The dominant groups are therefore unattuned and insulated against other perspectives and experiences and unaware of their privileged position with little cause to question or consider any other interpretations of reality (Brooks 2007). Women, on the other hand, have to familiarise themselves with a man's viewpoint to: 'understand the interests motivations expectations and attitudes in order to survive' (Nielsen 1990:10). Theories developed by the oppressed group will therefore encompass a broader range of interests and experiences. Some feminist standpoint theorists suggest that women's subordinate position in society places them in a privileged position from which to generate knowledge that is less distorted and less partial (Harding, 1991; Brooks, 2007). In answering claims about the impossibility of a coherent theory arising from women's oppressed views, Harding puts forward the notion of 'strong objectivity'. Thus:

“Starting thought from women’s lives increases the objectivity of the results of research by bringing scientific observation and the perception of the need for explanation to bear on assumptions and practices that appear natural and unremarkable from the perspectives of the lives of men in the dominant groupsmakes strange what had appeared familiar is the beginning of any scientific enquiry”.

(Harding 1991:150)

Harding’s strong objectivity is multidimensional involving an attempt to escape the Cartesian separation between subject and object, whilst retaining her own notion of ‘objectivity’ (Ramazanoglu 2002). Women from oppressed groups have no reason or motivation to misconstrue reality; therefore they are likely to develop a clearer and more trustworthy understanding of the world (Jaggar 2004, Brooks 2007). Ramazanoglu (2002) suggests that standpoint theorists have to grapple with difficulties of truth claims and the relationships between knowledge and power. She concludes that Harding remains attached to the notion of ‘objectivity’ despite its masculinist history because women’s experiences are ‘less false’ rather than being ‘true beliefs’ (Ramazanoglu 2002).

One obvious criticism that can be levelled at these assertions is that any standpoint, regardless of their situatedness, is no less partial than those they critique. It is difficult to reconcile the notion that an oppressed group is able to construe a truer picture of society because they understand a dominant group and that they have no particular axe to grind. Feminists such as Janack (1997) and Jaggar (2004) and, latterly, Harding (2004) have repositioned their initial epistemological claims of truth about a real social world, and now suggest that the viewpoint of the oppressed is at least a starting point for a research agenda that reflects important issues that would otherwise remain unseen and unchallenged.

A further critique of standpoint theory is that, in representing women’s experiences as a singular standpoint, women are portrayed as a homogenous group ignoring the potential internal power relations and

hierarchies. Most standpoint scholars now acknowledge that there are many different realities for different women, and that women are not a single entity with one unified standpoint. Harding (1991, 2004) points out that, whilst women's experiences provide new resources for research, there is no 'universal experience' and she urges a heightened awareness of diversity between women's standpoints in every class, race and culture. Feminists therefore have come to focus on the diverse array of experiences and new knowledge generated from a multiplicity of standpoints whilst paying particular attention to the unique perspectives on social reality those women's experiences can offer us (Brooks 2007).

3.2.6 Feminist Postmodernism

Feminist postmodern thought has arisen from the poststructuralist writing of French theorists and philosophers with a long and complex history (Ramazanoglu 2002). Postmodern theory extends from the weakening of radical politics, disenchantment with rationality and widespread optimism about technology in the promotion of popular culture...' (Oakley 2000:41). Postmodernists challenge both empiricists and standpoint theorists, suggesting that theories can lead to a partial understanding or approximations to reality. Similar to the standpoint theorists, postmodernist approaches have developed as a counter to positivism and conceptions of objectivity and universal truth (Leavy 2007a), rejecting claims of 'neutral' knowledge, objectivity and universal truths as unattainable goals. Rather than privileging female or feminine standpoints, however, postmodern feminists suggest that there are a variety of contradictory and conflicting views. Postmodern feminism questions traditional essentialist and universalist systems. Postmodern theory celebrates the diversity of women's lives, recognises and celebrates differences, allowing for multiple perspectives. Feminism itself can therefore fragment into a 'plurality of feminisms with a shifting interplay of rules, truths, selves, localities, communities, histories, discourses, and ways of exercising power' (Ramazanoglu 2002:102). Postmodern feminists critique standpoint theorists for being too firmly embedded in historical discourses between knowledge and power, arguing that standpoint is entrenched in a problematic politics of

essentialised identities (Harding 2005). Postmodern feminists warn that this essentialism and binary thinking in relation to medicalised birth does not allow for alternative explanations and fails to take relativists' expressions into account (Annandale and Clark 1996). Critiques of the postmodern position of plasticity and contingency suggest that there is so little epistemic unity within this theoretical framework that any potential for 'feminist epistemology' is lost. Feminist postmodernism therefore embodies some of the contradictions at the heart of feminist research:

"It points out that power is not unitary, and that some forms of power are situated and concentrated, therefore avoiding any sense of a feminist victimology. However, in the act of so doing it may seriously undermine the political role of feminist research, of incorporating women's lives and gendered experience into the corpus of knowledge".

(Millen 1997:8)

Ramazanoglu (2002) considers that postmodern feminist diversities make it difficult to take political action. Any hope of political transformation with no elemental feminist community or accepted philosophy is therefore difficult. In addition, postmodern feminists reject the idea of a reality that exists independent of discourse and therefore do not believe that women's experience provide any account of that reality (Ramazanoglu 2002). Although postmodern thought offers a framework of healthy scepticism about authoritative and absolutist claims (Walsh 2004), it fails to provide a coherent alternative.

It is essential to my mind that research about women's experiences of childbirth has a strongly political aspect, in the sense that it is important to change the androcentric view of labour and birth as being medical rather than a life event. Although postmodern feminism helps us to see possibilities between seemingly contrary discourses (Walsh 2004), holding a position of relativism in theory does not necessarily take us any further forward in developing a body of knowledge or feminist theories in practice (Wickham 2004).

Whilst taking on board the warnings of essentialism and binary thinking in relation to childbirth, feminist standpoint privileges women's knowledge and diversity within groups that allows the dominant medical discourse around childbirth to be challenged. Standpoint theory does offer a response to the positivist assumptions of much of the research in relation to childbirth, particularly in Ireland where there is little or no research published in relation to women's perspectives. Women's experiences are therefore rendered invisible. Standpoint theory is congruent with the aims of the research as it is primarily concerned with a need to understand what it is like to be in the position of the individual woman whilst acknowledging diversity and to hear previously unheard voices. It enables us to understand that childbirth experiences are not just determined by the physical and psychological elements but are also affected by the society and culture wherein they are located. As suggested by standpoint commentators, women's experiences offer an alternative epistemology and are a starting point for feminist research, giving voice to women to uncover knowledge that has heretofore been denied unseen and unheard. This includes uncovering social relations and structural influences that shape realities. Standpoint epistemology urges researchers to embrace diversities of social realities within groups, transforming knowledge into political action for social change. In order to capture some of these diversities, innovative methodologies and methods that acknowledge women as experts can be employed.

3.3 Methodology

Feminist methodology is informed by feminist epistemology; research is not just about women, they are not just 'put into' the research (Reinharz 1992), rather it entails valuing the unique knowledge of participants as experts, and it embraces women's lives and their situatedness within a social, cultural and political context. Similarly, Greene's (2007) thesis on mixed methods suggests that the methodology of a study is situated within a social context and is related to issues such as objectivity and subjectivity and the role of context and contingency between the 'knower' and the 'known'. The overall goal of feminist research is to

capture and accurately convey "reality"; in this instance, the reality (or at least partial reality) of women's experiences of childbirth within a social context.

As alluded to previously, researchers are influenced by a myriad of factors that strongly influence their epistemology, philosophy and choice of methods (Mason 2002), which in turn will shape how participants and data are interpreted, articulated and represented (Oakley 1999a). Some of my influences stem from my position as a midwifery lecturer within a prevailing health care environment where maternity care is governed by a medicalised system that reinforces the economic and organisational impulsion of hospitals rather than the needs of women (Begley and Devane 2003). Feminists reject knowledge claims based on dualism, and criticisms of epistemologies that deny subjectivity, situated interests, and the suppression of alternative forms of knowledge, but in doing so must offer an alternative.

Feminist beliefs and commitments explicitly strive to place women at the centre of enquiry whilst simultaneously being politically motivated and concerned with changing social inequality, therefore research that strategically helps address those concerns is needed. As pointed out in the previous section, midwives struggle within a paradox of opposing views about medical intervention and control on one hand and acting as advocates for women-centered care on the other (Sleutel 2000, Parratt and Fahy 2003, Page 2003, Freeman *et al.* 2006). Similarly, midwifery researchers may be caught in such a bind; polarised arguments about binary ideological stances may place the researcher in a dilemma. Aligning themselves with quantitative paradigms may cause challenges to their non reductionist, subjective belief systems, whilst adopting the more 'feminist' elements within qualitative paradigms may undermine the political aims of their research. Jaffe *et al* (1999) point to the perceived problems of generalisability and interpretative complexities of using solely qualitative research especially when effecting political change. Feminist researchers using diverse methods may have to adopt a dual vision working within the confines of social science whilst

maintaining the principles of feminist methodology (Reinharz 1992). Although feminism may be considered intuitively to be aligned with individuals and their qualitative experiences, to judiciously investigate the system within which midwives and midwifery researchers practise and to affect change calls for innovative and pluralistic research.

3.4 Feminist Methods

Qualitative research is often equated with feminist goals in that it mirrors much of feminist ideals in relation to challenging hierarchies and addressing power imbalance. Many avowedly feminist researchers define themselves because of their sole adoption of qualitative techniques and those who stray from this path are often rebuked (Ussher 1999). Oakley (1999b) asserts that methods and methodology are social constructions and that qualitative approaches have been gendered by their association with less powerful groups. Oakley and other feminists advocate for a range of methods within which quantitative methods are appreciated and accepted to enable women's experiences to have a more powerful influence (Oakley, 1999b, 2000; Shapiro et al, 2003). Quantitative research in relation to childbirth in Ireland has acquired political acceptability because of its scientific legitimacy and statistical rigour, therefore being more influential in informing maternity policy and public opinion. Qualitative research has to date been less influential. Operating solely from a different perspective and speaking a different language from the long accepted scientific discourse may disadvantage women. By being identified with 'less powerful', 'less scientific' methods and discourse whilst being alienated from powerful quantitative ones, qualitative research may be considered less important and a 'weaker' form of research.

In accordance with feminist epistemologies when undertaking this research, I reject dualistic thinking and binary rigid dichotomies that create one type of knowledge, and seek rather to 'cast a wide net' (Reinharz 1992) to search for understanding of childbirth experiences, whilst aiming to "increase the likelihood of obtaining scientific credibility

and research utility” (Reinharz 1992:197) and to argue for policy and practice changes (Shapiro *et al.* 2003). The diversity of women’s experiences and the critical elements of that experience offer a rich insight into women’s perceptions but are limited by the use of a single method of enquiry. A solely qualitative exploration of women’s experiences would not fulfil the strategic element of feminist research and would be inadequate to explore the complex dimensions of experience that require innovative methodological strategies.

Research methods are not inherently feminist nor are they homogenously linked to paradigms. Feminist researchers have long been discussing women’s multiple ways of knowing and seek to avoid false dichotomies between qualitative and quantitative methods (Leckenby and Hesse-Biber 2007). I consider that Feminist Standpoint Theory, in recognising the existence of multiple realities and world views whilst acknowledging the complexities of women’s experiences, is appropriate for a mixed method approach to the research question.

3.5 Mixed Methods

Mixed methods transcend the functional notion of what Johnson *et al.* describe as: “mixing elements of qualitative and quantitative approaches to improve the breadth and depth of understanding and corroboration” (Johnson *et al.* 2007). Greene (2007) suggests that mixed methods researchers may adopt a different way of thinking in order to understand the complexity of the social phenomenon being studied. She continues: “The critical features of ‘mixed methods thinking’ are the studies’ orientation around the broad purpose of generating understanding of social phenomena, its roots in a multiplicity mental model and its dialogic value commitment to engage with difference” (Greene 2007:20). Much of the discussion about mixed methods is confused by the lack of uniformity in the terminology and depiction of mixed methods as to when and how they are mixed and whether ‘mixing’ is at a paradigm, methods, or techniques level (Sandelowski 2003:325). Debates continue about the conceptual levels of mixed methods such as

concerns about the difficulties of integration with differences in underlying philosophies and epistemologies (Giddings and Grant, 2007). Although integration of paradigms is advocated for nursing research (Weaver and Olson 2006), other authors are critical about a perceived lack of ontological and epistemological coherence and a 'pick and mix' attitude towards mixed methods studies (Lipscomb 2008).

3.6 Combining Methods in Feminist Research

Many of the arguments put forward by mixed methods researchers have already been rehearsed in feminist literature as a rationale for a more considered, less dichotomized and a less elitist hierarchical approach to research paradigms and methods. Oakley points out that it was feminist social scientists who identified pervasive masculine ontological and epistemological biases (Oakley 1999a), and, in doing so, highlighted many of the criticisms of methodological elitism subsequently made by qualitative researchers and, latterly, by mixed methods researchers. Combining methods can further feminist concerns, enhancing advocacy and representation for women (Oakley 2000, Deem 2002), together with strategic use of data to affect policy change (Shapiro *et al.* 2003). Combining methods allows for women's multiple ways of knowing and used sensitively can empower and make visible women's concerns previously subjugated and unheard (Leckenby and Hesse-Biber 2007), by emphasising statistical outcomes. Mixed methods have been successfully employed within feminist research (e.g. Hodgkin 2008). The contention that combined methods can triangulate, complement or expand on the contribution of a single method and generate otherwise inaccessible knowledge (Johnson and Onwuegbuzie 2004, Mason 2002, Creswell *et al.* 2004, O'Cathain *et al.* 2007) is similarly invoked by feminist researchers. Diversity of feminist methods enhances understanding "both by adding layers of information and by using one type of data to validate or define another" (Reinharz 1992:201).

The feminist agenda involves understanding women's lived experiences and realities hence has affinities with the rationale for mixing methods -

to employ flexible research designs that can capture more fully the complexity of human phenomena and understand social experience (Mason, 2002, Sandelowski, 2003). Feminist researchers suggest that engagement with research should erode polarised debates between interpretive, constructivist or critical approaches, and produce work that is both theoretical and practical, abstract and concrete (Crawford and Kimmel 1999). The parallels between mixed method research and feminist standpoint theory are that both push on traditional paradigmatic boundaries in order to make visible new research questions that emanate from the margins of the social world (Ussher 1999). Part of the creative process involves a tension generated between researchers attempting to be 'true' to their feminist ideals, engaging and involving women as experts in the research process and producing evidence that is valuable for participants and communities (Crawford and Kimmel 1999). The purpose of the research study is to gain an understanding of the women's experiences as a multifaceted and complex phenomena and combining methods has the potential to further this aim.

3.6.1 Paradigms

A general definition of paradigms is: "shared belief systems that influence the kinds of knowledge researchers seek and how they interpret the evidence they collect" (Morgan 2007:50). There are three main approaches to mixing paradigms. The purist, incompatibility stance asserts that diametrically opposed paradigms and philosophical assumptions are incommensurable, so that true integration is impossible without violating philosophical ideals (Guba and Lincoln 1989, Masse 2000, Tashakkori and Teddlie 2003). Alternatively, Brewer and Hunter (1989) consider that differences between paradigms are complementary and valuable though not irreconcilable, and should be preserved to maintain methodological veracity. Multiparadigmism similarly recognizes the differences in opposing world views while celebrating the possibilities that each offers and the way that each complements the other (Monti and Tinggen 1999). A dialectic stance proposed by Greene and Caracelli (2003) suggests that paradigms are not intrinsically bound to particular sets of techniques but are historically and culturally embedded, and

whose synergy may yield new insights and understanding. Advocates for mixed methods approaches suggest that the 'paradigm wars' have given way to differing methods, that may be mixed and matched in creative ways embracing multiple methodologies (Maxcy, 2003; Greene, 2007) and an acceptance of mixed method inquiry as a natural complement to traditional qualitative and quantitative research (Maxcy 2003, Johnson and Onwuegbuzie 2004).

Ultimately, paradigm differences are thought to be unimportant to researchers engaged in research practice (Greene *et al.* 1989). Sandelowski (2003) similarly suggests that what signals critical differences in inquiry is the overall attitude toward, and the interpretive treatment of the data collected, which will reveal the researcher's 'viewing position' or paradigm stance. Morgan (2007) advances a pragmatic approach that recognises the connectivity between quantitative and qualitative research and, similar to Weaver and Olson (2006) from a nursing perspective, a disentanglement from the paradigm debate. The main concern of contemporary feminists is the relationship between the: "process and the product between doing and knowing – how what we do affects what evidence we get" (Letherby 2004:175). Feminist's research attempts to 'rise above' the paradigm debate and advocate the use of multiple methods and paradigms for a variety of reasons including concerns about philosophical and political commitments.

3.6.2 Alternative Paradigms

Having considered which paradigms would best provide a framework for the study I was guided by Greene and Caracelli's assertions that whilst epistemological and methodological pluralism is a good idea it is not intrinsically or automatically 'good science' (Greene and Caracelli 1997:5). Although feminism provides a theoretical and philosophical framework for the study I was conscious that ignoring concerns about paradigms may reduce the study to what Morgan suggest are 'method rules' (Morgan 1998). In eschewing any particular paradigm stance and embracing a multiplicity of epistemic and ontological positions feminist

researchers can draw on multiple stances to provide a framework for their research. I therefore used the broader definition of paradigms as a 'worldview' or set of assumptions that may actively promote the mixing of methods, along with context and theory (Creswell, 2003; Greene, 2007).

Many authors suggest that pragmatism is the best paradigm for justification of mixed methods research (Maxcy 2003, Johnson and Onwuegbuzie 2004, Morgan 2007), whilst Mertens (2003) advances the transformative perspective. Morgan (2007) offers an outline of key issues such as abduction, intersubjectivity and transferability that pragmatism has to offer social researchers but to my mind these are also fulfilled by a feminist approach. Johnson in the context of what she terms cross-paradigmatic understanding laterally asserts that philosophies should be 'partners' rather than 'dictators' of mixed methods research, recommending that paradigms be "fluid and inclusive so that it can adapt to particular research questions and needs" (Johnson 2008:203). Although there are affinities between pragmatist and feminist paradigms (Seigfried 2002), pragmatism does not explicitly address the centrality of women to the research process alongside the political element of the feminist agenda, therefore may not be as effective in an androcentric milieu. I therefore advance Feminist Standpoint Theory because it actively embraces the mixing of methods, corrects distortions of androcentric research by emphasising the importance and visibility of women's experiences, whilst within the realms of worldviews can be considered to have paradigmatic credentials.

3.7 Mixed Methods Design

Greene (2006) suggests a framework for viewing mixed methods research as a methodological or research paradigm. Addressing these issues in the context of 'defensible' mixed methods, Greene and Caracelli (1997) suggest that there are three levels of decision making that mixed methods researchers should consider: The political level or

purpose, the philosophical or paradigm level, and the technical or method level that is used for gathering and analysing information (Greene and Caracelli 1997:6). A number of typologies of mixed method systems have been devised by various authors (Caracelli and Greene 1997, Sandelowski 2000, Creswell *et al.* 2003). Caracelli and Green (1997) put forward a mixed method design framework based on two broad categories of component and integrated designs.

Greene suggests that mixed method designs are derived from the intent or purpose of mixing methods such as complementarity, development, and expansion (Greene 2008:14). A developmental mixed method strategy such as the development of an instrument is, by definition, sequential and assesses a number of constructs of phenomena (Greene 2007). The purpose of the development aims to acquire a better understanding by capitalizing on the inherent method strengths (Greene 2007:102), therefore the qualitative element of the Focus group interviews (FGIs) identified the attributes that were important to women from ten focus groups and the quantitative Discrete Choice Experiment (DCE) further established the importance of the attributes to a wider sample of women. The open questions on the survey instrument are enlightening as to why and how women choose the attributes and further highlighted aspects of their childbirth experience. The rich data that emerged from the qualitative comments from the open questions was compared with DCE results and the FGIs so that an integrated analysis of the data could be conducted. Greene (2007) suggests that returning to the results of the first methods after the second method is implemented and integrating the analysis constitutes a complementarity of mixed methods intent. The primary aim of the research design therefore entailed a dual purpose of development and complementarity.

3.7.1 Issues in Research Design

A recurrent thread in many of the discussions about integrating designs are that priority is given to either a qualitative or quantitative strand of the research and that there is a 'principal' and 'complementary' method involved in these designs. There is an implied divide between the

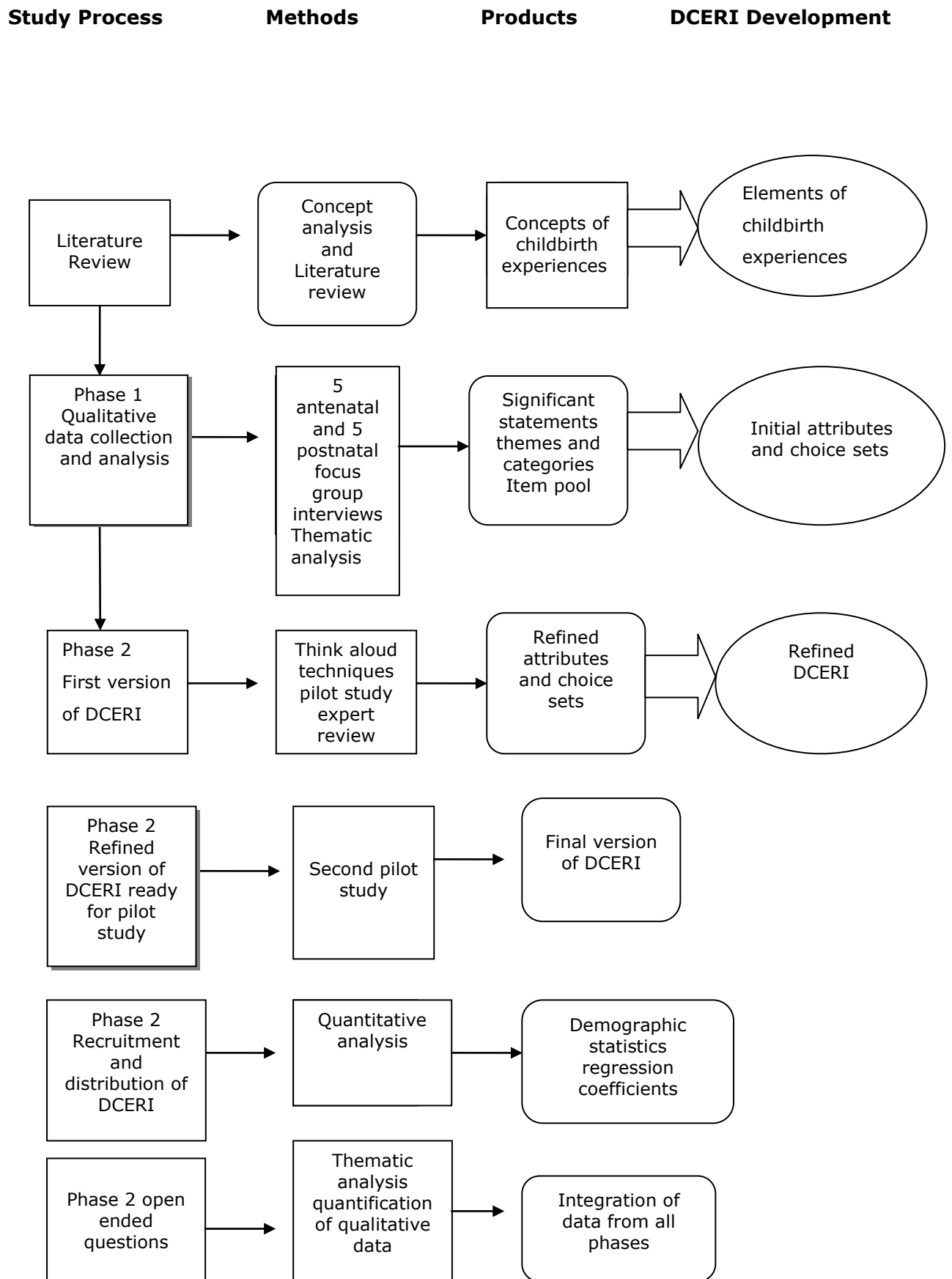
quantitative and qualitative elements and the 'mixing' has not been successful. The influence of political and technical issues in emphasising one element (usually quantitative) or another is acknowledged making it easier to be funded and published (Howe 2004, Creswell *et al.* 2006). Authors have criticised mixed methods because it often relegates qualitative research to a secondary or auxiliary status (Creswell *et al.* 2006, Giddings and Grant 2007). The feminist framework, which guided the study, suggests that the principal function of the research is to answer the research question and the elements within that are functions of that process. The avocation of one method as being the 'principal' and another as the 'complementary' seems more in keeping with a dualistic approach and a rejection of a holistic view of the research problem. The feminist principles of rejecting dualisms, and pluralist approach to inquiry and the elemental importance of experience would appear to reject an emphasis on either part of the sequential model used and a rejection of the qualitative element as a mere adjunct to the study. Both phases of the study were therefore given equal consideration. Although recent discussions continue to emphasise either the qualitative or quantitative element of the sequential exploratory design, it is suggested that it is possible to give equal weight to the quantitative and qualitative phases if time allows (Creswell *et al.* 2003).

3.7.2 Study Design

The aim of the research design is to provide evidence that could meaningfully engage the considerable literature on the experiences of childbirth in an international context and to contend with (within the context of Irish Maternity Care) what Greene and Caracelli (2003) refer to as the intricacy of producing evidence that is positioned diplomatically so as to engage in debates whilst remaining impartial. Compatible with feminist political goals, Creswell *et al.* (2003) also emphasise the importance of research projects addressing their intended audience, citing the advantages of the sequential design being more 'palatable' to a quantitatively orientated community including health professionals that may be unfamiliar or unwilling to accept a solely qualitative enquiry, thereby augmenting the possibility of policy change.

After much research and consideration of the literature, the most appropriate design of the study was deemed to be a mixed method sequential exploratory design consisting of two distinct phases characterised by an initial phase of qualitative data collection and analysis followed by a second phase of quantitative data collection and analysis (Figure 2), that is appropriate to the development and testing of a research instrument (Creswell *et al.* 2003). As shown in Figure 2 data is then integrated from all phases of the research.

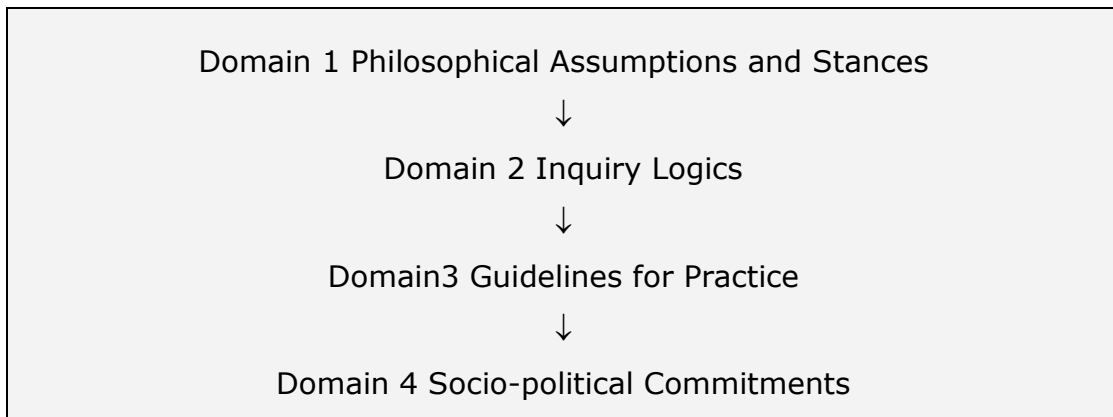
Instrument development usually includes sampling and implementing as well as the actual construction of an instrument (Greene 2007). The initial qualitative strategy therefore informs the subsequent quantitative phase to provide a unique multifaceted view of women's experiences of childbirth. The sequential design encompassed a desire for the diversities and opinions of individuals to be respected while providing information that would be useful at practice and policy level.



**Figure 2. Procedures for Exploratory Instrument Design
Creswell and Plano Clark (2007).**

Greene advances a framework and practical guidelines for an approach to mixed method inquiry with four interlocking but conceptually distinct domains (Greene 2006). The domains for social enquiry are outlined in table 2.

Table 2. Framework for social inquiry



(Greene 2006)

3.7.3 Domains for social enquiry

Domain one consists of the philosophical assumptions and stances that encompass conjectures of ontology and epistemology and the broader facets of the enquirer's 'mindset' (Greene 2006:96). The stance adopted for this research purports that historical philosophical disputes about paradigms are reconcilable through new emergent paradigms or worldviews (Tashakkori and Teddlie 2003, Johnson and Onwuegbuzie 2004). Feminist standpoint theory highlights the importance of women's situated worldviews, embracing multiple realities and rejecting singular 'truths'. My ontological and epistemological influences, both personal and professional, are articulated and positioned within the context of the study. The affinities between standpoint feminist theory and mixed methods have been identified in relation to the nature of the social world, the nature of knowledge and what is important and valuable to investigate.

The second domain of the framework Greene refers to are inquiry logics or methodologies. The domain identifies broad inquiry strategies and designs, and logic criteria of quality for both methodology and inference (Greene 2006). As interpreted by Greene (2006:93) methodology

structures the inquirer's gaze so that what is important to see is observed, recorded and understood in 'defensible' ways. The research process of this study is attuned to the feminist/standpoint framework of inquiry. The study is framed by feminist standpoint theory, the role and location of the inquirer in the study encompassed a reflexive approach with a view to reducing any potential power imbalance and producing data that are useful to women.

Domain three translates into the inquiry, steps and procedures and the tools and procedures framed by domain one and mapped by domain two. There is wide agreement that methods should serve the inquiry purpose (Greene 2008). The developmental exploratory design adopted with the development of the DCE is congruent with the feminist standpoint, philosophical assumptions and logics of inquiry and, more aptly perhaps, sought to answer the research question (the inquiry purpose). Sampling strategies, analysis, interpretations and reporting are framed by the principles of feminist research as outlined with an awareness of the potential power imbalance between the researcher and the researched. Analysis, interpretation and reporting honour the philosophical and ethical underpinnings of the research and are represented within historical, social and contextual contingencies.

The final domain of socio-political commitments represents the location of the inquiry, whose interest should be served with the approach taken, and whether the study contributes to collective theoretical knowledge and advises government decision makers (Greene 2006). The study was undertaken with a view to highlighting the interests of women in relation to their childbirth experiences and will contribute to knowledge about childbirth in Ireland with a view to influencing policy decisions.

3.8 Reflection on Feminist Principles

There is no single epistemological or philosophical premise on which to decide what kinds of knowledge are feasible, sufficient, and acceptable for feminist research, hence no single paradigm that is adopted by

midwives. I have endeavoured to use the following common threads of inquiry identified by feminist researchers such as reflexivity, using methods that serve rather than mould the enquiry and an orientation to social change (Crawford and Kimmel 1999). Draper's (1997) template for midwives undertaking feminist research is incorporated by; acknowledging women's experiences and voices as a source of knowledge, ensuring that I attempt to see the world from women's point of view, recognising the effect I have on the research, using reflexivity with a desire to improve women's lot in the process.

As a feminist, reflexive researcher employing both qualitative and quantitative methods, issues around the choice of such methods merit discussion. Feminists' concerns relate to the motivation for the conception of the research, the research process and analysis, the construction of knowledge, the value of the knowledge to women and how it was disseminated and utilised. My initial reflections on the application of a feminist perspective (Draper 1997, Crawford and Kimmel 1999) are now outlined.

The first tenet of feminist research is the unequal power between the researcher and the participant with a view to removing the hierarchical relationship between the researcher and participant. Involving participants at all stages of the research process and recognising women as the experts in their own experience was the starting point which influenced ongoing decisions and choices made during the research process. Recruiting, processing, and conduct of the focus group interviews (FGIs) aimed to reduce the power relationship between the researcher and the participants. Items and words used for the research instruments were identified by women and phrased in women's own words. The recruitment of women to respond to the study was carried out by clinicians to minimise elements of coercion or obligation to participate. The literature that women received was approved by the National Adult Literacy Agency so that it was accessible to as many women as possible. Both phases of the research supplied a contact number and the name of the researcher and support counsellors in each

unit, in case of any difficulties or as a resource if women wished to talk about their experiences.

A second tenet of feminist research is the recognition of participants as experts of their own experiences. Themes that emerged from the FGIs were returned to the participants to verify whether or not the information accurately reflected their experiences. 'Think aloud' interviews were held so that each item of the research instrument made sense to women. The research instrument endeavoured to maintain the originality and meaning of the attributes of the experience of childbirth as they were phrased in a reductionist manner. One of the concerns of the researcher was that women would not be willing to accept that an experience could be 'reduced' to attributes and that in that approach there would be elements they would have to choose and 'trade'. The pilot study of the survey instrument (Chapter 7), found that women did not object to the 'trading' of the attributes but found the instrument repetitive. The research instrument included an opportunity for women to add comments at different stages throughout the survey so that women would have an opportunity to explain their choices or make additional comments about their experience. The qualitative comments from the survey instrument were integrated with the DCE data and formed an important strand of its interpretation.

The third tenet of feminist research recognises the researcher as part of the research process. My role as a woman wearing different midwifery and research 'hats' had the potential to influence what the women in the FGIs discussed and the context in which they discussed their birth experience. I was aware that my experience, both personal and professional, was intrinsic to the research processes. There were instances when there were tensions between both roles as women would ask about certain aspects of their experience and discuss whether the professionals did 'the right thing' or not. Women also directly asked questions about what should happen and perceived me as an expert in that situation. Similarly, the survey instrument identified me as a midwife and a researcher and therefore may have influenced the aspects

of labour and birth that women commented on. My social location, from the choice of a research topic to decisions on how to formulate, analyse and present the material influenced the research process. A reflective diary on the process of the research was kept to identify areas of conflict and tension that arose (Appendix XXV) Women's experiences are not universal and my experience as a researcher was different within some of the focus groups. In the smaller groups there was more a feeling of an insider where women identified with me as a potential participant in their experience i.e. recognition of the emotional element of care and the importance of support. In larger groups, women were more likely to talk to one another and I felt I was seen as more of an 'outsider'. The use of the DCE invoked concerns about women being asked to respond to a postal survey at a busy and stressful time in their lives. Although a response rate of 59% was heartening I was also conscious of the difficulties women may experience completing the DCE which is cognitively demanding. I also had concerns about women being forced to decide between the scenarios especially as some may have been emotive for them. However many of the surveys indicated that women wished to make their views known and were glad to participate.

3.9 Conclusion

Feminist research and epistemologies, historically identified with qualitative research and constructivist approaches, have progressed to encompass more eclectic creative approaches to research including mixed methods that transcend disciplinary barriers. Feminists have argued convincingly that historical masculine bias in research has led to the subjugation of women's voices and the marginalisation of experiences as a valid form of knowledge. Within the maternity services midwives and midwifery researchers, have had difficulties in articulating any challenge to prevailing authoritative medical knowledge. Framed by these contexts women's experiences of childbirth tend to be ignored with more emphasis placed on safety and physiological outcomes rather than a holistic view of childbirth. Feminists challenge this misrepresentation grounding their work in feminist rather than androcentric theories and models that to date have been subject to a masculine bias. Feminist

researchers use eclectic research approaches including mixed methods, to serve the dual purpose of advocacy and feminist principles whilst adopting practices that will further the feminist agenda for women.

Feminist standpoint theory provides a framework within which to explore women's experiences of childbirth. The sequential mixed methods approach incorporates a mixed methods 'way of thinking' that utilise various forms of data to develop and complement one another. An outline of the phases of the research is presented in diagrammatic form in the following chapter. The design consists of two sequential phases. The initial qualitative phase involved the conduct of focus group interviews to identify the important elements of childbirth experiences. Phase 2 involved the development of a Discrete Choice Experiment research instrument (DCERI), utilising the findings from Phase 1. Phase 1 Strand 1, is described in the following chapter.

Chapter 4

Phase 1: Strand 1.

Ante Natal Focus Group Interviews

4.0 Introduction

In this chapter women's expectations for their childbirth experiences are explored. The data collection method is outlined. The use of focus group interviews (FGIs) to identify women's preferences for the attributes of the childbirth experience is explained. The strengths and limitations of FGI methods are summarised. The planning process and analysis of the FGIs is described. The results of five antenatal FGIs exploring women's expectations for childbirth are discussed in the context of contemporary literature. The use of a reflective journal was incorporated into the research methods to allow me to trace how my position as researcher and midwife may have impacted on the research process (Appendix XXV).

The concept analysis in the previous chapter identified the importance of women's expectations of childbirth and their role in influencing how women perceive their childbirth experiences. Unmet expectations can be a source of disappointment, whilst satisfaction with childbirth may be related to women's expectations of care, rather than to the quality of care she actually receives (Howell-White 1999). Although involving women in determining important elements of a service is deemed to be essential (Crow *et al.* 2002), there is a notable lack of research into women's expectations and experiences concerning childbirth in Ireland. There is a resulting under representation of service user's priorities in policy formation and in the provision of maternity services (O'Connor 2006, Devane *et al.* 2007). It was therefore important to explore women's needs in order to enhance their birth experiences. The purpose of the FGIs was to identify the key features of women's expectations for

their childbirth experiences and, in doing so, to contribute to the development of the research instrument.

4.1 Rationale for Focus Groups

The Discrete Choice Experiment (DCE) consists of a two part sequential strategy. The initial qualitative phase of this study, involved determining attributes of women's expectations for childbirth using focus groups, followed by the development and application of the DCE to establish the relative importance of these attributes. The sequential mixed method approach strives to combine the merits of both qualitative and quantitative paradigms to enhance understanding of the research problem by collecting diverse, yet complementary, types of data (Creswell *et al.* 2003). Focus groups are useful for instrument development (Nyamathi and Shuler 1990, Barbour 2005) and as the first step in the formulation of the DCE process (Ryan 1996, Hundley *et al.* 2001, Longworth *et al.* 2001). Focus groups are appropriate to the study as the research question sought to find commonalities rather than individual preferences for childbirth experiences, generating data through a synergy of discussion and debate. A qualitative descriptive design was used consisting of a combination of sampling, data collection, and analysis techniques presenting the research in everyday language (Sandelowski 2000).

4.2 Data Collection Methods

Focus group interviews are 'group discussions exploring a specific set of issues' (Kitzinger and Barbour 1999a:4), and are increasingly used in midwifery research (Parvin *et al.* 2004, Olsson *et al.* 2005, Ruppenthal *et al.* 2005, Hunter 2006). Wilkinson (1999) believes that they have advantages in minimising and dissipating the hierarchical nature of research whilst maximising contextual meanings congruent with feminist goals. Although employed in diverse ways, feminists view FGIs as "a multivocal narrative larger than the sum of its parts" (Leavy 2007b:185), resonant of the multiple realities of feminist standpoint theory and providing opportunities to explore conflicting views and

disagreements. Other advantages of FGIs includes their flexibility as a stand alone qualitative method or combined with quantitative techniques (Silverman 2004), and as a way of exploring experiences, opinions and concerns of participants (Kitzinger and Barbour 1999a). Bloor *et al* (2001) suggest that FGIs are particularly useful in providing a unique access to norms and meanings of an increasingly privatised present day society, which is less open to observational methods. The synergy of FGI discussion provides for a greater range of thoughts, experiences and ideas (Vaughn *et al.* 1996), and is more appropriate to the development of key attributes rather than individual in-depth insights. Women's expectations and experiences of childbirth have been explored through other means such as questionnaires (McCrea and Wright 1999), but more frequently phenomenological perspectives involving individual interviews (Lundgren 2005, Ogden *et al.* 1998, Berg *et al.* 1996). Individual interviews have been epitomised as the essence of empowerment congruent with feminist principles (Oakley 2000). Wilkinson (1999) however suggests that 'consciousness raising' through sharing experiences is particularly advantageous from a feminist perspective. Although no discourse or method is inherently emancipatory both Montell (1999) and Wilkinson (1999), argue that in addition to diffusing power relationships, FGIs produce women's knowledge that is situated and localised therefore appropriate to the development of the DCE. Wilkinson (1999) also contends that interactions within FGIs can enable participants to realise commonalities and gain a sense of the social and political contexts through which experiences are construed.

A common concern about the limitations of FGIs include producing information that lacks depth, overemphasising group consensus, and silencing voices of dissent (Carey and Smith 1994, Bloor *et al.* 2001, Sim 1998). Asbury (1995) suggests that skilful questioning by the moderator can help distinguish whether silence indicates agreement or an unwillingness to dissent. The possibility of group dynamics such as 'dominance' where some group members may be more assertive or articulate than others may occur (Henderson 1995, Twinn 1998) and hostility or suspicion between members that can hamper discussion

(Bloor *et al.* 2001). A particular concern for me was the possibility of a tendency towards 'polarisation' where participants express more extreme views than in private or may impart more information than intended (Morgan and Kruger 1993). In my attempt to create an environment emphasising participation, reciprocity and equality of the research relationship, I was aware that a participant might 'over disclose', however, participants who disclosed sensitive information have been received within a supportive atmosphere (Farquhar and Das 1999). The FGIs were considered to be the most fitting for the qualitative phase of the development of the DCE due to their affinity with feminist research principles and, with the development of preferences that would be pertinent to the nuances of an Irish political and social context.

4.3 Pilot Study

Pilot studies are a crucial element of good study design (van Teijlingen *et al.* 2001), affording the opportunity of assessment of recruitment strategies, sample size, and collecting preliminary data (Polit and Beck 2004). An initial pilot focus group study was carried out in a rural hospital. The sampling and recruitment procedure is explained in the following section

4.3.1 Sampling

A convenience sample for the initial pilot study consisted of participants who fulfilled the following criteria.

The criteria for inclusion in the research study were:

- over 18 years of age
- between 28 and 36 weeks gestation
- primigravid or multigravid (depending on group)
- ability to converse in English
- not booked for planned Caesarean Section

Participants legally above the age of consent who anticipated a vaginal delivery and who could express their expectations for the birth in English were identified as the most 'information rich' participants. The research sought to identify expectations in relation to labour and birth. Therefore women who anticipated a vaginal delivery were the target population. Women who were to give birth by planned caesarean section were excluded as they would have no expectations in relation to labour and birth. The maternity unit closest to the researcher was selected to act as the pilot site. Women who were in the third trimester of pregnancy were given an information leaflet by the administrative staff when they were attending for their antenatal visit between 28 and 36 weeks of pregnancy. This gestation period was chosen as women were likely to return to the hospital clinic at this gestation and may have had other anxieties such as fear of miscarriage earlier in pregnancy (Jomeen 2004). Women would also be aware of their expected mode of delivery.

4.3.2 Recruitment Procedure

A leaflet explaining the inclusion and exclusion criteria, the purpose, design and dissemination strategy of the research and the researcher's contact details was placed in the case notes of all eligible women by the administrative staff. A reply slip was provided for women to indicate to the researcher whether or not they would be willing to be contacted in relation to the study. Twenty women who were eligible were provided with leaflets, which were distributed by the administrative staff in the antenatal clinic over a period of two weeks without any positive responses. There were four responses declining to be contacted. A review of the reasons by the researcher and the staff found that women were 'too busy' and 'could not plan to attend a focus group'. A second attempt to recruit women involved the following revisions:

- The midwife in charge of the antenatal clinic, in addition to the administrative staff, reminded potential participants to return the reply slips.
- The date and time of the focus group session was identified on the leaflet

- Women who were attending parent craft classes were invited to participate
- Women were asked to provide a reason for their decision to decline participation on the reply slips.

During the following two-week period, thirty women who fulfilled the criteria were provided with the leaflets and requested to return reply slips. Ten responses were collected over a period of two weeks. Four of the ten women returned slips citing reasons for not participating as being 'too busy' and 'not interested'. Follow up telephone calls to the remaining six potential participants a week later entailed a discussion about the process and an opportunity to ask any questions about the research. The telephone call reiterated the eligibility criteria and identified that participants could communicate in English and would be able to take part in group discussion as suggested by Bloor *et al.* (2001). Six women subsequently agreed to take part in the focus group and four women attended. Potential participants were contacted by telephone to confirm attendance a few days prior to the group. The recruitment process provided valuable information to the researcher about possible recruitment problems with subsequent groups.

4.3.3 Interview Schedule

A semi structured interview using an interview schedule based on a topic guide formula with five categories of open ended questions (Appendix 1V) was used to generate initial discussion as suggested by Krueger and Casey (2000). A 'funnel' strategy was used beginning with an open approach moving towards more structured discussion of specific areas (Morgan 1997:41). Space was left on the interview guide where notes were recorded during the interviews.

The interview guide and group process worked well and the issues identified helped to develop more focussed probes for discussions in subsequent groups e.g. what women perceived as 'normal birth'. Van Teijlingen *et al.* (2001) suggest that pilot study information may be of

value. Following consultation with my supervisors as the data provided rich information it was included in the final analysis.

4.4 Main Study

The aim of the focus group interviews was to:

- explore women's expectations for childbirth
- identify components of the experience that are important to them

4.4.1 Sampling (Main Study)

The aim of sampling is to capture a relevant range of contexts of phenomena that enable the researcher to make strategic and cross-contextual comparisons and help build well founded arguments (Mason 2002). Participant characteristics need to be sufficiently homogenous so that members feel comfortable about expressing their opinions (Morgan 1997), but diverse enough to promote discussion. Due to time and financial constraints it was not possible to sample all maternity units therefore, a purposive convenience sampling method was utilised. The choices were based on the belief that knowledge of the population can be used to pick sample members (Polit and Beck 2004). Clinicians selected information-rich participants about issues of central importance to the purpose of the research. Sampling across a range of contexts increases the chances of being able to access complex nuanced contextual detail, increasing our understanding of how things work in specific contexts and how things work differently or similarly in other relevant contexts (Mason 2002:125). The four hospitals that were randomly chosen offered different models of service provision, were geographically diverse, with individual ethos, culture and practices and therefore provided this perspective.

Segmenting samples is closely tied with an emphasis on homogeneity and entails controlling the composition of the focus group to match categories of participants (Morgan 1997). A random selection of four maternity units using a random table method was selected from each

group according to the number of annual births (Table 3). The units were anonymised within Groups A to D, resulting in segmented samples of primigravid and multigravid participants from both rural and city populations. One maternity unit providing private care only was excluded from the random selection in addition to the unit where the pilot focus group was carried out.

Table 3. Sampling Frame for Randomly Selected Units

GROUP A N = 3	GROUP B N = 6	GROUP C N = 4	GROUP D N = 7
City population >6000 births Primigravid*	City population 3000-6000 births Multigravid**	Rural population 1500-3000 births Primigravid*	Rural population < 1500births Multigravid**

*women who have not experienced labour

**women who have experienced labour

The rationale for segmenting the groups was that the expectations of labour and birth for the multigravid group could be influenced by their past experience; consequently the presence of a more knowledgeable group could dominate the discussion (Geller and Holtzman 1995). Segmentation from a feminist perspective can reduce power dimensions and can help identify different cultural positions (Leavy 2007). The sample was further segmented into rural and city groups to include a mixture of populations accessing a variety of maternity care models with variable demographic, socioeconomic and ethnic characteristics.

4.4.2 Sample Size

Bloor et al (2001) suggest having a target to aim for regarding the number of participants felt to be optimum and endeavouring to meet these numbers. There is little consensus about what is the most appropriate size for a successful focus group. Smaller groups are easier to manage (McLafferty 2004) and fewer participants promote interaction (Carey and Smith 1994). Authors have worked with groups of five or six participants and as few as three (Twinn 1998, Lane *et al.* 2001, Kitzinger and Barbour 1999). Small groups may also be advantageous when discussing complex topics by facilitating greater discussion (Bloor *et al.*

2001) and are appropriate for those who might respond negatively if they feel that they have not had enough time to express their views (Morgan 1997). Larger groups can present difficulties for participants in expressing their views resulting in a chaotic group (Green and Hart 1999). Although attention to the composition of focus groups is crucial, the socially dynamic nature of the groups renders them unpredictable (Bloor *et al.* 2001) and will often reflect the circumstances rather than planning (Kitzinger and Barbour 1999). The findings in this study concur with Twinn (1998), whilst all groups provided rich data the optimum number of participants that maximised interaction and participation was four to five. Using the response and attendance in the pilot study and the suggestions for good practice (Wilkinson *et al.* 2004), in the main study I sought to over recruit by 50%.

4.4.3 Number of Focus Groups

The number of focus groups reflects the research plan, its' purpose, variability of responses and the influence of time and money (Bloor *et al.* 2001). Morgan (1997) suggests that a rule of thumb seems to be three to five groups. Consideration of response saturation should be made after the third focus group (Nyamathi and Shuler 1990) when additional data may not provide any new insights. In this study, the variability of participants within and across focus groups encompassed a diverse range of participants in relation to parity, non-national status, maternity models, and sociodemographic factors providing rich data. There was a consensus on the range of topics in relation to expectations of labour and birth that were important to women across all groups. Although women's experiences were unique, following five focus groups consistent issues emerged.

4.5 Accessing Institutions

Prior to any contact with the clinical staff, ethical approval was granted by each institution involved in the study. In addition to academic ethical approval each institution required a detailed submission to their ethics

committee about the proposed research. Two institutions required me to attend ethics approval committee meetings, whilst the remaining three institutions did so by correspondence. Each institution made requests for minor alterations of written material. One institution nominated a consultant obstetrician to supervise me and to whom I would give information about the progress of the research.

Initial meetings were arranged between the researcher and the midwifery managers in charge of each maternity unit to provide an overview of the research study. Such briefing of gatekeepers is crucial in optimising diversity in recruitment (Kitzinger and Barbour 1999). The midwifery managers gave permission for access to the clinical areas and provided the researcher with the contact names of midwives and consultants who were involved in organising and providing antenatal care for potential participants. The contact midwives provided valuable local information regarding particular hospital systems and issues such as the optimum location which would be accessible to women, and the length of time needed to recruit to and arrange the focus groups. Consultant obstetricians were also contacted to provide access to their consulting rooms.

The information leaflet as described in the pilot study included contact information for the researcher in case of any queries (Appendix V). The leaflet was examined by the National Adult Literacy Agency to optimise readability. A detachable slip enabled women to fill in their contact details, tear off, and place in the individual envelope provided to ensure confidentiality. Consulting rooms used a large envelope to collect the returned envelopes. A second visit to the units involved meeting the staff with an explanation of the leaflet and the eligibility criteria and the recruitment process. The contact person identified in each unit was given the details of the researcher so that any problems with the eligibility criteria and the progress of recruitment could be discussed. Bloor et al (2001) emphasise the advantages of recruitment via an intermediary and stress the importance of steps taken to ensure that research guidelines are adhered to. The contact person in each unit

proved invaluable to the researcher as they were instrumental in motivating staff to distribute the leaflets and in supporting the research and recruitment process. The researcher visited the administrative staff in relevant private consultation rooms to explain the process of recruitment and eligibility criteria and to clarify and answer questions.

4.6 Accessing Participants (Main Study)

The sampling procedure followed the process as outlined previously for the pilot study including the criteria for eligible participants with additional segmentation of the groups as explained earlier. Due to the relatively low birth rate in one unit, women who fulfilled the criteria were recruited through parentcraft classes and the public clinic to achieve optimal diversity within the group. Table 4, shows the access points for potential participants.

Table 4. Access Points for Potential Participants

	UNIT A	UNIT B	UNIT C	UNIT D
Access to participants availing of public model of maternity care	Public clinic	Public clinic Community Scheme	Public clinic	Public clinic
Access to participants availing of private or semiprivate care	Public clinic and Parentcraft classes	Separate semi-private and private clinics	Public clinic and Consultant Rooms X2	Public clinic and Consultant RoomsX3

4.7 Recruitment (Main Study)

The arrangements for antenatal care in each unit were unique with a number of variations depending on a multiplicity of factors such as the geographical location, whether care was private, semi private or public, and the vagaries of that particular unit. The units were situated in geographically diverse locations in the north, south, east and west of the country. The models of care available in the participating units are

outlined in the glossary. Maternity units consisted of either a stand alone hospital in one instance or part of a general hospital in the remaining three. A voucher for €40 was offered to women as an acknowledgement of their time their travel and child minding. Following discussion with my supervisors the amount was considered to be an incentive to promote participation without being coercive.

It was important to identify potential participants who availed of all models of care and as over fifty per cent of adults in Ireland have private health insurance (O'Connor 2006), it was necessary to access this group. Whilst some maternity units facilitated access to private and public models of care at the same clinic, others accommodated women in separate antenatal clinics for public, private and semiprivate care. Women in other units attended for private care in consultants' rooms usually located in residential areas separate from the hospital premises. Public maternity care was generally provided in the hospital or in an outlying clinic. Domiciliary (public) services were available in one unit. The sites were geographically disparate and travelling to most sites took several hours, therefore meeting with key personnel and arranging distribution of invitations to take part in the FGIs required several visits. In addition, when potential participants were contacted particularly in rural areas they had some distance to travel. Women without private transport found it difficult to attend as public transport was intermittent. In consultation with unit staff, I attempted to generate a diverse sample in relation to geographical, demographic and service models as far as was practical within economic and time constraints.

4.8 Distribution and Return of Leaflets

A total of 100 information leaflets and envelopes were supplied to each unit and distributed within the units as outlined above. The length of time for recruitment varied from unit to unit and ranged from 2 to 6 weeks. Recruitment in the smaller units took longer due to the lower numbers of women who were eligible to attend the clinic during this period.

4.9 Response Rate

The average response rate was 23% (Table 5). Most responses (68.3%), were positive about being contacted. Those who did not wish to be contacted cited reasons such as being busy with other children, geographically distant, or did not want to take part. Over 82% of those who were eligible and agreed to be contacted said they would attend and 66% of those actually attended.

Table 5. Distribution and Return of Leaflets

Unit	Unit1	Unit2	Unit 3	Unit 4	Unit5*	Total	% of previous total
No. of leaflets distributed	55	70	55	50	30	260	
No of responses	16	10	10	14	10	60	23%
Agreed to be contacted	13	6	7	9	6	41	68.3%
Eligible to attend	12	6	7	9	6	40	97.5%
Agreed to attend	12	4	5	6	6	33	82.5%
Attended FGI	7	3	4	4	4	22	66.6%

* Pilot unit

Two women who wished to participate were unable to converse in English. I explained as clearly as was possible that participants had to be able to understand the purpose of the study to give consent. The women agreed, but were disappointed. One potential participant was attending a counsellor due to a previous unhappy childbirth experience and although eager to participate, I considered that she may have been vulnerable in a larger group. Following a telephone discussion, the woman was happy with this decision. One participant developed a

potentially infectious condition and the safety of the other participants precluded her involvement in the group. The eligible participants who had agreed to take part were sent a personal letter thanking them for their interest and reiterating the date and time of the focus group interview.

4.10 Characteristics of Participants

The age group, years of education, motivation for attending the FGI and socio demographic information were obtained anonymously from each participant on an information sheet (Appendix V1).

Table 6 describes the characteristics of participants. They were aged between 22-39 years with gestations between 32-39weeks. Seven had already experienced labour once, and fifteen had not experienced labour. There was a mixture of nationalities, education levels, and rural and city populations. All participants were married, or had a partner.

Table 6. Characteristics of participants n= 22

Characteristic	No.
Age Group	
20-29	7
30-39	15
Ethnic Groups	
White Irish	15
Asian	2
White North American	2
White Canadian	1
African	1
Eastern European	1
Parity	
Primigravida	15
Multigravid	7
Education	
Higher education (university)	15
School education (secondary)	7
Marital Status	
Married	20
Partner	2
Rural/City	
Rural	12
City	10

4.11 Conduct of Focus Group Interviews

All FGIs were conducted in a room within or adjacent to the maternity unit therefore familiar to all participants. Each participating hospital provided the accommodation and refreshments free of charge. Posters indicating the location of the venue were placed along the route to the venue by the researcher. Staff at the reception areas and security staff were notified of the location of the group to guide participants. A notice was placed on the door to avoid interruptions. An atmosphere that facilitated trust is conducive to member's participation (Dilorio *et al.* 1994). Participants were therefore welcomed warmly, refreshments were served, and time allowed for participants to relax. The group sat in a semi-circular pattern around a table with the moderator in the centre of the group. The tape recorders were, with consent placed discreetly. Note takers who were independent colleagues were also positioned in an unobtrusive position. An overview of the study and focus group was presented and an opportunity was given for participants to ask any questions about the study. A consent form was signed by all participants (Appendix V11).

The participants were asked to introduce themselves and share with the group when their baby was due. The preamble had a dual role in identifying the voices for me, which could then be identified from the tape recording for the transcripts, and to establish when the women were due to have their babies. The gestational age of participants ranged from thirty two to thirty nine weeks. Each focus group lasted between forty five and seventy minutes using the semi structured interview used in the pilot study. (Appendix 1V)

4.11.1 Group Process

In keeping with the principles of qualitative and feminist enquiry it was essential that members of the group did not feel intimidated or ignored. Within individual interview settings, respect and understanding can be demonstrated in a relatively intimate context, but focus groups presented challenges in assisting all participants to feel involved and

respected. Consequently the 'ground rules' at the beginning of each focus group emphasised the importance of respecting all members of the group and that all individuals were afforded an opportunity to contribute to the discussion. The moderator reiterated that a range of experience and ideas were welcomed and that it was important to hear everyone's perspective. In this study participants were generally eager to hear others' opinions and experiences even though they might be contrary to theirs, and often encouraged quieter members to vocalise their views. The FGIs offered insights about women's beliefs, attitudes, hopes and anxieties about childbirth in their own words from their unique perspectives.

4.11.2 Role of the Moderator

The initial role of the moderator is to create an environment in which group members feel free to express their opinions and to continue to encourage interaction between participants rather than between the moderator and participants (Stewart *et al.* 1990). Moderator influence has been considered by Kruger (1998) and Greenbaum (2000) who highlight the need to control discussions authoritatively, whilst Morgan (1998a) suggests that the reduced influence of the moderator contributes to the setting of the research agenda and better access to participants' priorities and perceptions. Bloor *et al.* (2001) suggest that caution is needed in assuming affinities between fluid power relationships and FGIs as they may maintain their own hierarchies. In this study, I moderated all five focus groups and, in two instances, a note taker was present to provide feedback to the moderator on their perceptions of the prevalent issues. The remaining FGIs were moderated without a note taker due to the geographical location of the groups. I was conscious of striking a balance between an active moderator who generates interest in and discussion about the topic without leading the group to reinforce existing expectations (Sim 1998). I resolved to be open, reflexive and critical, in order not to support structures that perpetuate inequality (Cunningham-Burley *et al.* 1999). I asked the note takers (two groups) to provide me with feedback on my moderator

role and used my reflective journal to identify areas that could be improved (Appendix XXV).

The five FGIs involved different group dynamics, which influenced my role. Generally I adopted a 'low control-high process' moderator style (Millward 1995), which was adapted according to the dynamics, group size, and group composition. In selecting a minimally structured format, I was able to investigate women's views that stimulated ideas and provided me with insights into women's diverse expectations and experiences of childbirth. My role in larger groups was to encourage each individual to participate whilst smaller groups needed more assistance with interaction to offset the tendency to answer questions sequentially, which would have resulted in data similar to individual interviews.

All groups were rich in dialogue with few silences or gaps in the conversation. The smaller groups of three and four participants were easier to manage, produced rich data and a relatively passive role was adopted by the moderator. The larger group of seven participants included two participants who contributed little to the group and one dominant member. The potential for 'interactional difficulties' highlights the necessity for the moderator to encourage members who are not participating and to manage 'dominant' members of the group (Wilkinson *et al.* 2004). The initial prevalence of dialogue from the dominant participant challenged other members of the group. I used the tactics suggested such as thanking the participant for her contribution then addressing open questions to the remainder of the group. Elements of group process (Dilorio *et al.* 1994) came into play within the groups when participants became more vocal as the discussion progressed and the expert became less verbose. Many of the feminist ideals appeared to be fulfilled by the conduct of FGIs in terms of synergy and power dissipation. Women were willing and often anxious to tell their stories. Their voices were heard and were listened to as valid sources of knowledge.

4.11.3 Debriefing

Kvale (1996) suggests debriefing following qualitative interviewing as tension and anxiety may be experienced by the interviewees if they have shared personal and emotional experiences. Whilst individual interviews can use debriefing measures such as asking participants to bring up any further issues, in the context of focus groups this may provide a further opportunity for the dominant members to reinforce their opinions. Five minutes prior to the end of the allocated time the tape was switched off, I thanked participants and asked how they found the focus group process. I also spoke individually to participants who had raised questions, appeared anxious, had expressed particular fears, or those who had not contributed at all.

4.12 Ethical Issues

Ethical approval was granted to conduct the study from the Health Service Executive of the regions, Hospital ethic committees, and the University of Dublin, Trinity College, Faculty of Health Sciences Ethics Committees.

4.12.1 Informed Consent

As I have indicated above, particular attention was paid to individual participants and respect for their autonomy. Women were provided with an information leaflet about the focus group, which explained the purpose and process of the study, and emphasised informed choice, consent, and confidentiality (Appendix V11). I spoke to all potential participants by telephone prior to the FGIs to ensure that women understood their participation was voluntary, and confidential whilst reiterating the purpose and process of the FGI.

4.12.2 Non-maleficence:

At all stages of the research process, potential and actual participants were given an opportunity to ask any questions, voice anxieties, discuss the study, and could withdraw at any time. Only those who provided

their personal details and who consented to be contacted were invited to take part in the focus groups. Prior to signing the consent form the voluntary nature of the FGI and assurances of confidentiality were reiterated.

Each participant had my personal contact number and could contact me following the FGIs. Support services were arranged in each maternity unit if women became upset or wanted someone to talk to about any of the issues raised. I attempted to answer any questions posed by individuals following the FGIs and directed participants to appropriate services if required. I conducted the FGIs whilst scrupulously upholding ethical principles of privacy, confidentiality, rigour and fidelity.

4.12.3 Rigour

Rigour in the context of FGIs can be described by the techniques of credibility, fittingness, and confirmability (Polit and Beck 2004). Credibility relates to internal validity and was demonstrated by asking participants to read and verify the researcher's interpretation of the interviews and the emergent themes. Fittingness or applicability is demonstrated by confirmation by 'blind' inter rater reliability of identifying categories and themes. Confirmability is a process criterion demonstrating as clearly as possibly the evidence and thought processes that led to the conclusions reached. An audit trail consisting of raw data memoranda, documenting decision-making regarding development of themes and categories is demonstrated (Appendices 1X, and X.).

4.12.4 Reflexivity

Reflexivity as outlined in the research design consists of being aware of personal assumptions, biases, and interpretations, whilst being aware of my professional status and the possible impact on the interaction within the focus groups. As both researcher and moderator I attempted a balanced discussion whilst not appearing to welcome comments which expressed my own point of view (Lane *et al.* 2001). I was cognisant of the potential for bias during the data selection, analysis, and conclusions process (Reid and Gough 2000).

4.13 Data Analysis

The employment of computer software is thought to be a useful means of coding and retrieving data, but inadequate for rigorous qualitative analysis (Popay *et al.* 1998). Ultimately, data coding and managements is a matter of personal preference. I chose to manage and analyse data using 'Word' software and a personal computer to retain contextual understanding.

The primary objective of the data analysis was to represent the viewpoints of women who shared their childbirth experiences and to find areas that were important to them. There is little detailed guidance about FGI data analysis (Carey 1994, Kitzinger 1994, Wilkinson 1998). I used thematic analysis for practical and theoretical reasons. Joffe and Yardley (2004) contextualise thematic analysis in relation to other analytical procedures such as constant comparison and narrative methods, highlighting the differences between the approaches. They point out that the ultimate goals of various analyses are different in their theoretical underpinnings and analytical aspirations. Thematic analysis allows an explanation of the data, without the theoretical restrictions of interpretative phenomenology or grounded theory. Both phenomenological and grounded theory analysis requires detailed interpretation that was inappropriate to the development of the Discrete Choice Experiment.

The flexibility of thematic analysis means that themes can be generated both by deduction where the themes are explored using previous theory and research, and inductively from the data generated (Joffe and Yardley 2004). In the present study data were compared across groups and subsequent focus group data were analysed and compared to earlier groups (Kruger and Casey 2000). The analysis was primarily inductive identifying categories and subcategories into clusters that constituted themes as described earlier. Although the themes were inductively derived, sub categories such as 'choice' and control' are analysed referring to literature that incorporated previous research related to

these concepts. The findings are discussed exploring categories and themes with contemporary literature to elaborate on similarities which support and differences that refute previous findings. The approach, although presented in a linear form is one of interface between an iterative and a reflexive process that ensured that the themes had been developed from the original source. Analysis categories from each FGI were noted as outlined in Appendices X and X1. Because no significant group differences were noted all the sub categories were grouped together and treated as a single data set from which the themes were derived.

4.13.1 Analytic Approach

Focus groups are recognised as a discrete research method providing data that is distinct in a number of ways from that collected using other qualitative methods (Bloor *et al.* 2001), analysis strategies are adapted from a broad spectrum of qualitative data analysis methods (Wilkinson *et al.* 2004). An inductive thematic analysis approach was used, based on a structured framework (Colaizzi 1978). Each step of the analytical journey is clearly identified, (Appendices 1X, and X,) demonstrating how categories and themes were developed.

Thematic analysis is the 'drawing together and comparing discussions of similar themes and examining how these related to the variation between individuals and between groups' (Kitzinger and Barbour 1999:16). The analysis aims to describe how concepts are elaborated by groups or participants to identify meanings that are valid across many participants whilst retaining the qualitative nature of the data (Joffe and Yardley 2004). Each focus group was analysed separately and subsequent groups were analysed and compared with earlier groups (Krueger and Casey 2000). The issues identified were remarkably similar between city and rural FGIs. There were some differences about particular issues (such as choice of pain relief) for women who had already experienced labour.

4.13.2 Analysis Process

The first step of the analysis involved verbatim transcription which facilitated my continued immersion in the data. It also led to a greater understanding of and familiarity with interactions and the identification of individual voices within groups. I also listened to my own interaction with the participants to become aware of any potential bias in the responses and the verbal prompts and probes.

Step two of the analysis process entailed reading the transcripts through a number of times to give a sense of wholeness to the material (Colaizzi 1978) (Appendix V111). Step three involved extraction of meaning units that conveyed an idea related directly to the phenomenon under investigation (Burnard 1994). Each unit was identified numerically and this number was placed in 'superscript' at the end of each meaning unit to identify the location of that unit within the text (Appendix 1X). The origin and sequence of each idea or quotation was therefore identified and the context of any speech extract was easily returned to (Bloor *et al.* 2001).

Table 7. Example of Category Development

MEANING UNITS	FORMULATED MEANING	CATEGORY
FG 1.3..you don't know what's going on and it's your first time doing this thing and you don't know what's happening to you	Unknown	Anticipation and Apprehension
FG2.1 I am looking forward to it I want instant replay that's all I want ...	Looking forward	
FG3.3 well I was less anxious this time round like...	Less anxious	
FG4.3 everyone's first labour really is a worry people expect that they don't know the best thing to do	Worry about what is best	

Steps three and four involved working through the meaning units and extracting formulated meanings that condensed but remained close to

the text (Table 7). As meanings were devised, categories were created by grouping the main units together under a particular category (Appendix X).

The aim of developing a category system is to ensure that all meaning units in the text are accounted for (Frankland and Bloor 1999), and that the category system remains faithful to the text. Although the researcher sought to identify mutually exclusive categories this was not always possible and categories overlapped on occasion. Forcing data into exclusive categories may lead to a distinction that appears arbitrary and artificial (Joffe and Yardley 2004). Graneheim and Lundman (2004) suggest a constant forwards and backwards movement between the whole and parts of the text to ensure a true representation of participants' discussions. The concept of 'control' and 'choice' for instance were sometimes co-dependent and associated with 'relationships with professionals'. In addition, the emphasis in categories varied between groups.

The next stage involved collapsing the 'narrow' categories into broader ones. A colleague experienced in qualitative research (CB) independently examined the meaning units and categories that were applied to the text to verify that they were appropriate. Each category was reviewed to check for consistency. The researcher and supervisors discussed further emergent categories and themes. In analysing the data from the FGIs the researcher acknowledged the situatedness of opinions expressed and attempted to report the richness and complexity with which participants expressed their views (Myers and McNaghten 1999). The final step was to develop a theme or themes that encompassed the broader categories, three main themes emerged. The themes and categories were returned to each participant who was asked if the themes encapsulated the important issues discussed (Colaizzi 1978). All participants who replied, agreed with the themes and categories. The FGIs were identified anonymously as FG1 to FG5 and participants within each group were identified as a number in the group e.g. participant one in Focus Group 5 was identified as FG5.1.

4.14 Group Interaction

Crossley (2002) and Kitzinger (1994), suggest that explicit reference to the interaction between participants is part of the analysis process. Robinson (1999) considers the impact of dynamics, comments, anecdotes, questions and deferring to others' opinions whilst Stevens (1996), suggests tracing common experiences, conflicts, contradictions, alliances formed, disagreements and consensus. Gestures, expressions and emphases were included in the transcription of the data in order to help identify interaction among the groups and the guidelines by Silverman (2004:368) were drawn on for useful notations (Appendix X1). Tapes were replayed in order to clarify interactions. Longer quotations including interactive excerpts between participants were used in the text to provide a contextual understanding of the verbal exchanges (Bloor *et al.* 2001) and to elucidate and explain the origin of interpretations and findings.

4.15 Findings

Findings and discussion will be interwoven in order to present a theoretical interpretation of the findings as outlined by Gribich (1999) and Sandelowski (1995). Kruger (1998) suggests that, if a pilot focus group is successful, data should be used. The initial pilot study provided a rich source of data and it was decided, following consultation with the researcher's supervisors, to include these data alongside the main study. Three themes shown in Figure 3, emerged from the data entitled 'goal setting,' 'goal realisation' and 'contingency plans'. A cyclical format described by participants was that of 'goal setting', formalising and identifying goals; goal attainment the means by which they reached those goals; and contingency plans which sometimes meant resetting their goals.

Figure 3. Main themes Antenatal FGIs

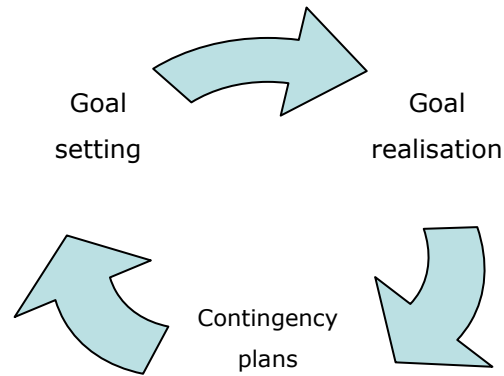


Table 8 shows the main themes and their related categories which are explained in the text. Each theme and category will be discussed individually and data compared with that emerging from the relevant literature.

Table 8. Main themes and categories

Goal Setting	Goal Attainment	Contingency Plans
Anticipation and apprehension	Relationships with professionals	Uncertainty, the ideal/reality gap
Sources of information	Control	Rationalising and accepting
Ideal experience	Choice	
	Coping with labour	

4.15.1 Categories Related to Goal Setting

There were three main categories related to the theme of goal setting.

- Anticipation and apprehension
- Sources of information
- Ideal experience

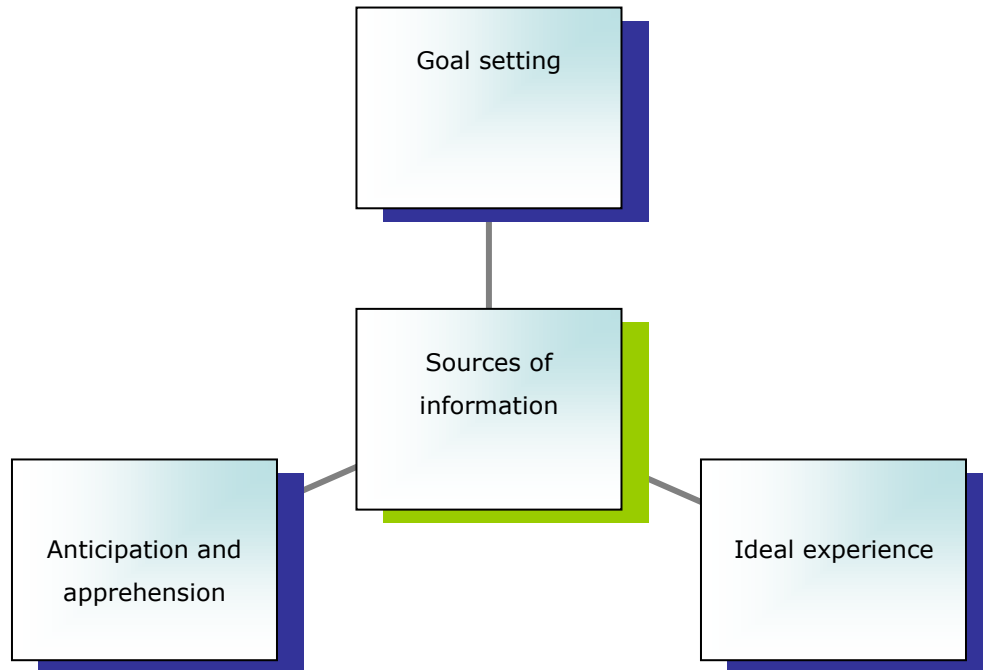


Figure 4. Categories related to goal setting

4.15.2 Theme 1. Goal setting

The first theme to emerge, 'goal setting', described women's feelings about their prospective labour, the manner in which they devised goals for their experience, and culminated in identifying what their ideal experience would be. The goals that women set were framed by their 'ideal experience' and were influenced by various sources of information comprising of both feelings of apprehension and anticipation. Descriptive quotes are used to indicate each category content and explain the analysis.

4.15.3 Anticipation and Apprehension: 'It's only one day'

Most participants started thinking about their labour and birth with a mixture of anticipation and anxiety about the process.

Primigravid participants were more likely to think about the labour later in their pregnancy than women who had already experienced childbirth.

The factors that reminded the participants about labour and birth were incidents such as an ultrasound scan, foetal movements etc:

"...when the baby actually starts kicking hard and then you think.... about it."(labour) ³ FG1.5

Multigravid participants said that reminders of their previous experience jogged their memories earlier in pregnancy. Attending hospital for their 'booking visit' prompted thoughts of labour:

"...when you go to the hospital and you get the book (information booklet) you look at the birth plan and go... oh god ...that reminds me." (laughs) ⁸ FG2.3

"yeah ...I don't think about it a lot but at night...when I am going to bed I wonder 'cos my waters broke...in the middle of the night the last time... I do think about it ...not in a nervous way I have to say."¹⁰ FG2.2

Although women in this study used adjectives such as 'afraid' and 'dreading it,' most women who expressed their feelings about labour and birth did so in a jocular manner accompanied by laughter and excitement and often tempered by parallel positive feelings of looking forward to having a baby. Fear in childbirth has been associated with negative experience of subsequent birth (Wijma *et al.* 2002) and may be an influencing factor increasing the rate of elective caesarean section (Waldenstrom *et al.* 2006). Although anxiety during pregnancy is a significant predictor of postpartum depression (Robertson *et al.* 2004), the prevalence of 'anxiety', 'worry' and 'fear' about childbirth varies across studies with unclear distinctions between terms. Primigravid participants in this study expressed positive anticipation of childbirth:

"...a giddy feeling (laughing) it's more than expectation than....I know this is going to be wonderful."⁹² FG5.2

"like it's only one day like I'm going to have a lovely baby at the end of it."¹²⁴ FG4.3

"everyone even the tiniest women to the shortest women they all manage.....to be positive is good"¹²⁵ (laughter) () FG4.4

Women in the primigravid groups also expressed difficulties in identifying specific goals as the process of labour seemed enigmatic. Apprehension about the process of labour and birth were expressed as 'going into the unknown', or 'unchartered waters'. The unknown experience of labour and birth was compounded by the lack of any identifiable comparative experience:

"everyone's first labour I think it is fear of the unknown really people don't know what to expect."⁷⁶ FG4.1

"You have no yardstick to measure it by I think it is because it'skind of the unknown isn't it?"¹ FG5.1

It is suggested that anxiety in pregnancy is U-shaped (Georgsson Ohman *et al.* 2003) with the least anxiety in mid pregnancy, however participants in one group felt they became less anxious about the birth closer to the event. This was greeted with amusement by other participants who considered the inevitability of the process and the absurdity of being anxious:

"I'm scared I'm less scared than I was ... definitely.....it's just like I think it's the hormones... (laughing)or something"³⁰ FG1.3

"..well it's probably cos you don't have a choice... (laughs) yeah it's just like I'm on this trip there is no way off this train track"³¹ FG1.5

In this study both primigravid and multigravid participants articulated anticipation and apprehension about labour and some individuals expressed both. The meaning of fear is ill defined in the literature (Jomeen 2004). The literature suggests that sources of fear are diverse ranging from previous experience, knowledge, or uncertainty (Melender 2002), worries about pain and physical injury (Lederman 1995) lack of

trust in the obstetric team, and fear of dying (Sjogren 1997). Fear may also have a protective effect and help women prepare, and can have positive meanings (Melender and Lauri 1999). Participants expressed a range of sources for being fearful including their ability to cope with pain and the support they could avail. A discussion amongst a primiparous group concluded that keeping the labour in perspective helped alleviate anxieties:

"...like it's one day it's going to happen it's one day of pain I'm going to have to get through it..."²⁵ FG1.6

"...and one day is a good philosophy I think."²⁶ FG1.7

"...yah people have been doing it for millions of years."²⁷ FG1.5

A discussion about the lack of information women received took place in a primigravid group. Two participants were unsure about their care and concerned about the frequency of their antenatal visits during late pregnancy when 'anything could happen'. Other members of the group reassured the women and clarified the type of service that was offered, explaining to participants that this was in fact the 'norm'. This type of supportive interaction was a feature of several groups where women shared information learned from one another and helped one another out:

"... I am worried because after a.... certain time everyone knows you should have ... be monitored every week after thirty four weeks I am now in my thirty ninth week ..." () 185 FG1.5

"you are like a nuclear reactor after about thirty five weeks..." () 195 FG1.7

"I see my doctor every two weeks there are two weeks between my appointments ... () you are having shared care"196 FG1.6

The analogy of the 'nuclear reactor' by one participant epitomised some participants' views of pregnancy as potentially dangerous. In a medicalised system of maternity care, where the concept of safety is ill

defined (Devane and Begley 2004), some participants welcomed more 'monitoring' and worried if this was not done. Evidence from this study is supported by the literature that does not assume that anxiety is caused by the same event(s) and that women have mixed feelings towards their impending labour and birth

4.15.4 Sources of Information: 'Less is More'

Participants in the FGIs quoted a range of sources which underpinned their expectations of labour and birth. Women received information from books, media, and antenatal classes, relatives and friends. Some groups referred to the 'baby channels' (television channels) and participants in all groups mentioned accessing information from the internet. The majority of stories of labour and birth originated from relatives and friends and, similar to previous research (Fenwick *et al.* 2005, Gibbins and Thomson 2001, Schneider 2002), the women's social network was the predominant influencing factor on women's expectations.

"I was talking to a few friends and that had been through it before.... so you turn to your own friends." ⁴⁸ FG3.1

"My mother had eight kids so she is better than any midwife"¹⁷ FG1.3

A primigravid participant had gleaned all her information about natural birth from two books she recommended to the remainder of the group. Participants in the group wrote the names of the books down following the interview.

"I read her book and I thought it was fantastic I was actually reading that from the start" ⁵ FG4.2

Participants in another primigravid FGI participants felt that there was some evasion from friends and professionals about what actually happened during labour and birth although they all alluded to 'horror stories':

"A secret club is the only way you can describe it"⁶ FG5.3

“that is what is annoying me like if they were to tell me about it then I wouldn’t be....as nervous” 41 FG5.4

Fisher *et al.* (2006) found that horror stories held great currency with expectant mothers, whilst Lundergen (2005) found that women who had different perceptions of birth were reluctant to share them with others. Similarly, a multigravid participant suggested that her positive experience was often not listened to:

“I know you don’t mind people being realistic but... you know you never hear the good stories and sometimes there ARE good stories...”⁴¹FG3.2

Fisher *et al.* (2006) suggests that negative aspects of birth were more readily listened to in a society where childbirth is medicalised and women feel disenfranchised from the experience. One group discussed being overwhelmed by ‘information overload’ from too many sources and had stopped listening to advice and attending antenatal classes as the information was often frightening:

“....on the information front less is morebecause you can terrify yourself.”²¹ FG5.1

“You just have to (looking at FG5.1)..... put yourself in a bubble against all that and don’t listen.”²² FG5.3

Although antenatal classes are a major source of information that can dispel and alleviate women’s fears (Barclay *et al.* 1997), women sometimes receive conflicting and unhelpful advice, (Schneider 2002) which does not prepare women for the reality of labour and birth (Di Matteo *et al.* 1993).

4.15.5 Ideal Experience: ‘that kind of natural is not necessarily good’

Many of the participants expressed their ideal or ‘dream experience’ as a natural or ‘normal’ labour and birth. Discussions about what women

perceived to be a 'natural labour' emerged when women discussed their ideal experiences of labour and birth.

The meaning of a 'normal labour' is much debated (Oakley 1981, Murphy-Lawless 1998, Gould 2000, Downe 2006). When probes such as: "what do you mean by normal?" were used, discussions produced little consensus among participants. Most groups referred to the birth itself as that which signified the 'naturalness' of the birth. Other groups debated the process of labour itself, and whether interventions such as artificially rupturing the membranes or having 'the drip' (referring to syntocinon) could be considered 'normal':

"I was induced and it was very unnatural." ⁵ FG2.3

"I would like to have it as natural as possible with as less interference as possible." ¹³ FG4.3

"...well active so that you could be walking around () and not confined to a bed so that you could try to do it ... try different positions." ¹⁴ FG4.2

"the gel is fine but if you had the drip it would come at you very fast then that might lead to more intervention... it's hard to say ..." ²⁷ () FG4.3

A single intervention (for example cervical ripening gel for induction of labour) appeared to fulfil an expectation of 'normality' but the consequences of a 'stronger intervention' for example a syntocinon infusion for induction of labour and the ensuing possibility of another intervention moved it into the realm of 'not normal'.

Discussions among the groups about the meaning of natural birth ranged from delivering the placenta naturally, (without active management of the third stage of labour) to avoiding a caesarean section. A multigravid participant stated that she had experienced both natural and caesarean section births. The 'natural birth' referred to a lengthy labour with an epidural where the birth was by forceps. The concept of normal birth can be viewed as multidimensional and dynamic (Downe 2006), and may take into consideration the woman's

interpretation of that experience. In this study, the 'naturalness' of labour and birth varied among groups and individuals. Some participants were also emphatic about the normality of pregnancy:

"I hate the term patient as well because we are not sick...."¹⁴¹
FG1.6

"well women have been having babies for years ...I'd love to have it that way natural....I think that would be nice people having babies all over the place with no problem ...if you could."⁴⁵ FG4.4

The last statement 'if you could'... was a common qualification of an expressed hope for the birth. Although both primigravid groups discussed their ideal births, participants in FG1 were more vociferous than participants in FG4 who expressed their views more tentatively, perhaps because of the presence of a dominant member of FG1 who authoritatively supported the idea of 'natural birth'. Discussions also centred on the type of pain relief that could be construed as 'natural':

"weeell..... I think it is it's natural (the epidural)"¹³² FG1.7

"yes but that kind of 'natural' is not necessarily good now... we are not ill"¹⁴³ FG1.6

Another primigravid group discussed the notion of 'natural' in relation to epidural analgesia. Speaking about friends who had experienced birth with an epidural, another participant was vehement that an epidural could not be 'natural'

"...you are completely dead now they didn't have the natural birth when the epidural is put in for the labour you cannot feel anything you would find it so hard so why would people do it?"¹¹² FG4.2

Across all groups, both multigravid and primigravid expressed a strong desire to avoid a caesarean section. The rationale for avoidance of a caesarean section varied from the consequent physical discomfort and risk of infection to missing the experience of birth.

"well it think a caesarean section I think would be the worst just because you would be off for six weeks you just can't drive or anything and the recovery is longer and that it is a major operations () and so I would prefer not to have that if I could"⁶⁸ FG4.1

"the MRSA especially if you get that if you are using the bath-after an operation in case you pick up anything and that is a big worry "¹³⁸ FG4.2

"I have had one caesarean and one natural and I would hate a caesarean section I would hate it that would be my worst nightmare..."¹⁶ FG2.2

"...no emotional thing at all.....other people I talked to said ...they felt alright about it (C.S.) they did make an effort...to make it sound like a birth but.....³⁴ FG2.2

Dodd *et al.* (2004) found that women have a strong preference for mode of birth in a subsequent pregnancy, a preference that is established within six months of the woman's birth experience. In an Irish context, Geary *et al.* (1997) reported that 98.5% of women would prefer a vaginal birth with 1.5% preferring a caesarean section. An Australian study Gamble and Creedy (2001) also reported that 93.5% of women would opt for a spontaneous vaginal birth. All groups were adamant that a caesarean section would be contrary to their ideal birth experience. Perhaps this is not surprising as one of the stipulations of the self selected sample was that participants were expecting a vaginal birth.

Participants in this study expressed positive, negative, and mixed feelings in relation to their labour and birth. They formulated aspirations for their labour and birth by integrating information from a variety of sources with their personal beliefs to define their ideal birth. Natural normal birth was the ideal but there was a wide variety of perceptions as to what constituted normality.

4.16 Theme 2: Goal attainment

The second theme to emerge from the data described the enablers and barriers to attainment of women's goals for their labour and birth, and consisted of four categories:

- Relationship with professionals
- Control
- Choice
- Coping Strategies

4.16.1 Theme 2: Enablers and barriers to attainment of goals

The four categories shown in Figure 5, identified issues that could positively or negatively affect women's desired goal for childbirth. Discussions and opinions around the categories were diverse, multidimensional, and difficult to disentangle due to the complex interaction between many of the categories. Choice and control were aligned specifically in some discussions while there were affinities between control and relationships with professionals in others. Relationships with professionals were similarly allied to issues of choice, control and decision making.

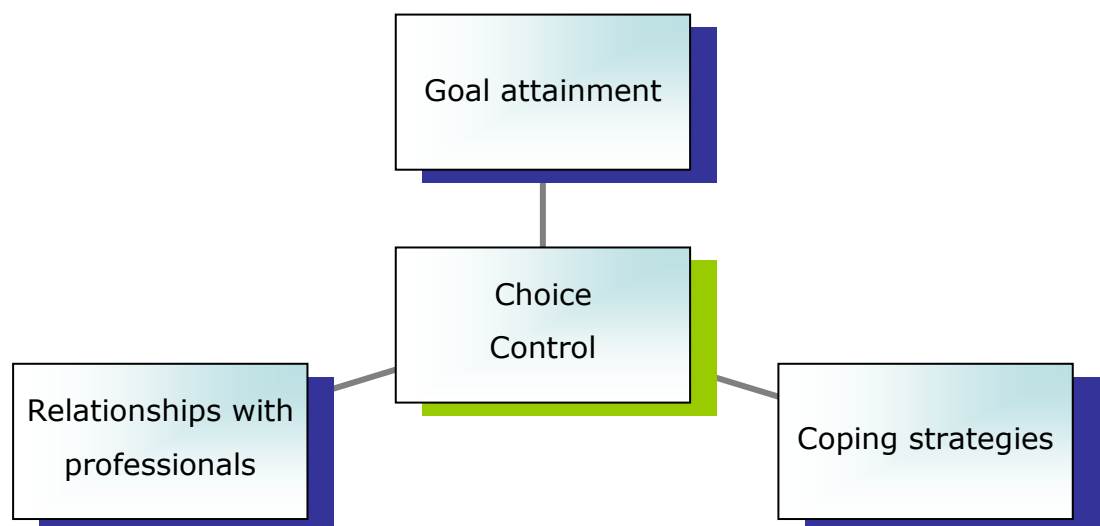


Figure 5. Enablers and barriers to attainment of goals

4.16.2 Relationships with Professionals: “If you take a notion against them you really are snookered...”

The relationship between women and the professionals was the most commonly and passionately discussed issue across all groups, and was most important in helping women achieve their goals. The labouring woman’s relationship with the caregivers is vital (Hodnett 2002). In this study, a good relationship with a professional was thought to have a mediating influence in relation to choice, control and information giving. Women sought trust and confidence in the expertise of professionals, and valued being treated with respect, being communicated with clearly and feeling supported. Barriers to the positive effects of the relationships with professionals included lack of professionals’ time, busy labour wards, hospital policies and personalities of the professionals. The dynamics of interpersonal relationships were also thought to be an important factor. The differing nature of relationships with doctors and midwives was discussed across all groups:

“..an experience with the consultants it is very clinical but with the midwives isn’t it’s very different the midwives are very practical and matter of fact”⁶⁷ FG5.2

The midwife was expected to have more time to develop a relationship with the woman in labour; doctors were perceived to be ‘busier’.

“I think it is a consensus building exercise ...the midwife can take more time to consensus build”⁶⁶ FG5.1

Participants felt that they had some responsibility towards the development of the relationship:

“...whatever that dynamic is and how you are feeling yourself”²⁰ FG5.3

A positive relationship with the midwife contributed to the experience in some instances, whilst in others it related to the consultant and his presence at the birth was welcomed:

“ He (consultant) does try to be there for the second stage of labour for the head being born...he loves the partners coming in I heard he loves that he says: “you can’t miss the birth of your first baby” (laughs)()¹²¹ FG4.3

A multigravid group recounted experiences of previous labours. One participant described her sense of loneliness in early labour and being left on her own:

“I wish I had that relationship pre birth that I had in the delivery theatre it would have been a good thing to have the relationship before you go into the labour room that is important to the whole experience”²⁴⁰ FG2.1

Similar experiences have been described by Hunt and Symonds (1995), where women in early labour were seen as an intrusion in a busy labour ward and categorized as ‘bad patients’. Negative relationships with professionals resulted in feelings of powerlessness, feeling afraid and obstructing the progress of labour. Participants in this study suggested a form of negotiation of control could be brokered if a good relationship with professionals had been forged. The importance of having a trusting relationship with the midwife in helping women make decisions was emphasised in one multigravid group:

“I said I’d be guided by the midwife that was the biggest thing being able to TRUST the midwife becauseif you cannot trust them if you take a notion against them you are really ...snookered”²³ FG3.3

Waldenstrom *et al.* (2004a) found that having a supportive midwife and doctor, being given timely information and having an opportunity to participate in decisions reduced women’s risk of perceiving that they had a negative experience. In this study having confidence in professionals was an aspect that would contribute positively to their experience.

Women wanted midwives to be confident so that they could instil that confidence in them. A discussion in one group suggested that even if professionals were not confident they should appear so:

“...and I think the confidence aspect is important there are a few that I would get an edgy vibe from...” FG1.2 ¹⁰⁵

“...yeah I’m sure that’s part of the training ACT (as if you are) CONFIDENT....” (Laughter) ¹¹⁴ FG1.6

Women who have a trusting relationship with the midwives caring for them feel they can release control of their bodies, and feel positive about themselves during birth and afterwards (Parratt and Fahy 2003). The influence of the midwife was described by a multigravid participant who contrasted the involvement of two midwives with her during her labour:

“It takes a long time to build a rapport and have the confidence to shout encouragement someone through it ...and... she was very timid”¹⁰² FG2.2

“when the other midwife came back again she got things going and really got involved”¹⁰⁵ FG2.2

Although time to develop a relationship with the midwife was important in this instance, in contrast relationships could be developed quickly due to the imminence of the delivery. Another participant in this group recalled her labour, which was progressing slowly. A younger ‘gentler midwife’ was then replaced by a more experienced midwife whom she described as her ‘cheerleader’ and the consequent effect on her labour:

“... she was awful mean to me, she was almost harsh, she said: “stop huffing and puffing”..... the other one was really sweet and nice ...but after a while I realized that no she (the harsh one) was getting the job done....making me realize I had to do more and be more be more strict with myself” ⁶⁰ FG2.3

Women have expressed a need for flexible relationships with midwives, giving them the authority to make decisions on their behalf, whilst retaining an active part in the control of labour (Bluff and Holloway

1994). Similarly, participants in this study wanted to feel in control in some instances but were willing to relinquish it in others. This was particularly evident when women spoke about the second stage of labour where they expected the midwife to be intuitive and have the confidence to take control if this was required. Women in Walker *et al.*'s (1995) study wanted the midwife to provide guidance during the more intense part of the labour – and valued the confidence and control a midwife was able to exert in these situations. The influence of external pressures, such as organisational control and the busyness of staff, which might dictate the nature of the relationship, was discussed in a primigravid group

“..if you have someone who is having a bad day for example I hope that doesn't affect the dynamics coming in to where I am giving birth”¹⁰⁶ FG5.1

“where the hospital is short of staff potentially and where there is a midwife between six birthing mothers... I hope there is somebody with me”¹⁰⁷ FG5.3

“they could have ... a busy day...they could have so many births in they could be at the end of their tether”¹¹⁵ FG5.4

The contextual nature of the Irish maternity services, being busy, the shortage of staff (Begley 2001), and the national bed shortage may have influenced these concerns. In an analogous context, a Swedish study reported similar concerns for women (Georgsson Ohman *et al.* 2003). In this study the busyness of the hospitals was mentioned more frequently in city areas where women felt that midwives were overburdened, and women actually felt sorry for them. Hindley and Thompson (2005) and Stapleton *et al.* (2002), found that midwives managed to convey their priorities of getting routine work done, and that women empathised with busy midwives, which in effect silenced any concerns they might have and stopped midwives becoming involved in their care. Although ‘emotional care’ was not mentioned explicitly it was obvious that women valued their emotional relationship with the midwife and were aware of its demands. One participant spoke about

the degree of 'engagement' of the midwife and the manner in which the midwife had become emotionally involved in her labour:

"I felt the midwife was so engaged...in the process to the extent that when I had my baby **I** was done.....I couldn't understand how she could move into another labour and start all over again she must have been exhausted and emotionally drained ...she gave so much" ⁹⁸ FG2.1

Despite never having met the midwife prior to the labour, a rapport had developed between the woman and the midwife that involved the woman being concerned about the emotional toll that the labour exerted on the midwife. Hall and Taylor (2004) likewise describe the potential connection between midwife and mother when the midwife is 'present' within the relationship. In the following excerpt the relationship with the midwife was contrasted to that with doctors:

"I thought the doctors and... I had more than one throughout the labour they were very standoffish ⁹² FG2.1

" I had no relationship with them at all so I would much prefer to be dealing with midwives (than doctors)" ⁹³ FG2.2

"...my experience with consultants has been very poor ..." ⁹⁴ FG2.1

Women may not articulate a role for doctors during labour (Beaton and Gupton 1990). In this study, relationship with doctors was mentioned in the contexts of their availability on occasions which necessitated practices such as suturing, emergencies such as instrumental deliveries, or infant resuscitation. Women's previous experiences of communication with doctors left a lot to be desired. Several participants used an analogy of 'a piece of meat' to describe how they felt while being sutured.

"He did not even say hello (doctor) I felt like a piece of meat I really did and the midwife was very supportive and she kept talking to me through that process" ¹³⁷ FG2.2

The analogy of a 'piece of meat' is also quoted in Green's (1990) study in relation to women feeling in control over what is done to them, and is often invoked to describe a feeling of powerlessness, lack of identity and lack of control. Midwives were sometimes seen as a shield or buffer to the lack of communication from doctors as this participant continued:

"...to do what he should have done basically to try to compensate for his behaviour which I felt was outrageous for that I pay tribute to her as well as she saw that I was getting a bit upset when he approached" ¹³⁸ FG2.1

The data provided important insights into women's expectations and perceptions of relationships with professionals during labour and birth. Few women mentioned having a known carer in labour although women sometimes mentioned 'their consultant' or 'their midwife' perhaps because continuity of carer was not an available option for them. Participants suggested an unspoken contractual reciprocal relationship with the midwife that they had to 'get on' and work with them. Hunter (2006) found that a relationship where there is 'give and take' between mothers and midwives, is also emotionally rewarding for the midwife. This study supports the evidence from Simkin (1991) and Hodnett *et al.* (2002), that women remember their birth experiences specifically in relation to the way in which professionals were involved in their care - a memory that is thought to have a greater impact on their long term feelings than physical aspects of their labours (Simkin 1991). In this study, the relationship with professionals was pivotal in providing a sense of participants' feeling in control, being involved in choice and decision making thereby mediating many aspects of the labour experience.

Multigravid groups vividly described their feelings about relationships with professionals in previous labours. Women were aware of the complexity and nuances of the dynamics that can occur, supporting McCreas' (1993) study that highlights the contextual nature of developing relationships with midwives. Primigravid participants were also aware of the need to develop relationships with professionals and

were aware of the potential barriers to developing relationships such as the fatigue of staff, the pressure of work, and the dynamics between individuals.

4.16.3 Control: 'I just feel it's like a cattle market'

Control is a concept that has been the subject of much debate in the literature relating to the experience of labour and birth and has been associated with positive psychological outcomes (Green *et al.* 1990) and positive birth experiences (Lavender *et al.* 1999, Hodnett 2002). Women who have managed to maintain control view childbirth positively, while those with negative experiences may perceive themselves as having lost control (Waldenstrom 2004a). Although the analysis focused on manifest content that is directly observable, latent content was used to describe occasions where the issue is discussed implicitly (Joffe and Yardley 2004). This was particularly evident in the discussions about the model of care the women chose. Categories of control have been identified as 'external control' (control over what is done to you) and 'internal control' (of your body and behaviour), (Green 1999). Participants referred to both relinquishing control over their bodies and what was being done to them:

"cos your body's not your own any more and it's really coming to terms with that and that extends into the labour"³
FG5.4

"I suppose the worse thing is that I lose control I get panicked and get frightened....and I wouldn't cope with it."¹⁶
FG2.1

A debate in one of the primigravid groups centred on what was perceived as a 'hormonal effect' in labour that contributed to loss of control:

"I suppose ... I'm hoping I will be able to control myself I'd say your hormones were all over the place when you are in labour you just I'd hate if I insulted the midwife" ()¹²⁴ FG4.1

This was greeted with laughter and nods of agreement by the remainder of the group, and a discussion about women in labour 'not being in their right mind'. Control is also related to the concept of dignity and privacy (Matthews and Callister 2004), which was discussed in the context of the number of people present at the actual delivery:

" they always come in and you know that some people say that when you are in labour that all dignity goes out the window so even for a caesarean section that you are completely naked ... in front of everyone"⁵⁶ FG4.4

"... yes that's probably the way it is you just have to accept that while it is worth it is a bitembarrassing I mean you are in the biggest pain that you have ever been in and... you have no dignity because there are so many people in and out .."⁵⁷ FG4.3

A discussion in another focus group echoed these sentiments:

" I think it is the publicity element and it's the whole humiliation factor of being naked in front of these people and maybe losing control ..."⁵⁵ FG1.5

" I just feel It's like a cattle market they just have people coming inand they are like sitting on a table and being pushed along..."⁷¹ FG1.4

Participants thought their own personalities contributed to their wanting to feeling in control during labour.

"lots of people have said just forget it 'cos I have a tendency want to ...dictate things"⁸ FG5.2

" I am a control freak.... I am a bit of a control freak"¹⁹⁹ FG2.1

Being a 'control freak' was part of the rationale given by women in their desire to control the process of labour and birth. One participant found that her peers did not share her ideas about retaining control:

"I find that people can be very dismissive of you if you want to control" ...⁴² FG1.4

Green *et al.* (1999) point out that the sense of being in control is not an objective state, but how the woman perceives her situation and her perception of being in control. The response in this particular group was that 'feeling' in control was important to them even if it was an illusion:

"Even if you feel you are in control though you are not that is the important thing"⁷⁷ FG1.2

Feeling in control was mentioned explicitly in all five groups and there were also implicit references to control in most categories and in instances where women felt powerless to change or potentially influence aspects of goal attainment. A multigravid group referred to previous labours where they had developed a rapport with their care givers and felt they had been able, potentially, to influence events. Although they had experienced difficulties in labour, one participant who had an instrumental delivery still felt in control because she was involved in the decision making:

"I was really happy with that (being left a little longer) and then I consented I knew they had given me the time and then they had to do what they had to do so I was happy with that."¹²⁶ FG2.1

Affinities between a sense of being in control, information, and decision making have been made by a number of authors (Waldenstrom 1999b, VandeVusse 1999). Brown and Lumley (1994) have identified that the most important factors related to satisfaction with birth were shared information and control in decision making. A participant in a primigravid group explained:

"I would like to be told all along this is what's going to happen...even if it's: "now we are going to give you an injection now – take a deep breath", you know... so I know - I feel in control"⁷³ FG1.4

Many women said that they chose a particular model of care to achieve what they perceived to be more choice and therefore more control in their antenatal care, which they hoped would continue on to the labour

and delivery. Jomeen (2004) suggests that opportunities for greater choice over care facilities and involvement with decision making impacts on women's feeling of control and this appeared to be the case in this study. Women may adopt an active or passive involvement in decision-making (Blix-Lindstrom *et al.* 2004). In the present study some participants wanted professionals to adopt a 'wait and see' approach whilst others wanted them to take control:

"the moment I walk through that door I am happy to...leave it up to the professionals." ²⁰¹ FG2.1

Participants in this study expressed the concept of control in several contexts. Control was related to choices, information giving and to models of care. Feeling out of control was linked to behaviours during labour, interventions, and the numbers of people who were present at the delivery. Lack of control was associated with lack of information, poor relationships with professionals, and feelings of powerlessness.

4.16.4 Choice: 'Well there's Choice and there's Real Choice'

Choice and control categories were often connected. Women in one group suggested that having choices gave them 'some control'. Similar to the theme of control, choice was often mediated by relationships with the professionals and information giving. Women used their limited choice of models of care to provide them with a feeling of being involved in their care. Private and semi private models provided an individual relationship with professionals rather than what participants described as an 'assembly line person'. The lack of individual attention and the feeling of 'being special' was important to participants. However, there was, scepticism on the part of some participants about the reality of receiving individual attention:

"you would like to think that ...you are one individual that is in here and you are not just the next patient"⁵⁰ FG1.6

"Well here you probably are the next patient (rueful laugh)"⁵¹ FG1.5

"If you are delivery ten or twelve that day..... but to you it's a special day.....of your entire life"⁵² FG1.7

The aspiration of one participant was perceived to be naive by another participant especially as the maternity unit was busy:

"I know some of the midwives have so much experience they have seen it all so many times before they are busy then you come along you know yourself....you understand where they are coming from..."⁵⁶ FG5.1

A busy work environment offers little opportunity to enter into discussions (Hindley and Thomson 2005), which can impinge on women's choices. Specific instances were discussed where participants expected choice could be available:

"just like to know my options and go with what I want "...⁸⁶ FG1.4

"I would expect that ...in a situation I would say I am in pain will you give me an epidural?"⁸⁸ FG1.4

"I'd like to deliver the placenta naturally I feel I have a choice"²⁰⁷ FG1.2

This interaction was greeted with scepticism by one participant who concluded that real choice was not a reality:

"there's a choice and choice like... we'll entertain this for a few minutes but then bang... (gestures with fist) ...so there's a choice and a proper choice."²⁰⁹ FG1.2

Such perceptions have previously been reported (Stapleton *et al.* 2002) where women felt that informed choice was often mediated by midwives ensuring that their own agendas were maintained. Quality and quantity of information (Proctor 1999) also played an important role in helping women make choices. Participants expressed a need for choice and involvement in decision-making at appropriate times during the process of labour:

“ they are the best people to judge that they can be in a better position to advise usto give us a choice and say look this is your situation”...²⁰⁶ FG1.5

The composition of one group included three participants who were not familiar with the Irish Health Care system. Although the focus of the study did not propose to discuss the various models of maternity care available, this issue was discussed in all groups. ‘Going Private’ or availing of private obstetric care rather than the public or alternative system of care emerged as an issue in relation to childbirth. Although one participant did not know what private care entailed, she chose this model due to comments she had overheard:

“but I heard someone saying that she would rather have both arms and legs off cut off rather than going public...() then I thought hey! I’m going private”¹⁹⁰ FG1.7

An animated discussion ensued about the advantages and disadvantages of private and public models of care. In a multigravid group the choice for private care which included accommodation in a private room if available, related to being able to have family members visit, which was constrained in the public system and having time with a consultant:

“It has nothing to do with the labour and delivery (going private) I wanted my child to come in and visit me as well, and you see the consultant can take his time and your husband can be there a lot of the time and that is good” ⁷³ FG3.2

Several women across groups stated that lack of privacy and lack of sleep due to neighbouring noise also prompted participants to choose private care. Both multigravid and primigravid participants also cited increased access to ultrasound:

“ I found it great ... going private some people say that if you are going public that the treatment is the same but ... you are waiting in big queues for your scan and ... it is twenty weeks before you get a scan”...⁶⁰ FG4.3

"there are definite advantages (of going private) my stomach was a bit small last time ...and two months before hand I had a scan but they didn't want to do a scan again.. I just didn't want to take any chances" ⁷⁴ FG3.3

The increase in access to technology 'not taking chances' therefore appealed to some women. The recognition of the woman as being an individual in contrast with the impersonal system of public care was also a factor in the discussion:

"yeah.... you are just a number and you wait for hours and there are other people there and people just feel intimidated by that you know"⁶¹ FG4.4

A participant in this group continued:

"I know it is expensive it is but you know ... it is worth it definitely because you get more scans and things so you know that the baby is ok even at sixteen weeks and you have another one at twenty weeksI am having one again on Monday that will be my last one to make sure the baby is ok and that it is at the right weight"⁶³ FG4.3

A participant in another group was not clear about the advantages of the private care model and regretted her choice:

"I'm regretting going private and now we are panicking actually paying all this money ... but it's too late in the game and we just don't know what to do ...I'm not too up on the whole scene"⁶⁸ FG1.7

A multigravid group discussed the advantages of the public system of care:

"Actually being in the public ward you learnt a lot because the nurses showing women how to bath the babies and what to do and you are there you have the company"⁷⁶ FG3.3

Another participant had opted for a model of care that provided continuity and more choice but had limited availability (DOMINO). Again this prompted a discussion among other members of the group who, due

to lack of information, had not realised that an alternative model of care was available. Green *et al.* (1998) similarly found that participants made different 'choices' in different areas depending on the policies and practices in use and on the models of care available. An environment that is conducive to women and midwives making choices is contingent on support from policy makers and managers (Kirkham 1999). Women in the FGIs were not always aware of the limitations of their choices in the 'macro' sense of policy and services provision therefore most choices were made in the 'micro' sense within the confines of restricted institutional availability. The limited choices of maternity service provision is criticised as a reflection of the patriarchal values in Irish society (O'Connor 2006), and the dominance of medicine in maternity services (Murphy-Lawless 1998). Although the rationale to opt for private care was explicitly expressed as 'nothing to do' with the labour and birth, there was an overwhelming sense, from the discussions among the groups, that availing of this model was a means of ensuring the safety of the baby and reducing the risks of labour and birth. This was vividly encapsulated in a statement in a multigravid group:

"If anything went wrong you would always wonder.... if you had gone private..."⁷⁵ FG3.2

Participants' choices were constrained because of lack of information and lack of resources. Within these limitations women sometimes felt choice was a token gesture rather than a reality, participants attempted to exert individual options available to them. Women in the FGIs appeared to be convinced that an increased access to technology e.g. more scans which was only available with private care, was a safer option for them and reduced the risk to them and their babies in addition to improving their overall care.

4.16.5 Coping with Labour: 'It's like a gamble really'

The ability to cope with labour was discussed among all groups. Primigravid groups discussed the possible effects that personality, pain relief and the support of their partner would have on the process of

labour whilst the multigravid groups used incidents and exemplars from their previous experiences to explain how they had managed past labours and envisaged managing forthcoming ones. The supportive role of the professionals was part of the coping process. The role of the partner was complementary but distinct from professional support in achieving the desired experience of labour and birth, similar to previous studies (Hodnett 1996, Bondas-Salonen 1998). In multigravid groups the role of partner was more clearly defined as the support person where as in the primigravid group the role of the partner was expressed tentatively:

"I think your mother for reassurance and your partner to see the child being born ..." ⁶⁷ FG1.5

Although partners were expected to play a largely supportive role, the midwife played a central supporting role for both the woman and partner

"the midwife is more important, the partner is there to support me and the midwife is there to support both of us" ³⁹ FG5.4

Women expected their support person to participate actively in the childbirth process. The partner's role centred on relaying of information, reassurance, being present as a familiar face and helping with memories as this multigravid group discussed:

"I used mine (partner) as the information gatherer 'cos people backtrack you know" ¹⁵³ FG2.2

"I needed him to be physically present and to see his face that's all I wanted the midwife did everything else" ¹⁸² FG2.1

"there was someone to relay what was happening...even though they don't do much for you just being there is important to them" ¹⁷⁹ FG2.3

" yeah it was good to get the information afterwards ...stuff that I did not remember it brought it back to me cos he remembered.. " (laughs) ¹⁶⁰ FG2.2

The timing of the admission to hospital was seen as a 'gamble' by primigravida groups who hoped they would be able to balance having made significant progress in labour prior to admission and avoiding leaving it 'too late':

"I would like to be positive you know... that what I am thinking is that when I get pains and things I will not rush into hospital straight away' ()⁷¹ FG4.3

"yeahI `m going to stay at home for as long as I can and cope myself ... I am going to try until I am really bad I will come in then." ⁷² FG4.1

A similar discussion amongst another group of primigravida participants echoed these views where participants worried about not being 'officially in labour' and expressed a sense of pride if they could progress at home:

"well I would like to stay at home as long as I canI would hope to arrive at hospital and be six cms dilated (laughs) ⁶¹ FG1.2

"YEAH... you know... have it within a few hours of arriving in hospital ... it's a bit like a gamble trying to decide what is the best time to go into hospital ⁶² FG1.3

"the panic element is..... I don't want to leave it too long and I don't want to go in too early..." () ⁶³ FG1.1

Women's confidence in their ability to cope with labour has been identified as a predictor of a positive childbirth experience. Bandura's (1977) theory of self-efficacy identifies a cognitive dynamic process in which an individual evaluates their capabilities to cope in different contexts and produce a desired outcome. Applying Bandura's theory of self-efficacy, current research on maternal confidence for labour proposes that women with increased self-efficacy in childbirth experience decreased levels of perceived pain and increased levels of satisfaction with birth (Lowe 1991,2000). More positive expectations of coping are therefore associated with positive outcomes (Ayers and Pickering 2005). Participants expressed

a desire for an active role in their approach to the labour, and believed that this could play a part in their ability to cope with labour:

"you have to have the right sort of mental approach to it"¹⁶
FG5.1

"yesIt's what you make of it"¹⁸ FG5.2

"there are certain things you can do to make your own experience better like being prepared bringing massage oils those kinds of things....."¹⁹. FG5.3

Although pain relief was not a dominant part of the discussion it featured more prominently in the multigravid groups who discussed their attitudes towards various forms of pain relief, and how they contributed to their coping with labour.

"I had pethidine but I wasn't out of it"⁵⁷ FG3.2

"the gas and air then..... I didn't over do that because I have heard people saying that it makes you nauseous."⁵⁸ FG3.2

"I did not want that (gas and air) that's the one fear I had fear of being sick that was nearly a phobia and ah I was more afraid of it..... than the pain I suppose." (laughs) ()⁵⁹ FG3.2

"I did consider an epidural at one stage but it was when I was ready to go into the delivery room and I didn't realise it ...they said: " no you are doing really well". I didn't bother with the epidural and sure enough it worked really well... I was glad after...."²⁵ FG3.3

Women in this study considered a diverse range of supports which would assist them to achieve their individual goals. Relationships with professionals, support of partner, feeling in control, and choice were important elements of coping. Expectations of labour are refined and developed with new information (Gupton *et al.* 1991). During discussions in the groups it was evident that information and ideas were being exchanged. Although defined themes are presented, the data suggest that choice, control, and relationships with professionals are interrelated and have affinities with participants' coping strategies.

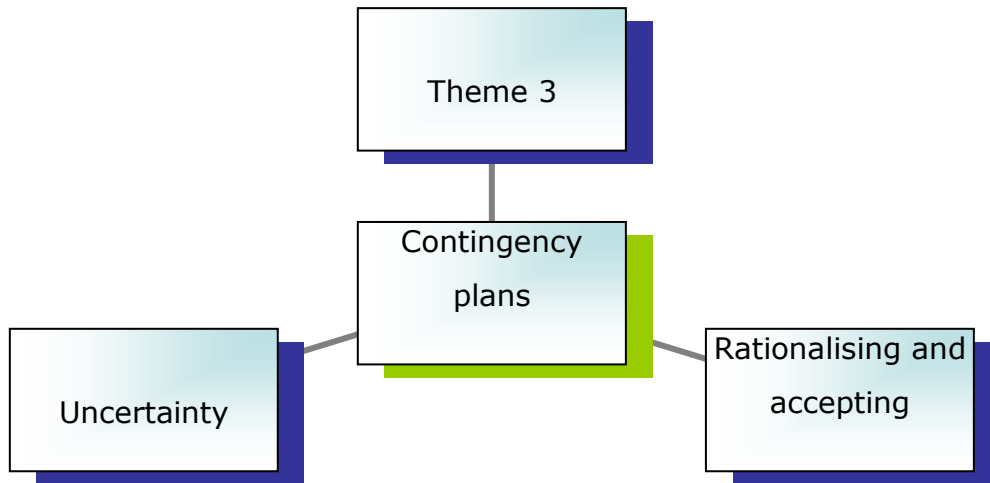


Figure 6. Categories related to contingency plans

4.17 Theme 3: Contingency plans

The final theme emerged from the categories of uncertainty resulting from rationalising and accepting unfulfilled goals. Coping with the insecurity of the potential dissonance between their ideal childbirth experience and the actual reality, women developed 'contingency plans' in the event that their ideal experience did not materialise (Figure 6).

4.17.1 Uncertainty: 'So many things that can go wrong'

Although there were affinities between the feelings of apprehension towards the 'unknown entity' of childbirth and the identification and formulation of goals in the first theme the ideal birth was couched in the context of what could happen in reality. The possibility of an ideal-reality gap led to a feeling of uncertainty that permeated discussions about the risks and possible outcomes associated with labour and birth. For Mischel (1988), (in the context of illness) uncertainty is a cognitive state that occurs in situations where the decision maker is unable to assign definite values to events or situations and/or is unable to predict outcomes accurately. Sorenson (1990) used Mischel's concept of uncertainty to explain how expectant women processed pregnancy-related events. Consistent with Sorenson's (1990) findings, in this study uncertainty was associated with participants' previous experience and

was also expressed in primigravid groups who referred to the unknown and potentially dangerous nature of labour and birth. The idea of uncertainty evolved during the course of the focus groups with more debate around the issue in the latter part of the discussions. The unpredictability of labour was frequently referred to in the following groups:

“you have no control over the situation to a great degree you are in one of those experiences where we don’t have much control”⁷ FG5.2

“you know you’re right can’t control childbirth I know there are aspects you can control...but not really”⁴³ FG1.3

Participants in the FGIs often expressed their ideal births with a proviso that they may not be fulfilled but welcomed the opportunity to ‘have a go’. There were several references in the text relating to labour as ‘a gamble’ and many statements expressed their hopes and fears and outcomes in terms of ‘being lucky’. Childbirth has previously been described as a ‘gamble’ and a ‘lottery’, (Szczepinska 1995), with elements of uncertainty. The dilemmatic nature of the discussions suggested that although participants espoused an expectation for ‘natural’ birth they did not completely commit to it as it was, from their perspective, unlikely to happen. A degree of uncertainty was accepted by some participants but provoked anxiety in others.

“In so many ways I’ve come to the conclusion that there is no way you can really plan for it that(laughs).....”² FG .1.5

“my mind was racing thinking about it cos you know there are ...so many things that can go wrong .”³⁷ FG1.5

“It’s not like you know what’s going to happen like.....you can go on thinking it’s like I’m going to have a normal delivery and at the last second.....like: ‘we need to do a caesarean’...”
FG1.7³⁹

“EXACTLY!” FG1.6⁴¹

Participants appeared to be disempowered and discussed differing strategies for coping with the uncertainty of labour:

“So it’s like ...I don’t know what’s going to happen so why even think about it?”⁴³ FG1.7

Participants evaded feelings of uncertainty by not thinking about it whilst others sought as much information as they could whilst others were more sanguine:

“ah just ..wing it and just see how it goes on the day”⁴⁵ FG1.5

The uncertainty of the process of labour and birth was also expressed in terms of a challenge that could result in a feeling of an achievement, which was also related to feelings of femininity:

“I think I would be disappointed if I didn’t do it... it’s not like I’m a rugby player or anything ... If you have gone this far you may as well give it a try...the experience anyway....It’s something to do with your femininity isn’t it?”¹²⁰ FG1.4

An Australian study (Fenwick *et al.* 2005) also found that women felt that being able to give birth represented their ‘womanly’ status. Participants in this study demonstrated a tentative approach in expressing their ideal labour and birth due to the unpredictable nature of labour resulting in a sense of uncertainty. There is evidence that childbirth is understood by professionals and parents as an inherently risk process which needs to be controlled (Olsson *et al.* 2000). Health professionals have come to rely on technology in an attempt to control childbirth (Fisher *et al.* 2006) with a consequent influence on women’s perceptions of their natural ability to give birth. In the context of the Irish maternity care system with low levels of staff and an emphasis on getting the work done (Begley 2001) in addition to high rates of intervention in labour (Kennedy 2002), participants in this study accepted that interventions would be carried out in their best interest and that of their baby. Women in this study adopted various strategies to cope with uncertainty such as avoiding thinking about it, ‘taking a chance’, seeking information, and adopting different models of care.

4.17.2 Rationalising and Accepting: 'It had to be done... too bad it wasn't what I imagined it to be and that was it'

Participants in this study felt they could readjust and adapt their expectations for their ideal birth if it did not materialise. Positive childbirth expectations have been shown to promote positive experiences in labour (Slade *et al.* 1993). Mozingo *et al.* (2002) describe the negative labour experiences of women who did not have their expectations of trust, power, control, and information giving from professionals fulfilled and their subsequent feelings of anger. Some women have found it difficult to reconcile themselves to having unwanted interventions and unmet expectations, (Porter *et al.* 2006), but also report feeling positive about their experiences if they had participated in decisions and had confidence and trust in their carers (Lundgren 2004). Participants said that they would have to accept a compromise, which involved the possibility of accepting an experience that they had not bargained for but that could be rationalised as it was in the best interests of the safety of the woman and baby. The possibility of unmet expectations was discussed across all groups more often at a later stage during the FGIs when discussions about the 'ideal birth' and the strategies for achieving it had taken place. All groups acknowledged a worse case scenario, which in this study was a caesarean section. Participants said that the experience of the labour and birth was important as it could influence their decision to have a baby in future:

"because I want more children and would not like to have a bad experience..... That would preclude me from trying for a baby in a few years so that is a factor that is there⁵⁴Fg5.2

"yeah well...I think the important question is will I do it again. most people will say yes ⁵⁶ FG5.4

Others considered that, if the baby was healthy the experience would not be that important, and they would have to reconcile themselves to a 'compromised' experience. A multigravid group discussed their first experiences of labour that did not meet their ideal of a natural birth, and one participant concluded:

"after he was born I felt that is what had to be done and...too bad it wasn't what I imagined it to be and that was it"³¹⁵ FG 3.2

Participants considered they had 'let themselves and their families down' if they had not achieved their goals. This was particularly relevant with regard to pain relief. Supporting the findings of Greene's (1993) study, women who aspired to a natural labour preferred to keep drug use to a minimum and prided themselves in coping with the lowest dose of painkillers during labour:

"I would be disappointed if I ended up having one (an epidural) but then it could be the best thing ever too.....but I would feel let downmy mom would be disappointed.... I would feel I let her down"¹¹³ FG 4.2

Participants felt that a sense of achievement giving birth 'naturally' could be marred by unwanted interventions:

"I would be so sated I would be so content to feel that I had done it myself that I had a sense of ownership and achievement whereas ...the more intervention the more it diminishes that.....I don't know maybe I won't care (laughs) but that's what I think."⁶⁷ FG5.1

Whilst an ideal birth was 'natural' and 'normal', most participants trusted professionals that any interventions in the labour may be a necessary part of the process of labour. Participants rarely discussed the necessity of interventions but had confidence that professionals would only intervene in the event of dangers to the baby or themselves:

"that episiotomything I would go mad if I had that done but like all these things the baby's is safest and the doctors know bestso I would have to have it done.....I have heard that often it is done unnecessarily I'm not talking about this hospital but in general like..." FG4.1

Interventions of themselves were deemed less important than the manner in which interventions were explained and carried out (Blix-Lindstrom *et al.* 2004). Women have welcomed obstetric intervention in

certain circumstances (Lavender *et al.* 1999) and active management of labour did not affect women's satisfaction with labour and delivery (Sadler *et al.* 2001). Discussing the possibility of a negative experiences participants said that if they were kept informed about the situation and understood the reason why something went wrong they could 'get their heads around it':

"yeah they can have bad experiences but as long as you are well informed you do have a little bit of choice"⁵⁹ FG5.2

"at least you can get your mind around it and you can say well – they did say this might happen"⁶⁰ FG5.3

Many women expressed uncertainty when talking about labour and birth, and in articulating their hopes for the labour and birth. Mischel's (1988) theory suggests that there are antecedents to uncertainty. Uncertainty is neutral until it is appraised as a danger or an opportunity, depending on effective coping strategies, then adaptation occurs (Mischel 1988). Uncertainty can be altered and women can adapt to the situation through various means such as social support and education (Field and Marck 1994). Women in this study relied on social support of partners and professionals and sought information from a variety of sources. Another coping mechanism which can be adopted emphasises the favourable aspects of a situation (Mischel 1988). In this study, the quality of the experience itself was often superseded in women's minds by the safe delivery of the baby. A participant in multigravid groups described her previous induced labour culminating in a vacuum delivery, where her baby required resuscitation - the antithesis of her ideal experience. Yet in the group discussions she never referred to her birth experience as being negative. The focus of her recall was that she became a mother of a healthy baby and that was paramount:

"you are a mother and it will be a happy experience no matter what way it goes."¹¹² FG5.3

4.18 Conclusion

The literature interprets women's expectations for childbirth as a complex dynamic process involving a variety of individual, social, institutional and cultural influences that are not accessed using traditional androcentric research approaches. Focus groups provided rich data and proved to be a fruitful method of engaging the method from a feminist perspective by listening and respecting women's worldviews of childbirth as valid sources of knowledge. The findings presented reflect the culture and context of a self selected group of women within the Irish maternity care system. This study demonstrates similarities between women's expectations for labour and birth in other cultures and contexts, but also identifies particular issues for women within the Irish maternity care system.

The FGIs were 'consciousness raising' as women discussed or discovered the lack of choice of services and the constraints therein. Women who had experienced midwifery services elsewhere were able to discuss the dearth of choice within the Irish system. The provision of 'private care' in addition to the availability of technology, whilst important for women, was juxtaposed with a dialectical desire for natural childbirth. Natural childbirth was variously defined with different perceptions within groups. Kitzinger (1994) suggests that FGI interactions identify important differences between participants, providing the researcher with an inside view into how meanings are negotiated and understood. Participants have an opportunity to clarify perceptions and explore reasons for differing opinions. Universally held truths can therefore be challenged, altered or shifted (Kitzinger 1994).

The FGI interactions were instrumental in raising awareness of potential gaps in women's knowledge. They also highlighted differences between and within groups and were valuable in addressing feminist goals. The FGIs enabled discussions about the maternity services and 'how it works', making what was previously invisible to women more visible. By highlighting differences relating to childbirth, dominant beliefs such as

perceptions of normality and choice were discussed and challenged. Most participants in this study aspired to a 'natural birth' with as little intervention as possible and hoped that the birth would not culminate in a caesarean section. Discussions about labour and birth emphasised the uncertainty approaching the event due to the unknown and unpredictable nature of labour and birth. Women adopted strategies that they envisaged would help them achieve choice and control within this context. Choices within the Irish maternity care system are limited; therefore many women in this study chose a 'private or semiprivate' model of care. They perceived they would receive individual attention, see a familiar face at the birth, have more privacy, and avail of more liberal access to technology such as ultrasound scans, which were perceived as assuring a safer outcome. Discussions enabled connections to be made between individual and collective experiences.

Although the study identified birth experiences as individual there was a range of elements that appeared to be shared. The themes, albeit identified in a linear manner were often interrelated within a network of other elements. Drawing on theories of self efficacy, uncertainty, and feminism, women's expectations for childbirth were influenced by their situatedness in terms of their social, cultural and political environment.

Even though most women aspired to fewer interventions and a minimum amount of pain relief, they would, when faced with the uncertainties of labour and birth, avail of these interventions as a 'fail safe' mechanism. Relationships with professionals were seen as central in helping women to meet their expectations of labour. In this sample, participants were aware that midwives and doctors differed in their philosophies. Participants said that a midwife who was flexible and engaged with them was more important than a familiar face, which was not an option in most instances. Relationships with doctors were perceived as less personal and sometimes negative, but for some participants it was important that they were available for emergencies.

A desired level of control was also important to women. Participants trusted that interventions would be warranted on the grounds of the safety of both mother and child and felt they were willing to accept that. Participants felt they would be happy to readjust their goals if their experience did not materialise and that they would have to accept that.

4.19 Limitations of the FGIs

A qualitative approach was appropriate as the purpose of the study was to investigate women's expectations for childbirth. The data produced was rich and appropriate to the aims of the study. Despite using FGIs that minimised moderator effect participants were aware that I am a midwife and this may have introduced the 'Experimenter effect' where participants behave in a particular way because of the characteristics of the researcher (Polit and Beck 2004). It may be possible that women who participated in the study were more able and willing to discuss their expectation than non respondents. The focus group samples were self selected, which introduced the possibility that some individuals had other motives for volunteering for the study, such as a desire to talk about their pregnancies and labour or to acquire the voucher that was offered. When asked about their motivation for participating, participants cited reasons such as helping the researcher, wanting to talk about their experiences, and wanting to be helpful to other women.

The following section Strand 2 of phase 1 explores women's experiences of childbirth through the use of postnatal focus groups interviews.

Chapter 5

Phase 1 Strand 2.

Post Natal Focus Group Interviews

5.0 Introduction

This chapter describes the initial qualitative phase strand two of the sequential design. In this chapter, the qualitative research question is explained and postnatal focus group interviews (PNFGIs) are used to explore women's experiences of childbirth in order to develop attributes for the Discrete Choice Experiment (DCE). This chapter considers the process and analysis of five postnatal groups in the context of a feminist standpoint framework as discussed in the previous chapters. The use of the reflective journal was incorporated into the research design and allowed me to examine how my social and professional position may impact on the process of the research (Appendix XXV). The literature pertaining to the relevant issues is incorporated into the text.

Women have expectations not only for the safe birth of their baby but also for the process of labour and birth including each woman's own actions and the kind of help she will receive from health professionals (Green *et al.* 1990, Stolte 1987). The concept analysis has defined the childbirth experience as a complex interplay of each individual woman's expectations, prior experiences, cognitive and physical perceptions, and the quality of support and care she receives. Patients' experiences should be the elemental source of any definition of quality (Berwick 2002), therefore, in the absence of any substantial research on the subject in Ireland, an exploration of women's experiences of labour and birth is appropriate as an indicator of the quality of maternity care. Standpoint theorists such as Jagger (2004) suggest that women are experts in their own experiences, questioning unexamined assumptions and producing more reliable appraisals of situations than a dominant

group. The political element of feminist standpoint attempts to reflect a female 'reality' from within the incomplete dominant hegemonic male discourse. The research aims to redress the absence of women's voices from the discourse around childbirth that to date has either been ignored or considered irrelevant. This exploration aims to use women's experiences to identify important elements of childbirth experience in order to develop the DCE instrument.

5.1 Research aim

To explore the childbirth experiences among women who have recently given birth.

5.2 Process

Following the antenatal FGIs a further five focus groups were convened in the same randomly identified maternity units described in chapter 4. Ethical approval and access to sites were achieved as described in chapter 4. A qualitative descriptive combination of sampling, data collection, analysis, and representation was utilised (Sandelowski 2000b) within the framework of feminist research. The feminist aim of the study is to give voice to women who have traditionally been marginalised in investigating women's childbirth experiences in Ireland.

5.2.1 Setting

Five FGIs were held, in each of the four randomly selected maternity units described in chapter 4 and, in addition the pilot study unit.

5.2.2 Selection of participants

A purposive sample of women who fulfilled the following criteria was recruited from the postnatal wards of the five units between September 2005 and June 2006.

- ≥18yrs old
- English speaking

- Had experienced labour
- Birth of a live baby
- Willingness to participate

Potential participants were invited to participate by the researcher during the postnatal period while they remained in the hospital following the birth of their baby. I had initially planned to follow a cohort of women through from the antenatal to the postnatal period. However, due to difficulties with recruitment for the antenatal focus groups (Chapter 4) it was decided that, in addition to participants of the antenatal focus groups, a further sample needed to be recruited.

5.2.3 Interaction of Participants

Issues related to group composition, moderator effects and the limitations of focus group interviews have been discussed in Chapter 4. Focus groups are unique, emphasising the importance of the interaction of the group in determining the quality of data (Kitzinger and Barbour 1999). Morgan (1997) suggests the possibility of using 'mix and match' designs with previous focus group participants being mixed with new participants. Postnatal groups consisted of mostly new participants apart from Unit B where five of the original group were joined by one woman who had intended to attend the antenatal group (Table 9). Discussions in all groups proved to be both lively and productive.

Table 9. Comparison of antenatal and postnatal focus group composition

Population	Antenatal group	Parity	Postnatal group	Parity*
Unit A (Rural)	4	Multigravid	5 (Pilot)	Mixture
Unit B (City)	7	Primigravid	6 (5+1)	Primigravid
Unit C (City)	3	Multigravid	4 (2+2)	Multigravid
Unit D (Rural)	4	Primigravid	7 (1+6)	Mixture
Unit E (Rural)	4	Multigravid	3 (1+2)	Multigravid

* Prior to this labour **Bold** denotes participation in antenatal group.

The effects of the composition of the group being either familiar with one another or strangers has been the subject of discussion in the literature (Thomas *et al.* 1995); however, in this study, there was little difference noticed in the interaction of the groups between participants known to each other from previous groups and those who were unacquainted, a finding supported by the work of Twinn (1998). Mixing groups is not inherently less productive provided that participants can discuss the topic comfortably and fruitfully (Morgan 1997), which was the case in this study. The purpose of the antenatal focus groups was to establish women's expectations for labour and birth and involved segmentation of participants into those who had experienced labour and those who had not. The postnatal focus groups explored the process of that experience therefore the continuation of the antenatal segmentation of groups was unwarranted as the premise on which they were established was no longer applicable, i.e. all participants had experienced labour and birth.

As the researcher was familiar with the individuals in both antenatal and postnatal groups, and had transcribed and analysed the data, links between antenatal and postnatal expectations and experiences expressed by participants were easily discernible.

5.2.4 Recruitment Process

The researcher consulted with the midwife in charge of the postnatal ward. Women who met the inclusion criteria were approached by the researcher and asked if they would be willing to be contacted in approximately three months' time in order to discuss their birth experiences. An information leaflet was given to the women similar to the antenatal FGI participants (Appendix V), with appropriately amended eligibility criteria, explaining the purpose of the study with the contact details of the researcher in case of further queries. A voucher for €40 was offered to women as an acknowledgement of their time, their travel, and child minding. Addresses of potential participants who expressed a willingness to be contacted subsequently were obtained either from the women themselves or by obtaining an addressograph from their hospital files with their permission. Many participants volunteered their mobile

phone numbers as a means of contacting them. Two potential participants who expressed literacy difficulties were given verbal information in addition to the written information, which they suggested partners would communicate to them. Two women, one from a city and one from a rural area, declined to be contacted, saying that they would not feel comfortable discussing their birth experience in a group situation. The researcher's previous experience with an overall response rate of 23% suggested a need for over-recruitment by at least 50%. The findings of the antenatal groups suggested that the optimum number for a focus group to maximize participation and quality of data was four to five participants, which supports Cote-Arsenault and Morrisson-Breedy's (2001) views. Therefore approximately twenty postnatal mothers were approached in each unit to generate a sample for each group.

Three months following the initial approach to the women in the postnatal areas, a letter was posted to all potential participants thanking them for their interest and inviting them to attend a FGI. The letter identified the date, time and location of the focus group interviews. The venue of the FGI can impact on the data (Bloor *et al.* 2001); therefore they were held within the hospital, which would have been accessible to most women.

Women were asked to reply to the researcher by text or by telephone indicating whether or not they were still willing to participate in the FGI. Potential participants were advised that the researcher would contact them the week before the event.

5.3 Pilot Study

A pilot focus group was held to determine whether recruitment would be similarly difficult to the antenatal groups and to ascertain whether the choice of having the babies present at the group would contribute to attendance and affect the noise level and interaction among the group. The pilot group was well attended with five mothers and three babies. The noise level was not found to be a problem, and the presence of the

babies increased the interaction among the group. Mothers spoke to their babies and referred to them when they spoke about their labours.

Table 10. Number of Mothers and Babies in Each Focus Group

Unit	No. of mothers	No. of Babies
Unit A	5	3
Unit B	6	3
Unit C	4	4
Unit D	7	4
Unit E	3	2

The week prior to the focus group the researcher contacted potential participants to confirm their availability and intentions regarding attending. A text message was sent to each potential participant who had given a mobile number to remind them of the date and time and a further request made for a response. Mobile text messaging proved to be an easy method for mothers to respond in their own time. Potential participants who did not have a mobile telephone (2) were telephoned. Similar to Chapter 4 ethical issues related to confidentiality, informed and ongoing consent during the process were strictly adhered to. Table 10 shows the number of mothers and babies that attended from each unit.

5.4 Group Process

The process of the focus group as described in Chapter 4 was utilised using a semi-structured interview guide (Appendix X11), adopting a conversational approach and a low intervention moderating style (Millward 1995) as appropriate amended to the group dynamics. Everyone had an opportunity to relate their experience of labour and birth prior to the group discussion. The opening question asked women about their babies, their babies' names and how many weeks old they were. Participants who did not bring their babies had photographs,

usually on their mobile phone, which they showed to the rest of the group. The group process included debriefing, and access to relevant personnel if participants became upset or who identified issues of concern as outlined in the antenatal FGIs. At the end of each focus group I summarised the main issues that women identified as being important to their childbirth experiences.

Table 11. Response and Attendance for Postnatal Focus Groups

	Requested access to contact details	Agreed to be contacted	Responded to contact	Agreed to Attend	Attended Focus Group
Unit A	15	12	10	8	5
Unit B	12*	12	8	6	6
Unit C	18	17	9	5	3
Unit D	20	19	13	5	4
Unit E	14	13	7	7	7
Total	79	73	47	31	25

*Permission given antenatally.

Table 11 shows the number of respondents for the postnatal FGIs. The demographics of the postnatal groups are shown in Table 12. Compared with the antenatal focus groups, there were fewer participants from different ethnic groups, and more women who had experienced more than one labour. There were also more participants from rural than from city units.

The numbers of participants ranged from 3-7, the larger groups were more difficult to manage as it was important that everyone was included and had their 'birth story' listened to. The smaller groups yielded rich data also and, congruent with what I had learned in the antenatal groups, five participants proved to be the optimum number of participants. Congruent with feminist principles individuals in this size group had the opportunity to discuss emotive topics about their

experiences similar to other authors (Cote-Arsenault and Morrison-Beedy 1999).

Table 12. Comparisons of Characteristics between Antenatal and Postnatal Focus Group Participants.

Age Group n = 25	Antenatal Group n = 22	Postnatal Group n = 25
20-29	7	10
30-39	15	15
Ethnic Groups		
White Irish	15	20
Asian	2	1
White North American	2	1
White Canadian	1	2
African	1	0
Eastern European	1	1
Parity		
First Labour	15	9
More than one Labour	7	16
Education		
Higher education (university)	15	16
School education (secondary)	7	9
Marital Status		
Married	20	23
Partner	2	2
Rural/City		
Rural	10	14
City	12	11

5.5 Rigour

The need to demonstrate the rigour of any study is in order to establish trustworthiness (Koch 1994). The notion of trustworthiness is based on care and accountability, open communication throughout the inquiry,

and ethical conduct. The data collected were reviewed by an experienced qualitative researcher (C.B). The interactions among participants and verbatim quotes enhanced a deep understanding of the data. Ethical issues as described in chapter 4 were strictly adhered to (Morrison-Beedy *et al.* 2001).

5.6 Data Analysis

I transcribed all the focus group data verbatim as soon after the interviews as possible including both words and emotions (Morrison-Beedy *et al.* 2001). Thematic analysis based on a phenomenological framework (Colaizzi 1978) as detailed in chapter four was used to analyse the data. Significant statements were identified, followed by the establishment of emergent categories and sub categories from the data and the formulation of three main themes. Participants were identified numerically as members of postnatal groups (FG.6- FG.10). Similar issues and themes were identified across all groups (Appendix X111). Participants were contacted to ascertain that they agreed with the themes and categories (Appendix X1V), all participants agreed. The themes were entitled 'getting started,' 'getting there' and 'the consequences of the experience'.

Table 13. Main themes and categories from postnatal FGIs

Getting Started	Getting there	Consequences
Expectations	Anxiety/Uncertainty	Memory
The twilight zone	Perceptions of reality	Isolation
	The control continuum	Effect on future pregnancy

5.7 Getting Started

This theme referred to women's experiences of being in early labour prior to and during admission to hospital, and their feeling of uncertainty as to whether they were in labour or not. The sub categories related to this theme consisted of 'expectations for labour' and 'the twilight zone'.

Participants who had taken part in the previous groups sometimes alluded to the expectations expressed therein and contrasted these with their experience. Women spoke about the incongruity between their expectations of how labour would start with the reality of becoming established in labour.

5.7.1 Expectations: 'you have a certain plan in your head about how it is going to go'

Some expectations of labour may help a woman cope with her actual labour but others may cause anxiety and diminish her ability to cope (Stolte 1987). Since 1975, studies have demonstrated that women who considered their childbirth experience to be positive reported that their expectations were similar to the actual event, while women who had a negative experience had expectations judged by the author to be unrealistic e.g. short labours (Clark 1975). Women in the FGI recounted a variety of experiences, some of which matched or exceeded their expectations and some which did not. In this study, primigravid participants were more likely to be disappointed by their experiences than multigravid participants. In general, women's expectations of becoming established in labour were described by women themselves as being unrealistic and were considered naive in retrospect. A discussion in one of the FGIs recounted a participant's bewilderment following two visits to the hospital, thinking she was in labour, and being sent home until labour was 'established':

'Well, I had great plans, you know, I was at home, I'll have a bath and the waters will break and that will be it" (laughs ...group laughs) ⁹⁷ FG10.5

Dissonance between the consumers' expectations and their perceptions of the service quality are important (Crow *et al.* 2002b, Green *et al.* 1990). Women's expectations encompass a divergence of issues that are individual and differ significantly from one another (Howell-White 1999). Expectations of childbirth appear to be an important predictor of psychological trauma during childbirth (Wijma *et al.* 1997, Czarnocka and Slade 2000, Soet *et al.* 2003), although (Slade 2006) suggests a

more complex interplay of predisposing (pre-pregnancy/pregnancy), precipitating (perinatal) and maintaining (postnatal) factors, relating to internal (within individual), external (environmental) and interactional factors, with no automatic link between the event of labour and delivery and traumatic symptoms.

Women have reported feeling angry, guilty and disappointed (Mozingo *et al.* 2002), when their expectations for the process of labour, interventions, their own performance, or the type of care they have received have not been met. In this study, a group of participants discussed the unexpected nature of events during labour and birth. Getting 'psyched up', an emotional and cognitive dimension of preparation for the birth, seemed to be an important element of expectation. One participant had been booked for an elective caesarean section and was unprepared and uninvolved when it was decided that she would have her labour induced instead:

"...all of a sudden at the last minute that changed, you know, I never wanted a caesarean section but I had myself psyched up and had myself convinced and mentally ready to have the caesarean..."⁸ FG9.2

"... like here I was I READ ALL MY BOOKS I had a birth plan which went in the bin the week before and here I was show me what to do" (crying voice)⁹FG9.2

"Oh god I would hate that" FG9.1¹⁰ (Chorus of agreement)

In another group, a participant who had experienced a previous spontaneous onset of labour had been induced in this pregnancy and was shocked at how unprepared she was. Other participants in the group had experienced similar unforeseen issues of unanticipated progression that did not meet their expectations.

"well it didn't (meet expectations) cos I was two weeks overdue and I didn't expect that ...was a big shock"¹ FG8.1

"it is all this expectation that it is going to happen on your due date and then you think, ok you are going into hospital

for an induction. Nothing happens straight away either, that was very upsetting, you know, that was the only thing"⁵ FG8.1

"yeah...that was one of the things that you do not expect" ⁶ FG8.2

"yes, you have a certain plan in your head about how it is going to go ..."⁷ FG8.3

Part of the feminist interpretation of the advantages of the FGIs is the potential for the individual experience to be collective, the 'me too' element of interaction. In this interaction, women shared stories with each other about being induced, identifying similarities in their feelings of bewilderment when labour did not occur spontaneously. A discussion in the primigravida FGI illustrated that participants had similar expectations about their labours, which were informed by antenatal classes, but which were not fulfilled:

"cos I felt I ...had this labour in my head that I would be at home for a while that I would go in and I would manage the contractions at homeback rubs and all that we learned at the antenatal classes and I had psyched up for that so"¹⁴ FG6.4

In all the FGIs, one or two participants felt that their expectations had not been realised. Green et al. (1990) found that having high expectations did not lead to feelings of failure and dissatisfaction but that low expectations were associated with poor psychological outcomes. In this study, some FGI participants who had expressed 'explicit expectations' were disappointed. One participant who had taken part in the antenatal FGI and who had expressed the view that an ideal birth was, for her, 'natural' without interventions experienced the antithesis of her ideal birth and was disappointed that she had not managed 'on her own'. Her unmet expectations were a source of sadness for her and contributed to her description of the overall experience as being 'terrible'. In the primigravid group, only one participant felt that all her expectations had been met whilst the remainder had unmet expectations about the whole or part of their labour. The uncertainty and feelings of

vulnerability and loneliness that many participants expressed at the onset of labour were characterised as 'the twilight zone'.

5.7.2 The Twilight Zone... 'I kept on wondering if it was the real thing'

Women experience their onset of labour in a number of different ways, often using their own diagnostic criteria, which differ from the classical diagnosis of labour (Gross *et al.* 2003). Cheyne *et al.* (2006) in a focus group study of midwives, found that their management and decisions relating to the diagnosis of labour, were coloured by a number of factors including the support that a woman had, how she was coping, and the requirements of the institution. Women in the FGIs were often confused as to whether they were actually in labour or not and sought advice from the hospital:

"I rang the hospital to say would I come in or what and they said stay at home as long as possible you will only be waiting around. They [contractions] weren't regular, like, so I thought they might ...not be the real thing, like"⁸⁵ FG7.3

Many participants said they felt lonely, isolated and unsupported at this time in the 'twilight zone' between two categories of 'being in labour' or 'not in labour'. Their experience echoed those in the previous FGIs (Chapter 4), who identified that they did not establish relationships with professionals until they were officially 'in labour,' when the tenor of their care changed. Many institutions require a clear-cut distinction between a woman being in labour and admitted to hospital, or not being in labour and sent home (Cheyne *et al.* 2006). This distinction can be difficult to decipher at times, (McNiven *et al.* 1998) especially as the duration of the latent phase of labour varies so greatly and may only be determined retrospectively (Cheyne *et al.* 2006). Professionals may be cautious about admitting women in early labour as interventions may be more likely (Holmes *et al.* 2001). The professional uncertainty about the diagnosis of labour has affinities with women's feelings of hesitation expressing their doubts as to whether or not labour had actually started,

whether it was 'the real thing', not knowing whether to attempt admission to hospital or not.

Women who felt they were in labour often experienced delays before they were assessed in relation to their labour 'status'. One participant described with disbelief how she waited for two hours prior to admission sitting outside in a public corridor in pain and unable to move. Other participants in the group were not surprised and were matter of fact about this type of delay:

"Yeah you have to wait your turn ..." ²¹ FG6.5

The pressure of workload also affected the admission process and the diagnosis of labour. Participants found that they were either asked to go home or had to wait to be admitted to the antenatal ward:

"and there were no beds for me and like I was there, I am hanging on to the side of the trolley with every contraction and they are looking up and down the corridor saying
"we are looking for a bed for you calm down" (gestures with hand) and my husband has my bag (mimics carrying a bag)and I am thinking this is crazy..." ²⁵ FG6.1

This participant was then admitted to the antenatal ward, which she felt was inappropriate to her needs and potentially upsetting to other women:

"well yeah ...then there was no room in the labour ward so they put me in the like... prenatal room with like these seven other women and they were like all sitting up (mimics women with magazine)....like reading magazines with their feet upI was in agony... biting my lip trying not to make noise" ²⁹ FG6.1 (laughing, everyone laughs)

Another participant recounted her admission to the labour ward and her disappointment when due to pressure on bed availability, she was sent back to the antenatal ward:

"yesI was 2 cms and they brought me up to delivery suite and I was still the same and they put me back out..." ⁸⁴ FG6.5 (rolls her eyes) (chorus of 'oh no!')

“somebody else needed the room obviously”⁸⁷ FG6.6

Again this seemed to be accepted by women as the ‘norm’ and participants were unsurprised perhaps because this was a busy city hospital. This issue of waiting for the official or ‘technical’ diagnosis of labour was also discussed in relation to being induced or waiting for prostaglandin induction to take effect.

“..... I had been in that pain for 14 hours and then the doctor said ok now we’ll put you on oxytocin but they could have done that before, I thought...” FG10.1

“the second gel the next day worked a little bit...little minor contractions during the day then..... but I was not really technically in labour”²⁹ FG10.2

Being in the twilight zone meant that women did not form a relationship with their carers who were ‘just in and out’. Authors in other contexts have also found that relationships with labouring women’s care givers are understood in the context of the institutional structures and work processes that shape their experiences (MacKinnon *et al.* 2005). In another FGI, participants were fearful that they would not get to the labour ward and would be in pain:

“then I was afraid that when I wanted to go to delivery ward I was worried they wouldn’t take me serious ...and I would be in a lot of pain like”¹⁵⁵ FG9.3

Participants in all groups often found becoming established in labour a time of uncertainty and loneliness when partners were not allowed to stay with them, and this was echoed in women’s experience of being induced and waiting for the official diagnosis of labour. The impact on the women of being in this ‘twilight zone’ between early labour/induction and being established in labour was that they felt isolated, ignored and seen as part of the ‘system’ as the following interaction demonstrates:

“... but the care up to that I thought it was a bit haphazard like, different people coming in and checking on you and like

every time it's someone different taking your blood pressure and... and checking there (vaginal examination)"⁶⁴ FG10.2

"Yeah (nodding) and you're thinking don't tell me they are checking up there...again..."⁶⁵ FG10.3

"Yeah I just thought anyone else want to have a go?"⁶⁷ FG10.4

Women in previous studies have identified incongruence between women's expectations and experiences of early labour (Beebe and Humphreys 2006). Once women were diagnosed as being 'in labour' they felt that the physical care they had received became more personal. Hodnett *et al.* (2003) suggest that continuous intrapartum support was associated with greater benefits when it began early in labour, similar to women's expressions of the importance of emotional support in early labour highlighted in this study. Once women were diagnosed as being 'in labour' they felt that they received more supportive care. The activity of the institutions involved seemed to have an impact on decisions about the diagnosis and management of their labours and affected the relationships with caregivers and participants.

5.8 Theme 2: Getting there

The second theme describes women's experience of the process of labour and their feelings once they were established in labour, which they expressed as feeling that they were 'getting there'. The theme included sub categories of 'anxiety', 'perceptions of reality' and the 'control continuum'.

5.8.1 Anxiety

Women experienced a variety of simultaneous emotions during labour, which were sometimes both positive and negative. Similar to women in the antenatal focus groups, many women in the postnatal FGI expressed anxieties about specific interventions. Some anxieties were related to procedures during labour while others related to more general concerns such as the environment. In the primigravid groups, a particular concern

in relation to episiotomies was expressed by one participant who had to undergo an episiotomy for an instrumental delivery:

"It was my worst nightmare when I was about four months pregnant, I said to her 'I have horrors about an episiotomy' (whispers) and she said (brightly) "we'll try and avoid it"¹⁷⁸
FG6.6 (laughter)

In another group of mixed parity, participants expressed anxiety about the uncertain length of labour and their vulnerability to interventions and hoped that the labour would progress quickly to minimise the likelihood of such interventions:

"luckily it was quick but if it wasn't quick that I was going to be forced into having something that I didn't want....I had this fear all the time"²⁷ FG9.1

Longer labours have been associated with negative birth experiences (Nystedt *et al.* 2005), an increased use of epidural analgesia, and consequent risk of operative interventions (Goldberg *et al.* 1999). Women may welcome interventions to shorten labour when it is prolonged (Lavender *et al.* 1998) and high satisfaction rates have been reported in primiparas with active management of labour (Sadler *et al.* 2001). The use of time limits alone has been criticised as a reductionist, disempowering approach to the complex phenomenon of labour (Mander 2006, Simonds 2002). However, the length of labour remains an important aspect of the birth experience to some women (Melender 2002) although not for others (Green and Baston 2003). Participants in the FGIs felt that their anxiety was heightened by the physical environment in the labour ward, particularly when they could hear others in labour.

"when I came in I could hear a woman roaring as well and I said: "I don't want to hear it, shut the door", and the midwife was saying she'll be over it soonok"⁶⁴ FG9.1

Many of the participants commented on the loudness of the noise from other women in labour. Participants in three FGIs found that the physical environment increased their feelings of anxiety, particularly if they had experienced a different environment in another hospital:

"Gawd what is happening here...in the room it was like a veterinary surgeon like they had that silver thing for washing your hands"¹⁴⁸ FG10.3

"the midwifery system is so different it is like a hotel you just feel really relaxed, a homely environment and you could go and ask midwives anything..... it was such a huge change, you know"^{147 b} FG10.4

The first stage of labour is thought to be a time of unique sensitivity to environmental factors (Honnebier and Nathanielsz 1994). In the UK, a large National Childbirth Trust study found that the physical environment can affect how easy or difficult it is for women to give birth (Singh and Newburn 2006), whilst Melender (2002), in a smaller qualitative study, suggests that the physical environment was not an issue for many women. A recent study of Swedish home births found that women fashioned a personal environment in order to create their own mental space whereas hospital environments were described by women as energy consuming and diverting focus from the labour itself (Sjöblom *et al.* 2006). A number of participants in the FGIs who had experienced maternity services in other countries thought the environment in Irish hospitals felt threatening and non-welcoming:

"the building itself, you know, it is so claustrophobic and give me a weird feeling emotions of this kind of almost a.....feeling of foreboding about the building.. ." ¹⁴⁵ FG9.2

'Well I don't agree¹⁴⁶' FG9.4

Other members of this group sought to defend the hospital and did not agree with this participant, but she retorted:

"the care services were fantastic..... listen.... I would not knock a nurse, any midwife, any doctor, no one..... but it is

extremely unsettling to come into the room with the paint coming off the ceiling"¹⁴⁴ FG9.2

Women's experiences and expectations are shaped by what they 'know', what women believe to be possible, and what they have come to expect (van Teijlingen *et al.* 2003). Participants in the FGIs who had not experienced services in another context or who were unaware of alternatives felt that they had received the best care possible. Similar to van Teijlingen *et al.* (2003), there was a degree of 'gratitude bias' that seemed to render participants reluctant to be critical or have someone else criticise the health services. Participants may have felt it risky to express dissatisfaction due to the limited availability of maternity services.

5.8.2 Perceptions of Reality 'You go into a different zone'

Women spoke about their feelings in labour in relation to being in another zone or feeling out of their bodies, being unaware of time regardless of the type of pain relief they received. However, many women expressed a feeling of unreality, a feeling of 'not being there during the labour'.

"I had a radio in the room and it was the strangest sensation, that, because I know the song that was on and it didn't sound like...it should ¹⁷⁰I knew the way it should have sounded but because of the altered state..."⁷¹FG9.2

The altered conscious state that women spoke about is interpreted by Parrat and Fahy (2003) as an adaptation to the challenges of labour, which blurs cognitive perspectives of time and fear. Women discussed the length of time they spent in various stages of labour, how they were progressing and their awareness of the time constraints that would be applied once they were admitted to the labour ward (Simonds 2002). Time was an important element of their labour and women perceived that forgetting about the time factor and being removed from 'reality' helped their progress. Participants in this study said it felt as if they had moved into another time zone:

"I just wasn't reacting to anything anymore, kind of after going through so much I think I was so caught up in it but so switched off..... you go into another zone as if ...they can't...nothing can hurt me anymore and it really was like that"⁷⁵FG9.1

A transcendental, spiritual, existential feeling has been a feature of some women's phenomenological descriptions of their experience of labour (Lundgren 2004, Sjöblom *et al.* 2006), similar to women in the FGIs who described themselves as 'being on a different planet'. The largest and most discussed category related to how women perceived themselves to be 'in control' during labour.

5.8.3 The Control Continuum

Women identified a feeling of control as being important to their experience and this aspect permeated the gamut of the experience. Rather than impose any particular meaning on the concept of control, a concept that has been widely debated in the literature, the intention of the author is to report what women said in relation to their perception of control. The word 'control' was often used by women in relation to their birth experiences. Similar to the antenatal FGIs, there were many areas of overlap where women's perception of control was related to other issues such as relationship with professionals. Women felt that being out of control was 'scary' but for individual women the issue of control encompassed a range of contexts or sub categories. There were five sub categories related to control: information, progress, and relationship with professionals, choice, and pain relief.

5.8.4 Control and Information: 'The woman at the machine wouldn't tell me'

Women felt that if they received information during the course of labour it helped them to feel in control:

"I think I'm a control freak. I need to know what was happening (laughs) at each stage I wanted to know exactly what was going on, like"¹³⁹ FG8.2

Women who were 'left in the dark' felt that information was being withheld for no particular reason. One participant, who had been moved from a midwifery model of care to a consultant-led model due to having meconium-stained liquor, found that the information giving in the hospital unit left a lot to be desired as she was not quite sure what the significance of the meconium was for her baby and asked midwives several times:

"I was worried that he (baby) would be poisoned and the woman at the machine didn't tell meI wanted to know that he was ok it was just on my mind all the time you know"⁷⁹
FG10.4

Similar to Walker *et al.* (1995), women who were transferred from midwifery led care felt that the transfer adversely affected their labour experience and feelings of control. Some members of the group were annoyed by this situation and felt that they should have received better information:

"you shouldn't have to ask....what you are saying and your experience or your reaction should be triggering the person caring for you to offer..... whateveror advice"⁸¹ FG10.3

This interaction is one of the few that directly addressed what women felt 'should have been done'. Women generally regarded that what was done had to be done and believed that it was in the best interest of them and their babies. There seemed to be no surprise among the groups when interventions were instigated against their will. As outlined previously, when there was a member of a group who had experienced maternity services elsewhere that offered more choice other women in the group were interested. However participants accepted that 'things are different here' (in Ireland) and the general feeling was that women accepted what was available. Another group discussed the 'little things' that made them feel they 'had a part to play' such as identifying the sex of the baby. Women said they wanted to find out themselves what it was; however, they were often reluctant to ask:

"No ... I didn't like it. I said 'is that the cord?' cos it looked huge and I couldn't decide whether it was a boy or a girl and I said ask what it is ...it was about ten minutes after when they turned around and they said "oh yeah, congratulations it is a boy"..."¹⁴² FG6.5

Discovering this information for themselves helped another participant, who felt that waiting for her and her partner to identify the sex of the baby was a continuation of her feeling of being in control during the latter stage of labour:

"It was fantastic I really felt in control and so happy that I was doing it... so happy that I was delivering her and anyway when she came out ... they didn't tell us what it.....was they just waited for us to see if it was a boy or a girl"¹⁴⁰ FG6.6

The importance of information-giving during labour has been emphasised (Kirkham 1989, Corbett and Callister 2000). Green *et al.* (1990) suggest that feeling in control is important to the experience of labour and birth in addition to postnatal emotional wellbeing. The perception of being in control and progressing without intervention was another aspect of control discussed by women.

5.8.5 Control and Progress: 'I'm doing it on my own, yeah!'

Women felt that they were in control if they spontaneously progressed in labour, therefore 'did it on their own'. Most groups discussed the relief they experienced when they progressed in labour without interventions and their disappointment if they did not:

"I was so proud of myself here I am in labour, I wasn't induced.... I don't have a drip....I'm doing it on my own, yeah!"⁸⁰ FG9.3

Another participant in this group said it was her lack of progress that made her feel out of control:

"..and then the whole loss of control when I was told that I had laboured through the night to be told that no I actually hadn't dilated any further"¹⁴⁰ FG8.2

When participants reached the second stage of labour the experience of their body taking over was discussed:

"from half twelve to half one I was pushing like... that was brutal, like, I felt like a split person (others laugh) you know what I mean"⁵⁹ FG7.7

Participants in another group felt powerful and exhilarated when their bodies 'took over':

"like it was good pain, it was good pain, I was glad it was manageable, at least the pushing part was good. It is such a powerful sensation"⁵² FG9.3

"like I can't stop here they are saying to me I have no control here, "you can't push yet" and I am saying 'I have no choice here'. Your body just does it"⁵⁴ FG9.1

When labour progressed too quickly participants also felt out of control:

"I didn't feel as if I was in control then... it was just because it happened so fast and then had to go into the other room then and into the other bed"¹⁶⁰ FG8.1

This view concurs with other reports of mothers' experiences of precipitate labours who felt panicked when labour progressed quickly (Rippin-Sisler 1996). However, the main source of anxiety for FG8.1 was that she would not get to the 'labour bed' and have to give birth in a 'normal bed'. Although a previous study found that women found hospital beds uncomfortable and unfamiliar (Lock and Gibb 2003), women in the FGIs, however, perceived the delivery bed as a place of safety. A discussion took place among the group about the necessity of giving birth in the 'delivery bed'. Participants concluded that it was an issue of safety so that if an emergency occurred stirrups could be attached:

"you are in a normal bed and then you are moved to a higher bed I think just in case you need to have a instrumental delivery or whatever and you can have the things for it" ⁵⁰
FG8.2

Participants in FGIs felt that it would not be safe to give birth in a 'normal bed' in case of emergencies. Although a recent survey found that women valued being able to stay in the same room throughout labour (Singh and Newburn 2006), women in this study did not have this opportunity as they often had to be moved to give birth to their baby. Women in the FGIs evaluated their experiences in relation to their performance and how they managed their births. The absence of interventions seemed to increase the amount of control they felt, and progressing naturally was thought to be preferential to being induced or having slow progress although a quick birth also contributed to women feeling 'out of control.'

5.8.6 Control and Relationships with Professionals: 'I had this threat hanging over my head'

This category was discussed explicitly and implicitly across all groups. Feeling in control was related to their relationships with professionals who could enhance or detract from their experience. Participants referred particularly to midwives and student midwives. Relationships with doctors were often considered in the context of incidents such as instrumental delivery or suturing. The quality of childbirth experiences has been shown to be related to the quality of relationship with the midwife (Berg *et al.* 1996, Halldorsdottir and Karlsdottir 1996). Participants described several interactions between professionals and the manner in which midwives acted as advocates for them:

"and there was another midwife who came to the delivery suite she didn't know me but she told the doctors to back off and let me have another push and it only took me about three or four pushes to actually get him out.... it made such a difference"²³⁸ FG6.3

Another participant described how a doctor had told her to have an epidural but the woman was reluctant and with the support and help

from the midwife she managed without it. Another participant described her relationship with the midwife whom she described as 'old school' and her struggle to maintain her mobility despite the midwife's wishes:

"but no.... the midwife insisted that I should have the drip and I was not happy at all because this meant that I would not be able to move around and I just sat on the side of the bed and she wanted me to stay in the bed" ¹⁵ FG9.1

The emotional support given by caregivers is thought to include encouraging women to remain upright and mobile (Johanson *et al.* 2002). Mobility has been associated with improved contraction patterns, shorter labours and a reduction in operative delivery (Albers *et al.* 1997), and should not be routinely restricted (Hofmeyr 2005). Many aspects of care such as electronic foetal monitoring and intravenous fluids have been found to interfere with women's coping strategies during labour (Spiby *et al.* 2003). The participant whose mobility was restricted recounted that she had the same midwife for the whole of her labour and felt that she detracted from her progress:

"... I had this threat hanging over my head that if things didn't progress quite quickly I would have the hormone so that really annoyed me 'but it's just this being....rigged up again... I didn't want that, I did not see the need for it and I tried_to argue... but they were not having it"²⁰ FG9.1

Although midwifery models of care have been described as a partnership with women based on a view that childbirth is a healthy part of life (Wagner 2001, Rooks 1999), midwives' encounters with women during consultations have also been found to convey a mechanistic and medicalised understanding of childbirth (Olsson *et al.* 2000). Johanson *et al.* (2002) suggest that midwives may reinforce medicalisation of labour and birth by using pervasive medicalised practices such as inappropriate electronic foetal monitoring. Carers may also be under constraints to control and hasten birth (Sleutel 2000). Staff who feel threatened may be put on the defensive by women's assertive behaviour (Green *et al.* 1990). The FG9.1 'managed' her midwife by cooperating

with her and avoiding conflict. A positive relationship with the midwife on the other hand empowered women and helped them feel in control:

“she was amazing and she fetched me water all the time and she seemed to understand my sign language much better than anyone else and you know you get (waves her arms around) I want this, I don't want that ...”¹²⁹ FG8.2

Participants when discussing their experience of early labour felt that the busyness of the unit impinged on their relationships with professionals, which in turn left them feeling isolated. Participants in one group remarked on the amount of paperwork midwives undertook and all groups mentioned foetal monitoring and how this detracted attention from them. Organizational procedures such as admission process and decisions about whether or not women were ‘officially’ in labour impacted on women’s feelings of being in control. One participant described that although she was ‘in agony’ the midwife was reluctant to admit her to the unit because she was a ‘primigravida in early labour’. Once she had been admitted her baby was found to be distressed and she had an emergency caesarean section, which bewildered the participant:

“I think the midwife didn't understand what was going on, like, she wanted to send me home, meanwhile like three hours later I have to have a caesarean”²²⁵ FG6.1

Whilst other participants in the group were sympathetic to this participant and there were murmurs of disapproval directed at the midwife, women did not seem to find that this was an extraordinary situation and accepted that due to the busyness of the unit at the time that was all one could expect.

5.8.7 Choice and control: ‘I was actually asked what did I want and how I wanted it - that’s what I got’

The category of choice and control was related to choice women had in relation to models of care and interventions during labour. Participants felt that they could avail of choices and that requests for pain relief or

interventions would be negotiated with them by midwives. One participant said that she was happy with all the choices she asked for;

"I was actually asked what did I want and how I wanted it, that's what I got"¹⁰⁷ FG10.3

Two units had midwifery pilot systems of care in place and women who had chosen these models spoke about the criteria for availing of this option and the hopes that women felt that might be 'taken away' from them if they had to revert to the hospital system:

"I was conscious during the pregnancy that if there was anything (wrong) that it (midwifery model of care) would be taken away...."¹⁷⁶ FG10.1

Women discussed the 'strictness' of the criteria for excluding them from this model of care citing reasons such as weight and height, which put them 'at risk' and which they found difficult to rationalise as they felt 'healthy'. Walker *et al.* (1995) also found that participants did not accept their perceived categorisation of being 'at risk'. A participant who had planned her birth around this model of care was disappointed when she developed problems during labour and her choices with regards to mobility and pain relief were suddenly taken away:

"I convinced myself throughout the pregnancy that would be the wayand then when that happened (transferred to hospital model) I didn't know what to ask for or what to do ...you know"⁷⁸ FG10.4

The other participants in this focus group, although sympathetic, did not appear to understand how upsetting this could be for the woman. They were not aware that this model of care existed and similar to participants in the antenatal FGIs (Chapter4) did not know that this option was available to women. Participants also felt that their wishes concerning their births were not always taken into consideration. One woman described how her baby was taken away from her as soon as he was born even though she had been told she would be able to have him in her arms:

"like yeah he was never put on to me I didn't have him on my chest" FG6.5

"oh no" FG6.1

"yeah well, when I got him he was dressed and everything"..... FG6.5

"Same with me" FG6.1

"yeah I was upset about that cos I wanted to be the first person to hold him" FG6.5

"oh yeah" () FG6.6

In addition to the privilege of being the first person to hold the baby, the baby friendly hospital initiative, (BFHI) suggests early skin to skin contact between mother and baby to encourage breastfeeding (WHO-UNICEF 1989). In another group a participant discussed how she had initially rejected the idea of having the baby born onto her chest but was persuaded by the midwife that it would be a good idea:

"I didn't want her delivered straight on to my chest, I went 'no, no please clean her' and the midwife went "you'd be surprised" and she was one hundred per cent right and that definitely made the whole thing so much better it meant something to me big time"¹³⁸ FG8.2

A primigravid participant who had expressed her desire for a 'natural labour' in the antenatal group felt she had no choice when it came to the actual experience. She experienced several interventions and used the example of having an episiotomy, which she described as her 'worse case scenario':

"and he came in anywayand he wanted to do that episiotomy thing and I didn't really want that done (everyone agrees) but they said to me: "you will have bowel trouble for the rest of your life if.... you don't have that done" so in the end I had that anyway"...⁶¹ FG7.7

There was no outrage expressed in the group participants seemed to accept 'that was the way', perhaps accepting the rationale for carrying out the episiotomy. A discussion ensued about episiotomies, and another

participant in this group said she had refused an episiotomy as she had previously had one and her midwife had been helpful and supportive. She had not had an episiotomy performed. There were variations in relation to choice and interventions across groups that were not solely explained by the characteristics of the participants. The influence of the workplace culture shapes midwives' perception of risk (Mead and Kornbrot 2004) and consequently their practice. Participants in the study assumed that any intervention was done with the safety of the mother and baby in mind and there was no discussion as the 'doctor knows best', and the 'status quo' was accepted. Another participant who opted for 'private care' could not believe that the system did not allow her to choose her place of birth:

"that surprised me, as a private patient I cannot believe that you don't have a choice you cannot pickit was here and that was that" ²⁵⁹ FG9.2

Similar to the findings from participants in the antenatal focus groups, there was a diversity of participants' experiences among groups in relation to choice and control. Exerting choice ranged from choosing the model of care to specific interventions. However these choices were always couched in the context of safety, the confines of available models of care, and deference to professional expertise.

5.8.8 Control and Pain Relief: "I wasn't crazy because the pain was under control"

Control and pain encompassed both issues of access to pain relief and pain relief as a method of feeling 'in control'. In some instances participants felt that pain relief was delayed or withheld from them without explanation. A participant in one group who had a previously lengthy labour said she had 'demanded' an epidural as soon as she got to the hospital only to find that she was about to have her baby:

"I did I felt sorry for the midwife because I was saying to her (emphatically) "I want the epidural, I'm having the epidural"
'FG 9.4

Another participant described how epidural analgesia helped her maintain control, conserve energy and contributed to what she described as a 'textbook experience':

"and then like I had the epidural and I felt very calm and relaxed and just like that was feeling in control and as I was continuing on I knew what was going on and I wasn't crazy because the pain was under control" ⁹⁴ FG9.3

This participant was a member of the antenatal group and had a previous painful and traumatic experience therefore this time she had opted for the epidural from the start. For this participant technology in the context of an epidural was a convenience, empowering and serving her rather than being it's 'victim' similar to previous reports (Davis-Floyd 2003), and she viewed her labour and birth as a personal triumph. For another participant avoiding an epidural and having the baby 'naturally' and 'having the experience' meant that she felt more in control:

"...in a sick way I wanted to see what it was like (everyone laughs) I had the epidural for the second and the caesarean for the first so I wanted to try and actually have one without either of those ... it wasn't as bad as the other two anyway"¹⁹⁰
FG9.1

Participants in this group had varied experiences of availing of pain relief and they concluded that the pressure on staff and the unit's individual nuances contributed to their access to pain relief. One participant brought a transcutaneous electrical nerve stimulation (TENS) machine but the midwife said she could not apply it and was not sure that she should use it:

"... I said "will I put this on or will it interfere with the machinery"? and she was humming and hawing, I was thinking hang on a second..... she didn't want it on at all and the labour was really painful"¹⁹⁴ FG9.1

The group discussed the pros and cons of this type of pain relief and the midwife's reluctance to help this participant who was struggling with her partner to apply the machine. This was an element highlighted by

another group also where the TENS machine could not be applied as the physiotherapy department who applied the machine had closed, and the woman's partner had gone home. Epidural analgesia was the most commonly discussed method of pain relief amongst all the groups. Participants sometimes felt that they were deliberately left waiting for an epidural and one group discussed the rationale for this:

"before they gave me the epidural and it took ages from the minute I got into the hospital I asked for the epidural and it took three hours to give it to me"⁵⁸ FG9.4

"three hours, same with me, but I think what they do is... they try to help things progress as much as they can on your own"⁶⁰ FG9.3

"yeah"⁶¹ FG9.1

"yeah they have to monitor a baby for a few hours before they give it to you to make sure it is safe"....⁶² FG9.2

"by the time they gave it to me I was... climbing the walls"⁶³ FG9.4

This was generally perceived to be an acceptable practice by participants. The interaction among the group could be interpreted as a 'consciousness raising' in that the culture of the unit may have been to administer the epidural later in the labour rather than earlier, alternatively in the context of the FGI there is the potential that inaccurate information may be reiterated (Hyde *et al.* 2005). However across all groups women experienced 'being left waiting' for an epidural which was a source of anxiety to them. One participant had given birth in another hospital where she had access to the epidural immediately and was not happy with being kept waiting, but had overheard staff talking about how busy the unit was. This participant eventually received her epidural when she was almost in the second stage and had her baby an hour later.

"I got to eight and a half centimetres on my own or nine centimetres and they had to give it to me then I just couldn't make it any further you know"¹⁷² FG9.4

Although she had a 'doula' or birth attendant with the objective of having as 'natural' a birth as possible the woman was happy to have had her epidural. The same participant also experienced a dural tap, severe headaches and received a blood patch but was happy to have had what she had wanted. When asked how she felt about her experience in relation to her expectations, she replied:

"it was fairly natural the delivery itit was not a caesarean but it was a vacuum delivery he was distressed, had one of those things attached to his head at some point"⁴³ FG9.4

The baby, it transpired from later conversations, was admitted to the special care baby unit; however this participant's perception was that the experience was 'fairly natural'. Perhaps this was because she had laboured at home for some time and that any interventions occurred in the latter stages of the labour when she was admitted to hospital. Similar to the women in the antenatal groups, women's perception of 'natural' encompassed a wide variety of contexts and any birth that was not a caesarean section despite interventions and instrumental births was deemed 'natural'.

In this study, five contexts emerged from the data that participants connected with their sense of 'feeling in control'. Whilst there was uniqueness to all women's stories and women had given birth recently, with many women having given birth more than once, there were some areas of agreement. A desire to feel in control was a common feature of women's experiences. Women felt that professionals controlled various aspects of the birth but this was mainly felt to be benevolent, and often occurred under constraints such as pressure of work and lack of staff and for safety reasons. Women felt empowered and in control when they progressed through labour themselves but disappointed if they needed help and had to be induced or have interventions. Controlling access to pain relief was referred to in terms of their own safety, as were certain interventions such as episiotomies. Relationships with professionals had a pivotal positive or negative influence on women's experiences of control, and women felt that you could be 'unlucky with

your midwife'. There was a reluctance to criticise professionals. Many participants empathised with them; exceptionally, one group did protest at one women's experience of not being given information and expected better of professionals. The third theme that emerged related to women's descriptions of the memory and consequences of the labour experience and how they sought to explain and rationalise their experiences.

5.9 Consequences

This theme referred to the feelings and consequences of the labour experiences for women. Although women did not remember the details of the physical experiences the emotional feelings were remembered and had consequences for their feelings towards another birth.

5.9.1 Memory: 'you don't remember what you have forgotten'

Women who had given birth three months earlier had often forgotten the details of their labour such as the physical elements and 'happenings' during labour and had to be reminded about these events. Participants did remember their emotions and feelings and 'horrible bits', particularly in relation to the care they received. Physical sensations such as pain had often 'faded' in women's memories as the following interaction demonstrates:

"like you forget about the pain of it so quickly after"⁴ 10.4

"yes it's likeyou don't remember what you have forgotten"
(laughs) ...FG10.3⁵ (all participants agree)

A participant in another interaction said that she tried to remember the experience of the birth especially the pain but could feel the memory fading:

"I have forgotten I know at the time it was bad even though at the time I KNOW IT WASsince then I find I am telling myself it wasn't.....but I know myself it actually was"²³⁸ ()
FG9.1

Participants wanted to remember the process of labour and employed strategies such as piecing together the jigsaw of events with their partners or, in one instance, writing an account:

“Like I wrote it down the next day I had a little note pad and wrote down just lashed down the sequence of events cos I thought I would forget but I haven’t forgotten”⁵ FG6.4

Memories appear to be a special part of the experience that women wanted to preserve. Memory for events during labour has been demonstrated to be accurate whereas findings about memory of pain are more inconclusive (Niven and Murphy-Black 2000, Waldenstrom *et al.* 2004b). Although Simkin (1991) found that women remembered details of their birth sixteen to twenty years following the birth many of the FGI participants said they forgot particular events and the sequence in which they happened.

“I talked through it one day with my husband and he..... told me yeah you did this and you did that, and that is what happened”⁸ FG10.4

What women did remember were instances where they felt ‘happy’, ‘in control’ and ‘powerless,’ the cognitive and emotional elements related to interventions and pain were remembered. In the immediate aftermath of the birth, many women found they were left on their own and attention was diverted from them to other women in labour.

5.9.2 Isolation: ‘there are just not enough people to look after you’.

Participants discussed their feelings after the labour and birth and the rationale for their being left in situations where they felt vulnerable. Women were reluctant to blame individuals and actually empathised with them, but it was the organisation or ‘the system’ that they were critical of. There were affinities between women’s feelings in early labour and those immediately after the birth when the excitement of the labour and delivery was over and they were again left feeling isolated and alone. A recent study on the constituents of ‘good’ childbirth found that

women wanted an unhurried atmosphere, a feeling of a staff presence and having a 'fair share' of the caregiver's time (Melender 2002). Participants in the present study spoke about being left with their babies after the delivery, and not knowing what to do with them. Again this was attributed to staff shortages and a busy unit in addition to organisational rules that did not allow partners to remain with them. One woman recounted that her husband was sent home following her emergency caesarean delivery and she was left with the baby whilst she was still numb with epidural analgesia.

"they were like 'your husband will have to go home' I was like you are kidding me (incredulous) I just had a baby and I can't feel anything" ...(gasps from others) FG6.1

It was interesting that in this instance; perhaps because the baby was also involved, other participants were critical of the woman being left in this situation. In another example, a woman who had recently given birth described how hungry she was and her difficulty at being left with her baby in her arms in a high delivery bed, with no cot, not knowing what to do with the baby.

"and then they had no cot to put him down I was still in labour room you see...in the big bed"⁶⁴ N FG8.1 (oooooh from others)

"....and I had nothing to eat so it was about half eleven eventually got a bed when we got down to, before that the nurse had taken him for a few minutes. I went to the coffee shop to get something to eat"⁶⁷ FG8.1 (other participants look aghast)

"cos it was nobody's fault it wasn't the staff's fault but it was a bit much having to wait for your breakfast"⁷⁶ FG8.1

Similar to other groups it was 'nobody's fault', there was reluctance by participants to criticise any individual and most problems were attributed to a shortage of staff. In another group following a discussion about how busy the unit was one of the participants concluded:

"there are just not enough people there to look after you"
FG6.6¹¹³ (all agree)

The lack of attention and time from staff was a feature of all groups in all areas. Two participants had experienced labour during quieter times and had more than one midwife looking after them, which was seen as a bonus. Similar to Baker *et al.* (2005), women found that the shortage of staff impinged on their experiences due to lack of supportive care. Shortcomings in care were attributed to lack of staff by most women. Interestingly, it was women who had experienced care in other countries who were more critical, indicating that the shortage of staff was unacceptable and women were being short-changed in relation to paying for what they perceived to be a substandard service.

5.9.3 Effects on Future Pregnancies: 'I feel as if I would not (have another)'

The experience of childbirth and the mode of delivery has been shown to influence women's decisions about whether or not to have a future pregnancy (Porter and Macintyre 1984). One of the participants described their experiences and the influence of these experiences on their future childbearing:

"all I kept saying to my husband was there is no way we are having any more children (everyone laughs) NO Way!"²³²
FG9.2

"has that worn off yet?"²³³ FG9.4

"nope!" (everyone laughs)²³⁴ FG9.2

"I'm making sure of that" ...laughing²³⁵ FG9.2

Women who have a negative birth experience are often deterred from having another child, and may postpone their next pregnancy for a number of years (Gottvall and Waldenstrom 2002a). A participant in this group described how she waited to have her second child after a traumatic first birth and how she felt that her experience impinged on her decision to have another baby.

"It was terrible ...it took my husband and I three years to get around to having one the last time however this time a week later I was like "we'll have a fourth"(everyone laughs)²³⁶
FG9.1

Another group of participants felt that the length and exhaustion of labour would affect their decision:

"I would not like to go through that again – not that it was sore as such just it is that it was so long really...I felt exhausted"¹⁷ FG10.4

"yeah I had very long labours as well... I feel as if I would not (have another)"¹⁸ FG10.1

Interventions in labour such as episiotomies were often discussed and 'getting stitches' was a commonly discussed aspect of labour that women dreaded. One woman felt that this would have put her off having a baby again:

"what would put me off ... they didn't give me enough local anaesthetic...so I was feeling the jag of the needle so..... that is a very strong memory still..."²¹ FG10.3

Having a baby at the end of it meant so much to women that they were prepared to overlook any problems they may have had:

"at the end even though I suffered a lot in the end I got a baby so it was worth it... Yeah it was" FG6.2

At least one woman in each of the groups stated that having the baby was worth any pain and suffering. Women may perceive that an alternative to procedures could endanger the lives of their babies, therefore are willing to accept them (Shearer 1983) and in the present study were unwilling to be critical of the staff in 'their hospital'. Similar to the findings of Shearer (1983) women also tended to be loyal to their own experiences. Participants were reluctant to be openly critical of the hospital or staff where they gave birth, however participants in a primigravid group said they would endeavour to have any future birth in a different environment if that was possible.

“I tell you I’m not having my next baby in here anyway”¹¹⁰
FG6.5

“no I wouldn’t either”¹¹¹ FG6.6

“I think my next baby will definitely be at home”¹⁵ FG6.3

“I never thought about that really”¹¹⁶ FG6.1

This was the first and only time women spoke about accessing other models of care. Perhaps as primigravidae they were unaware that other models were available to them and the FGIs acted as a ‘consciousness raising’, challenging dominant beliefs about what is on offer ‘must be best’. Women in this group commented that it was great to hear that they were not alone in their feelings about their labour experiences, particularly if they had experienced an operative delivery. Similarly, one participant said she would not have her baby in that particular unit and would opt for a home birth. The units that provided midwifery models of care differed as women were happy with their experiences and would return to them. Fenwick *et al.* (2005) suggests that women reframe their birth as a consequence of caesarean section when vaginal delivery may be seen as less safe, more uncertain and inconvenient. Women in this study seemed to have reframed their births in the context of organisational issues such as shortages of staff, which fell short of their expectations and decided that they would be as safe but achieve better control and support within a different model of care such as a DOMINO or home birth system.

5.10 Conclusions

The FGIs highlighted the importance of women’s expectations and experiences of childbirth challenging predominant beliefs that because they are not visible or not heard they are not important. I found that women were grateful for the opportunity to talk about their experiences and to hear about the experiences of others. The FGIs provided an effective space for women to reflect on connections between individual and collective experiences. Positioning outcomes for childbirth in

androcentric scientific terms without regard to women's experience works to effectively silence discussions and challenges to the status quo. The benefits of the FGI for feminist researchers similar to the antennal FGIs were highlighted such as 'consciousness raising' for participants about the possible limitations in the present service provision and the availability of other choices. The FGI data in this research helped women to voice their experiences by creating a dialogue in a supportive atmosphere where women could express their views.

Expectations and the reality of their experiences were sometimes incongruous, and some women felt disappointed both in themselves and in the support they were given particularly in early labour or if they were induced. The period before a woman was declared 'officially in labour' and immediately after birth was described as a time of loneliness and isolation. The process of labour was sometimes characterised by dissociation with reality, which had a function of an involuntary distraction from the events and time constraints. Memories of events were less clear than memories of feelings and emotions that women felt during their labour.

In this study women acquiesced to the biomedical assumption that technology is important for a successful delivery for several reasons. Some women believe it is safer for them and their newborns, whilst others felt more 'in control'. Although the concept of safety is ill defined, many women accepted interventions that they had specifically wanted to avoid because it was inferred by professionals that the safety of the mother herself or the baby could be compromised. Similar to Fenwick *et al.* (2005) women did not always choose birth technology and interventions, but were glad to have it available if they needed it. Women did not seem to have confidence in their own bodies to give birth successfully on their own. Their attempts to achieve a degree of normality were sometimes thwarted as a medical model of care was reinforced by midwives, specifically in relation to mobility and foetal monitoring. Women who were able to avail of midwifery models of care felt more positive about achieving their expectations.

Feeling in control permeated all aspects of the childbirth experience and affected it in a variety of ways from control of access to the hospital, partner's presence, to accessing pain relief. Although women were loath to ascribe responsibility about unmet expectations to any individual, many suggested that problems were as a result of staff shortages. In a country where hospital births are being increasingly centralised (Devane *et al.* 2007), and emphasis is on throughput (Begley 2001), there are few opportunities for women to make choices about their models of care. In this context and although women did not directly criticise individuals or hospitals, some women said they would opt for a different unit or a home birth if they had another child. Although the safety of home births in Ireland has been questioned (McKenna and Matthews 2003), in the absence of other alternatives such as midwifery models of care women felt that this may be the only way to achieve some control over the experience.

Women in this study wanted their birth experience to be as intervention free and natural as possible, but were not averse to availing of technology if it was appropriate. Women who give birth in Ireland do so within a context of a medicalised system of childbirth (Devane *et al.* 2007). The previous chapter (Chapter 3) raised issues about midwives working in the Irish health care system and difficulties in facilitating 'normal births' (Keating and Fleming 2008). It appeared that this was the case in some of the units where the FGI participants had their babies. The role of the health professionals in preparing and helping women through this life changing experience is pivotal, but is impacted upon by organisational systems and lack of resources and in some cases the perpetuation of the medicalised approach to birth.

5.10.1 Limitations of the study

The data presented in this study was from a self-selected sample of women from various locations around the country. There was a diversity of ethnic participants although there were no women of African origin. More than half of the participants (16/25) were educated to university

level and most were married. Most women had used the hospital based consultant led model of care, with one woman having availed of DOMINO services. Several women had been exposed to different models of care such as community based services in other countries. Despite the relative homogeneity of the group, there was a diversity of experiences and discussions provided valuable insights from a range of geographical and organisational contexts.

The following section, phase 2 strand 1, traces the development of the discrete choice experiment attributes and levels from the information gleaned in the first phase of the research design.

Chapter 6

Phase 2 Strand 1

Developing attributes for the DCE

6.0 Introduction

In this chapter the initial development of the Discrete choice experiment (DCE) attributes and levels are explained using data from the concept analysis and FGIs described in chapters four and five. The limited literature relevant to the development of DCE attributes is discussed. The concept analysis, contemporary literature about childbirth experiences and FGI data are combined to form an item pool for consideration of attributes. The chapter is organised in terms of the specific research questions posed in Chapter 1. It first reports on the development of the key attributes of childbirth experiences, and then explores the different levels of utility within the attributes. The development of attributes is achieved through an integration of discussions between a panel of economists experienced in DCE development, my own experience informed by my knowledge of the literature, and the moderation and analysis of the FGIs. The study used an exploratory sequential design, as outlined in the Chapter 3 to guide the transformation of the qualitative data into attributes, within the confines of economic theory. As with the qualitative strand of the research and in keeping with its feminist framework, a reflective journal was incorporated into the research design to trace my social and professional position and to examine how it may have impacted on the research process (Appendix XXV).

6.1 Background

There is little published work on the development of attributes from qualitative work and their transformation to the DCE attributes and levels, although an initial qualitative phase is highly recommended in the

literature (Louviere *et al.* 2000). Different methods have been employed in order to establish attributes and their levels including the use of theoretical arguments from literature (Ratcliffe 2000), using existing health outcomes (McKenzie *et al.* 2001), a combination of field notes, observations and theoretical framework (Douglas *et al.* 2000) and combining FGIs with literature reviews and policy statements (Hundley *et al.* 2001). Authors have also used expert reviews (Wright *et al.* 2000) and findings from randomised controlled trials (Ryan 1996). Although Cheraghi-Sohi *et al.* (2006) developed a conceptual map from the literature as the authors point out a 'top down' approach is taken, the attributes are defined from the literature. Whilst authors advocate the use of FGIs to develop attributes (Hundley *et al.* 2001) there is little information about how they are actually developed, despite emphasising the importance of the qualitative element of their work (Coast *et al.* 2006). Economics has traditionally been seen in terms of a positivist deductive ontology but economists such as Coast (1999) are exploring ways of expanding and integrating economic theory and practice including qualitative ontological and philosophical perspectives. Feminist economics although a relatively young field purports an interest in producing 'truer accounts' of the world and a reduction in unjust social relations, although there is little explicit reference to feminist concerns (Robeyns 2000). The feminist 'lens' through which I conducted the study will bring a critical perspective to bear on the DCE method with the aim of improving it. In addition the rigour applied to the FGI analysis the think aloud techniques with women enhanced the DCE development. The piloting of the DCE as explained in the following chapter will incorporate women's views as experts in relation to the attributes and levels. My aim is to oppose subjective and patriarchal assumptions of subjectivity, rather to include women and make their voices heard and their views visible in the development of the instrument as described.

6.2 Aim of the DCE:

- Identify components (or attributes) of the childbirth experience that are important to women
- Estimate the relative value or utility of individual components of the experience

There are five steps in the development of the DCE (Ryan 1996).

1. Establishing attributes
2. Assigning attribute levels
3. Creating scenarios
4. Establishing preferences
5. Analysing data

The following section describes the first two steps of the development of the DCE establishing attributes and assigning attribute levels. The remaining three steps are addressed in strand two chapter seven.

6.3 The Discrete Choice Experiment (DCE)

The term 'discrete choice' arose from the distinction between continuous and discrete variables. The word 'discrete' indicates that the choice is discrete in its nature; it is only possible to choose one alternative. A discrete choice occurs when the respondent faces a choice among a set of alternatives regarding a dimension of a good or service which meets the following criteria (Train 2003)

- The number of alternatives in the set is finite
- The alternatives are mutually exclusive
- The set of alternatives is exhaustive (all possible alternatives are included)

DCE is rooted in economic theory and is derived from key assumptions that consumers prefer one set of goods (or attributes) over another, and that they will 'trade off' choices to maximize their satisfaction or 'utility' (Ryan 1996). The DCE asks respondents to make a sequence of choices

which are illustrated in a number of scenarios. DCEs are used to examine the response of the individuals to changes in the scenario attributes. The added benefit of DCE over other preference elicitation techniques used in health care is that it is possible to isolate the individual contributions made by each attribute to overall utility, by disaggregating total utility and identifying the impact of each attribute. Although economic theory guided the development of the study it was difficult to identify attributes that were qualitative in nature and also 'finite'. Economic theory was a necessary part of the process but simultaneously had to be balanced with regard to the feminist principles and the centrality of women's voices to the research.

The following sequence was used to identify an item pool for the attributes of the childbirth experience:

1. Identification of item pool from FGIs, concept analysis and literature.
2. Blend evidence from the literature FGIs data and concept analysis
3. Develop attributes for the DCE within the context of economic theory

6.4 Attributes of childbirth experience identified in the concept analysis:

- Individual
- Complex
- Process
- Life event

Related Concepts

- Control
- Support
- Relationship with caregiver
- Expectations

Table 14. Themes and categories generated from antenatal and postnatal FGIs

Themes	Goal Setting	Goal Attainment	Contingency Plans
	Anticipation and apprehension	Relationships with professionals ↓	Uncertainty the ideal reality gap
	Sources of information	Control ↓	Rationalising and accepting
	Ideal experience	Choice ↓	
		Coping with labour ↓	
Themes	Getting started	Getting there	Consequences
	Expectations	Anxiety	Memory
	The twilight zone	Perceptions of reality	Isolation
		The control continuum ↓information, ↓progress ↓relationship with ↓professionals, ↓Choice ↓ Pain relief?	Effect on future reproduction

↓ Indicates interaction between categories

Five salient factors that were most frequently and most emphatically mentioned across groups and identified in the concept analysis and literature were:

1. Control (related to: pain, choice, information, relationship with professional progress)
2. Being seen as an individual
3. Having choice
4. Relationship with professional
5. Difference between expectations and reality

6.4.1 Establishing Attributes

The attributes were established by using the identified factors above to guide the wording of the attributes that would best convey the data gathered. There is a tension between the aims of qualitative work in

exploring and describing the attributes and the need to encapsulate the different aspects of the experience within a minimum number of attributes (Coast *et al.* 2006). Attributes that emerged from both the literature and the FGIs included a number of areas that were broad and could be conceptualised differently by women. For instance, a significant attribute was that a feeling of control was an important element of the experience. Establishing what 'control' meant to individual women as indicated by the previous concept analysis points to the complexity and multidimensionality of the concept. Control is not an objective measure and it is the woman's perception of control, which can include abdicating of responsibility (Green 1999) and relying on professional advice (Bluff and Holloway 1994) that enables women to feel in control. In addition, because the attribute 'control' was frequently identified it may be seen as a dominant attribute i.e. women would not be willing to trade off this attribute with others. Ryan (1996) suggests that options that are clearly dominant or dominated and unrealistic options should be removed. From the evidence of the FGIs themes the potential to feel in control during labour related to the six elements of: choice, information, pain relief relationship with professional, and progressing in labour by herself without interventions. When identifying attributes, consideration must also be given to the concept of inter-attribute correlation. This refers to the cognitive perceptions respondents bind to the attribute descriptions provided (Hensher *et al.* 2005).

As identified in Table 14, interactions between subthemes were evident. I was concerned that in forcing attributes into 'discrete' packages their meaning and therefore women's voices would be lost. Further to the discussion in Chapter 3, I was cognisant that the feminist framework of the study could be compromised by my attempts to distil the diversity of elements identified in the FGIs into five or six attributes. My intention was to preserve the qualitative meaning (Fleury 1993) of the attributes in the DCE by maintaining the meanings that women expressed in the FGIs, avoiding reductionist elements. I wished to avoid the summation of childbirth experiences as independent and decontextualised. I sought to develop more 'qualitative' attributes through the narratives that link

to the experience, whilst avoiding attributes that could take on a plurality of meaning. In order to meet the requirements of economic theory and practice I consulted with Julie Ratcliff at Sheffield University. She convened a panel of six academics that had experience of developing DCE to review the item pool arising from the literature, concept analysis and themes from the FGIs. The proposed attributes and the suitability of their inclusion were debated. Attributes that were not mutually exclusive were discussed including the theme of 'control' in particular. Potential attributes for the DCE and the possibility that respondents would 'trade' other attributes was discussed. The following section describes my conclusions and the attributes that were rejected in light of advice from the panel.

6.4.2 Attribute Levels

There is no definitive means of establishing levels of attribute but they must be realistic and tradeable (Ryan and Wordsworth 2000). Attributes that describe aspects of health services experience such as reassurance and the provision of information are known as process attributes (Ryan 1996) as distinct from outcome attributes that relate to clinical outcomes. Bradley (1988) suggests that process attributes can be described as the current situation and some policy change of interest in one or both directions. Special attention has to be given to the possibility that if the levels are set too far beyond current experience respondents may not take them seriously.

Traditionally levels are graded from 'least to most' therefore with process outcomes such as availability of pain relief this was not always straight forward. Levels of qualitative attributes can be difficult to code as women's perceptions of an attribute from 'least to most' can be variable. Levels of attributes were established through evidence from a similar study (Hundley *et al.* 2001) the focus groups, and literature. I initially had to consider whether the attributes of 'control' and 'expectation' would achieve the aims of the research in the context of economic theory.

6.4.3 Attribute Rejection

The DCE assumes that for each individual, an improvement in one attribute can compensate for deterioration in the level of another attribute (Taylor and Armour 2002). Individuals who will not trade are referred to as having dominant preferences for example, where an individual had a dominant preference for a particular attribute such as control. The attribute of 'control' was identified in all the FGIs and the literature and did not fulfil the DCE criteria of being discrete or mutually exclusive. Following discussion with an experienced DCE academic, Julie Ratcliffe, and an expert review panel at Sheffield University who had developed DCEs, the attribute of control as a discrete attribute was therefore rejected.

Whilst the attribute of control *per se* was not included, other attributes such as pain and involvement in decision making were included as they were identified from the literature and the FGIs as more discrete alternative *elements* of control. The emphasis within these attributes was therefore on women's perception of control related to these attributes as identified in the significant statements of the FGIs.

The literature indicates that expectations are a difficult construct to establish, being highly variable for individual women in the context of childbirth experiences (Harvey *et al.* 2002). What has been established, and what emerged from the FGIs, is that a dissonance between what women expected from the experience and the experience itself affected their perception of the overall experience (Stolte 1987). The attribute of 'expectations' was rejected from the scenarios because it encompassed complex elements of the childbirth experience, therefore expectations may have been a dominant attribute with wide ranging interpretations that would not elucidate women's experience because of its multiplicity of meanings to women. Following discussion with Julie Ratcliffe and the review panel at Sheffield University, the attribute of 'expectations' as a discrete attribute was therefore rejected.

For the purpose of developing attributes the themes and categories were reviewed. Although the thematic analysis provided a rich description of women's embodied experiences, the categories and the significant statements were more reflective of the important components of the experience. Following discussions with Julie Ratcliffe and the review panel, I reverted to the categories and the significant statements identified in both FGIs in order to establish the most important elements of childbirth experiences. The transformation of qualitative evidence to quantitative elements was both iterative and thematic. Iterations alone were not considered adequate to encompass the contextual elements of women's experiences and thematic analysis (Joffe and Yardley 2004) remained the focal element of analysis which was congruent with the ideals of the DCE that purports to identify the 'intensity' of preferences (Ryan 1996).

Subsequently, the DCE attributes were phrased to represent the contextual nature of its construction. An illustrative example and significant statement for each attribute from the FGI is given in the following section supported by data from the literature.

6.5 Relationship with midwife during labour and birth.

Significant Statement 'The midwife really engaged with me'

This attribute was identified from almost five hundred FGI significant statements from both antenatal and postnatal FGIs. The relationship with the professional (midwife) was pivotal to other aspects of the labour experience. A positive experience with a midwife provides psychological and physiological benefits for women, client satisfaction, and potential cost savings (Hunter 2002) with a long lasting effect on women's perceptions of the birth experience (Simkin 1991). The FGI statements described the relationship with the midwife during labour and birth as especially intense and inherently different from relationships with professionals at other times. Relationships during labour could be developed quickly indicating that continuity of carer was not always

important. The nature of the relationship with the midwife during labour has been variously described; a companion (Lundgren and Dahlberg 1998), a professional friend (Walsh 1999). Participants identified the importance of a midwife, having a 'presence', engaging emotionally with them, a factor that is also identified in the literature (MacKinnon *et al.* 2005). Some women in the FGIs described their midwife as 'mumsy' or having a 'mother like' relationship with them, a feature which midwives have described in antenatal contexts (Hildingsson and Haggstrom 1999) by community midwives. The absence of trust in the woman/midwife relationship combined with a lack of security results in less satisfaction with the birth experience (Berg *et al.* 1996). In the FGIs, women who had a trusting relationship with the midwife found their wishes regarding choice and control were respected consequently any worries abated and they were happy to let the midwife make subsequent decisions on their behalf. Women in the FGIs who expected more support during labour expressed powerlessness and disappointment. Similarly Mazingo *et al.* (2002) reported women feeling 'violated' when their expectations of trust, power, control, and information have not been met. Parratt and Fahy (2003) suggest that a trusting relationship with a midwife allows women to progress in labour, whilst Berg *et al.* (1996) identified the importance of flexibility in the relationship where the midwife was sensitive to women's needs for direction, encouragement and empathy at different times during the labouring process. Data from the FGI also identified the interactional nature of the relationship, often identifying its reciprocal nature where women empathised with the emotional burden of caring for someone in labour whilst coping with a physical workload. Similarly from the midwives' perspectives, Hunter (2006) points to the reciprocity of relationships which is echoed by elements of 'mutuality' (Kennedy *et al.* 2004) and collaboration (Coyle *et al.* 2001) in the context of birth centres.

Statements from the FGIs encompassed multiple facets of a relationship with the midwife such as confidence, trust, emotional engagement whilst identifying the need for reciprocity, advocacy and a feeling of being supported especially when labour was challenging for them. Women who

had availed of epidural analgesia can be less reliant on support from the midwife (Mander 2001). The attribute related to the relationship with professionals that embraced the concepts were identified as a 'partnership' with the midwife. The sequential nature and process of labour involves 'work' (Mackey 1995, Gould 2000), which had affinities with the core characteristic of the experience in the concept analysis, and the FGIs that identified women's processes of goal setting and goal attainment for labour and birth (Chapter 4). Women in the FGI described midwives 'working with you' encompassing attributes of partnership, flexibility and involvement with the woman.

6.5.1 Attribute 1: Midwife Works in Partnership with You During Labour and Birth

Levels of the attribute.

Although some participants described a relationship which grew over time with a woman either antenatally or within the time that they laboured, women found that productive relationships could be achieved in a short space of time. The level of the attribute that was considered discrete and finite was either present or absent women were asked to state "Yes" or "No".

6.5.2 Pain as an Element of the Childbirth Experience

Significant Statement: 'I felt in control this time with the epidural everything went well it was like a textbook really'

There were 150 significant statements relating to pain and pain relief which prompted animated interactions between participants in the FGIs. Within these interactions there was reference to availability of pain relief, avoiding certain types of pain relief and intricacies of relationships with feeling in control and pain relief which is substantiated by the breadth of literature identified in the concept analysis. Epidural analgesia was the most frequently discussed method of pain relief. Women's attitudes towards the pain is imbued with a multiplicity of meanings (Mander 2000), varying from negative effects (Slade *et al.* 1993,

Lavender *et al.* 1999) to a positive attitude such as productivity (Niven and Gijbers 1996), and a feeling and pride in mastering pain as an integral part of a self-actualizing experience (Callister *et al.* 2003). Pain during labour is progressive and stressful (Brownridge 1995) requiring different interventions and coping mechanisms at different times. Whilst some women in the FGIs felt they were succumbing if pharmacological pain relief was utilised, akin to Kannan *et al.* (2001) and similar to findings of Fowles *et al.* (1998), participants felt guilty for being 'drugged'. Alternatively, having adequate pain relief helped some women to feel in control. The choice of pain relief has been described as one of the easiest and most significant ways a woman can remain in control during labour (Leap and Anderson 2004). The FGIs concurred with the literature about the importance of pain as a contributor to the experience of birth as being individual, with a multiplicity of physiological and psychological mediating factors, with the women's ability to manage pain that can influence her perception of the labour experience (Lowe 2002).

Contextual factors may have influenced women in the FGIs (who also identified control as an important factor in choosing a birth centre) wishing to maintain a sense of personal control i.e. if the pain relief is not available they would cope without it. Conversely the diminution of other means of control i.e. organisational, philosophical, and personnel processes that could encourage the use of pharmacological pain relief within a hospital setting could have been influential as Surtees (2004) suggests availability of epidurals increased demand. [javascript:popRef\('b14'\)](#)

Women seemed to have a dread of not being able to have the choice of accessing epidurals if required. It was the availability of their chosen form of pain relief that was important to women. Some participants reported waiting a considerable length of time and were almost at the point of birth in some cases. A three hour wait was not considered unusual by women in the FGIs. Few participants mentioned pethidine but for others non pharmacological methods such as a birthing ball,

mobility and TENS were also important. Although mobility has been associated with positive birth experiences (Hardin and Buckner 2004), women in the FGIs were sometimes confined because of foetal monitoring or due to the wishes of the midwife. The attribute related to pain relief was therefore defined as availability of pain relief, as choice was an important feature of women's experiences for both pharmacological and non pharmacological methods

6.5.3 Attribute 2: Availability of Pain Relief

Levels of the Attribute

There were some differences between FGI participants; on one hand women were delayed in receiving their epidural analgesia and this affected their birth experience and made them feel out of control, whilst in other instances women's mobility was confined therefore they had to avail of forms of pain relief that suited this restriction. In two separate FGIs, women were unable to use TENS machines as personnel were unavailable to apply them. The levels were therefore based on the availability of the pain relief and were separated into medical and non medical forms. There were therefore four levels of availability of pain relief:

1. All types of pain relief are available to you at all times
2. All types of pain relief are available you may have to wait for up to three hours for an epidural
3. Non medical forms of pain relief are available only e.g. TENS and massage
4. All forms of pain relief except epidural are available

6.5.4 Individualised Care.

Significant Statement: 'I didn't want to be... you know an assembly line person'

There were over 45 significant statements from the FGIs that referred to this attribute and women felt strongly about the attribute. Coyle (1999) found that that patients who did not feel valued as individuals felt their identity was threatened by experiences perceived as dehumanizing,

objectifying, disempowering and devaluing. The statements from the FGIs encompassed valuing a feeling that their labour and birth was special, individual, and unique. Individualised care can be synonymous with consumerism (Williamson 1999) allied with a shift to a power relationship where the patient is expected to be much more autonomous (Deber *et al.* 2005), with individual dissatisfaction being a catalyst for the establishment of consumer groups (Tyler 2002). The concept of individualised although discussed within the literature is often ill defined. Individualised care from the patients' viewpoint relates to how much care is tailored to their individual needs, and secondly how well the patient's individuality is understood (Suhonen *et al.* 2007). The obverse of individualised care appears to be care that is routine and related to 'getting the job done'. Women in the FGIs referred to being treated as a 'person' using phrases such as 'not just a piece of meat', 'just a number', 'assembly line person' (Chapters 4&5). The notion of individualised care is not presupposed but develops in the interaction with staff (Lauver *et al.* 2002), entailing shared responsibility (Lundgren and Dahlberg 1998). Similar characteristics relating to women centered care have been defined as respect, safety, holism, and partnership, with consequent feelings of empowerment for women (Horiuchi *et al.* 2006). Contextual factors can also be influential (Mead and Bower 2000), such as organisation of care (Walsh 1999), the institutional environment (Hunter 2004), and the philosophy of carers, rather than a relationship with a particular midwife (Waldenstrom 1999b). Individualised care contributes to satisfaction with childbirth (Harriott *et al.* 2005), and with postnatal care (Twaddle *et al.* 1993). It is considered as an element of midwifery competence (Fraser 1999), exemplary midwifery practice (Powell Kennedy 2000), and a reason for women to avail of models of care that emphasise psychological aspects of childbirth. Positive birth experiences are associated with elements of individual differences such as coping strategies (Escott *et al.* 2005) medication and mobility (Hardin and Buckner 2004), and provision of information (Entwistle *et al.* 2004). Lack of individualised care has been associated with dehumanization and medicalisation of birth (de Costa and Robson 2004, Wagner 2001). Women themselves have expressed a need to be related to as an

individual during the experience of childbirth (Berg *et al.* 1996, Fraser 1999, Lundgren and Dahlberg 1998), treated with dignity and respect with a preferred level of control (Matthews and Callister 2004). The attribute identified was a feeling of personalised care i.e. that which encompassed individual nuances, idiosyncrasies and other facets of individual care.

6.5.5 Attribute 3: Care is Individual and Personal Levels of the Attribute.

The feeling that one is being treated as an individual is either present or absent therefore the levels of the attribute were present or absent and the obverse of individualised care was 'routine' care.

6.5.6 Interventions During Labour

Significant Statement: 'The ideal would be you know to get on without any interference at all'

Women in the FGIs spoke about interventions as 'interferences' exemplified by artificial rupture of membranes, repeated vaginal examinations, foetal monitoring, induction and augmentation of labour and episiotomies. Although some women in the FGIs were often vehemently opposed to interventions such as routine foetal monitoring, and episiotomies (Chapter 5), when or if the rationale for the intervention was explained to them they acquiesced. Women assumed that interventions were carried out in their best interest and therefore they 'did not matter'. It was not possible to specify all interventions as attributes. Progressing in labour related to some women's sense of achievement being able to progress in labour without intervention 'getting on' and 'doing it' on their own. Progressing by themselves meant that women felt more in control and was related to women hoping shorter labours would minimise the opportunities for interventions. Whilst women did not welcome interventions, they were not adverse to augmentation if they perceived the labour to be prolonged similar to previous findings (Lavender *et al.* 1999, Blix-Lindstrom *et al.* 2004), and were happy to be advised by midwives.

There is little research on the birth without interventions, as most research is carried out in hospitals (Beech and Phipps 2004). For some women in the FGIs, being mobile and changing positions, not requiring medical help enabled them to feel more in control, congruent with the findings of Hardin and Buckner (2004) where women with unmedicated birth reported feelings of empowerment and control. Although the rationale in the FGIs for not wanting intervention was 'personal' and interventions were largely unquestioned, women expressed pride and fulfilment in their achievement if they 'got away' without intervention. The attribute as described by women in the FGIs related to 'getting on' in labour or having interventions.

6.5.7 Attribute 4: Use of Interventions

Levels of the Attribute:

1. You get on in labour without any routine interventions
2. It does not matter how many routine interventions you have

6.5.8 Being Involved in Decision Making

Significant Statement: 'I didn't mind you know I asked if I could have another few pushes and they let me.....I was happy to have the forceps then'

The attributes of choice and control were affiliated for many FGI participants, however, as outlined previously these attributes were broad and conceptualised differently. For some women choice was related to their model of care and their access to technology, whereas for others it related to interventions and examinations that were carried out during labour. The FGI statements referring to being involved in decision making encompassed elements of choice and control, and was identified in over two hundred statements. Participants identified the importance of this aspect of childbirth experience in both antenatal and postnatal groups, with personal differences expressed in relation to their involvement in the decision making. Women spoke about their need to have as much information as possible, describing themselves as 'control freaks', whilst others were happy to have had an opportunity to

contribute to decision-making or in some cases relinquish responsibility altogether. Decision making related to choice, control and was often mediated by information and the relationship with the professional. Lack of information and being involved in decision making has been identified with dissatisfaction with intrapartum care by Brown and Lumley (1998), who used the phrase having an 'active say in making decisions' (Brown and Lumley 1997). Affinities between a sense of being in control, information, and decision making have been made by Waldenstrom (1999b) and VandeVusse (1999). The main focus in the FGIs was not about choice and control as a power resource rather how women described and defined their possibilities in terms of decision making and their potential to influence events. The attribute being involved in decision making was therefore expressed as it encompasses elements of choice and control that were expressed in the FGIs and in the literature.

6.5.9 Attribute 5: Being Involved in Decision Making

Levels of the Attribute:

The levels of the attribute were determined from participant's dimensions related to choice and control in the FGIs. Whilst some women wanted to make decisions others were happy for professionals to make decisions for them. Previous studies on choice control and involvement in decision making during labour (Hundley *et al.* 2001, Longworth *et al.* 2001) used similar dimensions of control and involvement of staff in decision making.

1. Staff make decisions
2. Staff make decisions but keep you informed
3. Staff discuss things with you before making a decision
4. Staff give you their opinion but you are in control of the decision

6.5.10 Medical Involvement in Care

Significant Statement "It was really nice to see her (Obstetrician), a familiar face... "

The involvement of the medical profession during labour and birth is an area which was identified in the FGIs, although it is not developed in the

literature. Private/semiprivate care (See Glossary) consists of privately paid consultant led care where women are seen antenatally and postnatally by a consultant obstetrician who could also be available for the birth. Over 50% of women in the FGIs availed of private care. Private maternity care accounts for the highest payouts by Irish insurance companies (Thompson 2006). Women who availed of private or semiprivate care were recommended to do so by family and friends. They valued the fact that they could meet an individual, named personal, consultant, who provided continuity of carer coupled with private accommodation following the birth. Several women in the FGIs were aware of midwifery led and birth centre models of care which entailed a different philosophical approach, and were dismayed that this was not a choice available to all women. During labour and birth, relationships with midwives were expressed differently to those with medical professionals (See Chapter 4). Throughout labour, doctors involved were usually junior doctors whose visits were impersonal and brief, at the request of the midwife, with little interaction with the women in the FGIs. Consultant obstetricians' involvement during labour and birth varied between participants who availed of private care. Whilst some consultants attended the birth others did not, but were usually made aware that a woman in their care was in labour and were in communication with the midwife. Most obstetricians in the sample units were engaged in 'dual practice' of public and private care. Women in the FGIs perceived private and semiprivate care to be safer due to the increased monitoring they received antenatally such as increased access to ultrasound, and the knowledge that if 'something happened' (during labour and birth) the doctor would be, if not present, at least available at short notice. Women who had not availed of private or semiprivate care were not as concerned about this aspect of care, and were happy that, if an emergency arose any doctor would be available.

Although obstetricians are typified as being most attached to technology and interventions including caesarean section and induction of labour (Reime *et al.* 2004), women in the FGIs found that midwives sometimes adopted a medicalised approach, which consequently limited their

choices unless a DOMINO service was available. As discussed in Chapter 3 midwives may have little choice but to adopt the institutional philosophy. Coyle *et al.* (2001) point to the differences between the prevailing ethos of a hospital and a birth centre where a non interventionist approach is enhanced by the fact that 'technology' such as epidural and continuous foetal monitoring was not readily available. Although it was not the intention of the research to examine the role that any model of care played in the experience of birth the issue arose spontaneously in all ten FGIs.

A consistent feature of the FGIs was that private care provided better guarantees of personalised high quality care by women in the antenatal FGI stage; however this care did not always extend to labour and birth. In the postnatal FGIs, women were disenchanted with their private care and had not perceived any advantages during labour and birth, but thought that consultants should be available in an emergency. Some women reported relief when 'their doctor' (consultant obstetrician) arrived, and were glad that they had been present at the birth. Women appreciated when consultants had 'popped in' to see them. The attribute which related to medical care was the presence or absence of a Consultant Obstetrician for the actual birth.

6.5.11 Attribute 6: You Would Like to Have a Doctor as Well as a Midwife With You During Labour and Birth

Levels of the Attribute:

The levels of the attributes therefore reflected the discussions among women in the FGIs about what women expected and experienced during labour and birth relating to the presence or absence, and the availability of the consultant obstetrician during labour and birth.

1. A midwife will be with you during your labour and birth and the consultant will join the midwife for the birth only
2. A midwife will be with you during your labour and birth and a consultant present only if needed such as in an emergency

6.6 Reflection and Conclusions

It was conspicuous that the attributes reflected an institutionalised birth experience with few aspirations for any alternative type of experience. Although some concepts such as 'continuity of carer' were referred to tangentially by women they were not explicit elements of the birth experience for women in these groups. In the UK Hundley *et al.* (2001), identified continuity of care as an important attribute of intrapartum care. Because this service was not available to women it was not identified as an important element of their childbirth experiences. There is evidence to suggest that preferences for attributes may be affected by the services consumers have experienced (Salkeld *et al.* 2000) including maternity care (Porter and Macintyre 1984, van Teijlingen *et al.* 2003).

The findings of the DCE suggest that issues related to the experience of childbirth such as 'control' and 'choice' although related to many aspects of care were considered to be too broad and complex to be included in the DCE instrument as dichotomous variables. Attributes need to be described in terms and language that respondents can relate to which may vary from one person to another. I found it difficult to imagine many of the attributes as 'discrete', i.e. having no other possible meaning. Process attributes are however more 'qualitative' hence, may not always be interpreted the same way by all participants. The DCE as an economic tool appeared to challenge the multiplicity of meanings espoused by the feminist framework. From a feminist standpoint perspective, it was of concern to me that elements of childbirth experiences have been omitted due to the nature of the DCE and economic theory. Although the intention of the research is to explore women's experiences of childbirth, the difficulty of distilling experiences into attributes has become apparent. With an emphasis on the title of 'exploration' women's experiences cannot be fully grasped in their 'totality', and the knowledge being produced will always be partial. Congruent with what Harding (2004) describes as 'strong objectivity' by understanding and acknowledging that truth is partial situated and

subjective, objectivity can be maximised. Although I had concerns about the limitations of the DCE as expressed above it was not a reason to abandon the design. In retrospect the FGI process could have been more focussed and elements of 'experiences' may have more effectively identified attributes that were 'discrete'. In addition although respondents were asked to look at scenarios as 'hypothetical situations' and to take into account choices that might not be currently available women appeared to be unaware or unwilling to consider other possibilities apart from what they had experienced.

Without a feminist perspective an understanding of women's experiences is likely to be different, lacking the contextual element of women's choices within the DCE and perhaps omitting questions of power within the analysis. Therefore although the study is conducted within the framework of traditional economic theory and practices my ultimate goal is to use 'strong objectivity', making visible women's childbirth experiences.

Hall *et al.* (2004) suggest that pilot testing including interviews about how attributes are perceived, understood and evaluated, is an essential component of identifying attributes. Coast and Horrocks (2007) have discussed methods of ensuring clear and concise attributes are developed using interviews. Further development of the DCE is described in the following chapter.

Chapter 7

Phase 2 Strand 2

Background, Recruitment and Distribution of DCE

7.0 Introduction

This chapter provides the rationale and theoretical background to the DCE and describes the second strand of the DCE development. In this phase, a pilot study is carried out using the attributes defined in the previous chapter. 'Think aloud techniques' and distribution of the instrument to a small convenience sample is used as a method of testing the validity and reliability of the instrument. In the final section, the recruitment of participants and distribution of the DCE instrument is described.

7.1 Rationale and Theoretical Foundation for DCE

The inspiration for using the DCE arose when seeking an alternative or an addition to statistical information and satisfaction outcomes in relation to childbirth experiences. As I have pointed out in the concept analysis the many methods developed in an attempt to 'measure' childbirth experiences are testament to the difficulties of elaborating on mortality and morbidity figures. Morbidity in relation to childbirth is difficult to quantify as the measures taken are open to subjective interpretation. Furthermore assessment of morbidity usually done by survey is a relatively crude measure that relies on the woman's perceptions of problems that have been identified by the researcher, and typically refers to physical outcomes. Women's perceptions of care has been dominated by satisfaction studies yet, in a multidimensional service such as health care, satisfaction measures are not sufficient to elucidate relative preferences for different attributes of the service (Ryan 2006, Crow et al 2002, Turriss 2005) although such information is important. In their systematic review Crow et al (2005) suggest that any

measurement of patient experience should aim to include a mixture of both qualitative and quantitative approaches. They suggest the DCE as a way of incorporating relative preferences and may be an optimal way of measuring consumer preferences. Ryan (1996) agrees suggesting that the DCE has many advantages over previously used 'satisfaction', 'Quality of Life', and economic evaluation tools because it enables consumers to identify preferences that they are willing to 'trade' or give up in order to have others.

The DCE measures stated preferences (what people say they will do) so that participants can choose what preferences they *would* make in a hypothetical scenario even if the services are not presently available (Payne and Elliott 2005). The DCE can therefore establish what preferences women would make for certain attributes of an experience and can be applied usefully to experiences of childbirth. The piloting phase involved determining the optimal design in addition to examining the relationship between design, and issues such as complexity of the choice task and cognitive demands.

The theoretical foundation of the DCE is complex, based on probabilistic choice theory and drawing on both random utility theory and the economic theory of value (Kjaer 2005). Random utility theory (McFadden 1973, Hanemann 1984) and Lancaster's (1966) theory of value, later developed by Louviere *et al.* (2000), proposes that individuals act to maximise utility based on their perceptions of the characteristics of a commodity, and that utility is a function of services rendered by those commodities. A study of women's preference for intrapartum care identified certain attributes of that care that maximised utility, and found that women would not, for example, want continuity of carer at the expense of decreasing availability of pain relief (Hundley *et al.* 2001). Women derive utility from their perceptions of the characteristics or attributes of the childbirth experience. The basis of probabilistic choice theory and modelling is that there is some uncertainty surrounding any individual's choices (they cannot always be predicted), therefore, instead of identifying one alternative as the

chosen option models, assign a *probability* to each alternative that might be chosen (Kjaer 2005).

7.1.1 Producing Scenarios

The initial development process described in the preceding chapter involved the identification of the attributes and levels of attributes of women’s experience of labour and birth. Hypothetical scenarios incorporating these attributes and levels were then placed in choice sets with a view to asking participants to express their preferences by choosing a particular choice set (Ryan *et al.* 2006). Women are invited to choose their preferred option from a series of choices in which each alternative in a choice set is described by a unique combination of attribute levels. Table 15 shows an example of a choice set consisting of two scenarios where woman are asked to choose either A or B.

Table 15. Example of a Choice Set

Scenario A ↓	Scenario B ↓
Care is individual and personal to me	Care is routine
I get on in labour with no routine interventions (like having my waters broken)	It doesn’t matter how many routine interventions I have (like having my waters broken)
Staff discuss things with me before making decisions	Staff make decisions but keep me informed
I can have non medical pain relief only, like TENS and massage	I can have all types of pain relief (including gas and air and pethidine) but no epidural
A midwife is with me during my labour. The consultant is only present if needed, such as in an emergency	A midwife is with me during my labour. The consultant joins the midwife for the birth only
The midwife works in partnership with me	The midwife does not work in partnership with me

Please tick (√) **either** A or B

Prefer A

Prefer B

The preferred alternative offers a higher level of utility (Longworth *et al.* 2001). The development of the DCE required the involvement of a

design expert, and planning in advance exactly which elements should be incorporated in order to permit the best possible inferences from the data (Louviere *et al.* 2000). The design was influenced by a number of considerations including the participants' ability and motivation to complete the DCE whilst maximising the properties of efficient design (Louviere *et al.* 2000).

7.2 DCE Design

The efficiency of a DCE model is a measure of the 'goodness' of the design relative to the optimal or best design possible. Street and Burgess (2004) have pioneered work concerning the 'D-optimality' criterion to produce statistically optimal experimental design incorporating Huber and Zwerinas' (1996) requirements of level balance, orthogonality, minimum overlap and utility balance. The design which Street and Burgess (2004) proved has the properties of near-optimal (94.4%) statistical efficiency. A design expert Leonie Burgess constructed the design with an efficiency of 99.6% (Burgess 2007, personal communication). The initial design as shown in Appendix XV11 was created in numerical form and was then converted into a choice experiment by inserting the corresponding attributes and levels (Appendix XV11). Each choice set consisted of two scenarios that mirrored the numerical design from which women were asked to choose their preferred scenario in the completed DCERI (Appendix XV11)

The design computed was a main effects design based on the differences in levels between the scenarios in A and the possible levels of each attribute in Scenario B (Burgess and Street 2005, Burgess 2007). A main effects design is a simple additive model i.e. based on a linear utility function where utility is a function of all attributes, and the assumption that preferences for attributes are independent (Taylor and Armour 2002).

7.2.1 Pairing Scenarios into Choice Sets

As with most studies, the large number of possible combinations of attributes and levels made it implausible to generate a design based on all possible permutations of the attributes (Ryan and Gerard 2003). Combining the 6 attributes, 2 with 4 levels and 4 with 2 levels, gave rise to 144 scenarios ($3^2 \times 2^4$). Random sampling theory guarantees that if a large enough sample is taken from the complete factorial design of the DCE it should closely approximate to the statistical properties of the factorial itself (Louviere *et al.* 2000). To avoid information overload, using a fractional factorial design with a limited number of scenarios is recommended (Ryan 1996). An independent sample of scenarios (i.e. combinations of attributes and levels) from the full factorial set was designed by Leonie Burgess. The number of scenarios increases factorially with the number of attributes and levels. Computer programmes or in this case, a design expert (Leonie Burgess), may be used to identify the optimal design. The fractional factorial design included a subset of 16 scenarios (representing an orthogonal array), from the original 144, to allow for estimation of all main effects. Each of these 16 scenarios was paired to retrieve the maximum information from each choice. Two sets of scenarios were produced with eight choice sets and one 'practice set' in each version. These 16 scenarios were randomly converted into 8 choice sets in two blocks (Appendix XV11).

Previous work in the field of intrapartum care has shown eight-pair-wise comparisons to be a manageable number that participants happily complete (Hundley *et al.* 2001, Longworth *et al.* 2001). More recent discussions around the optimal number of choice sets indicate that researchers may need to judge for themselves how to trade off statistical efficiency with potential losses in respondent efficiency (Burgess and Street 2006). I concluded that eight pair wise comparisons were appropriate to gain sufficient information without being too demanding for mothers who had recently given birth.

7.3 Developing the Discrete Choice Experiment Research Instrument (DCERI)

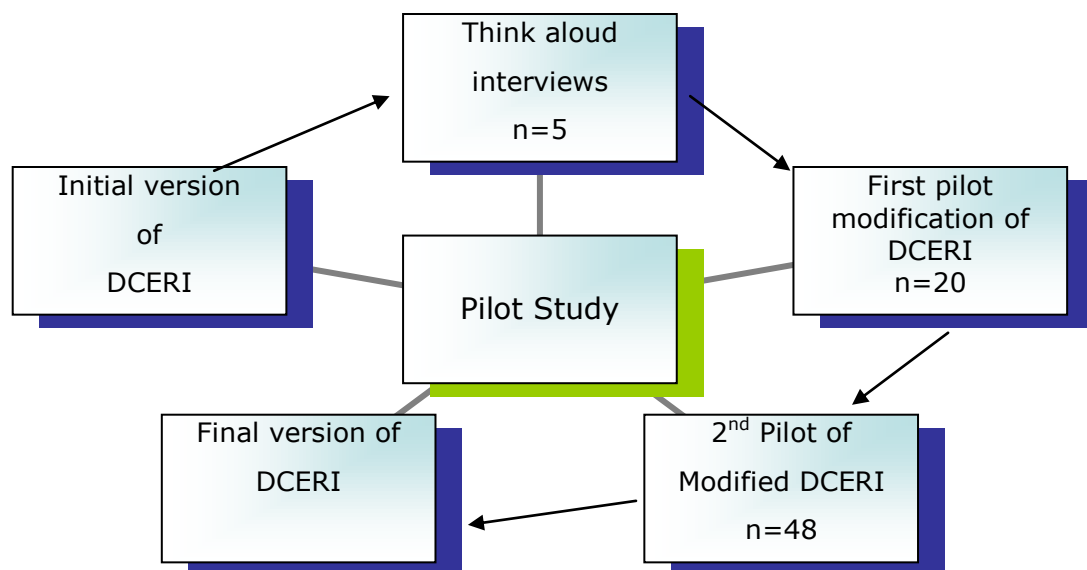
Once the design was complete the development of the instrument commenced using women as the 'experts' at all stage of the development. Although there is no 'gold standard' for the process, careful qualitative work in developing a DCE is recommended (Louviere *et al.* 2000). Qualitative data enables a better understanding of the study population (Grewal *et al.* 2006) and assists in the development of plausible and tradeable attributes (Cheraghi-Sohi *et al.* 2007). As discussed in the previous chapter, there is a tension between the qualitative data and their subsequent encapsulation into discrete attributes and levels within a DCE design (Coast and Horrocks 2007). From a feminist perspective, I was concerned about forcing women to choose between what may have been important elements for them. As discussed in the research design, and the previous chapters, essentialist and universalist positions previously ascribed to women's experiences were the antithesis of what I wanted to achieve. In addition to reflecting on my own position as a researcher, I spent a considerable time piloting the DCERI in order to ensure that women's voices were heard within the quantitative milieu and that the development of the instrument accurately reflected a variety of perspectives and viewpoints resulting in an inclusive approach that is important to feminist research.

7.4 Validity and Reliability

The foundational attributes and levels of the DCE were developed during the Focus Group Interviews (FGIs) (Chapters 4 & 5), ensuring that they were grounded in the qualitative evidence of women's experiences. The piloting phase was conducted to review, validate and enrich the DCERI. Piloting is essential to the validity and reliability of a survey instrument, which relies on shared assumptions and understandings of the questions and response categories (Bowling 2002), an area which has been identified as requiring further research with the DCE (Ryan and Gerard 2003).

The validity of an instrument is not proven, established or verified; rather it is supported to a greater or lesser degree by evidence (Polit and Beck 2004). The limitations of some aspects of validity and reliability are acknowledged in the context of maternity services where there is little comparative evidence about women’s preferences in relation to the experience of labour and birth (Goodman *et al.* 2004, Devane *et al.* 2007), and the DCE as a relatively new method in health research. There is little consensus across disciplines about methods for establishing the validity and reliability of the DCE itself (Ryan and Gerard 2003). The validity of this instrument was tested using a combination of evidence from ‘thinking aloud’ techniques in addition to written pilot tests of both ‘blocks’ or versions of the instrument. The pilot study was carried out in the four randomly chosen hospitals and the pilot site.

Figure 5. Procedures for Pilot Study



7.5 Procedures for Pilot Study

Oppenheim (1992) suggests that almost all range and aspects of an instrument can be piloted. Figure 5 shows the sequence of the piloting procedures. The piloting process was conducted over a period of four months and involved progressive modification of the DCERI. The piloting

consisted of a combination of written feedback and qualitative evidence from 'think aloud' interviews. Following the first phase of interviews and piloting, all issues emerging from the data were used either to modify the DCERI or to inform the subsequent piloting of the DCERI. The 'think aloud' interviews were followed by an initial pilot study of a sample of 20 women. A second piloting of an amended version of the DCERI with the assistance of 48 women resulted in the final version of the DCERI.

7.5.1 Thinking Aloud Techniques

The initial pilot of the instrument involved the use of 'think aloud' techniques (Suchman and Jordan 1991), which have been used recently in the development of DCE in the context of primary care (Cheraghi-Sohi *et al.* 2007). 'Thinking aloud' refers to the use of verbalisation to access the respondents' thoughts and feelings about the questions in the instrument, and to understand their ideas and interpretations of the attributes and levels as they read the DCERI (Murtagh *et al.* 2007). This has the potential to provide additional insights and often unanticipated information regarding the comprehension and acceptability of the instrument.

Five women were randomly selected by postnatal clinical staff and asked to read the DCERI for the first time. I returned to the participants approximately twenty minutes later and read through the DCERI with them. The interview schedule is outlined in Appendix XV. I asked women whether they understood the format of the instrument. I used verbal probes to understand and explore women's comprehension of the attributes and their levels, in addition to their opinions about the practicability of, and their willingness to identify trade and distinguish between attributes. In particular, I sought women's opinions about the four level attributes, what they would consider 'least to most'. All participants agreed with the levels for the attributes for pain relief and decision making.

My previous experiences suggested that women might want to talk about their recent experiences, and this proved to be the case. I used

guidelines from recent research related to postnatal counselling and debriefing (Kitzinger and Kitzinger 2007). The emphasis during the interaction was listening to women talk through their story. Some attributes were highlighted as areas of concern to women, with ensuing conversations around their particular experience. These exchanges had a dual purpose of listening and talking to women about their experiences and in developing a rapport with women, whilst understanding their rationale for choosing or rejecting specific attributes and levels. The results of the 'think aloud' interviews were combined with the written piloting of the DCERI (see below) in order to modify areas of concern. Notes were taken during the conversation, in relation to the attributes using a grid system (Appendix XV).

All women said the attributes were important to them, that they would trade between levels, and they did not have any other items to add to the DCERI. However they did have difficulties in choosing between scenarios and found the instrument repetitive.

7.5.2 Written Pilot

Following the 'think aloud' interviews, the written pilot test of the instrument was distributed to test the acceptability and comprehension of the DCERI. A convenience sample of women selected by postnatal clinical staff that fulfilled the criteria of the study were asked to complete the DCERI. The DCERI was accompanied by a front sheet that included a number of relevant questions based on Oppenheim's (1992) suggestions in relation to questionnaire development.

- 1) How long did it take to complete?
- 2) Were the instructions clear?
- 3) Were any questions unclear or had double meanings?
- 4) Were all choices included?
- 5) Did you object to answering any questions?
- 6) Was the layout clear and attractive?
- 7) Any other comments

Both versions of the DCERI were tested (both had the same attributes and levels but differently ordered). Women in the pilot study were chosen by clinical staff in both city and rural hospitals and the DCERI instruments were distributed by them and returned to me between June and August 2007. A sample of 20 women completed the first pilot version.

7.5.3 Initial Modification

The initial modification consisted of changes of the format and presentation of the DCERI. Advice was sought from print designers and combined with evidence from the literature regarding the presentation and content of the DCERI (Edwards *et al.* 2002). The National adult literacy agency (NALA) also edited the DCERI in relation to wording, language layout and presentation.

Women found the grey/white format of DCERI 'uninteresting,' so this was altered to colour as some women suggested. Participants were also inclined to read across attributes, therefore the colour graduated from dark to light as a guide to the participants and a space inserted between scenarios. Some women ticked all boxes in the choice set, rather than one box at the end. An additional instruction was therefore inserted relating to ticking the 'end box'. The font size and format was altered, and the layout of the questionnaire was made as attractive and as accessible as possible. Women commented on the repetitive nature of the DCERI. Notes were inserted at the top of the page encouraging women to continue, whilst acknowledging the repetitive nature of the choices. A space was allowed after each choice set, to accommodate comments women would like to make about the scenario they choose. The inclusion of open questions and spaces for comment added contextual information to the decisions made by participants congruent with the feminist goals of the research.

7.6 Results of Modified Pilot Study

Following the initial pilot study and modification, the second version was distributed by clinical staff to 60 women, 30 of block 1 and 30 of block 2. A total of 48 instruments were completed 26 of block 1 and 22 of block 2, the results of both were compiled. The results of the written pilot were collated and analysed using SPSS version 14.0. The characteristics of the sample are shown in Table 16.

Table 16. Demographic Characteristics of the Sample n=48

Age years (S.D.)	29.68	(7.1)	
Location of birth n %	rural	30	62.5%
	city	18	37.5%
Marital status n (%)	Married	26	54.2%
	Single	16	33.3%
	Living with partner	6	12.5%
Education n (%)	No Qualifications	3	6.3%
	Junior Cert	3	6.3%
	Leaving Cert	5	10.4%
	Certificate/Diploma/ Degree	28	32.6%
	Postgraduate	9	18.8%

Most participants gave birth in rural hospitals (n = 30, 62.5%) were aged between 28 and 35 years with a mean age of 29.6 years, and were married (n = 26, 54.2%). A large proportion of women stated their highest qualification was a degree or professional qualification (n = 18, 37.5%). Most participants had a first degree or professional qualification (n= 18, 37.5%), and described themselves as 'white Irish' (n= 32, 66.7%).

There were an equal number of women who had given birth to their first baby (n = 24, 50%) and those who had experienced a previous birth.

The most common type of birth was a normal delivery (n = 16, 33.3%), followed by ventouse birth (n = 13, 27.1%) and forceps delivery (n= 8, 18.8%). (Table 17).

Table 17. Parity and Type of Birth Cross Tabulation

	Type of birth					Total
	Normal Delivery	Forceps	Ventouse	Caesarean Section	Other	
Multigravida	8	5	2	4	5	24
Primigravida	8	3	11	2	0	24
Total	16	8	13	6	5	48

Table 18 shows the length of time it took for participants to complete the DCERI. Most women completed the DCERI in 10 minutes (n = 18, 37.5 %); there were three participants who said it took 30 minutes. However, women who said it took longer to complete the instrument commented that they did not find the DCERI difficult to complete, did not object to answering any of the questions posed and found the instructions clear. Those who did not find the instructions clear (n = 10) commented on the repetitive nature of the DCERI rather than the phrasing or language of the attributes.

Table 18. Time in Minutes to Complete DCERI

Minutes	Frequency	Percent %
2	3	6.
5	9	19
8	1	2
10	18	38
13	1	2
15	10	21
20	2	4
25	1	2
30	3	6
Total	48	100.0

Table 19 shows participants' ratings of the completion of the DCERI. Most women said they found the format of the DCERI slightly difficult (n = 18, 37.5%), and six women (12.5%) indicated that completion was 'very difficult' although they had completed the instrument in a short time.

Table 19. Rating Completion Difficulties and Minutes to complete

Minutes to complete	Completion Difficulties				Total
	Very Difficult	Moderately Difficult	Slightly Difficult	Not Difficult	
2	2	0	0	1	3
5	2	2	4	1	9
8	0	1	0	0	1
10	1	3	8	6	18
13	0	1	0	0	1
15	1	1	3	5	10
20	0	0	1	1	2
25	0	0	1	0	1
30	0	2	1	0	3
Total	6	10	18	14	48
Percent	12.5	20.8	37.5	29.2	100.0

7.6.1 Comprehension of Attributes

During the 'think aloud' sessions, women found the first choice set more difficult but then said they 'got the gist' of it, became accustomed to the format and understood the decision context. Women who contributed written comments also said that the first choice set was difficult but that it became easier. Table 20 shows how participants rated the attributes. Participants said that all attributes were either 'important' or 'very important' to their experience of labour and birth. The most important attributes for women were: availability of pain relief (n = 13, 27%), being involved in decision making (n = 11, 22.9%) followed by both individual care and partnership with midwife (n = 10, 20.08%)

Table 20. Most Important Attributes

	Frequency	Percent %
individual care	10	20.8
partnership with midwife	10	20.8
pain relief	13	27.1
presence of a consultant	4	8.3
involved in decision making	11	22.9
Total	48	100.0

The final attributes and levels following the focus group interviews are shown in Appendix XV11. The following section explains the rationale for each attribute revision.

7.7 Revised Attributes

7.7.1 Attribute 1 (Individualised Care)

Women immediately understood this attribute and were happy with the wording. Women liked the combination of the 'individual' and 'personal' and felt it made sense to them. Women stated that routine care was not necessarily 'bad' but that it did not encompass the feeling of being 'special'. Although I had some concerns that this attribute was similar to the 'partnership' attribute, women distinguished clearly between these attributes, one as a more 'general' feeling about the whole package of care rather than any individual involved in their experience.

7.7.2 Attribute 2 (Midwife working in partnership)

This attribute also 'made sense' to women who felt they understood what working together means and that you were not 'pulling away' from the midwife and the sometimes complex relationship that was described in the qualitative evidence from the FGIs, which could alter during the course of the labour and birth depending on the context. Women attributed characteristics to the midwives that they had experience with previously such as 'mumsy', 'brilliant' and 'an angel', but also expressed

previous unpleasant experiences and the role of 'luck' where you might not 'click' with the midwife.

7.7.3 Attribute 3 (Use of interventions)

Women did not understand what was meant by 'intervention' and did not refer to the explanation of the term. An exemplar of an intervention was therefore defined within the attribute (like having your waters broken). Women also felt that although they might want a minimum of intervention this might depend on how they were getting on in labour and did not like the word 'minimum', which, they felt, made it difficult to choose between levels. The phrase of 'getting on' in labour was clear to women. The attribute level was therefore changed to 'no intervention' for level 0, and level 1 remained as before. Women also felt that labour and birth should be explicitly mentioned, so these words were added to the attribute. Some women interpreted the wording of 'intervention' differently, an explanation of phrases such as 'intervention' and 'individualised care' was given in the DCERI prior to women being asked to make decisions about their choices.

7.7.4 Attribute 4 (Involvement in Decision Making)

Although this attribute was clearly understood, the levels of the attributes were more contentious. Women felt that the decision making should be explicitly about labour and birth, and this wording was added to the attribute. The rationale underpinning this attribute was consistent with the qualitative FGIs data, which highlighted that it was the ability (or the perception of that ability) to contribute to the decision making process that, was valued regardless of the outcome. Level Zero was considered insufficiently 'strong' and the phrase 'staff made decisions for me' was inserted. In addition, level two and three were thought to be quite similar. After some discussion with women, level three was more clearly defined as 'I will be in control of decisions '.

7.7.5 Attribute 5 (Availability of Pain Relief)

As discussed in the previous chapter, the phrase 'pain relief' was the phrase that women understood in relation to labour and birth. This

attribute was also contentious as women did not understand what non-medical pain relief was and wanted exemplars of the type of pain relief that was being referred to. Consequently, these exemplars were defined in the attributes e.g. the wording used in the attributes was also altered and now began with 'I will be able to have...'

7.7.6 Attribute 6 (Presence of Consultant)

There were no misunderstandings about this attribute and the women were happy with the levels of the attribute. The revised attributes that were used in the final DCERI instrument are outlined in Appendix XV11.

7.8 Face Validity

Face validity refers to the investigator's assessment of the presentation and relevance of the instrument and whether the questions appear to be relevant, reasonable, unambiguous and clear (Bowling 2002). The attributes were based on the qualitative evidence from the FGIs and were therefore considered relevant and reasonable. The 'think aloud' technique and the feedback from the piloting of the DCERI suggested that women were clear about the relevance and meaning of the instrument.

7.9 Content Validity

Content validity relates to the appropriate use of items for the construct being measured (Polit and Beck 2004) and, in relation to the DCE, refers to all aspects of the experimental design, such as choice of attributes, attribute levels, and ordering of attributes (Kjaer 2005) in addition to missing or superfluous attributes (Marks 2005). The attributes of the DCERI were constructed from contemporary literature and the qualitative evidence of the FGIs and were developed from what women perceived to be important elements of the labour and birth experience. Both the think aloud techniques and the written pilot study results suggested that additional attributes were not required, and there were no superfluous elements of the DCERI. As outlined below there were some modifications of the attribute levels and the ordering of attributes.

7.10 Criterion Validity

Criterion validity is assessed by comparing a new measure with an existing 'gold standard' scale. In this instance there was no 'gold standard'. However there have been examples of a DCE being used in related studies (Hundley *et al.* 2001, Longworth *et al.* 2001), which identified similar attributes and levels to those in the present work. These instruments were, nevertheless, developed within a different maternity care provision and socio cultural milieu in the U.K, with national accessibility to models of care including midwifery led units, and a strong consumer influence for 'natural birth'; therefore they may be inappropriate in the context of the Irish maternity care system. Some attributes in the UK studies, for example, identify 'continuity of midwifery care' , or 'knowing your midwife' as important attributes of intrapartum care, services which women accessing Irish maternity services may not have access to, and moreover may not recognise as an important element of intrapartum care because they are not available. These attributes were not identified or explored in the DCE.

7.11 Convergent Validity

Convergence indicates that different methods of measuring a construct yield similar results, and different approaches should converge with other measures of the same construct to which it can be related (Polit and Beck 2004). The format of the questionnaire included a page with direct questions about the attributes where respondents were asked to rate the attributes and identify the most important one. The findings regarding the initial ranking and rating of the attributes are compared to ascertain whether or not those attributes identified as 'very important' by the majority of women in the direct questions also appear as highly important in the results from the DCERI (Chapter 9). This method has been proposed with previous use of DCE in maternity care (Hundley *et al.* 2001).

7.12 Theoretical Validity

In the context of the DCE, theoretical validity involves checking that model coefficients have the plus or minus signs expected, given the underlying economic theory or, more indirectly, whether results are consistent with 'intuitive' expectations (Ryan and Gerard 2003). In the context of the present DCE incorporating qualitative attributes, it is difficult to envisage how one would 'intuitively' predict women's preferences as utility would be individualised. Some participants, for example, would prefer to experience pain during childbirth and would consider pain an empowering part of the birth experience, whilst others would consider the pain of labour and birth disempowering and that could have a detrimental effect on their birth experience. Most DCE attributes encompass quantitative elements whereas the attributes and levels in this study were qualitative in nature. This inhibited predictive ability and theoretical validity, as utility for individuals is individually perceived and may not be predicted

7.13 Rationality

With regard to DCEs, rationality of responses or internal consistency is based on the assumption that individuals assume a compensatory decision making process when presented with choice sets; that is, respondents consider all attributes and levels of attributes and make choices within those (Ryan and Gerard 2003). Respondents are therefore willing to trade across all attributes (Louviere *et al.* 2000), consistent with the theory of utility (Ryan and Bate 2001). The psychology literature indicates that, far from being 'rational' in the economic sense, respondents may employ simplifying heuristics (cognitive shortcuts) to simplify tasks they are presented with, thereby ignoring much of the information with which they are presented (Gigerenzer *et al.* 1999, Lloyd 2003). This is refuted by other authors (Cairns *et al.* 2002) who suggest using ways of combining economic and psychological views of decision making in order to better understand it (Ryan and Amaya-Amaya 2005). During the 'think aloud' techniques and the written completion of the pilot DCEs, women had taken time to

consider all attributes, rather than employing ways of simplifying the task. However, in order to encourage women to 'trade' a line in the instructions suggested to women that they may have to 'give up something' in order to get another.

7.14 Menu of Choice Sets

Whilst many women described the choice sets as repetitious and sometimes confusing, all women attempted to complete the questionnaire. The choice task was a considerable cognitive challenge with respondents being required to process a large amount of information, involving the simultaneous comparison of different levels on 6 attributes. Participants described the format of the choice sets as 'complicated' or 'complex'. Authors agree that DCEs should not be too complex, but there is no guidance about what constitutes 'complexity' (Ryan and Gerard 2003). Women in the think aloud group felt that the repetition of the attributes contributed to the complexity of the instrument. The completion of the DCE involves thought processes where the respondent first learns how to answer the DCE before becoming fatigued (Grewal et al 2006). A 'practice' set and clearly explained examples mitigate against the negative aspects of the process and may maximise validity of responses. These principles were embedded in the DCERI. The format of the DCE dictates that choices of attributes and levels must be repeated. The format of the initial modification of the DCERI was adapted to include encouraging phrases, and reiterations that repetition was a normal part of the DCERI.

7.15 Reliability

The DCE has been established as a reliable instrument for eliciting consumer preference (Stirling *et al.* 2000, Telser and Zweifel 2007), yet reliability is rarely assessed in DCE related to health care (Ryan and Gerard 2003).

7.16 Stability

I considered the test-retest reliability by administering the DCERI to the same sample on two occasions several weeks apart (Marks 2005), to assess the stability (reproducibility of responses) of the instrument. Test-retest procedures have been used infrequently with DCE in relation to knee injuries (Bryan *et al.* 2000), and nursing roles (Caldow *et al.* 2007), and not in the context of intrapartum care. When the issue of retesting was broached with women, although they did not refuse, several said that they thought they would be very busy and would be in a 'different frame of mind' a few weeks later and this would affect their preferences. Previous research demonstrates that women's perceptions of their experiences are initially positive, giving a 'halo effect,' and subsequently may alter over weeks and months (Waldenstrom *et al.* 2004b), therefore influencing the perceived stability of the instrument. It was therefore decided not to perform a test retest on the instrument.

7.17 Conclusions of Pilot Study

The 'think aloud' technique and piloting of the questionnaire provided an effective means of adapting, enriching and validating the DCE instrument. The 'think aloud' technique yielded rich data, and was useful in identifying precise problems with wording, comprehension, and overall usability of the DCE. The range and complexity of reasons behind responses to choices was evident and, although the DCERI was considered repetitious, women attempted to complete it. Some women struggled with the hypothetical task of putting themselves in a situation of choosing between menus of attributes and their choices seemed to be determined by their previous experience. Women sometimes had to be prompted to go outside their immediate experience so that they were not limited by that experience, as has been identified with previous research (Cheraghi-Sohi. 2007).

Although the DCE is being increasingly used in the health field, it is a technique that is still evolving, and there are many areas particularly around validity and reliability that require further research (Ryan and

Gerard 2003). The absence of a gold standard in developing the DCE and the exploratory nature of the research, in addition to the lack of comparative evidence, presented a challenge in establishing the validity and reliability of the study. As I have previously pointed out, the piloting of the DCERI although time consuming was considered an important part of the development of the instrument and proved to be extremely valuable. The final version of the instrument (Appendix XV11) proved to be user-friendly easy to read colourful and not too large. The following section describes the recruitment and distribution of the DCERI.

7.18 Distributing the DCERI

My experience with the FGIs had reiterated the importance of establishing relationships particularly with 'gatekeepers' in the clinical areas. Prior to conducting the study I held informal information sessions in all of the areas. I met with ward managers, students and staff in all areas including Clinical Practice Coordinators, and midwifery lecturers to ensure that everyone knew about the study. As in my previous experience we identified one contact person in each area with whom I could subsequently liaise. This was useful in terms of recruitment and because some units were geographically distant from me.

7.19 Recruitment

A purposive sample of women who met the inclusion criteria, (Section 5.5.2) were recruited through the postnatal wards of the four hospitals. Following meetings with the hospital managers, and bearing in mind the ethical issues of confidentiality and informed consent, it was decided that the midwives on the unit were best placed to recruit women, ensuring that women would not feel pressurised into taking part. Midwives agreed that they would distribute and collect cards requesting women who were eligible to participate to provide contact information. Women agreeing to be contacted were informed that the DCE would be posted to them in approximately eight weeks time. The completed cards were placed in a post box that was placed in each unit. The cards and

box were branded by a 'duck logo' (Appendix XV1), which was used to identify the study and was used as a theme during the research process. I visited the hospitals every few weeks to collect the completed information that midwives referred to as 'the duck study'. My contact information was supplied on the cards, and I requested women's names and addresses. A brief explanation of the study was also given on the card. Bundles of cards were often mislaid, therefore I could not accurately estimate how many were actually distributed and midwives' workload precluded monitoring on their part.

7.19.1 Recruitment Progress

Recruitment rates were variable in different units. The number of births in the city units meant recruitment was supposedly easier and quicker. There were difficulties with recruitment in one busy city unit, where the collection box could not be placed in a central area. Health and safety issues meant that it could not be placed outside the midwives' office in a public postnatal ward either. Following negotiations with clinical staff an appropriate collection point was identified for the collection of cards, nevertheless recruitment continued to be extremely slow. Following several meetings with the 'gatekeepers' and midwifery managers I redoubled my efforts, speaking to groups of students during lecture time, and making myself available to midwives for informal discussions. Recruitment in this area never really improved; conversely, recruitment in the private/semiprivate area was brisk. Over a period of six months only 49 women availing of public maternity care were recruited and 122 who had availed of private/semiprivate care. The result from this hospital was therefore 'skewed' with more private/semiprivate patients.

7.19.2 Returns

When I received the cards, the woman's details were entered into an 'Access' programme alongside the unique number of each DCE which was printed on the back of the instrument. The DCE was then sent to the potential respondent without any particulars apart from the identifying number, to maintain confidentiality. A Freepost envelope was included with my address, and the first page of the DCE included my

mobile phone number alongside an explanation of the rationale for the study. When the DCE was returned, the unique identifier was matched with the respondent and those who had not replied were sent one reminder within two weeks.

The anticipated recruitment time for 1900 women had been three months. However, following six months of recruitment 905 participants had provided their contact details in order to receive the DCERI. Due to time and financial constraints, and following consultation with my supervisors, recruitment ceased.

7.19.3 Summary

The pilot study provided useful information that was used to adapt the DCE and make it more 'user friendly'. The 'think aloud' techniques enabled me to identify what women understood by the attributes and levels that had been identified. The DCERI was modified twice to ensure it could be understood and was 'user friendly' for busy mothers. My earlier experience with the DCE provided me with valuable contacts in each of the units for recruitment purposes. Recruitment in one area started slowly and remained so despite adopting several strategies to improve it.

Chapter 8

Demographic results of the DCERI

8.0 Introduction

The DCERI was made up of two sections: the first section consisted of demographic questions the second section was composed of the Discrete Choice experiment. This chapter describes the demographic characteristics and the statistical analysis of the sample. Responses to five specific questions about women's childbirth experiences are also presented. The DCE section was analysed separately and is reported on in the next chapter.

8.1 Statistical Tests

Data were analysed using SPSS for Windows. The results are a summary of the major findings. The study was primarily a descriptive one using means, frequencies and cross tabulations; statistical tests of significance such as chi-square tests were used for the ordinal and categorical variables. Statistical significance was taken to be at least at the 0.05 level of probability.

8.1.1 Response Rate

There were 2,500 cards requesting women's names and addresses circulated to the four sites over a period of six months between August 2007 and February 2008. The recruitment process is discussed in the previous chapter. A total of 905 women provided their names and addresses, indicating their interest in participating, and were posted surveys to complete. Five hundred and thirty seven completed surveys were returned giving a response rate of 59.3%. Six women had not completed the DCE scenarios, explaining that they 'could not choose' or 'mixture of both' therefore was excluded from analysis, giving a total of 531 participants.

Table 21. Number of Surveys Sent and Response and Non Response Rates by Site

	Total sent	Responders	%	Non responders	%
Rural 2	78	53	67.95	25	32.05
City 1	286	171	59.79	115	40.21
City 2	364	209	57.42	155	42.58
Rural 1	177	98	55.37	79	44.63
Total	905	531	58.67	374	41.33

Women who had not responded to the initial request were sent one reminder as explained in the previous chapter. The response varied by site with the highest response rate being from a rural hospital and the lowest from a rural hospital (See Table 21).

8.2 Ease of Completion

The pilot study had identified that women found the DCE type of survey difficult to complete. Adaptations based on women’s comments were used; however, most women said they found the survey either ‘very difficult’ (n=34, 6.4%), ‘quite difficult’ (n=140, 26.4%) or a ‘bit difficult’ (n=223, 42%) to complete with 129 women (24.3%) reporting that they did not find completion difficult (Table 22).

Table 22. Ease of Completion

	Frequency	%
Very difficult	34	6.4
Quite difficult	140	26.4
A bit difficult	223	42.0
Not difficult	129	24.3
No comment	5	0.9
Total	531	100.0

Most women n = 218 (41.1%) said it took them less than 10 minutes to complete the survey (Table 23). The times reported ranged in minutes from 2-120 with some women commenting that they completed the survey over a period of days ‘leaving it down and picking it up later’, as perhaps would be expected of a new mother.

Table 23. Minutes to Complete (Banded)

Length of time to complete in minutes	Frequency	%
< 10	218	41.1
10-15	139	26.2
16.00 - 25.00	88	16.6
26.00+	86	16.2
Total	531	100

General comments about childbirth experiences were coded, and will be reported on later. Women were also given an opportunity to comment following each scenario, and these are reported on in the next chapter.

8.3 Demographic Characteristics of the Sample

Table 24 shows the characteristics of the sample. The age of respondents ranged from 18-43 years with a mean age of 32.35 years (S.D 7.1). There was little difference between the mean age of women having their first babies (31.2 years, S.D. 6.3) and women having a subsequent baby (33.2 years, S.D. 4.8), similar to the national average age of all mothers of 31 years (Central Statistics Office, 2008).

Most women were married (n= 403, 75.9%), with 34 women (6.4%) describing themselves as single, and 90 (16.9%) as living with their partner. The percentage of single mothers in the sample is considerable fewer than the national average of 32% (ESRI and Department of Health and Children 2008). The age of respondents was associated with their marital status. The mean age for married women being 33.2 years (S.D. 5.3), single respondents 25.4 years (S.D. 5.3), and the mean age of women living with partners was 29.4 years (S.D. 5.4). Most women had given birth 12-24 weeks prior to completing the DCERI. The mean age of babies in weeks was 18.0 (S.D. 6.4).

Table 24. Demographic Characteristics of the Sample

Age years (S.D.)	32.35	(7.1)	
Baby weeks: (S.D.)	18.0	(6.4)	
Parity n (%)	Primigravida	296	(55.7)
	Multigravida	233	(43.9)
Marital status n (%)	Married	403	(75.9)
	Single	34	(6.4)
	Living with partner	90	(16.9)
	Other	2	(0.4)
Education: n (%)	No Qualifications	17	(3.2)
	Junior Cert	35	(6.6)
	Leaving Cert	90	(16.9)
	Certificate/Diploma	173	(32.6)
	Degree	33	(25.0)
	Postgraduate	81	(15.3)

Respondents were mainly educated to Diploma, Degree, and Postgraduate level (n=387, 72.8%). Seventeen respondents (3.2%) had no qualifications and 125 (23.5%) of respondents had secondary school qualifications.

Table 25 shows the ethnic origin of the sample. Four hundred and fifty one respondents (84%) described themselves as white Irish, whilst there were 59 (11%) women who described themselves as 'Other white background'. The remainder of respondents came from a variety of ethnic groups with low percentages in each group. The sample therefore consisted of fewer than the national average of 4% of mothers of Africa ethnicity and 3.9% from accession states. (ESRI and Department of Health and Children 2008). As in the FGIs the purposive sampling was expedient in relation to time and expense but may have been influential in the relatively homogenous group therefore generalising results to the

population would need to bear in mind the self selecting nature of respondents.

Table 25. Ethnic Origin

	Frequency	Percent %
White Irish	448	84.4
Other white background	56	10.5
Black Irish	6	1.1
Irish Traveller	4	0.8
African	5	0.9
Any other black background	2	0.4
Asian Irish	1	0.2
Chinese	2	0.4
Any other Asian background	2	0.4
Other including mixed background	3	0.6
Blank	2	0.4
Total	531	100.0

In addition to demographic characteristics women were asked five questions related to their childbirth experiences. Respondents were asked to tick a box related to the following:

- type of care
- information about options of care
- type of birth
- worry prior to labour
- happiness with experiences
- Pain relief used.

This information was collected in order to establish whether there were any differences between demographic characteristics and other variables, and as a means of exploring relationships with the DCE.

8.3.1 Type of Care

Two hundred and eighty women availed of public maternity care services (52.7%) and 246 women (46.3%) availed of private or semiprivate care, similar to the national rate of 50% of Irish adults who avail of private/semiprivate health care (O'Connor 2006). Three women (0.6%) availed of Domino care (Table 26). Due to the limitations of statistical analysis on such a small group those who availed of Domino care were included in public care.

Table 26. Type of Care

	Frequency	Percent %
Public	280	52.7
Private/semiprivate	246	46.3
Domino	3	.6
Blank	2	.4
Total	531	100.0

There was an association between the site and type of care as shown in table 27. The majority of responders from one city site 71.3% (n=122) were private/semiprivate care users whilst 28.7% (n= 49) used public maternity services. This was related to recruitment problems in a particular unit where there were separate private/semiprivate postnatal and public wards as described in the previous chapter. This percentage was reversed in one rural hospital with 80.6% (n= 79) of responders using public and 19.4% (n= 19) using private or semiprivate maternity services.

When asked whether information about the different maternity care options available was given to them, 138 women (48.5%) who availed of public maternity care services said they had received such information, whilst 146 (51.5%) women had not. One hundred women (59.6%) who availed of private/semiprivate care said they had not been

given this information whilst 148 women (40.3%) said they had been given information.

Table 27. Site and Type of Care Cross Tabulation

Site		Type of care		Total
		Public	Private/ Semiprivate	
city1	Frequency	49	122	171
	% within site	28.7%	71.3%	100.0%
city 2	Frequency	124	85	209
	% within site	59.3%	40.7%	100.0%
rural 1	Frequency	79	19	98
	% within site	80.6%	19.4%	100.0%
rural 2	Frequency	31	20	51
	% within site	60.8%	39.2%	100.0%
Total	Frequency	283	246	529*
	% within site	53.5%	46.5%	100.0%

*Missing data from 2 respondents

8.3.2 Type of Birth

The sample of women who took part in the study had anticipated having a normal vaginal birth and had experienced labour; therefore those who experienced caesarean sections would have been 'emergency' procedures. Three hundred and forty eight women (65.8%) reported having a normal vaginal birth, 22 women (4.2%) experienced a forceps delivery whilst 84 women (15.9%) gave birth by ventouse delivery and 75 (14.2%) by caesarean section. The national average rate for

spontaneous delivery in 2006 was 59.8%, with 15.3% instrumental rate and 24.3% Caesarean section rate (ESRI and Department of Health and Children 2008).

Table 28. Type of Care and Type of birth Cross Tabulation

Type of birth		Type of care		Total
		Public	Private/ Semiprivate	
Normal vaginal birth		205	143	348
	% within Type of care	72.4%	58.1%	65.8%
Forceps birth	Frequency	10	12	22
	% within Type of care	3.5%	4.9%	4.2%
Ventouse birth	Frequency	43	41	84
	% within Type of care	15.2%	16.7%	15.9%
Caesarean Section	Frequency	25	50	75
	% within Type of care	8.8%	20.3%	14.2%
Total	Frequency	283	246	529*
	% within Type of care	100.0%	100.0%	100.0%

* Missing data from 2 respondents

Table 28 shows that there were differences between the groups in relation to the type of maternity care the women received. The rate of normal births for women in the public maternity services was 72.4% (n=205) whilst for women attending private or semiprivate care the rate was 58% (n=143). In this sample the rate of caesarean section for women availing of the public maternity system was 8.8% (n=25), whilst for women who availed of private or semiprivate the rate was over double, at 20.3% (n=50). The rates of instrumental births were also slightly higher in the private and semiprivate groups. Fifty two women (18.5%) in the public maternity services and 53 women (21.5%) in the private/semiprivate care group had instrumental births. A chi square statistic was calculated to test the significance of the differences between type of care and type of birth. A statistically significant relationship was noted between type of care and type of birth ($\chi^2 = 17.1$ df = 3 p < .001) at the .001 level.

8.3.3 Site and Type of Birth

The type of birth also varied among the rural and city sites, although the number of births among sites varied considerably therefore comparisons have a limited interpretation. Table 29 shows the highest percentage of normal births was in a rural hospital at 76.5% (n = 75) and the lowest percentage of normal births was in a city hospital at 57.3%., (n = 98) The highest percentage of instrumental delivery in a city hospital was a rate of over 23% (n = 49) but this hospital also had a lower caesarean section rate of 8.8% (n = 16) compared with 22.8% (n= 39) in the other city hospital. The sample from this hospital had a higher percentage of private/semiprivate care users.

Table 29. Site and Type of Birth Cross tabulation

Type of birth		Site				Total
		city1	city 2	rural 1	rural 2	
Normal vaginal birth	Frequency	98	142	75	33	348
	% within site	57.3%	67.9%	76.5%	64.7%	65.8%
Forceps birth	Frequency	12	3	3	4	22
	% within site	7.0%	1.4%	3.1%	7.8%	4.2%
Ventouse birth	Frequency	22	46	14	2	84
	% within site	12.9%	22.0%	14.3%	3.9%	15.9%
Caesarean Section	Frequency	39	18	6	12	75
	% within site	22.8%	8.6%	6.1%	23.5%	14.2%
Total	Frequency	171	209	98	51	*529
	% within site	100.0%	100.0%	100.0%	100.0%	100.0%

*Missing data from 2 respondents

The numbers of births in rural areas were less than 5 in several instances therefore the rural sites were combined for the purposes of statistical analysis. When the rural sites were combined there is a statistically significant relationship between the site of birth and the type of birth. ($\chi^2 = 16.756$. df = 6 p< .01).

8.3.3 Expectations and Experiences

The literature review established that women's expectations, positive or negative, were often associated with childbirth experiences, therefore women were asked about their degree of worry prior to the birth and how happy they were with their childbirth experiences. A total of 59 women (11.2%) were unsure about feeling worried before the birth, and 41 (7.7%) women were unsure about their happiness with the experience of birth. Four hundred and forty seven women (84.4%) described themselves as being 'very happy' or 'happy' with the experience of birth. Two hundred and forty five women (46.1%) described themselves as being worried or very worried prior to the birth.

A cross tabulation between women's worry prior to the birth and their happiness with the birth experience demonstrated that the majority of women were not very or not at all worried prior to the birth, and were either happy, or very happy, about the birth experience.

8.3.5 Worry and Happy with Experience

Forty one women (7.7%) of the total sample were not happy or not at all happy with their childbirth experiences. The percentage of the total sample (3.3%) who were not happy with their birth experience were not at all or not very worried prior to the birth whilst a similar percentage of the sample (3.2%) were very worried or worried prior to the birth. Due to the small number of respondents in some categories a chi square statistic was unable to be calculated.

The categories were subsequently recoded as shown in Table 30, into 'combined worry' and 'combined happy'. A chi square analysis to test the significance of the difference between being worried and happy noted no significant relationship between participants' worry and feeling happy with their childbirth experiences.

Table 30. Combined Worry and Combined Happy Cross Tabulation

Combined worry	Frequency	Combined happy			Total
		not sure	happy/ very happy	not happy/ not at all happy	
not sure		6	47	6	59
	% within combined worry	10.2%	79.7%	10.2%	100.0%
worried/very worried	Frequency	21	207	17	245
	% within combined worry	8.6%	84.5%	6.9%	100.0%
not worried/not at all worried	Frequency	14	193	18	225
	% within combined worry	6.2%	85.8%	8.0%	100.0%
Total	Frequency	41	447	41	529*
	% within combined worry	7.8%	84.5%	7.8%	100.0%

*Missing data from 2 respondents

8.3.6 Happy with experience and type of birth.

Most women described themselves as being 'happy' or 'very happy' with their birth experience (84.1%, n=447). When the type of birth was cross tabulated with women being happy with their experience of birth, 311 women (89.3%) who experienced a normal birth described themselves as being 'very happy' or 'happy' with the birth experience (Table 31). Twenty women (5.7%) who had a normal birth described themselves as 'not happy' or 'not at all happy' with their birth experience. Women who experienced a ventouse birth were most likely to describe themselves as being 'not at all happy' (n=6, 7.1%), with their birth experience. Of the 75 women who experienced a caesarean section, 53 women (70.7%) reported being 'happy', or 'very happy', with their birth experiences, whilst 12 women (16%) said they were either 'unhappy', or 'not at all happy', with their birth experiences.

Table 31. Type of birth and Happy with Experience Cross tabulation

Happy with Experience							
Type of Birth		Very happy	Happy	Not sure	Not happy	Not at all happy	
Normal vaginal birth	Frequency	182	129	17	11	9	348
	% within Type of birth	52.3%	37.1%	4.9%	3.2%	2.6%	100.0%
Forceps birth	Frequency	5	13	2	2	0	22
	% within Type of birth	22.7%	59.1%	9.1%	9.1%	.0%	100.0%
Ventouse birth	Frequency	28	37	12	1	6	84
	% within Type of birth	33.3%	44.0%	14.3%	1.2%	7.1%	100.0%
Caesarean Section	Frequency	30	23	10	9	3	75
	% within Type of birth	40.0%	30.7%	13.3%	12.0%	4.0%	100.0%
Total	Frequency	245	202	41	23	18	529*
	% within Type of birth	46.3%	38.2%	7.8%	4.3%	3.4%	100.0%

*Missing data from 2 respondents

Due to the small numbers in some cells a chi square was unable to be conducted; however the ventouse birth and forceps birth were combined and recoded under the heading of 'instrumental birth' and the variables 'happy' and 'very happy' with the birth were also combined and a chi squared analysis conducted. The majority of women in the three groups were 'happy', but those experiencing a normal birth were more likely to be 'happy' or 'very happy' than the other groups. Women who had a caesarean section were the least likely to be 'happy' and those most likely to be 'unhappy', whilst both assisted groups were more likely to be 'unsure' (Table 32).

A chi square analysis was undertaken on the combined groups ($\chi^2 = 22.394$, $df = 4$, $p < .0005$). There is a statistical relationship between the

type of birth and women's feelings of happiness with the birth experience

Table 32. Combined Births Combined Happy with Experience

Type of birth	Combined happy with experience				Total
		not sure	happy/very happy	Not happy/not at all happy	
Normal vaginal birth	Frequency	17	311	20	348
	% within new birth	4.9%	89.4%	5.7%	100.0%
Caesarean section	Frequency	10	53	12	75
	% within new birth	13.3%	70.7%	16.0%	100.0%
Instrumental birth	Frequency	14	83	9	106
	% within new birth	13.2%	78.3%	8.5%	100.0%
Total	Frequency	41	447	41	529*
	% within combined birth	7.8%	84.5%	7.8%	100.0%

*Missing data from 2 respondents

8.3.7 Happy with Birth and Age of Baby

The intention was that women would complete the questionnaire three months following the birth, calculated by asking the age of the baby in weeks. This period of time was chosen because of previous experience of the 'halo effect' where women who are initially happy with their experience of birth may feel more negatively once time has passed.

Table 33. Happy with experience and mean age of baby

Happy with experience	Mean (Baby weeks)	Frequency	Std. Deviation
very happy	17.6490	245	4.14878
happy	17.5842	202	4.04149
not sure	17.8537	41	4.17469
not happy	18.8261	23	3.85713
not at all happy	17.7778	18	4.08088
No comment	0	2	.00000
Total	18.0019	531	6.44205

Some women took some time to complete the survey, and responded to reminders. The range of baby ages was from eight to thirty weeks. However, the mean number of weeks postnatal for the sample was 18 weeks (S.D. 6.4) and there did not seem to be an association between the age of the baby and women's report of their happiness with the birth experience (Table 33).

8.3.8 Pain Relief Used

Epidural analgesia was most frequently used by 33.3 % (n= 177) of respondents, followed by pethidine/gas and air at 32% (n=170). These individual percentages may have been higher as 17.5% (n=93) of respondents used a mixture of both. Non medical pain relief was used by just 2.8% (n=15), and 74 women (13.9%) did not use any pain relief. (Table 34)

Table 34. Pain Relief Used

Type of pain relief	Frequency	Percent %
No pain relief	74	13.9
Non medical pain relief	15	2.8
Pethidine/Gas and air	170	32.0
Epidural	177	33.3
Mixture of above	93	17.5
Total	529*	99.6
Blank	2	.4
Total	531	100.0

*Missing data from 2 respondents

8.3.9 Parity and Pain Relief

The type of relief used was associated with the parity of the respondents. Fifty six respondents (24%) did not avail of any pain relief in the multigravid group, compared with 18 women (6.1%) in the

primigravid group. The most commonly used method of pain relief was epidural analgesia (n=177, 33.3%).

Table 35. Parity and Pain Relief

Parity		Pain relief used					Total
		No pain relief	Non medical pain relief	Pethidine /Gas and air	Epidural	Mixture of above	
Primigravida	Frequency	18	7	81	120	70	296
	% within Parity	6.1%	2.4%	27.4%	40.5%	23.6%	100.0%
Multigravida	Frequency	56	8	89	57	23	233
	% within Parity	24.0 %	3.4%	38.2%	24.5%	9.9%	100.0%
Total	Frequency	74	15	170	177	93	529*
	% within Parity	14.0 %	2.8%	32.1%	33.5%	17.6%	100.0%

*Missing data from 2 respondents

One hundred and twenty women having their first baby (40.5%) and 57 women having a subsequent baby (23.6%) used epidural analgesia (Table 35). Ninety three women (17.6%) used a mixture of medical pain relief including epidural analgesia; therefore the percentages within these groups may have been higher. A chi square analysis showed a statistically significant association between parity and pain relief used. ($\chi^2 = 59.474$. df = 4 p< .0005).

Table 36 shows that when the type of pain relief used was cross tabulated with the site where women gave birth there was a higher rate of epidural analgesia in one city hospital with 82 women (48.0 %) compared with 60 women (28.7%) in the other city hospital. There were differences between the rural sites also with 20 women (39.2%) and 15 women (15.3%) in the other rural hospital availing of epidural analgesia. Associations were found between the type of care that women availed of and their choice of pain relief as shown in table 37.

Table 36. Site and Pain Relief Used Cross tabulation

Site		Pain relief used					Total
		No pain relief	Non medical pain relief	Pethidine/ Gas and air	Epidural	Mixture of above	
city 1	Frequency	25	3	33	82	28	171
	% within site	14.6%	1.8%	19.3%	48.0%	16.4%	100.0 %
city 2	Frequency	31	4	69	60	45	209
	% within site	14.8%	1.9%	33.0%	28.7%	21.5%	100.0 %
rural 1	Frequency	13	4	53	15	13	98
	% within site	13.3%	4.1%	54.1%	15.3%	13.3%	100.0 %
rural 2	Frequency	5	4	15	20	7	51
	% within site	9.8%	7.8%	29.4%	39.2%	13.7%	100.0 %
Total	Frequency	74	15	170	177	93	529
	% within site	14.0%	2.8%	32.1%	33.5%	17.6%	100.0 %

Respondents using public maternity care had higher rates of different pain relief choices with the exception of epidural analgesia. Those who availed of non medical pain relief comprised the lowest percentage 2.8% (n= 15).

Table 37. Type of Care and Pain Relief used Cross tabulation

Type of care		Pain relief used					Total
		No pain relief	Non medical pain relief	Pethidine/ Gas and air	Epidural	Mixture of above	
Public	Frequency	42	10	105	72	54	283
	% within Type of care	14.8%	3.5%	37.1%	25.4%	19.1%	100.0%
Private/ S.Private	Frequency	32	5	65	105	³ / ₉	246
	% within Type of care	13.0%	2.0%	26.4%	42.7%	15.9%	100.0%
Total	Frequency	74	15	170	177	93	529
	% within Type of care	14.0%	2.8%	32.1%	33.5%	17.6%	100.0%

Ten women (3.5%) who availed of public maternity care, and 5 women (2.0%) with private/semiprivate care used non medical pain relief. The

percentage of public care users who availed of epidural analgesia was 25.4% (n=72) whilst the percentage of private or semiprivate care users was higher at 42.7% (n=105). A Chi-square test indicated that there is a statistically significant association between the type of care and type of pain relief used. ($\chi^2 = 18.504$. df = 4 p< .001).

Table 38 shows that when pain relief was cross tabulated with women's reports of being happy with the birth experience, the small number who used no pain relief (n= 74) had the highest percentage of being 'very happy' with their birth experience (n= 45, 60.8%). Most women who used gas and air/pethidine (n= 150, 88.2%), and epidural analgesia (n= 151, 85.4%) also described themselves as being 'happy' or 'very happy' with the birth experience. Eleven women of the 23 who described themselves as 'not happy' with the birth experience had availed of the epidural analgesia (48%). Eighteen women were 'not at all happy' with their birth experiences and the 6 women (33.3%) within this group had used Pethidine/Gas and air.

Table 38. Pain relief used and happy with experience Crosstabulation

Pain relief used		Happy with experience					Total
		Very happy	Happy	Not sure	Not happy	Not at all happy	
No pain relief	Frequency	45	17	5	4	3	74
	% within Pain relief used	60.8%	23.0%	6.8%	5.4%	4.1%	100.0%
Non medical pain relief	Frequency	5	7	1	2	0	15
	% within Pain relief used	33.3%	46.7%	6.7%	13.3%	.0%	100.0%
Pethidine/Gas and air	Frequency	73	77	10	4	6	170
	% within Pain relief used	42.9%	45.3%	5.9%	2.4%	3.5%	100.0%
Epidural	Frequency	84	67	12	11	3	177
	% within Pain relief used	47.5%	37.9%	6.8%	6.2%	1.7%	100.0%
Mixture of above	Frequency	38	34	13	2	6	93
	% within Pain relief used	40.9%	36.6%	14.0%	2.2%	6.5%	100.0%
Total	Frequency	245	202	41	23	18	529*
	% within Pain relief used	46.3%	38.2%	7.8%	4.3%	3.4%	100.0%

8.4 Summary of Findings

The major findings of the study are as follows. The majority of the respondents were married, with a mean age of 32.35 years, were 'White Irish', with an education above leaving certificate level, and with slightly more respondents having their first baby. Whilst most women expressed a degree of difficulty in completing the DCERI, the most frequent time taken to complete the survey was 15 minutes or less.

The cross tabulations identified some associations between the childbirth variables and demographics. Over half the respondents did not receive any information about any other models of maternity services. Women were mostly 'happy' or 'very happy' with childbirth experiences, there was no association noted between women's feeling of worry prior to the birth, and their feelings of happiness with birth experiences, or between the type of care, or the age of the baby. There were no significant differences in demographic characteristics and responses to childbirth experiences by parity, educational level or hospital site, but those experiencing a normal birth were more likely to be happy or very happy with their birth experiences.

Epidural analgesia was the most frequently used form of pain relief followed by pethidine/gas and air and very few women used non-medical pain relief. The small group of women who used no pain relief had the highest percentage of being 'very happy' with their birth experiences. Women who availed of epidural analgesia were mostly birthing for the first time; and used private/semiprivate care. Most women who had no pain relief had given birth before.

The type of care that women availed of appeared to have several statistically significant associations. Women who availed of public care had predominately more normal births than those who availed of private and semiprivate care. Those who availed of public care were less likely to have an emergency caesarean section or an instrumental birth. Women who had private or semi private care had over double the

percentage of caesarean sections in addition to a higher rate of instrumental births. Women who availed or private/semiprivate care also had statistically significant higher rate of epidural use, perhaps due to the higher caesarean section rate.

The site of birth was associated with the type of pain relief used, with differences in rates between sites. The highest percentage of women who availed of epidural analgesia was in a city hospital but this was closely followed a rural hospital. Women were mostly happy with their birth experiences, those who experienced normal births being the mostly likely to report being 'happy' or 'very happy'. Women who gave birth by caesarean sections were most likely to be 'unhappy', with those having an assisted birth most likely be 'unsure' about their birth experiences.

The respondents were a relatively homogenous group in terms of their demographic profile. There were some statistical differences between those who used public care and those who used private/semiprivate care.

The following chapter begins with the ranking and rating measures of the birth experience attributes, followed by the DCE analysis. The open questions from the DCE are also analysed and the data is integrated.

Chapter 9

Analysis and Findings

9.0 Introduction

The analysis of the discrete choice experiment (DCE) in this chapter was designed to elicit personal preferences for childbirth experiences of women who gave birth in two rural and two city hospitals in Ireland. The purpose of this chapter is twofold: to describe the DCE analysis and results, and to present the results of the qualitative responses to open questions in the DCE. The chapter begins with a description of the data analysis from the DCE, including the rating and ranking measures. The thematic analysis of the open questions is then described and incorporated with the findings from the DCE. The chapter concludes with a discussion of the findings integrating data from the DCE, open questions and Focus Group interviews (FGIs). The demographic data reported in Chapter 8 is included where appropriate.

Women's preferences for attributes of childbirth experiences were explored using the following methods.

1. Simple rating exercises to establish which level of each attribute women preferred (Table 39), how important the attributes were (Table 40), and a ranking exercise to find their most preferred attribute (Table 41).
2. The DCE analysis where respondents considered eight choice sets and chose between scenario A or B.
3. Qualitative data in response to open questions asking whether respondents wanted to make further comments on their childbirth experiences and about the choices they were asked to make.

9.1 Preferences for Attribute Levels

The rating exercise (Table 39) presented all the attributes and their levels to establish women's preferred level for each attribute prior to completing the DCE. The advantage of asking about preferences for levels is two fold. It can act as an introduction to the concept of choosing between levels of the attributes and in addition can be used as an indicator of convergent validity.

Table 39. Preferences for Attribute Levels

Attribute	n	%
Individual Care		
1. Care is individual and personal to me	444	84.0
2. Care is routine	84	16.0
Availability of Pain relief		
1. I can have all types available at all times	406	76.9
2. I can have all types of pain relief at all times but I may have to wait 3 hours for epidural	41	7.8
3. I can have all types of pain relief but no epidural	23	4.4
4. I can have non medical pain relief only	58	10.9
Midwife		
1. The midwife works in partnership with me	507	96.0
2. The midwife does not work in partnership with me	21	4.0
Interventions		
1. I get on in labour with no routine interventions	233	44.0
2. It does not matter how many routine interventions I have	295	56.0
Decision Making		
1. Staff go ahead and make decisions for me	28	5.3
2. Staff make decisions but keep me informed	96	18.1
3. Staff discuss things with me before coming to a decision	319	60.4
4. I am in control of decisions	85	16.2
Presence of Consultant		
1. a midwife is with me during labour and birth and the consultant present only if needed such as in an emergency	325	61.6
2. A midwife will be with me during labour and the consultant joins the midwife for the birth only	203	38.4

Table 39 shows the most frequently preferred attribute levels. Women were more likely to prefer individualised care, all methods of pain relief to be available at all times, and a midwife who works in partnership with them. Women's responses were more equivocal in relation to interventions with a slightly higher percentage unconcerned about how many interventions they experienced. Women mostly preferred a discussion prior to coming to a decision and involvement of a consultant in an emergency only.

Table 40. Rating the Importance of Attributes

Attribute	Very Important		Quite Important		Not at all Important	
	n	(%)	n	(%)	N	(%)
1. Midwife/partnership	470	88.5	54	10.2	4	0.8
2. Decision making	431	81.2	89	16.8	8	1.5
3. Pain relief	418	78.7	106	20.0	4	0.8
4. Individual care	408	76.8	108	20.3	12	2.3
5. Interventions	227	42.7	272	51.2	29	5.5
6. Presence of consultant	145	27.3	253	47.6	130	24.5

Women were asked to rate the importance of each attribute individually (without reference to other attributes). Table 40 shows that most women considered partnership with the midwife, decision making, pain relief, and individual care to be 'very important'. Interventions and the presence of the consultant were considered very important by just 42.7% (n=227) and 27.3% (n=145) respectively. Over 50% of women indicated that the use of interventions was 'quite' but not 'very' important. The presence of a consultant was the only attribute that 130 women (24.5%) did not consider at all important.

Table 41 shows the results of the ranking exercise where women were asked if they could be sure of having just one of the six attributes, which they would choose.

Table 41. Ranking Preferred Attributes

Attribute	n	(%)
1. Pain relief	142	26.8%
2. Individual care	123	23.3%
3. Midwife/partnership	106	20.0%
4. Decision making	98	18.6%
5. Presence of consultant	46	8.8 %
6. Interventions	13	2.5%
Total	528*	100

* Missing data from 3 respondents

Pain relief was most frequently chosen as the preferred attribute, followed by individual care and partnership with the midwife. Presence of a consultant and interventions were ranked fifth and last respectively, hence were least frequently cited as the preferred attribute. Similar to the ratings exercises, ranking introduces the concept of choosing between attributes, and can be used as an indicator of convergent validity. The results are compared with the DCE findings in the next section.

9.2 Preferences for Attribute Levels and other Variables

The responses to women's preference for attributes above were cross tabulated with variables of parity, hospital site, type of birth, and qualification but no significant differences between groups were found, with the exception of the attribute 'presence of consultant'. Women who had private/semiprivate care were more likely to prefer the consultant to be present at the birth 83% (n=234), than women who had public care 37% (n=91) respectively (Table 42).

Table 42. Medical Presences and Type of Care Cross tabulation

Type of care	At birth	Emergency only	Total
Public	91 (37%)	155 (63%)	246
Private/Semiprivate	234 (83%)	48 (17%)	282
Total			528

There was no association between parity and the preferred attribute however there was an association with marital status. Choice of pain relief was the preferred attribute for single women whilst working in partnership with the midwife was most important to married women and those living with partner.

Interestingly, there was little difference between the type of care availed of and the preferred attribute. Women with public care chose individual care in slightly higher percentages (n=70, 24.8%) than women with private/semiprivate care (n= 53, 21.5%). The consultant presence was chosen by a higher percentage of women with private/semiprivate care (n=33, 13.4%) than those with public care (n= 13, 4.6%) (Table 43).

Table 43. Type of Care and Preferred Attribute Crosstabulation

Type Of care	Most important attribute						Total
	Individual care	choice of pain relief	partnership	interventions	decision making	consultant presence	
Public	70	81	57	6	55	13	282
	24.8%	28.7%	20.2%	2.1%	19.5%	4.6%	100.0%
Private Semi Private	53	61	49	7	43	33	246
	21.5%	24.8%	19.9%	2.8%	17.5%	13.4%	100.0%
Total	123	142	106	13	98	46	528*
	23.3%	26.9%	20.1%	2.5%	18.6%	8.7%	100.0%

* Missing data from 3 respondents

The results of the ranking and rating measures are discussed in the next section alongside the DCE findings

9.3 Analysis of DCE Data

The DCE approach allows identification of which attributes are significant determinants of the values individuals place on them. By giving the attributes different values, it becomes possible to determine their relative importance (size of coefficient estimate). The DCE allows respondents to choose one scenario over another by weighing up the differences between the attributes and their levels. The analysis identified to what extent the attributes for the experiences of childbirth have a significant impact in the decision to choose between experience A and experience B as outlined in the DCE scenarios (Louviere *et al.* 2000). The design described in chapter 7 is a fractional factorial experimental design because it is not feasible to use all possible combinations of all the attributes and levels. The fractional design had 16 scenarios which, Street and Burgess (2004) proved, have the properties of near-optimal (94.4%) statistical efficiency for parameter estimation for a model of main effects.

A main effect is defined as the direct independent effect of each attribute upon the response variable choice, - independent of all other attribute effects (Hensher *et al.* 2005:116). The main effects additive model used derives a linear combination of the weights of each level of all attributes. It is standard practice with the DCE to assume a linear function. A fixed-effect logistic regression was performed on the data and coefficients were estimated. The significance level was 5%. The utility function can be estimated using this model, which shows the utility that individuals obtain from a given combination of attribute levels.

From the regression model the following was determined:

- Which attributes were considered important to the birth experience? If the coefficient of the attribute was found to be significant at the 5% level then it could be assumed with relative certainty (95%) that respondents considered it to be important.
- The relative importance of each attribute. The size of the coefficient made it possible to determine the importance of one attribute relative to another and its influence over utility.

9.4 Coding and Interpretation of Data

Data were coded as outlined in Appendix XV111 and STATA (www.stata.com) was used to calculate a main effects model. Interaction effects tested differences in preferences due to hospital site, parity and education using a logistic condition (fixed effects).

In order to estimate a choice model, data that indicate chosen and rejected alternatives as well as the set of alternatives (i.e. the choice set) are required (Louviere *et al.* 2000). This is accomplished by the creation of a number of variables for each attribute being coded (Hensher *et al.* 2005). The number of new variables created is equivalent to the number of levels of the attribute being coded minus 1 (the base level). The coding and interpretation used for the attribute

'decision making,' for example, consists of four levels therefore it is necessary to create three variables, from 'least to most'. At level '0' staff make decisions, and at level '3' women make decisions. The recoding of the levels of attributes was adjusted to reflect a base level denoted by '0', and 'higher' levels of 1, 2 and 3 for these variables are coded as 1. Dummy codes denote the existence of a particular attribute with a one and its absence with a zero (Hensher *et al.* 2005). Dummy codes were therefore applied as level 1=1, level 2= 1, and level 3=1. The effects are then measured per unit of change.

According to random utility theory, when choosing between scenarios X and Y, respondents choose the alternative that leads to the higher level of utility (Hanemann 1984). Hence the respondent will choose scenario Y over scenario X (the base alternative) if the utility associated with scenario Y is greater than the utility associated with scenario X.

The general form of the utility model estimated is:

$$V_{in} = \sum_i \beta_i X_{in} + \sum_p \psi_p W_{pn}$$

Where V is the utility associated with a birth experience in for individual

X_{1n}...X₆ are attribute levels impacting on the birth experience.

W is a vector of individual characteristics associated with women's birth experiences, β_i the coefficient estimates for each attribute in the matrix (1-10) and ψ_p the coefficient estimates for personal characteristics.

A linear form of the utility function describes utility as a function of a constant plus each of the attributes. The general model is outlined below:

EQUATION (1)

$$V = \mathbf{ASC} + \beta_1\text{ind_care} + \beta_2\text{interv} + \beta_3\text{dec1} + \beta_4\text{dec2} + \beta_5\text{dec3} + \beta_6\text{painr1} + \beta_7\text{painr2} + \beta_8\text{painr3} + \beta_9\text{consult} + \beta_{10}\text{partner}$$

The linear additive model means that: utility is derived from the constant (ASC) plus individualised care, plus intervention, plus decision making 1,2,3, plus pain relief, 1,2,3, plus consultant presence, plus partnership. The alternative specific constant (ASC) was used as a parameter for a particular alternative to represent the role of unobserved sources of utility (Hensher *et al.* 2005). The ASC for an alternative captures the average effect on utility of all factors that are not included in the model.

The size and statistical significance of coefficient estimates determine the relative importance of individual attributes. The sign (positive or negative) on the estimates provides the direction of the effect. Generally, the higher the size of the coefficient, the greater the importance of the attribute in determining overall utility. A positive sign indicates that as the level of the attribute increases per unit of change, so does the utility derived whilst a negative sign indicates that as the level of the attribute increases the utility derived from that attribute decreases. The coefficients can therefore be used to estimate the relative importance of the attributes to one another. The effect on overall utility of changing the level of an attribute by one unit is indicated by the size of the coefficient. The significance levels of each of the coefficients indicate whether or not the attributes have an important impact on the preferences or utility (Ryan 1996).

9.5 DCE Results

The demographic characteristics of respondents have been reported in the previous chapter. A summary of the coefficients and the associated p values are presented in Table 44. Based on the sign (plus or minus) and significance of the regression coefficients, four of the six attributes were found to have a significant impact on women's choices of scenarios. We see that individualised care is significant, interventions and decision

making at levels 1, 2, 3, are not significant. Whereas pain relief at all levels, consultant presence and partnership with the midwife are significant and hence may be deemed to have an effect on utility.

Table 44. Model 1 Basic Main Effects

response	Coef.	Std.Err.	P> z	Significance
asc	.0935753	.036	0.010	
ind_care	.292	.038	0.000	significant
interv	.0192	.036	0.594	not/significant
dec1	.061	.063	0.334	not/significant
dec2	.043	.071	0.546	not/significant
dec3	-0.073	.063	0.249	not/significant
painr1	.897	.067	0.000	significant
painr2	.872	.067	0.000	significant
painr3	1.620	.078	0.000	significant
consult	-0.116	.036	0.002	significant
partner	.995	.042	0.000	significant

Conditional (fixed-effects) logistic regression Number of obs. = 8466

LR chi2 (11) = 1236.99; Prob > chi2 = 0.0000

Log likelihood = -2315.8336 Pseudo R2 = 0.2108

The coefficient results for each attribute are discussed below alongside individual ratings of the attribute levels seen in table 39; ratings of the importance of attributes in table 40, and their ranking for comparative purposes are depicted in table 41.

9.5.1 Individual Care

The coding of data is shown in Appendix XV111. The first attribute in the basic effects model was a choice between care that is either routine at base level '0', or care that is personal and individual to you at level '1'. The positive coefficient means that the level 1 'individualised care' is preferred to the base level of 'routine care'. Individualised care has a positive coefficient of .292 and is significant as the p value = .000.

Therefore women were more likely to choose scenarios that had a level 1 (individualised care) over a scenario that had level 0 (care is routine); and it is therefore an important element of the birth experience.

The response was congruent with the rating tool where 84% (n=444) of women preferred individualised care to routine care 16% (n=84). Four hundred and eight women (76.8%) also rated individualised care as very important. When women were asked to choose one of the six attributes, individualised care was ranked second with 23.3% of respondents (n=123) choosing it as their preferred attribute. This attribute was clearly important to the birth experience.

9.5.2 Interventions

The base code for interventions was that women would progress in labour without intervention, or '0,' and level '1' indicated that 'it does not matter how many interventions.' Whilst the analysis indicates that the coefficient was positive the difference, at 0.594, did not reach a statistically significant level. Women did not choose scenarios with level 0 (no interventions) over a scenario that had level 1 (it does not matter how many interventions). In the context of the DCE the numbers of interventions were therefore not an important element of the birth experience for most women.

The attribute level ratings showed that 56% of women (n=295) chose 'it did not matter the number of interventions' whilst 44% (n=233) preferred to 'get on in labour with no interventions'. However 42.7 % (n= 227) rated interventions as very important, 51.2% (n=272), quite important and 5.5% (n=29) percent of respondents thought interventions were not at all important. This attribute was ranked last of the six attributes with just 2.5% (n=13) of respondents considering it their preferred attribute.

9.5.3 Decision Making

The base level for this attribute '0' was 'staff make decisions for you'. Levels 1, 2, 3, are relative to 'staff make decisions for you,' with the

respondent taking increasing responsibility for decision-making. However, all levels of decision making were found not to be significant and would therefore not have an impact on participants' choices between scenarios A or B.

The rating exercise found that most women preferred staff to discuss things with them before coming to a decision (n=319, 60%), but only a minority wanted to be in control of decisions (n=85, 16%), and 96 women (18%) preferred staff to make decisions but wanted to be informed. The least preferred level was 'staff make decisions for you' (n=28, 5.3%). Although 81.2% of respondents (n=431) rated this attribute as 'very important', in the context of the DCE the attribute was less important than other attributes. When confronted with choosing one attribute, decision making was ranked fourth of the six attributes with 18.6% (n=98) choosing decision making as their preferred attribute.

9.5.4 Choice of Pain Relief

Choice of pain relief was coded as outlined with the base level of 'only non medical pain relief available' coded as '0', or base level, relative to subsequent levels of increasing availability. The next level, all types except epidural (painr '1'), was significantly important of itself with a coefficient of .897 with $p = 0.000$, therefore women would be more likely to choose scenarios with 'all types of pain relief except epidural' over a scenario that had the base level of 'non medical pain relief only' (painr 0). Moving to the next level (all types available but a wait of 3 hours for epidural (painr '2'), was significant with a similar co-efficient of .872 $p=0.000$. Moving from non medical pain relief to the final level where all types of pain relief are available all the time (painr '3') was the most significant with a coefficient of 1.62 ($p=0.000$). Hence, moving from the base of 'only non medical pain relief available' (painr= 0) to 'all medical pain relief except epidural' (painr 3) seems to have the highest impact on the choice between scenarios. Therefore, relatively speaking, any additions to levels of availability of pain relief that women were offered are more preferred and they are more likely to choose an option

that offers increased availability of pain relief. All types of pain relief being available all the time is the most important attribute, clearly having the highest impact when it came to women choosing between scenario A and B.

Congruent with the rating scale, most women preferred the availability of all types of pain relief the entire time (n=406, 76.9%). Whilst the results of the DCE established an exponential rise with increased levels of the attribute, the rating scales demonstrated slightly different ordering between women's preferences for the levels of the attributes. Table 40 shows the next most preferred level was for non-medical pain relief (n=58, 10.9%) followed by a wait of 3 hours for epidural (n=41, 7.8.%) with the least favoured option being all types of pain relief but no epidural (n=23, 4.4%). Pain relief was rated as very important by 78.7% (n= 418) of women. Congruent with the DCE results, pain relief was also ranked first of the attributes with 26.8% (n=142) choosing it as their preferred attribute. Choice of pain relief was therefore clearly the most important attribute of the birth experience for most women.

9.5.5 Presence of a consultant

The base level for the presence of the consultant was 'present only in emergency' whilst the consultant being at the birth was coded as 1. The coefficient has a negative sign indicating that, as the level of the attribute increases, the utility derived from that attribute decreases. Women's preference therefore was to have a consultant present in an emergency only and this impacted on their choice of scenario. Women were more likely to choose a scenario where the consultant was present in an emergency only over a scenario where the consultant was present at the birth. The coefficient was -0.116 p= 0.002.

The rating tool confirmed that women's preferences were for a consultant being present in an emergency only (n=325, 62%), rather than for the birth only (n=203, 38%). One hundred and forty five women (27.3%) rated the attribute as very important. However it was ranked fifth of the six attributes with just 8.7% (n=46) of respondents

ranking the presence of a consultant as their preferred attribute. The ranking measure in this case differed from the levels in the DCE where the consultant was present at both levels and respondents decided which level they preferred. The differences in the results therefore could be a product of the way in which the levels were set.

9.5.6 Partnership with the Midwife.

The base level for this attribute, 'the midwife does not work in partnership with me' was significant in relation to level 1 'the midwife does work in partnership with me'. This attribute was important for women per unit of change, with a coefficient of .995 at a p level of .000, which was significant. This was the second most important attribute of the birth experience. Women valued this attribute highly, and chose scenarios where they were more likely to work in partnership with the midwife.

The rating exercise similarly found that women preferred the midwife to work in partnership with them (n=507, 96%), whilst only 4% (n=21) did not. Partnership with the midwife was rated as very important by the highest percentage of women at 88.5% (n=470). The attribute was ranked third of six attributes, with 20% of respondents (n=106) ranking partnership with the midwife as their preferred attribute. Partnership with the midwife was clearly an important element of the birth experience for women.

9.6 Interaction Models

Interaction effects occur when the preference for the level of an attribute is dependent on the level of a second attribute (Hensher *et al.* 2005:116). Although main effects are of primary interest, interaction effects can provide insights otherwise not possible, and either ignoring or assuming non-significance of interactions in application can be dangerous (Louviere *et al.* 2000). A logistic regression model was undertaken to identify interactions between the site where the woman gave birth and the attributes identified in the DCE. The impact of parity and education were also explored.

9.6.1 Interaction and Site

An interaction model was carried out to estimate whether the preference for levels of attributes was dependent on where women had given birth i.e. either in a rural or city hospital. Most of the coefficients in relation to the attributes as shown in Appendix X1X, were similar to the main effects models, therefore one could interpret that there are other factors (rather than the rural/city) that are more important, as the interaction model is consistent and similar to the basic model.

9.6.2 Impact of Parity on Preferences

An interaction analysis of parity demonstrated differences in relation to three attributes: individual care, the consultant being present in an emergency and working in partnership with women. Certain attributes were of slightly more importance to women who had already had a baby (Appendix XX). Having individualised rather than routine care, for example, had an effect on women's choices of scenario in the multiparous group but the coefficients were similar to the main effects model (Coefficient .292 and .263). Multiparous women were also more likely to choose a scenario where the consultant was present for an emergency only (Coefficient -.011 and -1.58). Working in partnership with the midwife (Coefficient .995 and .970) was also significant in the impact it had on whether women chose scenario A or B. However, the overall model was similar to the main effects model and significance values were similar with few differences between the coefficients.

9.6.3 Impact of Education

The final interactive model explored the impact of education on women's preferences for the attributes. The interactive model was again consistent with the basic effects model with little difference between the coefficients with all attributes as seen in Appendix XX1.

9.6.4 Validity Issues

Internal consistency was measured by using a 'dominant pair' or practice scenario where all attributes of one scenario were the same as the other

with the exception of one: 'partnership with the midwife'. This attribute was chosen because the FGIs established that this attribute was particularly important to the birth experience and it was postulated that women would prefer more rather than less of this attribute. The monotonicity test involved *a priori* identification of a pseudo choice, which contained one clearly superior option. Of the respondents, 97.5% (n=515) chose 'partnership with the midwife,' with all other attributes held equal, and 2.5% (n=13) of women chose 'no partnership with the midwife'.

Convergent validity was assessed by relating it to other measures of the same construct to which it can be expected to relate. The simple ranking and rating measures discussed above were congruent with the DCE analysis.

9.7 Summary of DCE Results

In summary, based on the size and significance of the regression coefficients, the analysis clearly identifies the four most important attributes of the childbirth experience. The DCE established that women set clear priorities, preferring all types of pain relief to be available to them at all times, having individualised care, midwives working in partnership with them, and the consultant present for emergencies only. Decision making during labour and the use of interventions were not significant elements of the childbirth experience when women were confronted with scenario choices. There was little impact on women's choices when the interactions of hospital site, parity, and education were considered. The attribute 'pain relief' in particular influenced women's choices with additional levels of availability increasing the likelihood that women would choose scenarios with those options. This attribute had the highest impact on the choice between scenarios. The findings of the regression model suggest that the second most important attribute was 'working in partnership with the midwife' followed by individualised care and the least important attribute was decision making.

9.8 Open-Ended Questions

The following section outlines the analysis of the qualitative comments from the open questions and their integration with the DCE results. Women were given an opportunity to comment on two occasions:

1. A general comment following the demographic information asking women if they wanted to add anything about their experiences of labour and birth
2. Following each choice set, including choice 1 which was a 'practice choice'

9.8.1 Practice Choice

Choice 1 was a 'practice choice' where the attributes and levels of both scenarios were the same apart from one see Appendix XV111. The 'practice choice' was inserted so that women had an opportunity to practise reading through a less complex choice set in addition to testing their comprehension and rationality. The practice choice was inserted following an example of a finished choice in order to help respondents to become attuned to the survey method in addition to 'monotonicity testing' (see section 9.9). One hundred and seventy respondents (32%) wrote comments following the 'practice' choice. There was a high level agreement about the rationale for choosing partnership with the midwife, for instance: "because I would want the midwife to work with me", whilst several respondents referred to previous experiences that underlined the importance of this attribute. "Working together made me feel more than just a number." Some respondents were not entirely happy, stating: "A would be better but still not very convinced " and : "NEITHER OF THESE !", however scenario A was ticked.

9.8.2 Comments Following Choice Sets

Women seemed to have taken time in reading the scenarios and made comments such as "Experience A is more personal", "Experience A is more of a team effort with me at the centre", "Experience B is perfect for me", or "just like my experience". One woman commented "the best

of both worlds - choice of all pain relief and partnership with midwife". The rationale for choices were in the majority related to pain relief "decision was made on pain relief available", "pain relief is the most important", "no epidural sounds horrific", and "non medical pain relief useless," "just give me my epidural!" Other comments suggested contrary opinions "did not want epidural", "would prefer non medical pain relief," "no intention of having epidural, had really bad backache last time".

9.8.3 Integration of Data from General Comments

When considering the integration of data from the general comments I was guided by Onwuegbuzie and Teddlie's (2003) description of analytical techniques from which interpretations are made either in a parallel integrated or iterative manner. The comments were interpreted iteratively using thematic analysis as described for the FGIs. Although it was not intentional to have an 'embedded design' – where one set of data provides a supportive role secondary to the other type of data (Creswell and Plano Clark 2007, Creswell 2003), the amount of data generated from the open questions required integration into the overall study.

Comments were transcribed into a column in the SPSS data base. Each group of choice set comments was scrutinised in order to establish whether there were any patterns in relation to individual scenarios, or consistent comments in relation to attributes. No consistent patterns could be identified. Most comments were made in the general comments section, and these were analysed thematically as explained in the next section.

Thematic analysis was utilised to quantise data because, in the context of mixed methods, such analysis has the potential for a more comprehensive means to legitimate findings (Tashakkori and Teddlie 1998), and is in keeping with the feminist framework of the study. Sandelowski (2001) concurs, suggesting that by quantising data emergent patterns are more clearly identified by displaying information

numerically, which can also help in clarifying meaning. The analysis of open ended responses was sometimes challenging due to the brief, decontextualised and sometimes sparse content. Disadvantages of open ended questions can include difficulties such as disparate topic responses making standardisation and reduction into codes very difficult (Dillman 2007), although this was not the case with the general comments.

The open questions were intended to, and provided, women with an opportunity to specify and elaborate on their experiences in addition to illuminating the rationale for their choices, and elaborate and explicate why certain elements of childbirth were important to them. From the experience of the FGIs, I was also aware that many choices would not be 'cut and dried' and that contextual links were important for both women and the researcher, bearing in mind the feminist framework within which the research is situated. Dillman (2007) suggests that there is a 'social exchange' involved in respondents answering surveys where they may feel a responsibility to reply to written survey instruments, similar to a social interaction with another person. There was a sense from many of the questionnaires of an interaction of some type rather than a simple cognitive exercise. Some responses were written in capital letters or followed by exclamation marks to emphasise the points being made. One questionnaire included a 'good luck' card and several included good wishes for the study completion.

9.8.4 Analysis of Qualitative Data

The responses to the open-ended questions were analysed using a qualitative method of thematic analysis as described in Chapter 4. Ethical issues and issues of rigour and transparency were adhered to. The data were viewed by two researchers, one being an experienced qualitative researcher (CB) who independently reviewed and concurred with the categories generated.

A comment was defined as a word clause or sentence containing a single attitude consisting of a feeling or cognition (Miles and Huberman 1994).

The responses to the open-ended questions were coded thematically and content analysed using adapted guidelines by Coliazzi (1978). Significant statements from each description that directly pertain to the phenomenon were extracted (Appendix XX11). Meanings were formulated from these significant statements and were organised into descriptive themes (Appendices XX111 and XX1V). I developed an initial set of themes, and examined the theme categories for consistency in meaning and context. Five hundred and five comments were made. Eight major themes were identified from general comments on aspects of the birth experience (Table 45).

Table. 45 Frequency of Themes and Number of Comments

Themes	Frequency	No. of comments	Percentage of total
1. Aspects of care	78	151	30%
2. Pain relief	58	94	19%
3. Support	38	50	10%
4. Description of childbirth	43	70	14%
5. Interventions	24	37	7%
6. Environment	29	67	13%
7. Expectations/information	14	25	5%
8. Survey	7	11	2%
Total	291	505	100

Table 45 shows the number of comments that were made for each theme. Respondents commented on more than one theme therefore the total number of comments outnumbered the frequency of the themes. 'Aspects of care' was the most frequently commented on theme followed by 'pain relief,' 'description of childbirth' and 'support'. The following section provides a description of commenter's and non-commenter's selected characteristics cross tabulated with the identified themes.

9.8.5 Respondents

Two hundred and ninety one women (54.9%) commented, with remarks ranging from two words, to four or five sentences, to one page.

Comments were transcribed and typed into a column of the SPSS programme and were coded numerically 1-9 reflecting the identified themes 1-8 with an additional code for those who did not comment. The codes were re-entered into the SPSS programme. Thematic frequencies could then be identified in addition to any emergent patterns in relation to the sociodemographic and attribute data. In order to identify potential patterns between themes and demographic characteristics, comparisons were made between themes relating to parity type of birth, qualification and the site where women gave birth.

9.8.6 Characteristics of respondents

The highest response rate was from women in a rural hospital with a 'no comment' rate of 8.8% (n=21) and the lowest response rate was from a city hospital with a 'no comment' rate of 38.8% (n=93). Two hundred and forty women (45.1%) did not comment. Primigravidae were slightly more likely to comment than multigravidae (n=157, 53% and n=134, 46% respectively). Table 46 shows that the most common area for comment for both groups was in relation to the theme of 'care' followed by 'pain relief'. Primigravidae were slightly more likely than multigravidae to comment on environmental factors (n = 18, 11.5% and n = 11, 8.2%), and interventions (n = 15, 9.5%, and n = 9, 6.7%), respectively.

Table 46. Parity and Themes Crosstabulation

Parity	Support	Description of childbirth	Interventions	Environment	Pain relief	Care	Information / Expectations	Survey	Total
Primigravida	18	24	15	18	31	42	6	3	157
	11.5%	15.3%	9.5%	11.5%	19.7%	26.75%	3.8%	1.9%	100%
Multigravida	20	19	9	11	27	36	8	4	134
	15%	14.2%	6.7%	8.2%	20.1%	26.9%	6%	3%	100%
Total	38	43	24	29	58	78	14	7	291

Table 47 shows that the lowest percentage of those who commented (n = 6, 2%) did not have any qualification, whilst the highest percentage were those with a certificate/diploma (n= 95, 32.6%). The number of respondents did not, however, increase exponentially with educational level. Those at degree and postgraduate level were also less likely to comment.

Table 48 shows that when the qualitative themes were cross tabulated with the respondent site, within the total comments from each site the most frequent comments were about 'pain relief' and 'care'. Women in city 1 commented more frequently about pain relief (n = 26, 25.7%) whilst those from city 2 had proportionally more comments related to environmental factors (n= 16, 13.8%) and women in rural 1 site were more likely to describe their childbirth (n = 11, 26.2%). Respondents in rural hospitals were less likely to comment on interventions than their city counterparts.

Table 49 shows that when the type of birth was cross tabulated with the qualitative themes a similar focus amongst all types of birth was related to 'pain relief' and 'care'. Within the group of women who had a caesarean section, women were more likely to describe their childbirth experience (n=10, 21.8%).

Table 47. Qualification and Themes Crosstabulation

Qualification	Themes from general comments								Frequency (percent)
	Support	Description of childbirth	Interventions	Environment	Pain Relief	Care	Expectations /information	Survey	
No qualifications	1	3	0	0	1	0	1	0	6 (2%)
Junior Cert.	0	3	0	2	3	9	1	0	18 (6.2%)
Leaving Cert.	10	3	4	3	14	13	1	1	49 (16.8%)
Certificate/ Diploma	13	20	10	9	12	24	5	2	95 (32.6%)
Degree	12	8	6	8	17	22	3	2	78 (26.8%)
Postgraduate	2	6	4	7	11	10	3	2	45 (15.5%)
Total	38	43	24	29	58	78	14	7	291 (100%)

Table 48. Comparison of Site and Themes from Open Questions

		Support	Description of Childbirth	Interventions	Environment	Pain Relief	Care	Expectations Information	Survey	% of Total comments
City1	Frequency % within site	8 (7.9%)	14 (13.9%)	10 (9.9%)	10 (9.9%)	26 (25.7%)	26 (25.7%)	7 (6.9%)	0	101 (34.7%)
City2	Frequency % within site	18 (15.5%)	13 (11.2%)	12 (10.3%)	16 (13.8%)	18 (15.5%)	32 (27.6%)	4 (3.4%)	3 (2.6%)	116 (39.9%)
Rural1	Frequency % within site	7 (16.7%)	11 (26.2%)	1 (2.4%)	2 (4.8%)	9 (21.4%)	9 (21.4%)	2 (4.8%)	1 (2.4%)	42 (14.4%)
Rural2	Frequency % within site	5 (15.6%)	5 (15.6%)	1 (3.1%)	1 (3.1%)	5 (15.6%)	11 (34.4%)	1 (3.1%)	3 (9.4%)	32 (11%)
Total		38	43	24	29	58	78	14	7	291

Table 49. Type of Birth and Themes Crosstabulation

	Support	Description of Childbirth	Interventions	Environment	Pain Relief	Care	Expectations/ information	Survey	% Total comments
Normal vaginal birth	27	28	16	19	38	48	9	6	191
% within type of birth	14.1%	14.6%	8.4%	9.9%	20%	25.1%	4.7%	3.1%	65.6%
caesarean section	5	10	4	5	8	10	3	1	46
% within type of birth	10.9%	21.8%	8.7%	0.9%	17.4%	21.8%	6.5	2.1%	15.8%
Instrumental birth	6	5	4	5	12	20	2	0	54
% within type of birth	11.1%	9.3%	7.4%	9.3%	22.2%	37%	3.7%	0	18.6%
Total	38	43	24	29	58	78	14	7	291

9.9 Description of Themes from Open Questions

In order to clarify the meaning of the themes, examples of quotes from the open questions are presented in the next section. Further excerpts are provided when integrating the data with the DCE and FGIs. The themes are presented in order of frequency.

9.9.1 Theme 1: Aspects of Care

This theme relates to comments about the quality of care that did not relate to support and pain relief. There were 151 comments about aspects of care, mainly descriptive accounts of staff, which were mostly positive. The majority of comments were about midwives, sometimes without contextual reference, describing them as "brilliant", "wonderful", "calm," "natural", "experienced" "compassionate", who "gave excellent care". Negative comments included midwives being "harsh", "unsympathetic", and "irritated by my crying", "talking over me," "nervous, consulting others all the time". Women seemed to be happy with midwifery care and suggested that "consultant not needed." Other comments related to 'staff'; being ignored by staff was likened to "rude shop assistant clattering around while I was cut open".

9.9.2 Theme 2: Pain Relief

This theme relates to women's descriptions of pain accessibility, and efficacy of pain relief. There were 94 comments relating to women's accessibility to pain relief, their rationale and context for the choice of pain relief and its efficacy. A third of women mentioned that pethidine and entonox were "useless" or "didn't work". The most frequently mentioned was epidural analgesia, generating 53 comments. Two thirds of comments were positive "would recommend it totally," "helped me feel comfortable," "relaxed," "in control". Ten women referred to having non medical or no pain relief. One woman commented that there was a lack of information about non medical pain relief, and complementary therapies "were not encouraged" whereas medical pain relief was "pushed at classes".

9.9.3 Theme 3: Support

Women described the support or lack of support that woman felt they received during labour and birth. There were 50 comments on the theme of support from professionals and also from their birth companion or partner. Although there were fewer comments about this theme than others, the remarks women made were emphatic and enthusiastic, sometimes poignant, with multiple exclamation marks. Words such as "AMAZING!!" and "fantastic" were used about the midwives, who made women "feel relaxed and at ease labour a lot quicker and easier than expected". Women said "my husband helped make the experience spiritual" and "great experience thanks to midwives".

A number of women had, however, been separated from their partner and some had been left alone, which made them feel very lonely and frightened. Twelve women said they did not have a positive experience, however, and wrote of the importance of continuity of personnel, instances of lack of support in labour and a midwife's lack of interest in the baby. One woman wrote how there was "better treatment for animals" than she had received. Some of the comments relating to lack of support also alluded to the few staff and the busyness of the unit

9.9.4 Theme 4: Description of Childbirth Experiences

Personal descriptions of the process of labour and birth and comments about physical and psychological experiences of childbirth were included in this theme. Seventy comments related to a description of the respondents' experience of labour and birth. Women gave contextual information, providing a synopsis of what had happened in addition to how this impacted on their experience. There were comments about the uniqueness of the birth with comparisons with previous birth, "no two are the same," "this was much better than before", "not as frightened this time".

Some women commented negatively about their experience and described the labour as "hard", "long and painful", or "scary", "terrifying", "traumatic, had to block it out" and "had c.s. so

disappointed". Some respondents described the effect that the experience would have on their future childbearing "wanted 2/3 children would seriously think about getting pregnant again". Mixtures of positive and negative comments were also made, such as "quick labour, unbearably painful but felt part of decision making control".

9.9.5 Theme 5: Interventions

This theme related to women's descriptions and comments about interventions such as induction of labour. There were 37 comments about interventions. Most comments related to induction of labour combined with comments about the desire for normal and natural labour with no interventions. Six commented positively about interventions "induced with twins was safest for babies", "intervention was important as baby was breech". Negative comments were mainly about induction of labour and episiotomies. One described her episiotomy as 'excessive' and another 'had no choice about the cut'. There were twelve comments about having natural birth and avoiding interventions. There were also some comments with a mixture of feelings towards the experience: "Induction meant experience was out of control but overall experience was good - care excellent".

9.9.6 Theme 6: Comments on Environment

The theme relates to external factors such as busyness and pressure on staff that impacted on the birth experience. There were 67 comments about environmental influences and their impact on the birth experience. Women who gave birth in rural areas commented positively, considering the environment to be more relaxed, whereas the city respondents commented on the busyness of the unit and aesthetic issues such as 'peeling paint'. There were fewer comments about lack of space and hygiene issues from rural respondents. Women described the environment as "relaxed", "safe" and "comfortable". Several women who had paid for private or semiprivate care were "disappointed" because they could not access a single room although they had "forked out so much money". There were some comments about hospital food and hygiene. All comments about the food were negative, describing food as

“awful,” “lacking in nutrition” and “terrible”. Comments about hygiene were negative apart from one positive comment describing the hospital as “very clean”. Others felt hygiene was “poor” or “one of the negatives” and “went home afraid I would get infection”.

9.9.7 Theme 7: Expectations/Information

This theme relates to comments women made about what they expected and what general information they received or did not receive. There were 25 comments on this theme. Women’s expectations were disparate, ranging from “knowing about pushing sensation,” “worried and anxious about birth”, to “everything was better than expected”.

9.9.8 Theme 8: Comments about the Survey

There were eleven comments on this theme. Eight women expressed “difficulty choosing” between the scenarios, most were positive about the survey “glad it is being done” and “glad to help” whilst several respondents commented that completing the survey helped clarify the most important attribute and said it “helped decide what is really important.”

9.10 Trading of Attributes

Concurrent to Lancaster’s (1966) economic theory of value women deliberated their individual preference for key characteristics when considering what alternative choices they would make. ‘Trading’ involves the sacrifice of one level on an attribute to achieve an increase in another. Women would therefore be willing to trade one attribute for another because they would be compensated for by having an increase in the level of another attribute (Ryan *et al.* 2000). Women appeared willing to trade and indicated that they understood they had to give up some elements of the birth experience in order to maintain others: “for decision making had to give up partnership with midwife” and: “this is the only time I would consider dropping the midwifery partnership everything else is perfect” or: “would prefer to work with midwife but no routine interventions and pain relief made me go with A”. Some

respondents felt in the context of choosing one attribute would ensure that other attributes be less important or considered their effects on the birth experience could be counteracted. For example, comments on a choice set included "the midwife working in partnership negates the fact that care is routine" and "If care is individual the rest will fall into place".

The marginal rate of substitution i.e. the amount of a particular item that must be given to a respondent in order to compensate exactly for the loss on one unit of another item (Hensher *et al.* 2005) was not determined because of the qualitative nature of variables. It could not be assumed that difference between levels were of equal importance, for example with availability of pain relief it is not possible to say how much better level 1 is over levels 2 or 3. Some respondents appeared unwilling to trade, making comments such as: "I would always forgo pain relief for midwife" and "although pain relief is important midwife working in partnership with me trumps everything else".

Qualitative comments sometimes indicated respondents' willingness or unwillingness to trade reflected their actual choices; however, some did not. An example of a respondent who appeared unwilling to trade and one who did not trade are given below.

1. Respondent 232. This respondent indicated that choice of pain relief would be the most important attribute to her and that 'pain relief would definitely influence my choices.' Following each scenario this respondent made a comment about the rationale for her choices. Her choices for each of the eight attributes appeared to be based on the highest level of pain relief availability therefore each choice reflected her comments, as follows:
 - Choice 1: 'all types of pain relief is important because you don't know how it's going to go on the day'.
 - Choice 2: 'Again pain relief is why I picked B'
 - Choice 3: 'What makes B attractive is all types of pain relief but also being in control the midwife working with and being in control of decisions'

- Choice 4: 'This time it's the care the pain relief and being in control of decisions that swung it.'
- Choice 5: 'This is almost perfect except for not being in control of your own decisions and the consultant not being present for the birth'.
- Choice 6: 'The pain relief is the all important and three hours waiting is a long time to wait if you're in pain'
- Choice 7: 'Again the pain relief swung it but three hour wait is a disgrace'
- Choice 8: 'Again the pain relief is the most important people should always be given the option of having an epidural'

This respondent demonstrated a dominant choice for pain relief. Interestingly this respondent indicated that she used gas and air only for her normal birth and described herself as 'very happy' with her birth experience.

2. Respondent 161. The respondent ticked 'working in partnership with the midwife' as the most important attribute. However within the scenarios and qualitative comments the availability of pain relief was not 'tradeable' and all choices were based on the scenario with the availability of the highest level of pain relief.

- Choice 1: 'Prefer A because would like to go into labour myself and have all pain relief available all the time'
- Choice 2: 'Prefer B but would like to have midwife work with me'
- Choice 3: 'Pain relief is very important would give up partnership'
- Choice 4: 'Again pain relief very important after my last experience'
- Choice 5: 'would trust staff with decisions'
- Choice 6: 'would have to pick A because of pain relief but midwives involvement would make a huge difference'
- Choice 7: 'would let staff intervene but would like to go into labour myself'
- Choice 8: 'Again pain relief is an important factor for me so had to lose partnership'

This respondent was aware that the attributes she would have to forfeit were important to her, but that the availability of pain relief was more important in many instances.

Some respondents appeared to demonstrate dominant preferences. i.e. they always chose the option with the best level of a given attribute and as such are termed 'non traders' (Ryan *et al.* 2000). The rationale for such choice behaviour is thought to be influenced by previous experiences and the complexities of decision making (Scott 2002) as demonstrated by respondent 232 (above). Dominant preferences are sometimes excluded from analysis but recent evidence indicates that the inclusion of respondents with dominant preferences does not disturb results (Neuman 2008); therefore they were included in this study.

9.11 Integrating Results

Table 50 shows a matrix of the attributes from the ranking, rating, and DCE coefficients. The integration of the results is explained in the context of the commenter rate of 54.9% (n=291), acknowledging that those who did not comment may have had a different rationale or perspective to those who did. The choices of attributes were based on evidence from the FGIs and the literature therefore it was not surprising that women rated all six attributes as very important in the rating exercises. The rating exercise did not provide any information with regard to the relative importance of each attribute. When women were confronted with choosing between attributes however, they clearly prioritised the three attributes that were found to be significant during completion of the DCE.

Table 50. Matrix of Attribute Importance Ranking, Rating, DCE Co-Efficient and Themes

Attributes	Preferred attribute ranked	%	Attributes rated as very important	%	DCE coefficients	Themes from general comments (In order of frequency)	%
1. Choice of pain relief	142	26.7	418	78.7	Significant	1. Aspects of care	30%
2. Individual care	123	23.2	408	76.8	Significant	2. Pain Relief	18.5%
3. Midwife/partnership	106	20.0	470	88.5	Significant	3. Support	10%
4. Decision making	98	18.5	431	81.2	Not Significant	4. Description of CB	14%
5. Consultant	46	8.7	145	27.3	Significant	5. Interventions	7.3%
6. Interventions	13	2.4	227	42.7	Not Significant	6. Environment	13.2%
Total	531	100				7. Expectation /information	5%
						8. Survey	2%

9.11.1 Compatibility Between Results

The most important attributes clearly identified by both rating ranking exercises and the DCE were similar, albeit with slightly different ordering as:

- Choice of pain relief
- Partnership with the midwife
- Individualised care

The DCE established that women valued some attributes considerably higher than others. This is an important finding in the context of providing an optimum birth experience for women, where the choice of pain relief combined with partnership with the midwife and individualised care are more important than the presence of a consultant, having routine interventions and being involved in decision making. The themes identified from the qualitative comments differed from the DCE attributes yet they encompassed similar elements. Aspects of care, for example, contained elements of partnership with the midwife, and being involved in decision making. The theme of support also referred to the relationship with the midwife. Consistent with my experience of analysis from the FGIs some themes overlapped with others. Environmental issues, for example, impacted on the availability of pain relief, on the quality of care and support and the relationship with carers, and subsequently impacted on the birth experience. The section below integrates the qualitative data with the DCE results and refers as appropriate to the demographic and FGI results.

9.11.2 Childbirth Experiences

It was not surprising that, in addition to the themes that related to attributes of birth experiences, women wanted to articulate their own birth experiences and convey their feelings, both positive and negative, about them. As identified in the concept analysis and the literature referred to in chapters four and five, women's childbirth experiences were intense and related to physical and psychological dimensions. Most

responses identified certain elements of the experiences that were 'good' and 'bad,' supporting previous research (Waldenstrom *et al.* 1996, Lavender *et al.* 1999), alongside the FGI analysis that identified simultaneous positive and negative feelings within birth experiences.

Descriptions of labour were often graphic, and it was evident that women felt strongly about certain issues with the addition of exclamation remarks and capital letters. The descriptions of childbirth experiences were mostly positive describing it as "incredible", "intense", "overwhelming", "special", "like nothing else", "thrilling" and sometimes credited the midwife and/or partner with helping to make the experience positive. Labour pain was described as "exhausting", "really painful," "excruciating," "terrible," "suffering," and "agonizing". Similar to the FGIs, women's views were often a mixture of positive and negative elements.

Women having their first baby were more likely to describe their birth experience than women who had already experienced childbirth (Table 47). Women who had given birth by caesarean section were more likely to comment and it appeared to be important to them to describe their birth experiences and to put their choices into context. Women in this group were less likely to be happy with their experiences as outlined in chapter 8, perhaps the DCE gave them an opportunity to convey their feelings. Women described being "so disappointed" as they had anticipated a normal birth whilst others expressed "relief after a long labour". The issue of intense physical pain and accessibility to all types of pain relief, both medical and non medical, was raised in the context of childbirth experiences. Similar to the FGI analysis, themes often overlapped and issues such as support and environmental issues impacted on choice of pain relief because of the pressure of busy units and lack of facilities.

9.11.3 Pain Relief

Availability of pain relief was clearly identified as the most important attribute with all types of pain relief being available all the time having

the most important influence on women's choices of scenarios, and therefore their utility. The DCE analysis clearly identified availability of pain relief as the attribute that had most impact on childbirth experiences. The increasing availability of pain relief – from non medical to all types of pain relief being available all the time, was the most important influence on women's choices of scenarios, therefore had the most impact on their childbirth experiences. The impact of parity, education or hospital site on preferences for pain relief was not significantly different in the DCE interaction model; therefore across all strata the choice of pain relief was considered an important element of childbirth experiences.

Both primigravidae and multigravidae commented in equal proportions on the availability of pain relief. The importance of pain relief was mirrored by the number of qualitative comments (n= 94, 18%) suggesting it was the possibility of being able to avail of all types of pain relief that was important to them. Although only 33.5% (n=177) of respondents availed of epidural analgesia it was the most frequently commented upon. Qualitative comments indicated that, due to previous experiences, women wanted pain relief to be available even if they did not avail of it and those having their first baby were anxious to have pain relief available also. Women having their first baby frequently commented they had been advised or "warned to have epidural" by friends, they were fearful about not being able to access epidural analgesia, stating: "feel happier with possibility of epidural", or "terrified not to have epidural". Women who were single or living with partner were more likely to rank pain relief higher than those who were married (Chapter 8).

Respondents felt strongly that "all choices should be available", and "pain relief is really important". Some women were unable to avail of their choice of pain relief for a variety of reasons such as "chart missing", "nobody available" or "no room available". Women from a busy city hospital were more likely to comment on the busy environment and its affect on their availability of pain relief. Some women perceived that

"staff did not want me to have an epidural" and felt they were made wait, similar to the data from the FGIs.

Few women used non medical pain relief. The demographic analysis (Chapter 8) identified that only 15 women (2.8%) availed of non medical pain relief. Some women described TENS as "useless". Women felt epidurals were 'pushed' at antenatal classes, and during labour had little support for non medical pain relief "staff did not know how to work the TENS machine". Positive comments such as "hypnobirthing empowered me to have no pain relief." "Mobilizing," "Pilates" and "yoga" were also mentioned. One woman wondered "if I had water could I have done without epidural".

Seventy four women (14%) had no pain relief (Chapter 8), and commented that they were "proud" to have no pain relief, or "glad to have done without epidural". Some women expressed appreciation about not being forced to have an epidural: "birth plan was respected," "felt better with no epidural," and "glad I was allowed get on without epidural." The data from Chapter 8 also found that women who had no pain relief had the highest percentage of being 'very happy'; with their birth experience.

Some comments reflected what women expressed in the FGIs - that despite being in advanced labour women felt they had missed out when they had to wait or did not have time to avail of epidural analgesia. Comments such as "quick labour no chance to get epidural," "wish I was told the most suitable time to get epidural," "8cms by the time I got it". There was an overwhelming sense from the comments that women felt deprived and anxious if access to epidural analgesia was delayed and that there was nothing that would ameliorate that feeling. Women intended to "definitely have one again", "couldn't do without it," and "thank God for epidurals!" Women described having waited for hours, and their relief when the epidural was administered helping them feel relaxed and in control.

Remarks made following the choice sets such as “no epidural sounds horrific”, “knowing there was a possibility” of the epidural and “such a relief” indicated that, even in advanced labour, the thought that an epidural was available was important to women. Some women on the other hand were pleased that they had managed without an epidural and did not want the choice. Alongside the DCE, the qualitative comments reinforced what the FGIs had also established, that availability of pain relief was one of the most important elements for the birth experience.

9.11.4 Partnership with the Midwife

The DCE analysis found that partnership with the midwife had a significant impact on women’s choices of scenarios. This attribute was the second most important in the DCE analysis therefore had a higher impact than individual care, consultant’s presence, decision making and interventions. In addition to the significance of this attribute from the DCE analysis, the qualitative comments provided contextual information about the importance of women’s relationship with the midwife encompassed by the themes of support and aspects of care.

The theme ‘aspects of care’ referred to relationships with staff and mostly referred to relationships with midwives. Similar to the FGIs, partnership with the midwife was seen as an individual relationship that developed in a particular context with individual needs and priorities and negotiated outcomes. One woman commented “had three different midwives all were good in their own way”. The majority of women spoke of the support of midwives, who were described as “pleasant and supportive”, “reassuring”, “encouraging”, “wonderful!!”, gave “excellent caring” , “helped me make decisions” and that the help and support that they provided was “crucial”, “respectful” and “vitaly important to happy and safe delivery!!”

Respondents were sometimes critical of midwives when they perceived they did not listen when women had concerns that they were progressing swiftly in labour, and the consequent effect on their birth experiences. Comments such as midwives “disbelieving”, “staff did not

listen" with a "rushed delivery" and "almost gave birth alone". The 'aspects of care' reiterated what many women said in the FGIs and the DCE that mentioned the support and care of midwives and their importance to birth experiences. Respondents commented that having a familiar face was important to the development of a relationship and changing personnel was an issue for some ; for example, "had three midwives would have liked just one", "paid for semiprivate but disappointed with different personnel"; ...this affected labour and made it "difficult to keep rhythm of labour". Environmental factors such as a busy unit also impacted on the relationship and the attribute was aspirational for some women; "partnership is the ideal but they are too busy."

9.11.5 Individualised Care

The DCE established individualised care as a significant attribute that influenced women's choices of scenarios. Individualised care was clearly an important element of women's childbirth experiences. The thematic analysis did not specifically identify individualised care, but it was referred to explicitly and implicitly under the themes of 'support' and 'aspects of care'. Women commented on being left alone especially in early labour, feeling frightened and, as one woman said, "like a number" with "no individualised care". However comments such as "the midwife helped make my experience special", were made. Midwives were important to individualised care, women felt "like I was the only one giving birth", and were trusted, they were "honest about the delay getting epidural". Women appreciated the midwives' support and trusted them feeling "confident" and "in good hands", particularly in a new city unit where they had "total privacy" and one midwife caring for them. A minority commented that midwives did not take much notice of them and their labour was "all in a days work". Another woman remarked that her partner had been told to go home and she "felt so alone". One comment suggested a "culture of individual care needs to be fostered, another encapsulated women's expressions that "if you have individual care the rest will fall into place". Similar to the FGIs, the busy unit was

often mentioned as a reason for not having individual care; one comment was “staff are too busy to see you as special.”

9.11.6 Presence of Consultant

This attribute was significant in the DCE in that women wanted a consultant in an emergency only. Although only 46 women (8.8%) identified the consultant as being their preferred attribute, it was ranked 5th (Table 41), 145 women (27.3%) rated their presence as being ‘very important’ (Table 40). The demographic analysis found that consultant presence was more important to women with semiprivate care than those who had public care (Chapter 8). Although the attribute was a significant one according to the DCE there were few comments about consultant’s presence and those that were made were within the theme of aspects of care and support. The qualitative comments provided a range of opinions. Women commented positively about “their consultant,” describing their presence as “reassuring,” contributing to “feeling safe” and “present every step of the way”. Critical comments about consultants mostly related to their absence for women who had paid for private or semiprivate care. A minority of women said they “never saw consultant,” “my consultant not there”; one remarked “consultant at conference!”, whilst another wrote “dissatisfied with consultant – waste of 3K”. There were several comments expressing surprise that the consultant was not present at all and how much midwives did; one comment was: “consultants overrated”, and “midwife care is all you need”.

9.11.7 Decision Making

The comparison with the ranking and rating exercise following the DCE result pointed to ‘Decision making’ as being relatively unimportant in the context of the DCE. Although, in rating the attribute levels, 60% of respondents identified that they would like to be involved in decision making, (Table 39), few qualitative comments provided information about this attribute. Comments included “happy for staff to make decisions”, “too tired” or “don’t want anyone making decisions for me”. Some comments about interventions included references to lack of

discussion around decisions related to induction of labour and episiotomies. Women felt they did not have a choice when it came to interventions, with some women describing a "lack of discussion", "just a brochure", and "more discussion needed". Decision making was ranked fourth as the most important attribute (Table 41), and 81.2% (n=431) considered the attribute 'very important,' (Table 40). Therefore in the context of the DCE respondents were more likely to prioritise other attributes. As identified in the discussion about dominant choices, the few respondents who did comment had very strong feelings in relation to decision making. It appears that women were willing to give up this attribute in order to gain other elements of childbirth experiences that they wanted.

9.11.8 Interventions

The analysis of this attribute was complex with a mixture of results from different measurements (Tables 39, 40, 41). In the context of other choices the DCE established that interventions were not significantly important to the childbirth experience. The ranking of attributes found that only 13 women (2.5%) identified interventions as their preferred attribute. Conversely, when women were asked to rate attribute levels individually 227 (42.7%) considered the attribute 'very important', 253 (47.6%) 'quite important' and only 29 women (5.5%) considered interventions 'not at all important'. There were thirty seven comments (7%) about interventions mostly referring to induction of labour, including feelings of being excluded from decisions around particular interventions. Some comments related to lack of intervention: "left too long before having c.s." and "should have had episiotomy to avoid bad tear". Others felt pressurised into having interventions with one respondent suggesting "you have to be assertive to have no interventions". Women mentioned not liking the treatment by a doctor who wanted her labour to be accelerated and another wrote of being "threatened with caesarean section by doctor". Induction of labour elicited mainly negative comments: "persisted for three days with different people examining me every few hours"; women described feeling "bitter", "out of control", and that the induction was "painful" and

“traumatic”. Women felt their views were not always taken into consideration, using phrases such as feeling “stressed and frustrated,” and “pressurised” and “body not ready, did not want induction”, “left me no energy for labour upset about that”.

Women also expressed a desire for “natural birth with little interference”, “less invasive births are the ideal for me”, or “disagree with active management”. Interpretation of the quantitative data alone could suggest that women were ambivalent about interventions; however, the qualitative data suggest that women’s preferences for interventions were not ambivalent as respondents expressed strongly held preferences, some positive and some negative. It was the manner in which interventions were instigated that often mattered. Resonant of the FGI data, whilst individuals expressed preferences for natural childbirth with few interventions, women also felt that any interventions would be instigated in their interest therefore, in the context of DCE, other elements of childbirth experiences were more important.

9.11.9 Environment

Although this was not a feature of the DCE, an additional theme identified in the comments related to the physical building and the busyness of the units where women gave birth and this impacted on all aspects of their birth experiences. The majority of comments were about the pressure staff were under in addition to remarks about the building and hygiene. Similar to discussions in the FGIs, comments related to the lack of capacity in addition to structure of the building. The hospital was “bursting at the seams,” “cramped,” “overcrowded” with buildings described as “shabby and dirty”.

Women were worried about the capacity of the hospital to accommodate them for labour and birth, and knew that they would have difficulties being admitted: “reluctant to admit because of shortage of beds”. Several comments from city hospitals similar to FGI discussions suggested strategies used to access the hospital quickly “waited outside in early labour until it became established” or “slept in car”. One woman

was discharged and gave birth on her return journey “delivered on the side of the road”. The lack of space affected their care; “induction was delayed 3 days - no beds” “unable to get epidural no room available”, “stressful arriving in X as no beds”, and “rushed out of delivery room”, and “rushed to labour ward”. Respondents “felt we were in the way”, “difficult to get care when they are so busy”, “waited for hours worried about progress”, “no monitoring, bordered on neglect”, and “rushed out no skin to skin contact with baby”. Women also commented on difficulties establishing relationships with midwives due to staff being busy and, similar to the FGIs, commented on being alone and frightened in early labour. Women in both city hospitals commented on the lack of privacy and having to labour in the corridor or in a ward “labouring in public waiting for admission”, which they found “embarrassing in front of everyone”. The stress staff were under impacted on women themselves but also on others as they “felt sorry for new mothers”, and “empathised with staff” because “they were under such pressure care was bound to be affected”.

9.11.10 Comments about Survey

Completing the survey sometimes helped women to decide what their most important attribute was e.g. respondent 139 said “presence of the consultant is the most important” and after filling out the rest of the form “I feel pain relief is important to me also”. Women did express difficulties with being forced to make choices and sometimes expressed their unhappiness when they were forced to include attributes that they had to trade.

9.11.11 Expectations and Information

This theme was not an attribute identified for the DCE but emerged from the qualitative comments related to information and expectations of childbirth. Women articulated feelings of worry prior to the labour and birth but suggested that information and education prior to the labour and birth often ameliorated these feelings. Women suggested “preparation is essential” and made comments about “being in the right mindset”. There were several comments on the acquiring of information

“preparation is key”, with an emphasis on “psychological preparation”; antenatal classes women felt should be “mandatory”, and “clear advice minimised anxiety”.

9.12 Reflection on DCE and Childbirth

There is a paucity of literature investigating the possible effects of combining open and closed ended questions. Research exploring the specific effect on responses to open-ended questions when preceded by closed-ended questions is limited (Vitale *et al.* 2008). The existing research evidence indicates that the manner and context in which questions are asked influences its answer (Peterson 2005). The general comments were placed between the sociodemographic information and the choice sets; however, responders may have previously read the survey and this may have influenced their responses.

There are also few examples of open questions being used as part of the DCE, although one study was followed by a semi-structured interview to evaluate respondent understanding of the scenarios (Kenny *et al.* 2003). The qualitative comments enhanced my understanding of women’s rationale for their choices in the DCE. The women who responded to the DCE were a relatively homogenous group as discussed in Chapter 8. The DCE choice sets were sometimes subtle with little difference between choices therefore women may have experienced difficulties in its completion. Women who provided qualitative comments were mainly from the middle strata of educational achievement. The survey was approved by the National Adult Literacy Agency (NALA) therefore should have been accessible to most women; however, it was only available in English so women who did not speak English were unable to respond.

A response rate of 59% was calculated for the return of the questionnaire. The time and effort that women spent completing the survey and their comments indicated that they felt strongly about childbirth and wanted to help with the research; however, the response rates may have been affected by the ‘forced choice’ method of the

survey that does not allow an indifferent response as some women commented that they would like 'neither scenario' or 'a mixture of both'. The survey had been piloted extensively and, in response to feedback, amended to include encouragement to complete throughout the process. Over 97% of women completed all the scenarios, a higher response rate than a similar study (Hundley *et al.* 2001). Similar to previous studies this indicates a high acceptability of the DCE for women using maternity services (Hundley *et al.* 2001, Longworth *et al.* 2001, Pitchforth *et al.* 2008).

The linear additive model was estimated, which means that preference for any attributes are independent of the level of other attributes. However, interactions between qualitative attributes may be present. For example, if a respondent had 'partnership with the midwife,' they might think that the midwife would not allow any unmet need for other attributes such as decision making and interventions. Interaction terms were not included in this model but may be worth considering in future work.

There was evidence that some women did not 'trade'. Economic theorists attribute responders' failure to make trade offs to a variety of effects. Choices are not always made on the basis of maximising utility rather a wide spectrum of influencing factors including responders' emotional and psychological states can be related to choice decisions (Araña *et al.* 2008, Ratcliffe and Longworth 2002). Hsee and Rottenstreich, (2004) conceive that choices made by individuals are an interplay of two paradigms; valuation by utility and valuation by feelings. Consequently, emotional and affective components of making choices may affect the linearity of economic theory. Childbirth is an emotional process therefore women may be apprehensive about certain attributes such as having all available methods of pain relief available, counteracting other trading possibilities.

9.12.1 Impact of Experience on Attributes

Furthermore, the DCE choices were made in the context of hypothetical choices and the qualitative comments related to 'real' experiences. Previous studies suggest that in the context of DCE consumers 'prefer what they know'; therefore respondents who have experienced an attribute often rate it more highly than those who had not experienced it (Salkeld *et al.* 2000, Ryan and Ubach 2003). Similarly maternity services users have been shown to prefer the 'status quo' assuming that the services being offered are likely to be the best available (van Teijlingen *et al.* 2003). In economics this is known as the endowment effect and is postulated to be caused by a lack of information in relation to alternative attributes (Ryan and Ubach 2003).

There is some evidence that previous experience also affects preferences for attributes (Salkeld *et al.* 2000). Previous childbirth has been shown to have significant influence on choices for specific attributes (Neuman and Neuman 2007). This was apparent from some comments e.g. respondent 232 in example one above of a 'non traders'. She articulated that a painful birth experience influenced her decisions to the extent that all the scenarios were chosen on the basis of the availability of pain relief. In this study, however, when the interaction model of the DCE was carried out the impact of parity had little effect on the choices of scenarios.

9.12.2 Integrating Data

The themes identified from comments in the open questions reiterated many already identified in the FGIs. The corroborative rationale for mixed methods and its usefulness in helping us enhance the breadth and depth of our understanding (Johnson *et al.* 2007), is borne out by this study. Whilst the DCE provided the statistical analysis results, the general comments, in addition to those following each choice set, added an extra dimension to the research in contextualising the data. Although there were slight differences in the ordering of the attributes, those from the ranking exercise, DCE and thematic qualitative comments were in overall agreement. The qualitative comments in the open questions

added several themes relating to childbirth experiences that were important to women, and that would have otherwise been omitted. The theme of environment, for example, impacted on other attributes such as relationship with the midwife and the availability of pain relief.

The DCE analysis found that the attributes of decision making and interventions were not significant elements of women's childbirth experiences. In the context of the DCE, women appeared willing to prioritise other attributes. The qualitative comments added individual expressions from those who felt strongly about decision making and interventions, and how it impacted on their experiences. Ten respondents to the survey and four women in the FGIs stated that they were forced to have unwanted interventions, for example, and felt traumatised afterwards. In the context of feminist research the voices of individuals particularly those who express a minority opinion is important, and may have been unheard by a singular research method. It was evident that the data from the FGIs and the comments provided contextual information where women trusted that interventions would not be instituted unnecessarily, and therefore were willing to prioritise other attributes of the birth experience.

The comments indicated that, whilst statistical analysis, ranking and rating measures indicate the importance of certain attributes, there is evidence that a minority of respondents held different opinions that needed to be articulated. From a mixed method perspective, although the statistical analysis provides more stark numerical priorities, the qualitative comments allow for explanation and expansion of choices along with hearing the minority opinions that are not statistically represented.

9.13 Conclusion

The mixed methods approach yielded both 'soft' and 'hard' data providing valuable information about how women prioritised their attributes for birth experiences and the context in which they made their

decisions. Although women's experiences of childbirth have been acknowledged as an important part of maternity care, the provision of services continues to emphasise a model that prioritise morbidity and mortality to the exclusion of other factors. In the context of the recent review of maternity services in Dublin (KPMG 2008) and the increasing centralisation of services in larger centres as a means of providing more effective care, women's priorities may be different to policy makers who emphasise the availability of 'specialist services such as neonatal and medical facilities' (KPMG:69). In such instances the DCE can provide valuable information about what women require from the provision of maternity services. It would appear that services that enable partnership with a midwife combined with choices of pain relief and individualised care could provide an optimum birth experience for women.

The DCE appeared to be acceptable to women as a means of determining important aspects of the birth experience and the addition of open questions helped to clarify the rationale for women's choices. Women's birth experiences were not enhanced by all aspects of the prevailing model of care. It is evident from the DCE that some components such as the presence of a consultant and interventions and decision making were not valued by most women. It was evident that women may 'weigh up' their birth experiences differently to service providers. Interventions were interpreted or valued differently by women and were mostly seen as 'benign'. Further research is required in relation to qualitative attributes where the direction of women's preferences may not be as clear as in other areas of health preferences. The final section will discuss the results in the context of contemporary literature.

Chapter 10

Discussion and Recommendations

10.0 Introduction

The final chapter of the dissertation restates the rationale for the research and reviews the methods and philosophical framework used in the study. The main section of this chapter summarizes the results and discusses their implications in the context of contemporary literature. In the final section, recommendations are put forward for future research, education and policy initiatives related to improving women's childbirth experiences.

10.1 Rationale for Research

The rationale for this study sought to address the dearth of research about women's childbirth experiences in Ireland. The DCE approach was used because of its' ability to model preferences and their interrelationships, and therefore can develop new insights about preferences for the childbirth experiences. The use of an innovative sequential mixed method approach within a feminist framework challenged the notion of singular realities as defined by current biomedical approaches that have been restrictive in assessing important elements of childbirth experiences. A feminist analysis helped to uncover the subtleties of individual experiences that would otherwise remain unexpressed, in addition to revealing commonalities of shared experiences. Feminist standpoint theory enabled the identification and interpretation of the social and political contingencies surrounding women's childbirth experiences in Ireland.

10.1.1 Review of Research Question

The aim of the study: An exploration of women's expectations of and preferences for childbirth experiences.

Objectives:

1. To determine women's expectations for their childbirth experiences
2. To identify the components or attributes of childbirth that are important to women
3. To determine the relative value or utility that women assign to elements of their experience
4. To investigate the associations between women's preferences regarding childbirth experiences, and variables such as parity, age, and model of maternity care.

Phase one of the exploratory sequential design utilised Focus Group Interviews to address the first two objectives - to establish women's expectations and experiences of childbirth, and identify the components that are important to women. The second phase used information from phase one to develop the Discrete Choice Experiment. The DCE is an economics tool that was used to establish women's preferences for the attributes of their childbirth experiences and to determine the relative utility of those attributes. The DCE responses were analysed to discern which attributes were most important to women, and to identify associations with sociodemographic variables, addressing objectives three and four. The DCE also included open ended questions that provided contextual information. The depth and texture of data from both phases contributed to valuable and original insights into women's childbirth experiences in Ireland.

10.1.2 Summary of the Results

The study provided a unique blend of 'hard' and 'soft' data to describe the important components of childbirth experiences within a contextually rich milieu. The DCE coefficients established that whilst women valued all attributes, they set clear priorities. The most important attributes of childbirth experiences were the availability of pain relief, working in partnership with the midwife, individualised care and the presence of a consultant in an emergency only. Interventions and decision making were not found to be significant. The qualitative data provided

information that enabled more contextual interpretations of these findings. A minority of participants expressed the importance of decision making and interventions to their birth experiences. Women's priorities were also contingent on the environmental milieu within which they gave birth. The complementarity of both types of data highlighted that whilst women in this study mostly welcomed the availability of technology they simultaneously valued the provision of emotionally supportive aspects of labour. Women's experiences were complex, diverse and related to identified attributes, but were also framed by cultural, social and environmental influences. The study concluded that the biomedical outcomes that currently define the 'success' of childbirth in Ireland provide a partial picture of the realities of women's childbirth experiences. Childbirth experiences could have a profound affect on women with both positive and negative feelings expressed. The consequences for women ranged from exhilaration and feelings of empowerment to negative perceptions of their abilities and fearful attitudes towards future childbearing.

10.2 Feminist Standpoint Theory Revisited

One of the aims of feminist standpoint theory as outlined in Chapter 3 is to explore childbirth experiences to generate a female 'reality' to fill the knowledge gaps in dominant male discourse. In Gross's terms (1986:202-203) "feminist theory is not simply interested in reversing the values of rational/irrational or in affirming what has been hierarchically subordinated, but more significantly, questioning the very structure of binary categories".

The sequential mixed method design combined with feminist standpoint theory enabled childbirth experiences to be viewed through a wider 'lens', whilst acknowledging women as experts, validating their experiences as legitimate forms of knowledge. Standpoint theorists understand knowledge as situated; rejecting previous distortions of 'objective' reality, therefore 'seeing' from the perspective of marginalised groups. Feminist standpoint theory as outlined in Chapter

3, rather than producing abstract ideas, seeks to give descriptions of women's experiences including exhilaration, fear and pain. Women's verbal and written portrayals of their experiences as described in the FGIs and the DCE open questions were powerfully evocative, graphically depicting childbirth experiences as intense, emotionally and physically challenging.

The framing of the study from a feminist standpoint theory requires analysis from a theoretical and descriptive perspective. Analysis therefore requires interpretation of the location in which the experiences are constituted. Harding (1991) maintains that standpoints are not merely perspectives, suggesting that: 'it takes science and politics to achieve a standpoint' (Harding 1991:276). Ceci (2000) adds that understanding lived experiences is about the structure and relationships that construct those realities, and the meanings created from those contexts. The exploratory nature of the study has provided original insights and awareness of the influences that impact on childbirth experiences. Consistent with the socio political commitments of mixing methods (Greene 2006) outlined in the research design, the discussion and recommendations of the study are attempts to interpret those insights within contemporary socio political issues that shape women's childbirth experiences. The discussion refers to previous chapters including the DCE statistical data, qualitative data from the open questions and Focus Group Interviews (FGIs) to enhance the complementarity of data (Greene 2007).

The combined results of both phases of the study show that women's experiences of childbirth are complex, with a myriad of interrelating factors that form the web of the experience itself. Women's experiences in this study embraced a plurality of perspectives and multiple realities with a proliferation of voices even within individual experiences.

The complexity of the evidence demonstrates that any attempt to typify women's experiences would be to undermine their multidimensional meaning and significance. In this respect the DCE was able to establish

which elements of childbirth experiences were most important. Despite being aware of difficulties with essentialist categorisation of women's experiences, women across all groups and within both phases of the research in some instances shared 'common ground'. Bordo (1992) suggests different groups of women share a profound commonality of experiences that should not be overlooked. The integration of the data in Chapter 9 expanded on the quantitative data from the DCE to enhance and elucidate the rationale and context for the priorities that were identified.

10.2.1 Breaking from Binaries and Ditching Dichotomies

Childbirth experiences as discussed in previous chapters defy binary reductionist categorisation but consist of interlocking physical and emotional elements framed by social and cultural determinants. In the present study women's perception of childbirth and birth experiences were often couched within a medicalised framework of language and discourse. However, Davis Floyd's description of belief systems about childbirth as either 'technocratic' or 'wholistic' summarised as "to fully believe one is to fully disbelieve the other" (Davis-Floyd 2003:158), is not evident in this study. Women did not express belief systems within these mutually exclusive dichotomies but placed themselves at various points between the extremes. Women endorsed feminist assumptions of evading a singular reality of childbirth experiences. Whilst a minority of women subscribed to a technology-orientated belief system i.e. had a wholly 'medicalised' view of childbirth and another minority had an extreme 'wholistic belief system.' The findings from the current study emphasised to a 'middle of the road' approach, representing a 'pick and mix' stance located somewhere on the continuum between extremes. For example, some women adopted a mixture of 'natural' birth elements such as non medical pain relief but wanted to give birth in hospital in case of an emergency whilst others combined having a doula for labour support, but also utilised epidural analgesia at the end of labour (Section 5.8.9).

Women did not define their experiences according to the inflexible categories and unbending definitions of normality. Women expressed diverse definitions of normality extending to the inclusion of a spectrum of interventions and the use of epidural analgesia (Chapter 4). What was important to women was framed by what Wijma *et al.* (2002) describe as personal and external conditions. Women were anxious that they coped and managed the birth in the best way they could, but this was predicated on environmental factors such as support of staff and the busyness of the unit. In this study childbirth experiences were perceived within fluid parameters and could be altered by contextual factors. Women wanted, as one participant suggested, 'the best of both worlds – comfort and safety'. Women wanted reassurance (both physical and psychological) in the form of partnership with the midwife, individualised care, shared decision making, and the availability of a consultant in an emergency, combined with availability of pain relief and accepting interventions if required. The blending of flexible, emotional, physical and technological support enhanced women's experiences.

Congruent with Fenwick *et al.* (2005), the findings of this study support their conclusions that women do not choose or expect labour to be a medicalised event nor did they consider themselves 'passive objects of medical surveillance and management' (Annandale and Clark 1996:30). The significance of the DCE attributes coupled with the qualitative comments and the FGIs demonstrated that choice of pain relief, particularly epidural anaesthesia, and partnership with the midwife were most highly valued by women, followed by individualised care and the availability of a consultant in an emergency. The evidence from the open questions and the FGIs ascertained that attributes were not mutually exclusive. Women wanted a blend of attributes personalised to their own requirements that were contingent on the environment and the progress of labour. The present study provided a unique perspective from both the open questions and the DCE identifying the importance of the availability of technology such as ultrasound scans, monitoring, and all types of pain relief even if they were not utilised. Women wanted birth experiences that were 'as natural as possible' but did not want to be in a

position where they were locked into that decision and unable to change their minds.

Women's approach to childbirth in this study did not support Zadoroznyj's (1999) 'activist' or 'fatalistic' conclusions about social group differences. The DCE interactive regression model demonstrated that variables such as the hospital site, parity and educational attainment had little or no impact on women's preferences. This was also true of the FGIs, and the comments following each choice set (Chapter 9). There were no systematic patterns to account for differences between women's orientation towards childbirth and their demographic characteristics or experiences. The uniqueness of experiences was apparent, congruent with feminist analysis of a departure from universalising women's experiences and recognition of subjective differences among women.

Most women in this study viewed childbirth as 'normal', with the potential to become otherwise, rather than the biomedical view of birth as normal only in retrospect, but few women were totally committed to the 'natural' belief system. Although feminism is often aligned with 'natural' birth, criticising what is perceived as the male appropriation and medicalisation (Oakley 1993, Cahill 2001), other feminists are concerned with the equally essentialist tendencies to valorise natural birth (Beckett 2005). Natural birth can, indeed, emphasise another form of 'non medicalised' control (Zadoroznyj 1999). Women in this study did not want to be committed to either extreme, caught in the middle between competing ideologies (van Teijlingen 2005) or in a political ploy to contest medical control (Beckett 2005).

It should be borne in mind that the study related to hospital births and the study sample as outlined in Chapter 8 was relatively homogenous. Most women approached birth as 'knowers' in the system within which they are forced to work. Hence, for some women, being aware of the exigencies of the institution involved a survival strategy where women framed their choices in terms of restrictive medical hegemony. Conversely, women also demonstrated that they could strategise

proactively by using consensus building to form alliances and work within 'the system'. Strategies included opting for particular models of care, building relationships with midwives and 'managing them', refusing or insisting on certain types of pain relief, and locating their childbirth experience in institutions where they had access to technology. Those who were unaware or new to the 'system' (Chapter 4) were puzzled and angry about the limited choices that were available to them.

10.2.2 Uncertainty and Childbirth Experiences.

The concept of uncertainty is outlined in Chapter 4 where women in the antenatal FGIs expressed anxiety and trepidation about forthcoming labours, and filtered throughout childbirth experiences in the postnatal FGIs. Oakley observes that chance is seen as a 'feminine' nature in the Cartesian revolution, an unpredictable force with: "a tendency to disrupt the cerebral operations of man" (Oakley 2000:159). Feminine uncertainty therefore needs to be controlled and rendered predictable by man. The quest for certainty is an important goal of modern science (Downe and McCourt 2004). Part of the rationale for increasing technological interventions stems from a desire to overcome the uncertainty and inherent unpredictability of labour. Women, in adopting this frame of reference sought to reduce the uncertainty of childbirth in different ways. Women's descriptions of childbirth encompassed feelings of 'going into the unknown', 'horror stories', and a view of childbirth as 'a lottery' and a 'gamble'. The themes of 'goal setting', 'goal attainment', and 'contingency plans' identified in the antenatal FGIs demonstrated that women had ideal experiences in mind, however the process (goal attainment) was tempered by the 'unknown entity' of labour. The process by which the goals were achieved; the experience itself was less of an issue than the outcome, a live and healthy baby. Women were pragmatic about the use of interventions and technology and were often resigned to unmet expectations.

An important finding of this study is that participants did not appear to recognise the significance of their childbirth experiences, and consequently devalued them. When experiences did not meet their

expectations it seemed to be a price that women were willing to pay in order to have a healthy live child because 'you can't have everything'. The findings of the present study appear to agree with Oakley's (1981) observations that technologies imply a transformation in social relations by acquiring their own identities. Women in this study equated technology with safety and reliability whilst the labour itself was uncertain and uncontrollable. It seemed eminently sensible for women therefore to prepare for all eventualities. Young (1984) suggests that by valuing technology over subjective experiences, women are alienated from their own birthing experiences. Childbirth experiences therefore become less valued and technology becomes more 'real'.

An original finding in this study was that women felt they had to accept that their primary concern of a healthy live baby was achieved; how that came about was not as important as their experiences. The potential for childbirth as a 'rite of passage' and a transformative experience as outlined in the concept analysis was evident for some participants in this study, but appeared to be subsumed by uncertainties about the process for others.

10.2.3 Uncertainty and Pain Relief

The issue of uncertainty ebbed and flowed throughout the themes of the FGIs and caused anxiety at different stages of labour for different reasons. The complexity of pain and its significance related to childbirth experiences is discussed in previous chapters. Hodnett's (2002) systematic review of 137 reports exploring factors influencing women's evaluations of their childbirth experiences, found that attitudes and behaviours of caregivers were more powerful influences than pain relief and intrapartum interventions. In the present study however, women emphasised choice of pain relief as the most important attribute of the birth experience followed by partnership with the midwife.

Access to pain relief was also part of the complex network of influences identified in the theme of 'getting there' relating to women's anxiety about their progress in labour (Chapter 5). Women in the FGIs and

comments from the open questions reiterated that the prospect of not having pain relief available to them was 'terrifying' and 'horrific'. Women were influenced by their friends who 'warned' them to have an epidural. Although fear of pain was cited as one of the reasons for availing of an epidural woman also spoke of their isolation, being left alone, coupled with a need for control (Chapters 4,&5). Spiby *et al.* (2003) maintain that women may use pain relief as a strategy for coping with panic rather than for pain in unsupportive circumstances. The instances where women felt supported by midwives who 'engaged with them' (Chapter 4) was countered by those who also felt isolated and lonely.

Women's contributions support the complexity of the discussions in the literature about pain relief. However, many of the studies cited were carried out in areas where there was a potential for multiple choices with regards to the place of birth which impacted on the contextual influences of coping with labour pain, choices that were not available for women in the present study. The rationale for wishing to give birth outside the traditional hospital setting has been related to avoiding pharmacological pain relief (Hildingsson and Haggstrom 1999). In a medicalised system where women have little opportunity for choice and control, it could also be postulated that the availability of an epidural was one way in which women could perceive that they had some control (Devane *et al.* 2007).

Although women spoke passionately about many aspects of labour, pain relief was one area identified in both qualitative and quantitative data where women expressed the strongest views. Above all other attributes it seemed that women felt it was their right to have all types of pain relief available to them all the time. Although there is no legal right to pain relief in childbirth in the United Kingdom (Barnett 2007) or in Ireland, for these women it seemed unthinkable that epidural analgesia would not be available at all times.

Whilst some women construed 'natural childbirth' as one with no pain relief one FGI group discussed the relative 'normality' of epidural analgesia (Chapter 4). Although some women in the FGIs considered

pain to be a 'natural' part of childbirth they also thought that epidural analgesia should still be available, similar to data from Goldberg *et al.* (1999). Pain, as discussed in the concept analysis (Chapter 2), can be exacerbated by lack of support and anxiety. Individual support with home births and birth centres can help with individual supporting strategies, and alleviate the potential for discouragement from using personal coping resources and non pharmacological methods (Coyle *et al.* 2001, Spiby *et al.* 2003). Women in the present study did not appear to be aware of the possibility of using their own coping strategies or non pharmacological methods of pain relief. There was little encouragement for women to develop or investigate alternatives both antenatally, where epidurals were 'pushed,' and during labour when midwives were unable to help them apply TENS (Chapter 5). One of the ways in which women dealt with the uncertainty and loneliness, and for some to gain attention, was to 'demand' an epidural. Although epidural analgesia was available in all units, the delay for women or the unavailability of labour ward beds was distressing and women spoke about the 'relief' of having an epidural, even in advanced labour. The relief was also evident in the open question comments (Chapter 9).

Epidural analgesia was most frequently referred to and appears to have been the pain relief method of choice. For those who attempted to use non-medical pain relief their efforts were sometimes thwarted as staff could not, or would not, help them. Whatever type of pain relief women chose, withholding or delaying pain relief was distressing for women. One of the findings from this study was that some women were disappointed and felt deprived not to have had 'their epidural' because they progressed quickly in labour. Multiparous women in advanced labour said they 'demanded' and had 'their epidural'. For some women epidurals were normalised as part of the birth experience and they felt they had missed out by not having it. The epidural itself appeared to have become a 'rite of passage'. Traditionally, the medical model of birth has been accused of wanting to 'get rid' of the pain (Stern 1997), with pain cited as the cardinal fear of labour (Camann *et al.* 2002), advocating the widespread use and availability of epidural analgesia. The

results of this study are consistent with Leap and Anderson's (2004) observations that pain for women was mostly seen as something to be avoided or relieved mostly by pharmacological means. Most women did not ascribe any meaning to pain other than its avoidance, however for a minority of women experiencing pain was empowering and increased their sense of self-efficacy, and women felt proud to have managed childbirth without pain relief.

In this study, although an antipathy to childbirth pain was expressed, epidurals seemed to be a panacea for other uncertainties such as an element of choice, control, and a feeling of relaxation and serenity. It may be that, as Surtees (2004) suggests, the availability of pain relief increases the demand, or that as Leap and Anderson (2004) believe, to offer pain relief to women in labour is irresistible. Their suggestion that midwives adopting the 'working with pain' rather than the 'pain relief' paradigm can enhance women's belief in themselves (Leap and Anderson 2004), was often not feasible to women in this study due to the rushed environment and lack of support. A recent study comparing women's choices of pain relief in midwifery led and consultant led units in Ireland, concluded that when women were offered other options such as hydrotherapy and TENS fewer women chose epidurals (Begley *et al.* 2009). The reality of pain for women was individually construed. The availability of pain relief (even though it may not be used) reassured women and reduced uncertainty.

This was evident by the DCE attributes for pain relief being the most significant, women's comments about not trading the attribute of pain relief, combined with the FGI comments and those from the open questions. The interpretation of the DCE analysis suggested little difference with interactions of parity, education and site.

Although being left alone was inconceivable to women, the absence of supportive elements of labour appeared to be more understandable for participants in this study than access to all forms of pain relief. Due to the rushed environment, many women could not depend on the support

of staff and, as Mander (2001) suggests, women who avail of epidurals are less likely to rely on support from midwives. Hodnett et al. (2009) found that one to one care in labour and a more homely environment can contribute to lower epidural rates. It is not surprising therefore that being frightened, being in pain, being alone, not feeling supported and feeling out of control caused anxiety, which women sought to relieve by resorting to epidural analgesia. On the basis of these findings it appears that in the context of an institutional setting where women could not be certain of how they would cope with labour, what type of support they would receive, and how labour would progress, the availability of pain relief appeared to be one certainty that women felt they could cling to.

10.2.4 Interventions and Uncertainty

Women who welcomed interventions in this study did so because it offered them a degree of certainty, a sense of control, the promise of pain relief, a feeling of peace and safety, and an amelioration of previous 'bad' experiences. Others found interventions intrusive, unwelcome and distressing. The reductionist image of woman as machine prone to faults that can be repaired by interventions centres on a construction of birth as 'normal' or 'abnormal' alongside a continuum between health and disease (Oakley 1993). Whilst 'natural birth' is often associated with activity, labour that is managed is often characterised as passive. Women in this study rejected this typology, often accepting interventions on what they considered their own terms. Women were sometimes critical because interventions were not instigated more readily.

Although there were exceptions, the DCE analysis showed that most women in this study did not consider interventions an important attribute of the childbirth experiences – in the context of other attributes. The data from the FGIs and open questions established that women appeared not only to accept interventions they also expected them. Women in other contexts have expressed a desire for interventions and a high level of technology (Hundley *et al.* 2001), and did not view interventions negatively because they offer reassurance in

case of an emergency (Entwistle *et al.* 2004). Similar to their attitude towards epidurals most women viewed interventions as part and parcel of their labours.

Although interventions have been labelled as costly, dangerous, invasive and dehumanizing, ameliorating the potential for childbirth to be a significant life event for women (Wagner 2001) the current study found women had a different perspective. Many women in this study felt empowered and actively involved in the use of technology similar to Davis-Floyd's analysis (2003), whilst those who opted for a more natural birth, and succeeded, felt equally empowered. Analysed from a feminist consciousness that rejects singular truths and encompasses reflexivity, women's childbirth experiences require interpretation within a matrix of other interpretations. Women's apparent acceptance of interventions may have been related to their expectations. Sociological and ethnographic analysis suggests that interventions do not necessarily lead to dissatisfaction, related to congruence between women's expectations and experiences (Davis-Floyd 2003, Kornelsen 2005).

Most women approached childbirth with an open mind, being flexible and adaptable expressing a 'wing it and see' attitude, using technology as a 'safety net' to be used if required. Hauck *et al.* (2007:244) suggest that women's flexibility could be a compromise of ideals, where women's adoption of achievable expectations is a 'survival strategy' to lessen the dissonance between their anticipation and their actual experiences. Moreover, interventions have the potential to create a power imbalance between the woman and the professionals whilst alienating the woman from an empowering experience (Murphy-Lawless 1998). On the other hand, Davis-Floyd (1994) suggests that women will increasingly become empowered by technological interventions. Most women in this study accepted that technological intervention was almost inevitable therefore part of 'normal' childbirth.

Kornelsen (2005:1495) describes flexibility as a 'double edged sword'. She contends that by adopting a flexible strategy to an unknown situation such as childbirth creates the potential for the imperatives of

technology. However, flexibility in women's minds in the FGIs did not represent a bowing to medicalisation and accepting technology at the whim of a professional. For women experiencing a long labour who had 'had enough', they felt they had 'given it a shot'. In this study women rarely actively resisted technological interventions and accepted interventions. This was partly due to what they perceived as the inevitability of such a possibility but also because they trusted the professionals implicitly. Women seemed unaware of the potential for the cascade of interventions that persist even for women who are considered 'low risk' (Roberts *et al.* 2000, Tracy and Tracy 2003). Women were not unduly worried by having interventions and they did not appear to diminish their experiences. Women seldom related to the risks attached to interventions which were commonplace, therefore seemed to have been normalised.

Women on this study who had private or semi-private care had higher rates of epidural analgesia, caesarean section rates, and instrumental births (Chapter 8). Private care has previously been associated with higher levels of intervention, caesarean section, and instrumental delivery rates (Roberts *et al.* 2000), higher episiotomy rates (Shorten and Shorten 2000) and increased costs (Tracy and Tracy 2003). Women chose private care because they felt safe, had more access to technology, and they wanted to see a familiar face (Chapter 4). Although the presence of a consultant was not ranked highly in the context of other attributes, women who had private or semiprivate care valued the consultant's presence more highly (Chapter 9).

Women found that choosing private health care resulted in more personalised care; however, as Murray and Elston (2005) observe, private care is often dependent on highly technologised obstetric practices. An important element of the study highlighted that for most women this was part of the attraction of private care with increased access to antenatal ultrasound scans. It is difficult to extrapolate reasons for the higher caesarean section rates, but the notion that it was due to the propensity for obstetricians to intervene is simplistic. Perhaps

women were willing to accept interventions from a familiar face that they trusted. Women may have chosen this model of care because they shared their obstetrician's beliefs about childbirth and, as Howell-White (1999) suggests, endorse their practice as appropriate. Importantly however, the present study findings suggest that some women were disappointed that their expectations in regard to having private or semiprivate care had not been met and this impacted on their birth experiences (Chapter 9).

The DCE analysis established that women did not consider interventions to be an important element of childbirth experiences, although a minority of women expressed a vehement resistance to any interventions (Chapter 9). Women's apparent acceptance of the inevitability of interventions may be due to a societal perception of technology as a means of ameliorating risk. In all industrialised countries, the rate of obstetric interventions has been rising (Wagner 2001). Although women did not explicitly speak about risks related to childbirth, allusions to uncertainty, lack of control and the 'gamble' of labour implied that women had become attuned to labour as essentially 'risky'. The notion of a 'risk society' suggests that risk is not a choice that can be ignored, because it has become an 'inescapable structural condition' of modern society (Beck 1996:31). The pregnant body has been constructed as doubly at risk and women doubly responsible where blame for risk is projected toward the women (Lupton 1999). One cannot ignore the possibility that women's rationale for accepting interventions was framed by the presentation and/or interpretation of labour as 'risky' to women, who then became willing consumers of technology because, as Simonds and Rothman (2007) point out, this is how hegemony works. Jordan (1993) claims that in the context of technology women are 'inert' because they are not involved in operating or interpreting technology.

On the basis of this study women appeared to lack confidence in their own abilities to give birth without interventions. There were instances where women felt supported by professionals usually midwives who

encouraged them and boosted their confidence however these were in the minority. Women in both ANFGIs and PNFGIs spoke about the inevitability of interventions. The theme of uncertainty that permeated the focus groups in chapters 4 and 5 related to the uncertain trajectory of labour and doubts about how they would 'cope'. Chapter 4 demonstrated that women's expectations of birth were often couched by anxiety about labour seen as 'a gamble' described in section 4.16.5., where 'so many things can go wrong' (section 4.17.1.). The sub category of 'anxiety' (section 5.8.1.) related to women's vulnerability regarding specific interventions such as episiotomies and instrumental births. Antenatally women felt safer if technology such as ultrasound scans were frequently used feeling that one did not want to 'take any chances' (Section 4.16.4). Although many women aspired to childbirth without interventions women sometimes referred to their pregnant bodies as potentially dangerous 'nuclear reactors' where 'anything could happen' as conveyed in section 4.15.3. Although labour and birth without interventions was expressed as a desire it was mostly regarded as being unlikely. One ANFGI participant who was attending the DOMINO service explained her perception of the inherent 'naturalness' of labour and birth expressing confidence her own ability to give birth without any interventions (Section 4.15.4.), whilst other members of the group were sceptical about this. Another FGI participant who was determined to give birth without interventions did so despite what she expressed as a 'threat hanging over my head' (Section 5.8.6), that interventions would be initiated at any time. It could be inferred therefore that the professionals caring for her had no such confidence. Women who had given birth without interventions described themselves as being 'lucky' or 'getting away with it'. Although there were instances where midwives helped women birth without interventions such as instrumental births (Section 5.8.6), the discouragement that women felt they received in utilising non medical pain relief appeared to underline professionals including midwives lack of confidence in women's innate abilities. It is difficult to extrapolate the reasons for this. Participants in both phases of the research commented on the organisational imperatives of hospitals how busy midwives were, and how loathe they

were to add more pressure to the staff. Although the contexts were not always evident there was a palpable feeling that professionals caring for women lacked confidence in women's potential to give birth without interventions, and therefore did not instil confidence in them.

Women who managed to birth without interventions said they felt confident and proud of themselves and spoke of the influence of the relationship they had with the midwife that enabled them to birth. Those who had unwanted interventions were sometimes traumatised particularly if they were against their explicit wishes. Some women were however reassured by the availability of technology and welcomed interventions.

In this study women perceived and valued interventions and risks in different ways. A common concern for women was that the trajectory of childbirth could not be predicted, therefore it seemed sensible to women to 'cover all options'. Women used a variety of anticipatory strategies to enable them to achieve their ideal experiences but were prepared to have contingency plans (including the use of technology) if obstacles arose during the process. What was important to women was not what was done, but 'how it was done.' Women who wanted to experience a labour that was as intervention free as possible although they expressed disappointment were also satisfied that professionals would not intervene without cause. Participants in the FGIs referred to the manner in which interventions were initiated and how important that was for them. Women who retained a sense of control (section 4.17.2.), or who felt they had been given a chance before interventions were initiated were happy they had been given some degree of choice and involvement in decision making. In section 6.5.8., although the participant experienced an instrumental birth she felt that she had been supported and her wishes acknowledged, by giving her an opportunity to try to give birth on her own. The intervention was therefore on her terms and she was happier with that outcome. Women expressed both passive and active participation in decision making in different situations and sometimes adopted a 'wait and see' approach. The importance of

individualised care and being responsive to women's individual circumstances and need for support was reiterated. Although identified in the FGIs decision making was not identified as being one of the most important attributes in the DCE, therefore in the context of other attributes women appeared willing to forgo decision making in favour of other aspects of childbirth experiences. However the importance of individualised care and the need for support particularly by midwives would appear to indicate that when decisions such as the introduction of interventions had to be made women relied on health professionals to evaluate their individual needs to acknowledge their wishes. One FGI participant (Section 4.17.2.) and two respondents to the DCE referred to having no choice about interventions and two respondents said an episiotomy was performed against their expressed wishes. Women who had developed a relationship with an obstetrician or midwife and who was involved in a discussion about the intervention were much more likely to accept and felt less traumatised by the intervention although it may not have been their first choice.

One of the most important findings of the study was that at the heart of women's inability to question the use of interventions seemed to be a lack of realisation about possible negative consequences or, indeed, to imagine any other option. Women's reluctance to criticise what they had experienced seemed to be related to an inability to conceive of any alternative that could better enhance their birth experiences. There was also a noteworthy omission in this study of women's realisations of their own capacities to give birth. In the main, technology and interventions had become normalised, reliable, and safe.

10.2.5 Uncertainty and Decision Making

In the context of the DCE, decision making as an element of childbirth experiences was not important for most women. However, the comments from the open questions and those regarding interventions in the previous section, established that a number of women felt strongly about this attribute. The attribute of decision making was formulated in

the context of women expressing a need for control during childbirth (Chapter 6). The complexity of feeling in control as discussed in Chapters 2 and 5, is associated with women having 'mastery' through making major decisions themselves (Wright *et al.* 2000). The findings from the current study concur with Green's (1999) conclusions, where control can arise from feeling supported (i.e., by the midwife's presence) when it was wanted and when it was not, and from being able to hand over control or let the midwife take control when appropriate. Abdicating decision-making responsibility can be part of a wish for control (Green 1999). The present study supported those conclusions; whilst most women assessed themselves as having an active role in their experiences they were also happy to relinquish decision making as it was, in fact, the role of professionals in their view.

Although there are no comparative Irish studies, a conjoint analysis study comparing women's preferences between home and hospital births in the UK found that 'ability to make your own decisions' was more preferred by home birth rather than hospital birth respondents (Longworth *et al.* 2001). A Scottish DCE study of intrapartum care similarly found that decision making was one of the most important attributes for women alongside pain relief (Hundley *et al.* 2001), and Hodnett (2002) in her systematic review found that decision making was one of the most important factors related to satisfaction with childbirth experiences. Women in the current study differed, preferring attributes such as pain relief for example, which could be thought of as a product of decision making.

A number of interpretations are possible. The predominance of hospital births in Ireland could mean that for participants, decision making is constrained therefore it is not seen as a viable choice. Partnership with the midwife was one of the most important attributes, therefore women may have viewed decision making as part of that partnership and likewise decision making could be considered as integral to the 'individualised care' attribute. Alternatively, in the context of uncertainty, women deferred to 'authority', as in professional judgment,

to make decisions for them. The evidence from this study suggests that in busy hospitals, often with lack of professional support women felt unable to make decisions. There was evidence that women were unhappy when they felt they had no choice about interventions such as episiotomies (Chapters 4 & 9). The feminist ideals of childbirth having the potential to have long term emancipatory consequences (Leap and Edwards 2006) were not achieved for the minority of women in the study who expressed their unhappiness and helplessness with decisions made during childbirth. Women who espoused a commitment to 'natural' birth sometimes changed to adopt the 'irresistible metaphor' of the biomedical model (Machin and Scamell 1997) and they succumbed to interventions.

Given the complexity of factors that can impact on individual decisions, uncertainty in decision making as demonstrated in this study is perhaps inevitable. Having informed choice is a precursor to decision making (Leap and Edwards 2006). In previous sections, I have pointed to women's seeming lack of awareness of any potential disadvantages of interventions, and lack of knowledge about alternatives such as non medical pain relief, or the advantages of ambulation and adopting different positions during labour and birth. In the context of this knowledge vacuum, women may have felt unable to make decisions autonomously. The background within which women prioritised decision making also has to be considered.

Kornelsen (2005) found that choosing home birth was a preference to have control over decision making. In a context where home births are actively discouraged (O'Connor 2006) and women's conviction that the treatment they receive is the best available women trusted health professionals with decision making. Similar research in the UK showed that women also trusted health professionals to make decisions for them leading to 'informed compliance' rather than 'informed choice' (Stapleton *et al.* 2002).

From a sociological perspective, abdicating responsibility and control to medical practitioners is interpreted as an extreme form of “flexibility” where women actually feel powerless in the context of making complex decisions and allow others to make decisions for them (Kornelsen 2005). Murphy-Lawless (1998) agrees, suggesting that in the context of dominant ideologies such as medicalisation, women attempt to take control from a position of powerlessness and subordination. Women are also influenced by the prevailing discourse and birth culture within which they give birth (Davis-Floyd and Sargent 1997). It appears from this study that most women did not aspire to autonomous decision making due to a combination of factors. The busy, medicalised environment within which they gave birth, their lack of knowledge to make informed choices, their trust in professionals to make decisions for them, and the wider societal influences relating to risk may have been influencing factors.

10.3 Partnership with Midwives

The role of the midwife ‘being with woman’, endorsed by An Bord Altranais (2001), as the expert in normal births, implies both emotional and practical support for women throughout childbirth. The DCE established that partnership with the midwife was the second most important attribute of birth experiences. There is a myriad of research reiterating the importance of the relationship with the labouring women (Chapters 4 and 5). Rothman’s description of mutual participation (Rothman 1991), best illustrates the flexible and adaptable nature of the relationship with midwives that enhances women’s experiences. The qualitative data from the FGIs and open questions found that women’s attempts to achieve their ideal birth within a hospital system in this study could be helped or hindered by their relationship with their midwife, and in turn this was affected by the environment and culture of the institution. Women found that midwives often acted in a capacity of what Crabtree (2004), describes as ‘buffers’, by utilising tactics to lessen the likelihood of interventions such as operative deliveries and

interceding, for example by asking doctors to 'back off' (Section 5.8.6.) to give them more time in the second stage.

Midwives also supported women's belief systems of maintaining normality by covert means in a variety of ways akin to what Kirkham (1999) terms 'doing good by stealth'. Midwives' challenges to culture and practices were often implicit rather than explicit; therefore they maintained normality 'by stealth'. Although women in this study were often distressed because they were not admitted to hospital in early labour, it may have been a strategy by midwives to maintain normality and to lessen the probability of interventions. Women may not be aware of the rationale or understand the decision therefore, do not perceive that they are supported by the midwife. Instances like this were, however countered, where overt medicalisation was recreated by midwives in instigating practices that inhibited some women's quest for normality (Chapter 5). Similar to previous findings (Hindley and Thomson 2005), midwives often practised within a dominant culture of a medical paradigm, and women had to be assertive to resist interventions. In an Irish context midwives face difficulties in maintaining normality in labour due to pressure from peers, managers and institutions (Keating and Fleming 2008).

An important finding from the study is that, although partnership with the midwives was highly valued, women were often constrained from establishing partnerships until their designation as 'officially in labour' was conferred, which was also dictated by the needs of the busy unit. Prior to the official 'diagnosis' women often felt isolated and alone (Chapter 4). Although the relationship of the midwife was the fulcrum of many aspects of women's experiences, it was the wider interaction with 'the system' that often impinged on the formation, and the potential capacity, of this relationship. Women, particularly in busy environments, described their difficulties in initiating and maintaining relationships in this situation (Chapter 9).

10.4 Authoritative Knowledge

Previous chapters have discussed the way in which midwifery knowledge and practice is often limited, dominated by medical knowledge, confined by medicalised models of care, lack of support from colleagues, management, and governing authorities. Jordan (1997) observes that authoritative knowledge is not related to those in positions of power and authority but knowledge that is legitimised, produced, and reproduced within a community of practice. One system of knowledge then becomes accepted as the reasonable, shared, natural order i.e. the way things are, (Jordan 1993,1997), often leading to a diminution of other ways of knowing. Women seemed to acknowledge biomedical authoritative knowledge. Their acceptance of interventions and their apparent deference to professional judgement and authority seemed reasonable as it was what was believed in their social network and community. They regarded availing of interventions and the use of technology as common sense. As reported in the FGIs, it was only through the 'consciousness raising' by women who had experienced maternity services elsewhere that women began imagining that better or different forms of care could be available.

Harding (1991) suggests that women are conditioned into thinking their experiences lie to them, and are influenced by the conviction that the experiences of the dominant societal group produce more believable insight. In this study, although women were unhappy with elements of their experiences, they appeared to accept the biomedical meaning of success as 'a live healthy baby' even to the detriment of their childbirth experiences if necessary. The findings of the study suggest that, in adopting the prevailing biomedical priorities, women devalued their own experiences. The FGIs and open questions determined that women perceived they received the best care available, were loyal to the staff and to their experiences, and were reluctant to criticise as people were doing their best. Women in the FGIs who had experienced maternity care in other systems were the most likely to be critical of staff, who were defended by other members of the group (Section 5.8.1).

However, most women were critical of the system that caused staff to be so pressurised because that affected multiple aspects of care. A biomedical authoritative knowledge prevailed and was sustained by women's social network, and reinforced by the care they received.

Women in the FGIs spoke about their sources of information in section 4.15.4. Participants reported that the majority of information they received about labour and birth originated from their social network of relatives and friends. Participants reported that 'horror stories' were a commonly shared experience however, women who had 'good stories' to tell were sometimes reluctant to share them because they felt guilty when others had difficult labours (4.15.4.) Although women used a 'pick and 'pick and mix' approach to technology women rarely subscribed to a totally 'holistic model'. Two FGI participants who did not subscribe to the medical model when it was articulated in the FGIs were greeted with some scepticism by other members. Within the groups there was little discussion about women's inherent natural ability as most women anticipated interventions. In section 9.11.3. women's comments to the open questions reiterated the beliefs that women in the FGIs reported being 'warned to have an epidural' by their friends whilst expressing fear related to delayed access to an epidural because of what women described as 'horror stories' relayed by friends. Women appeared to accept societal perceptions that technology is progressive and bestows safety. Women's beliefs in the increased safety conferred by repeated antenatal ultrasound scans expressed in chapter 4 and the seeming acceptance of the inevitability of interventions in chapters 4 and 5, demonstrated that most women accepted the biomedical model of the inherent risks and uncertainty of labour and birth. Labour and birth were therefore deemed normal 'only in retrospect'. Two FGI participants and ten comments on the DCEs related to issues about the possible side effects of technology such as the 'patient' status, mobility restrictions, or the potential for a cascade of interventions such as foetal monitoring that could ensue. FGI participants' reactions to others in the group who experienced an unwanted episiotomy, or monitoring against their will for instance was not greeted with surprise but rather acceptance

that it was to be expected. What would be considered 'medicalisation' seemingly accepted as the norm for most women.

In Ireland women's access to maternity services is almost exclusively through the General Practitioners (G.P.s) who are the 'gatekeepers'. Although their role within the provision of maternity care has significantly reduced (Wiegers 2003), G.P.s are the first point of contact for women, thereby reinforcing a biomedical approach to childbirth. Health professionals in Ireland have attempted to control and limit women's knowledge about reproductive choices (Murphy-Lawless 1993). Obstetricians have used a variety of strategies to dissuade and subvert women's access to other forms of maternity care (O'Connor 2006), thereby minimising women's exposure to any alternative form of knowledge. In the present study, it was evident that most women were unaware of the possibility of any maternity system other than a hospital-based consultant-led one.

The gendered element of health care is apparent in Ireland, as in most Western countries, as the majority of obstetricians are male whilst the majority of midwives are female (O'Connor 2006). Obstetricians hold a higher status and are more influential in policy formulation, and in decisions about economic priorities. Medical knowledge appears to be more highly valued than other forms of knowledge. The recent KPMG report (2008) had six specialist advisors, most of whom were obstetricians. Marie O'Connor (2006) suggests that government, parliament, and state have combined to construct and enact a medicalised system of maternity care provision, by accepting the dominant biomedical discourse. Women's experiences are therefore supplanted and deligitimised by privileged obstetric knowledge (Jordan 1997). As discussed in Chapter 2, women's views appear tangentially important in recent maternity services reports and plans. Obstetricians in Ireland have managed to sustain their monopolisation of the system of care backed by the state (O'Connor 2006); therefore other forms of knowledge are often marginalised or ignored.

The antenatal FGIs established that, although women received information from a wide variety of sources, the type of knowledge gleaned was medicalised. It was noticeable that there was an emphasis on the value of technology and epidurals from participant's peers who were of a like mind. Thornton (2003) observes in the context of perceiving risks, personal recommendations are highly valued alongside personal experience and social networks. Women did not seem to avail of the wealth of information regarding information outside the biomedical sphere. The evidence from this study suggests that medicalisation as a pervasive form of social control is linked to broader influences such as societal trends. Trends such as an increasing spread of technologies that are seen as progressive, and a society that is risk averse, facilitates medicalisation. Births outside highly technical hospitals may be seen as 'less progressive' births.

Evidently, some women felt they were active participants but, as Simonds and Rothman (2007) ask, in what? Whether women were involved in better ways of giving birth or in the 'colonization of their bodies by medicine' (Simonds and Rothman 2007:287) is open to question. Women did not query the social order of the system and there was a sense of inevitability about using medical pain relief and interventions. In this study there was little awareness of the iatrogenic potential of interventions. Non medical pain relief was used by very few women as outlined in Chapter 8. Although the open questions revealed references to hypnobirthing and yoga, women also commented on the lack of information about non medical pain relief and the difficulties of accessing non medical pain relief in labour. Women referred to medical pain relief being encouraged in both antenatal classes and during labour, whilst non medical pain relief was discouraged (Chapter 9). From the beginning of their pregnancy, therefore, women were immersed in a biomedical model of childbirth that was reinforced by their care, their peers, and society.

10.5 Maternity Services

One of the findings of the study highlights the failure of the maternity services to provide care where women have confidence in themselves and their ability to labour and birth without interventions and technology. However most women were happy with their labour and birth and were not averse to interventions. This may, however, merely indicate that women responded positively because they think they had received the best care available, and are not aware of the potential for other choices. The majority of women in Ireland have access to hospital-based maternity care with limited capacity for other care options, whilst home births are a marginalised choice (Chapter 2). The configuration of maternity services can influence women's belief systems. The dichotomy of childbirth options based on current maternity policy and service providers attempts to polarise women into stereotypical groups, however women tried to ameliorate attempts to typify their choices and used a 'pick and mix' approach

The prevalence of women's preferences for pain relief underlines women's lack of confidence of the potential for physiological birth. Women in some of the FGIs had previously experienced interventions such as ARM and found that labour pain was increased therefore would not have considered going into labour without the availability of an epidural. Two FGI participants and twenty respondents to the DCEs referred to their potential to utilise non medical forms of pain relief. The seeming lack of professional support for women who wished to utilise non medical forms of pain relief both in antenatal classes and during labour and birth may also have contributed to their choice of availability of all types of pain relief as the most important attribute.

The minority, albeit important number, of women who expressed a desire to maintain a more 'natural approach' to childbirth had little opportunity to experience any type of care other than the medicalised hospital model. Only one of the hospitals offered a 'DOMINO' system of care. If women have beliefs outside the prevailing model this can present difficulties to their experiences. To embrace a 'holistic approach'

in the context of a medicalised maternity system would be unrealistic and could cause a dissonance between women's expectations and their experiences. Women may therefore 'opt' for a belief model that fits in with social, organisational and societal norms.

Rothman's (2007) suggestions that institutionalisation of birth disempowers the birthing woman by homogenising childbirth experiences was not always upheld. Individualised care was identified in the FGIs as the way in which the system worked. Women who knew the 'system' managed to navigate and negotiate their way through it and, in doing so, many achieved the type of birth they wanted whilst some did not. In choosing individualised care and partnership with the midwife as important attributes of the birth experience, combined with the evidence from the FGIs and open questions, women appeared to be aware of this potential threat to their identity, which they wished to avoid. The basis on which women were able to achieve this was a mixture of preparation, support from the midwife and partner during labour, the environment in terms of how busy it was, and the progress of labour itself. 'Knowing the system' arose from a mixture of previous experiences and information from peers. Women then knew what choices were available and which parameters applied therefore could choose and combine the desired elements of their experiences.

The environment impacted on women's feelings of uncertainty. Rothman suggests that in the context of institutionalised birth the 'tempo' of the institution dictates activity where 'predictability is important, timing matters...and women are moved from place to place' (Rothman 2007:67). Emphasis is therefore given to increasing throughput rather than women's experiences. Although referred to in the FGIs women also commented in the open questions about the environment being 'rushed', staff 'rushing around' being 'rushed' to labour ward, then being 'rushed out' and not having time even to hold their newborn babies (Chapter 4).

Women in early labour reported being 'in the twilight zone,' uncertain about their status as 'genuine' labourers, which caused a feeling of

isolation that was apparent in the FGIs and the open questions (Chapter 5). Similar experiences have been reported in a recent Swedish study (Carlsson *et al.* 2009) where women felt anxious and uncertain during the early stages of labour. Women waited for beds so that they could be induced, so that pain relief could be administered and so that they could gain access to the status of being 'officially in labour'. Women also wondered whether the rushed staff could possibly provide individualised care (Chapters 5, & 9). However, women did not aspire to availing of other models of care because they were outside their own experience.

The mechanical 'conveyor belt' system that women in this study spoke about is necessitated by the volume of births in centralised systems (Perkins 2004). The recent report on Dublin hospitals suggests that active management is instituted because of the large numbers of births (KPMG 2008). Walsh (2007:19) observes that where the environment is less pressurised and there is one to one midwifery care for women in labour, midwives are more likely to adopt a 'being with' rather than a 'doing to' ethic. In present day society speed and technology has become valued and midwives, like others, reflect and contribute to that society. Brown and Chandra (2009) suggest that midwives may be more connected to women if they were less connected to their watches. However, midwives may be apprehensive about not using technology due to a fear of adverse outcomes and the possible risk of legal action (Begley *et al* 2009).

One of the aims of medicalisation is to censure the inherent unpredictability of childbirth by attempting to harness and control it in order to render it less uncertain. Some women in the present study had adopted the medicalised version of labour involving time constraints, limits to the defined stages of labour and promise of safety and relief of pain as part of the arsenal to combat uncertainty. Others actively rejected time limits and pain relief; however, they were in the minority. Rather than attempting to render birth predictable, some authors suggest that embracing uncertainty is the optimum way to provide women with better childbirth experiences. Downe and McCourt portray

the unpredictability of labour as an interactive physical and psychological process for instance the woman's feeling of loneliness and her response to pain: "whilst the overall pattern may be predictable the interacting elements and processes that produce the outcome are not" (Downe and McCourt 2004 :14). Downe and McCourt (2004) believe that childbirth is managed in a way that seeks to integrate these essentially unpredictable processes of childbirth to ensure certainty, and in doing so, this can endanger mother and baby on several levels. Attempting to achieve certainty by exacting time limits on stages of labour, instituting interventions needs to be reassessed. Rhona McCandlish suggests that there is a need to move beyond the dogma of certainty and fixed patterns of care to a more "creative uncertainty" (McCandlish 2001: 401). This would require a whole system approach Downe and McCourt (2004), involving attitudes, beliefs, practices and relationships. This study adds to the literature demonstrating that women assumed the care they were given was the best available, and that they lacked information about alternatives. If measures such as morbidity, mortality and satisfaction continue to be used to evaluate maternity services the existing patterns of care might not change. Complex multidimensional measures such as the DCE, and the inclusion of women's experiences are integral to evaluating maternity services.

10.6 Conclusions

The use of a sequential mixed method design framed by feminist standpoint theory has demonstrated that the void characterised by dichotomisation of paradigms and methods can be addressed. The initial use of qualitative inquiry guided the subsequent quantitative phase with open questions, and integrated both ways of knowing, portraying a symbiotic relationship and producing contextually rich insights. The use of a mixed methods way of thinking has embraced the feminist notion of multiple realities rather than singular 'truths'. The techniques used have allowed women's views of birth experiences to be measured by combining a number of key characteristics rather than one indicator such as satisfaction. The DCE demonstrated that all aspects of birth

experiences, although important, are valued differently. The value attached to the attributes of the birth experience can be used to determine the importance of the different levels, allowing policy makers and service providers to assess the impact of applying new models of care.

In the context of this study no single authoritative structure dominates how women's experiences are framed and created. The results of the research demonstrated the complex convergence of societal, institutional, and individual influences such as authoritative knowledge, a quest for certainty, a risk averse society, the increasing availability of technology and interventions. The socio political context within which childbirth experiences are perceived as uncertain, frightening, dangerous, and painful and require interventions that are accepted and normalised is a product of our present day society.

10.6.1 Implications for health care research

As previously discussed, the findings from the study suggest that women's experiences of childbirth can be better understood when examined from multiple perspectives. The study raised a unique awareness of many aspects of childbirth experiences that are complex and interwoven and cannot be measured by dichotomous suppositions that represent reality in a hierarchical way. The deconstruction of authoritative knowledge claims and a challenge to the superiority of biomedical knowledge legitimates other ways of knowing. Acknowledging the importance of women's experiences would involve alternative cultural institutional structures and norms that encompassed being 'with woman'. Researching such issues is difficult but should not be avoided if women's childbirth experiences are to be taken seriously. The complexities of the results demonstrate that reflexive, innovative approaches need to be employed to address such issues. Midwifery research and, in particular, a body of midwifery knowledge in relation to childbirth experiences is lacking in Ireland and requires urgent attention. Progress regarding a unique epistemological body of knowledge for midwives is slow and may not be feasible in the short term. However, in

the meantime the midwifery profession must continue to embrace uncertainty and seek to investigate different world views challenging powerful, singular, biomedical realities.

It is recommended that researchers:

- Develop a midwifery knowledge base by encouraging midwives to conduct and publish studies that provide contextually rich evidence to balance dichotomous suppositions of singular childbirth realities
- Encourage the development of complex dimensions for assessing childbirth experiences across all stakeholders, replacing reductionist binary measures that marginalise psychological and emotional elements
- Promote research involving the meaningful participation of women to gain a better understanding of women's childbirth experiences

10.6.2 Implications for maternity services

The implications of the study suggest that the current provision of maternity care based on a consultant-led model and centralised services may not provide women with optimum childbirth experiences. Women's experiences reflected a medicalised approach to childbirth which often fell short of what would be considered 'good practice'. The environment within which women gave birth, particularly involving time constraints due to the throughput in busy units, impacted on all aspects of their experiences. The study highlighted the isolation and loneliness women experienced in early labour and the lack of support throughout labour. The presence of a consultant was not a significant attribute of childbirth experiences but the study findings suggest that women value the availability of pain relief, partnership with the midwife and individualised care. These elements have limited potential in large centralised units therefore women should have access to alternative models of care, particularly those that instil confidence in their own abilities to labour and give birth. The study, in highlighting the importance of pain relief for women, presents difficult, challenging, and sensitive issues for midwives. The present configuration of Midwifery-Led Units, although

emphasising supportive and individualised care elements of childbirth and the realisation of women's potential for physiological birth, eschew interventions such as epidural analgesia. Women's choices are therefore confined to alternatives between two extremes of service provision. The provision of DOMINO services is inconsistent and dependent on the area where the woman happens to live. The present system of MLUs situated within a hospital setting may provide an interim solution; however, creative ways of providing appropriate services require development.

Recommendations for policy makers and organisers of midwifery services include that:

- Women as users of the services and midwives as key providers should play a meaningful role in national and local policy and development
- Policy-makers should consider women's childbirth experiences an integral part of the emergent and established models of care to provide future guidance for development
- Maternity care providers should develop alternative models of care such as integrated birth centres where women can develop partnerships with midwives across service provision

10.6.3 Implications for the midwifery profession

The study highlights women's lack of confidence in physiological labour and birth. Women's belief in technology and interventions and their seeming lack of awareness or knowledge about side-effects highlight issues of informed choice. In the context of a busy medicalised system of care the 'system' mitigates against one to one care in labour with consequent lack of support and information for the labouring women. The system based on maximum throughput means that midwives are unable to provide care in accordance to their philosophy of being 'with woman'. What is required a rethinking of the present system including culture, attitudes, and practices. A reconfiguration of the maternity services, grounded in women-centered care based on appropriate evidence and debate as referred to in previous recommendations will

take time. In the short-term the processes can be initiated by the following recommendations for the midwifery profession:

It is recommended that midwives:

- Promote debate and awareness particularly with consumer groups regarding issues such as informed choice during childbirth
- Encourage midwives to examine barriers in relation to maintaining physiological birth critically
- Support midwives who aspire to fulfilling the philosophy of women centered care within units and organisations
- Educate student midwives and junior doctors in relation to informed choice during childbirth

10.6.4 Concluding Comments

Women in this study experienced childbirth within a narrow medicalised parameter with lack of awareness of any other options or their own physiological potential. Women agree that the outcome of a healthy baby is paramount therefore they do not question the dearth of choices within maternity services. Obstetricians have done little to promote midwifery care through policy development perhaps due to the potential threat to their status. Midwives have to date been relatively constrained in their involvement in political debates about childbirth, and in their publication and dissemination of existing knowledge about the limitations of present models of care, and their impact on women's childbirth experiences. The study suggests that polarised debates, dichotomized services and competing ideologies do not serve women well. Women, rather than being caught in the middle, need to be more realistically involved in policy and practice to meet their needs. The ultimate goal is for women in Ireland to have optimum birth experiences in an environment where they feel safe and supported. Women as experts in their own experiences have the capacity to contribute to national, political, social and cultural developments in maternity services. It is clear that childbirth experiences are construed differently by individuals and groups of people involved in maternity care. This

study has shown that it is possible to move beyond binary indices by using qualitative research as a starting point for assessing the components of childbirth experiences that are important to women. The study offers a unique insight into possible starting points for midwives, health care managers and policy makers. The preliminary steps outlined in the recommendations seek to improve policies, research, services, and debates that highlight the importance of women's birth experiences. The ultimate goal for women is to realise their own capabilities within the process of childbirth. The potential for empowerment and achievement through childbirth experiences cannot be lost and replaced with impersonal services and technologies that disengage us from a process that can be transformative, self actualising and life changing.

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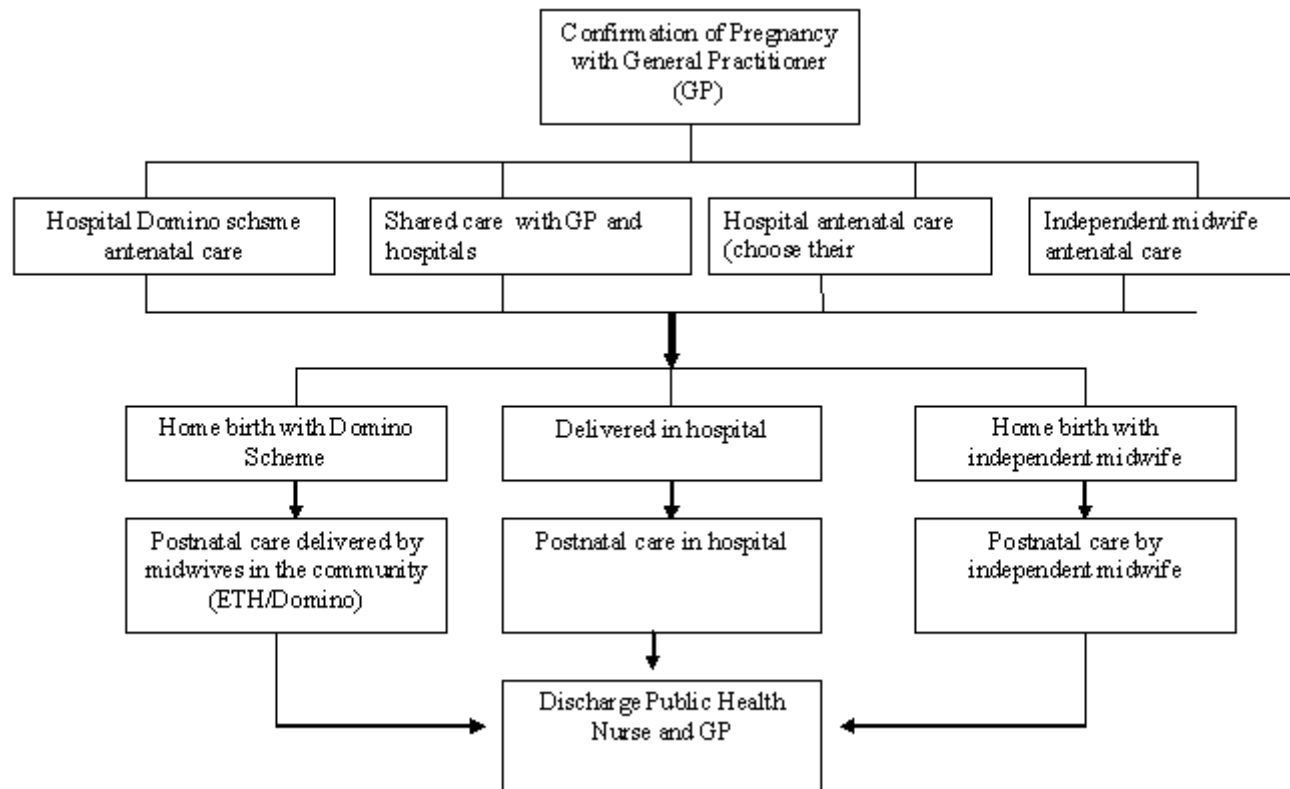
Zhang, W.-H., Alexander, S., Bouvier-Colle, M.-H. & Macfarlane, A. (2005) Incidence of severe pre-eclampsia, postpartum haemorrhage and sepsis as a surrogate marker for severe maternal morbidity in a European population-based study: the MOMS-B survey. *BJOG: An International Journal of Obstetrics and Gynaecology* **112**(1), 89-96.

APPENDIX 1.

Published Paper

Appendix 11

Access to maternity services in Ireland (KPMG 2008).



From: KPMG (2008) Independent Review of Maternity and Gynaecology Services in the Greater Dublin Area. *Final Report*, 2008. pp. 1-236

Appendix 111

Competing Ideologies of birth

Medical model	Social / midwifery model
<ul style="list-style-type: none"> ❖ Doctor centred ❖ Objective ❖ Male ❖ Body-mind dualism ❖ Pregnancy: only normal in retrospect ❖ Risk selection is not possible ❖ Statistical/biological approach ❖ Biomedical focus ❖ Medical knowledge is exclusionary ❖ Intervention ❖ Public ❖ Outcome: aims at live, healthy mother and baby. 	<ul style="list-style-type: none"> ❖ Woman/patient centred ❖ Subjective ❖ Female ❖ Holistic ❖ Birth: normal physiological process ❖ Risk selection is possible ❖ Individual/psycho-social approach ❖ Psycho-social focus ❖ Knowledge is not exclusionary ❖ Observation ❖ Private ❖ Outcome: aims at live, healthy mother, baby and satisfaction of individual needs of mother/couple.

From van Teijlingen, E. (2005) A Critical Analysis of the Medical Model As Used in the Study of Pregnancy and Childbirth. Sociological Research Online, 10 (2), Retrieved from <http://www.socresonline> on June 5th 2007.

Appendix 1V

Interview guide focus Group Interviews

Introductions:

Could you tell me your name

When did you have your baby?

Opening question 5 mins

Can you remember the labour and birth?

Transition questions 5 minutes

Have you spoken to anyone about the labour and birth?

You all had expectations about the birth Did you achieve those expectations?

What preparation helped you most?

Prompts

How do you think the experience of labour and birth is important

Key Question probes and prompts that may be used to elaborate on the answers

What was the best part about your labour and birth?

What was the least enjoyable part of the labour and birth?

Probes e.g. what helped you feel in control

What made you feel confident?

Ending question

Of all the areas we have discussed, what would be the most important for you?

Summary: give a short overview of the key themes that emerged

Ask members if they feel this reflects the discussion.

Ask members if there is anything else in relation to their experiences that needs to be addressed

Thank participants for interest and co-operation

Appendix V

Information leaflet for antenatal FGIs

Appendix V1

Demographic Information from FGI participants

Please complete the following information

This information is anonymous:

Occupation _____

Age _____

Level of Education: (tick each one which applies to you)

University

Secondary School

Primary School

What was your main reason for agreeing to take part in the study?

Appendix V11

CONSENT FORM

For Focus Group Interviews.

Working title of study: An exploration of women's expectations and experiences of childbirth

Name of researcher(s) Patricia Larkin

Procedures: Focus Group Discussion

Thank you for agreeing to take part in the Focus Group interviews. In order to take part you will be asked to sign this consent form below please read the following paragraph before you sign.

Declaration:

I have read or have had information sheet about the research read to me and I understand it.

I have been given opportunity to ask questions and I am satisfied with the answers.

I understand that taking part is voluntary and I can withdraw at any time.

If I withdraw from the study I know it will not affect my access to services or legal rights.

If I give my consent it means that results of the research may be published.

I am over eighteen years of age.

I am willing to be contacted about three months after the birth for a further group discussion.

I hereby give my consent to take part in the research

Signature of participant

_____ **Date**

Address

Thank you

The Researcher.

Statement of investigator's responsibility: I have explained the nature and purpose of the study. I have answered questions that the participants may have regarding the research

I feel participant understands and is freely giving consent and that they can withdraw from the research at any time.

Signature of researcher and date _____

Appendix V111

Steps in the analysis of qualitative data

Read through the entire protocol (the participant's description) for a sense of the whole.
1. Extract significant statements that directly pertain to the investigated topic.
2. Formulate meanings as they emerge from the significant statements.
3. Repeat the above steps for each protocol and organise the formulated meaning into clusters of themes.
4. The results of the analysis so far are then integrated into an exhaustive description of the topic.
5. Formulate the exhaustive description of the phenomenon into a statement of identification of its fundamental structure.
6. To validate the analysis, return to each participant and ask if this analysis describes her experience

Source: Colaizzi, P.F. (1978) Psychological research as the phenomenologist views it. Existential-phenomenological alternatives for psychology: 48-71.

Appendix 1X

Step 1 & 2 of Colaizzis Framework

Extracting significant statements formulating meanings.

FG21. I actually started thinking about it when I came to the hospital I started thinking it really struck methe last time I was here was when I had the last baby¹
triggers for memory

FG23. It was a really positive experience ²
Positive experience

FG23. I really had only thought about it when I saw the hospital³
Reminded by hospital

FG21. I think ever since I was pregnant the labour I had was very hard...⁴
Hard labour

FG23. I was induced and it was very unnatural ⁵
Induction unnatural;

FG23. the whole way through now was I was praying that I would go on my own that it would be natural ⁶
Hoping for natural birth

FG23. I hope it would be a different experience to last time ⁷
Different experience this time

FG24. when you go to the hospital and you get the yellow book you look at the birth plan and.... go oh god! (laughs) its scary thinking about it⁸
scary thought

FG22. I started thinking about it at the scan at 32 weeks that's when I started thinking about it⁹
scan as reminder

Appendix X.

Condensing categories into clusters stage 3

1. Optimistic
2. Learn from experience
3. Natural Ideal
4. Negative experience
5. Lucky experience
6. Surreal dream
7. Hazy recollection
8. Conflicting emotions
9. Feeling alert
10. Running a marathon
11. One day
12. Romantic notions
13. Hard but positive
14. Feeling the birth
15. Unnatural induction
16. Avoid caesarean section
17. Terrified
18. Dispassionate environment
19. Strangers at birth
20. Feeling overwhelmed
21. Perfect moment
22. Difficult memory
23. Relief
24. Magic moment
25. Ownership of birth
26. Feeling out of control
27. Timing of pain relief
28. Feeling under pressure
29. Going against advice
30. Timing of admission
31. Lectured about dangers
32. Not Taken seriously
33. control of bodily functions
34. Policies and procedures
35. Following instincts
36. Negotiating interventions
37. Decision making
38. Pain relief
39. Accessible
40. Motivational
41. Detached staff
42. Left out
43. No time to prepare
44. Individual information
45. Distant voices
46. Being assertive
47. Feeling like an object
48. Explanation of interventions
49. Asking questions
50. Partner detached
51. Partner Relaying information
52. Reassuring presence
53. Partners presence
54. Partner's memory
55. Familiar face
56. Unable to function
57. Fighting pain
58. Coping with pain
59. Personal characteristics
60. Previous experience
61. Information from friends
62. Ownership of birth
63. Sharing experiences
64. Information from books
65. Plans go out the window
66. out the window
67. Resigned to experience

Appendix X

Final Themes and Categories Stage 4

1. Formulating and identifying expectations – goal setting

- A Individual influences
- B Sources of information
- C Previous experience
- D Ideal experience uncertainty

2. Enablers and barriers to goal attainment- achieving goals

- E Choice and
- F control
- G Communication and information
- H Relationship with staff
- I Role of partner
- J Strategies for coping with labour

3. Contingency plans - Reconciling unfulfilled goals

- K Uncertainty Ideal reality gap
- K Accepting and rationalising

Appendix X1

Notations

Notations: Transcript conventions

[to indicate the point at which the current speaker is overlapped by another's speech

(attempt) suggestions reading uncertain transcription

_ Speakers emphasis

WORD loud utterance

[] transcriber added text e.g. pause sign body movement acting out

Source: Silverman, D. (2004) Qualitative Research: Theory, Method and Practice: London, Sage Publications Inc. Page 368.

() murmurs/ chorus of agreement (added by P. Larkin)

Appendix X11

Interview guide postnatal FGIs

Introductions:

When did you have your baby?

Opening question 5 mins

Can you remember the labour and birth?

Transition questions 5 minutes

Have you spoken to anyone about the labour and birth?

You all had expectations about the birth Did you achieve those expectations?

What preparation helped you most?

Prompts

How do you think the experience of labour and birth is important

Key Question probes and prompts that may be used to elaborate on the answers

What was the best part about your labour and birth?

What was the least enjoyable part of the labour and birth?

Probes e.g. what helped you feel in control

When did you feel out of control?

What made you feel confident?

Ending questions

Of all the areas we have discussed, what would be the most important for you?

Summary: give a short overview of the key themes that emerged

Ask members if they feel this reflects the discussion.

Ask members if there is anything else in relation to their experiences that needs to be addressed

Thank participants for interest and co-operation

Appendix X11

Ground Rules and General Information

Welcome to all, Personal Introduction

Purpose of the study is to find out what women would like from their experience of labour and birth

Focus group:

Recap on information sheet
No right or wrong answers
Everyone has something to offer
Participants need not agree with everything others say
Confidentiality assured
Sharing of ideas and experiences
Trusting environment that participants can share
Respect privacy of all participants

Information will contribute to maternity services
Researcher will not be able to advice
Overview of type of questions that can be asked
Researcher happy to take specific questions after the group as appropriate
Participant(s) free to leave at any stage
Contact details of researcher for participants for any further queries

Sign consent form

1

Appendix X111

2

Amalgamated categories from 5 PNFGIs

(COLOUR CODED FOR DIFFERENT GROUPS)

Memory of experience

- cannot remember
- did not register information
- rationale for not remembering
- memory fades
- Experience not as vivid
- Can remember some
- Remember bits and pieces
- Hormones affect memory
- Memory changed
- memory horrible bits
- partner memory
- made notes
- wanted to remember
- memory will never forget
- forgetting experience

Pain

- unbearable pain
- feeling out of control
- non medical pain relief
- choice of pain relief
- gas and air
- wanted to use TENS
- disinterested midwife
- wanted to use TENS
- partner putting on TENS

- midwife would not help with TENS
- policy of waiting
- epidural appeared pain relief wore off at crucial hour
- kept asking for epidural
- delayed anaesthetist
- pain relief wore off
- anaesthetist returned
- too late for epidural
- interaction about pethidine
- pethidine slowed labour
- staff unfamiliar with TENS
- unavailable TENS
- deep breathing helped labour
- listening to radio
- staying mobile
- waited 3 hours for epidural
- easy with epidural
- no epidural
- Pain manageable
- couldn't get epidural
- not a full epidural
- different sensation with this epidural
- limited effect of epidural
- epidural helped control could push with epidural
- staff delay epidural
- rationale for delaying epidural

Appendix X1V

Verifying postnatal FGI themes



The University of Dublin Trinity College

Faculty of Health Sciences

School of Nursing & Midwifery Studies

24 D'Olier Street, Dublin 2, Ireland.

Tel: 01 608 2692 Fax: 01 608 3001

Discussion Group Experience of Labour and Birth

Dear XXX,

I hope you and your family are well. Thank you for attending the discussion group (seems so long ago now). I would be grateful if you could look at the list of themes and answer the two questions following. You can write overleaf if you like. Could you put your answer in the stamped addressed envelope and put in the post. I'm hoping people will post them with their cards. Hope you have a happy Christmas and all the best for 2007!

Patricia Larkin (Midwife)
Midwifery Doctoral Student.
E-mail: larkinpa@tcd.ie
Mobile 086-6221601

Please read the themes below. These were what women said were the most important parts of the labour and birth experience after 5 group discussions.

Theme 1. Getting Started – This was about starting labour either naturally or being induced and had 2

1. Expectations women were either happy with or disappointed in the whole experience what women thought would happen and what did happen.
2. The twilight zone – was the time women talked about not knowing if they were in real labour or not.

Theme 2 Getting There – about the important parts of the whole labour

1. In another world – women felt the experience was 'unreal'
2. Anxiety a lot of women said they were anxious

Feeling in control- this had five parts

1. women felt they wanted control of pain relief
2. women wanted more choice about the hospital and interventions
3. wanted to be seen as an individual and have a good relationship with staff
4. wanted to feel in control of information
5. wanted would like to control the progress of labour and do it on their own

Theme 3 consequences this was about the effect that women said the experience had on them:

1. Memory- women remembered how they felt but did not remember all the events that happened
2. Isolation- women felt alone and did not get enough attention in early labour and just after having the baby
3. The experience of labour and birth would affect women's decision to have a baby or not in the future

Do you recognise any of your experiences of labour and birth in this description?

Is there any part of the experience of labour and birth that I have left out that you would like to include?_____

Thank you (You can write overleaf if you like)

Appendix XV

Interview format and grid system

For think aloud techniques

Opening question:

How are you feeling?

How is your baby?

How do you feel about your labour and birth?

Reading the first attribute

What does that mean to you?

Probes

Is (attribute) important to you?

Why that is (attribute) important?

What do you think about choices (between levels of attribute?)

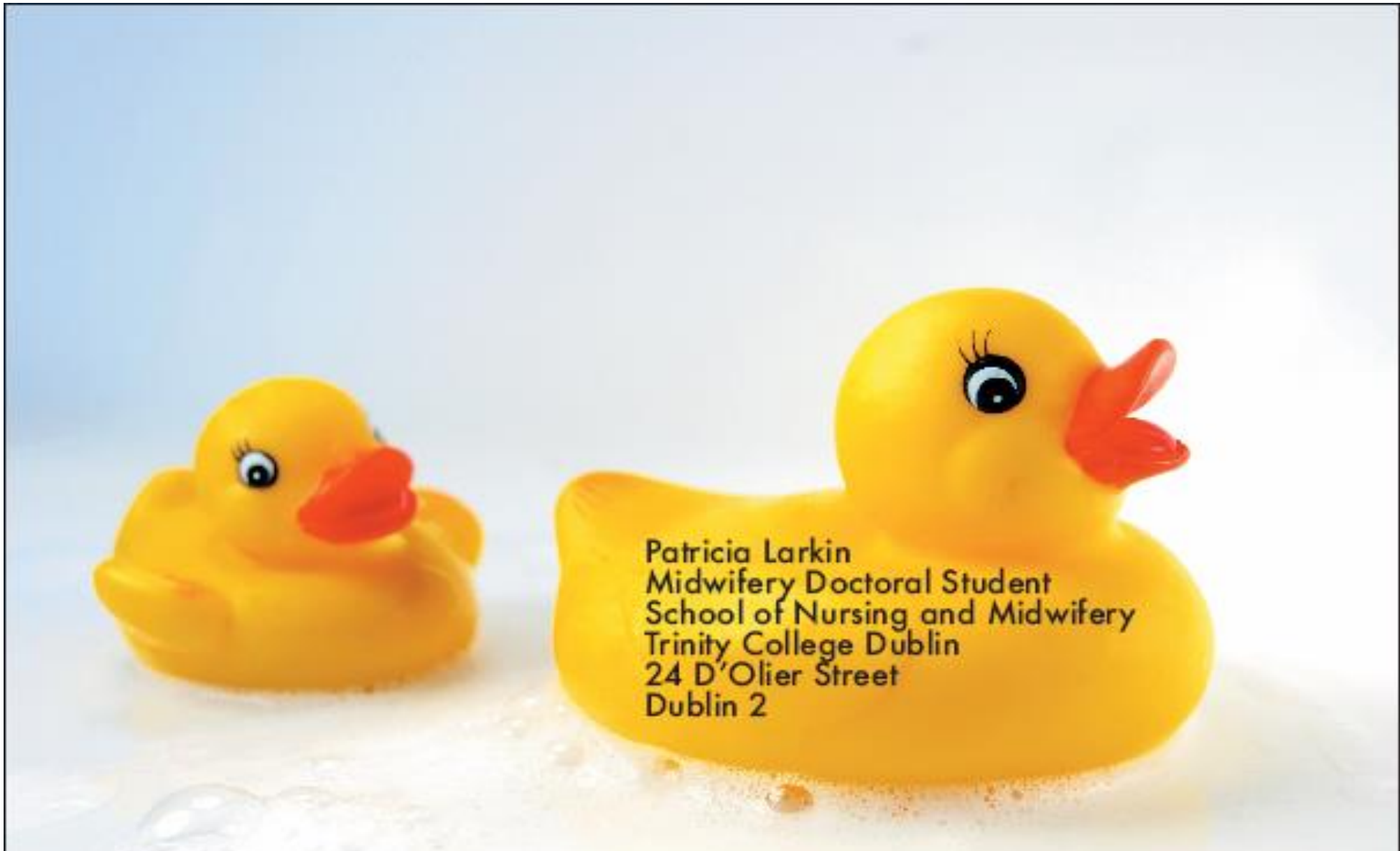
Would you be willing to give up one for another?

Grid system for asking questions during think aloud interviews

Interview number	Attrib 1	Attrib 2	Attrib 3	Attrib 4	Attrib 5	Attrib 6	Levels	Trade	Omissions?
1									
2									
3									
4									
5									

Appendix XV1

Card distributed to mothers requesting contact details.



Patricia Larkin
Midwifery Doctoral Student
School of Nursing and Midwifery
Trinity College Dublin
24 D'Olier Street
Dublin 2

Tell us what is important for you during labour and birth

Congratulations on the birth of your baby. I hope all went well and that you are looking forward to the next exciting stage!

I am a midwife looking at women's experiences of labour and birth. I would very much like to hear your views on what you think is most important to women at this time. I would like to invite you to take part in my study by asking you to complete a short questionnaire which I will post to you in a few months time.

Your opinions and experience are very important and will help to give a true picture of what women need at this time.

If you are willing to take part in this study please fill in your name and address in the space provided and leave it at the ward office **IN THE BOX PROVIDED**

It is important to note that all information you provide will be treated in strict confidence.

Thank you for considering this invitation and congratulations again

Wishing you all the best for you and your family

Patricia Larkin (Midwife)

Name _____

Address _____

_____ **Mobile Number (optional)**

Appendix XV11

DCE design in numerical form

Level (0)	Level (1)	Level (2)	Level (3)
Care is individual personal to me Level (0)	Care is routine Level (1)		
The midwife works in partnership with me	The midwife does not work in partnership with me		
I get on in labour with no routine interventions (like having my waters broken) Level (0)	It doesn't matter how many routine interventions I have during labour (like having my waters broken) Level (1)		
Staff go ahead and make decisions for me Level (0)	Staff make decisions but keep me informed Level (1)	Staff discuss things with me before making decisions Level (2)	I am in control of decisions Level (3)
I can have all types of pain relief at all times Level (0)	I can have all types of pain relief but I may have to wait up to 3 hours for an epidural Level (1)	I can have non medical pain relief only, like TEN or massage Level (2)	I can have all types of pain relief (including gas and air and pethidine) but no epidural Level (3)

<p>A midwife will be with me during your labour and birth and the consultant only present if needed e.g. in an emergency</p> <p>Level (0)</p>	<p>A midwife will be with me during labour and the consultant will join the midwife for the birth only</p> <p>Level (1)</p>		
---	---	--	--

	Option 1								Option 2						
ATTRIBUTE	Individual care	Partner-ship	Interventio ns	Decision making	Pain relief	Consultant Presence		Individual Care	Partner-ship	Interventio ns	Decision making	Pain relief	Consultant presence		
B L O C K 1	0	0	0	0	0	0	1	1	1	1	3	1	1		
	0	0	1	3	3	1	2	1	1	0	2	0	0		
	0	1	0	1	2	1	3	1	0	1	0	3	0		
	0	1	1	2	1	0	4	1	0	0	1	2	1		
	1	1	1	3	2	0	5	0	0	0	2	3	1		
	1	1	0	0	1	1	6	0	0	1	3	2	0		
	1	0	1	2	0	1	7	0	1	0	1	1	0		
	1	0	0	1	3	0	8	0	1	1	0	0	1		
B L O C K 2	0	0	1	1	1	1	9	1	1	0	0	2	0		
	0	0	0	2	2	0	10	1	1	1	1	3	1		
	0	1	1	0	3	0	11	1	0	0	3	0	1		
	0	1	0	3	0	1	12	1	0	1	2	1	0		
	1	1	0	2	3	1	13	0	0	1	1	0	0		
	1	1	1	1	0	0	14	0	0	0	0	1	1		
	1	0	0	3	1	0	15	0	1	1	2	2	1		
	1	0	1	0	2	1	16	0	1	0	3	3	0		

Appendix XV11

Completed DCERI instrument

Appendix XV111

Coding and interpretation for analysis of attributes and levels

	Variable names	Level 0	Level 1	Level 2	Level 3
Attribute 1 Individual care	ind_care	Routine (0)	Personal & individual (1)		
Attribute 2 Interventions	interv	You get on, no inter (0)	As many interv as needed (1)		
Attribute 3 Decision-making	dec0,dec1,dec2,dec3 - dummy variables, dec0 omitted variable	Staff make decisions (dec0=1)	Staff make decisions u informed (dec1=1)	Staff discuss w u first (dec2=1)	U in control of decisions (dec3=1)
Attribute 4 Pain relief	painr0,painr1,painr2,painr3 - dummy variables, painr0 omitted variable	Only non-medical avail (painr0=1)	All medical except epidural (painr1=1)	All medical, wait up to 3hrs epidural (painr2=1)	All pain relief, medical & non-medical avail (painr3=1)
Attribute 5 Consultant	consult	Consultant only in emerg (0)	Consultant at birth (1)		
Attribute 6 Partnership	partner	Midwife not in partnership (0)	Midwife in partnership (1)		

Note: A dummy code denotes the existence of a particular attribute with a one and its absence with a zero

Appendix X1X

INTERACTION MODEL WITH SITE

EQUATION (2) – RURAL V CITY

$$V = \mathbf{ASC_c} + \beta_1 \text{ind_care} + \beta_2 \text{interv} + \beta_3 \text{dec1} + \beta_4 \text{dec2} + \beta_5 \text{dec3} + \beta_6 \text{painr1} + \beta_7 \text{painr2} + \beta_8 \text{painr3} + \beta_9 \text{consult} + \beta_{10} \text{partner}$$

Model 2 – Interaction model with study site (rural v city)

response	Coef.	P> z
asc_c	.1155044	0.007
ind_care	.2923089	0.000
interv	.0194596	0.589
dec1	.0616488	0.333
dec2	.0436434	0.543
dec3	-0.073197	0.251
painr1	.90000452	0.000
painr2	.8748133	0.000
painr3	1.620937	0.000
consult	-.1164502	0.002
partner	.9960347	0.000

Conditional (fixed-effects) logistic regression Number of obs = 8466

LR chi2 (11) = 1237.68, Prob > chi2 = 0.0000

Log likelihood = -2315.4878 Pseudo R2 = 0.2109

Appendix XX

Interaction Model 3 Impact of parity

EQUATION (3) - Parity

$$V = \mathbf{ASC} + \beta_1 \text{ind_par_m} + \beta_2 \text{interv} + \beta_3 \text{dec1} + \beta_4 \text{dec2} + \beta_5 \text{dec3} + \beta_6 \text{painr1} + \beta_7 \text{painr2} + \beta_8 \text{painr3} + \beta_9 \text{cons_par_m} + \beta_{10} \text{part_par_m}$$

Model 3 – Impact of parity on preferences

response	Coef.	P> z
asc	.0857186	0.011
ind_par_m	.2632254	0.000
interv	.0208429	0.545
dec1	.0015858	0.979
dec2	.0403459	0.558
dec3	-0.013402	0.823
painr1	1.03533	0.000
painr2	.5270357	0.000
painr3	1.429769	0.000
cons_par_m	-.1588366	0.004
part_par_m	.9709083	0.000

Conditional (fixed-effects) logistic regression Number of obs = 8433

LR chi2(11) = 885.58, Prob > chi2 = 0.0000

Log likelihood = -2480.0425 Pseudo R2 = 0.1515

Appendix XX1

Interaction Model Education

EQUATION (4) - Education

$$V = \text{ASC_e2} + \text{ASC_e3} + \beta_1 \text{ind_care} + \beta_2 \text{interv} + \beta_3 \text{dec1} + \beta_4 \text{dec2} + \beta_5 \text{dec3} + \beta_6 \text{painr1} + \beta_7 \text{painr2} + \beta_8 \text{painr3} + \beta_9 \text{consult} + \beta_{10} \text{partner}$$

Model 4 – Impact of education ('low' versus 'high')

response	Coef.	Std. Err.	P> z
asc_edhi	.097111		0.022
ind_care	.290133		0.000
interv	.0202475		0.575
dec1	.0614322		0.335
dec2	.04368		0.543
dec3	- 0.072822		0.254
painr1	.898447		0.000
painr2	.8772792		0.000
painr3	1.623605		0.000
consult	- .1136694		0.002
partner	.9929813		0.000

Conditional (fixed-effects) logistic regression Number of obs = 8435

LR chi2(11) = 1228.24, Prob > chi2 = 0.0000

Log likelihood = -2309.4049 Pseudo R2 = 0.2101

Appendix XX11

Meanings and significant statements from open questions

The worst experience during labour was my husband was asked to leave whilst I was given the epidural this was personally very distressing why is it necessary? surely partner can stand other side and comfort?	separated from partner distressed being alone
My birth experience with my 4th baby was fantastic.	
I truly believe it was the best as it was the least hands on. I was left in a dim room on my own for 2 hours to labour by myself. I was shocked as the nurse realised that the baby's head was crowning. If I had been in the delivery room it would probably have felt like a more painful experience.	fantastic experience Least interference best left in dim room laboured alone
My first birth was very high-tech and much less enjoyable.	valued no interventions
Women need to be more empowered- the midwives do a brilliant job and can enable women to have this experience	support from midwives improves experience hooked to monitor and left alone
I was hooked up to a monitoring machine where I was left to dilate from 7-10cms on my own	

Appendix XX111

Descriptive themes from open questions

1. separated from partner
2. distressed being alone
3. fantastic Experience
4. valued no interventions
5. left in dim room laboured alone
6. Environmental influence
7. Interventions
8. Midwives improve experience
9. Unhappy with treatment
hooked to a monitor and left
alone
10. mobilizing and birthing ball
improved experience
11. importance of midwife
12. midwife support and guidance
13. busy environmental factors
14. busy felt they were in the way
15. lack of pain relief
16. Midwife think they know
everything
17. Crowding makes it difficult for
staff to give private personal
care
18. midwife busy
19. lonely
20. Separated from partner
21. Busy environment
22. pain relief
23. Changed personnel
24. feeling lonely lack of
information
25. incision 'excessive'
26. consultant not met
27. individual and personal care (
referring to attributes
28. old building
29. consultant presence
30. psychological preparation
31. preparation and education
enables better experience
32. Mobilizing to deal with
contraction
33. husband presence
34. Persistent induction
35. Not impressed
36. presence of consultant
37. Birth plan is a joke
38. preparation alleviates anxiety

Appendix XX1V

Final themes from open questions

Support

1. separated from partner
2. distressed being alone
3. support was good during labour but staff rude in the postnatal ward
4. left in dim room laboured alone (PREFERRED)
5. lonely
6. never saw consultant

Comments about the childbirth experience

1. nearly had baby in the car on the way to the hospital
2. first labour hard
3. Overwhelmed overjoyed with fourth child all births are vaginal normal
4. lucky fourth baby most difficult
5. people say you forget but you don't
6. Second labour easy
7. wonderful experience
8. unsure about experience baby's heart dropped quite scary
9. quick labour this time
10. emergency cs so disappointed

Interventions

11. 1st birth a lot of interventions monitoring and forceps
12. natural labour with little interference is the ideal
13. less invasive labours is an important part of choice for me
14. episiotomy not explained did not know if it was a choice
15. No choice about episiotomy blocked out a lot of what happened husband told me afterward
16. induced with twins policy is to do what is safest for babies
17. disagree with active management
have to be assertive to have no intervention

Appendix XXV

Excerpt from Reflective Journal in relation to FGIs

Today was my first focus group interview with six women who were having their first babies. I had someone giving me feedback which made me really nervous but got through it. The room was too warm and I was quite uncomfortable although I had tea for everyone water would have been better!. Anyway the group went well although one woman spoke too much and one did not say anything. I used all my probes and prompts but they did not work. The feedback I got was that I could have tried a bit more so I will use that in future. I asked everyone to tell us their names so that I could recognise them for transcribing and I think the next one will be better as I will not be as nervous and I can direct questions a little better. They asked me some direct questions saying well what you think about that. So I had to give them some information but made it as 'generic' as possible. One woman e mailed me about an infection she had and I gave her information after the FGI they all spoke about private care (had not intended this to be an issues) but it was. I was surprised that it was 'non nation' women who were less anxious and appeared to believe in themselves more than the women from Ireland...

Excerpt from Reflective Journal in relation to FGIs

Today I spoke to a group of women about their childbirth experiences they were very informative and spoke passionately about what was good and not so good about their experiences. As a midwife I was appalled at some of the situations women found themselves in and about the treatment they received. They seemed to take it all in as an inevitability but I was shocked especially when a woman discussed how she would have liked to have been the first person to hold her baby and when she eventually touched her the baby was dressed!!!

There seems to be such a lack of real 'midwifery' care for these women. I cannot help thinking with my 'midwifery' hat and tried not to appear shocked. I was also surprised that women were so adamant about epidurals and again shocked that women seemed not to be aware of the side effects. One woman had hers when she was 9cms dilated where is the midwifery care here? I tried as much as possible to stay out of the discussions but women did ask me some direct questions which I tried to answer in a non judgemental way. My feminist principles mitigated against the smash and grab' approach but I felt I could not raise women concerns after the fact and stayed quiet but I wanted to say this is not good care!

Excerpts from Reflective Journal related to DCERI

I found it really difficult to ask women to read the DCERI using the 'think aloud' technique. I was aware that many of them were tired two were on their way home and had packed their bags and were waiting to be collected. However as usual I am constantly amazed at how much time women are willing to give and how generous they are. I also slipped into my midwife mode as I was asked about various labour and birth issues. However I felt in the spirit of the research it was alright to do so. The women who complete the pilot written DCERI were equally helpful but also tired and did not want to complete another one thank you very much! I must say I understood their sentiments.

I am really frustrated with the slowness of the recruitment particularly in one area despite my best efforts. This morning a really pleasant student midwife went around to all the women and asked them and actually got four participants for me but that was it for the week!

