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How domesticity dictates behaviour in the birth space: Lessons for designing birth environments in institutions wanting to promote a positive experience of birth

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ABSTRACT

Background: limited efforts have been made to understand the complex relationships between women's experiences of birth and the influence of the design and environment of a birth space. Domestic aesthetics in a birth space are believed to be an important aspect of optimal birth unit design.
Aim: to explore the concept of domesticity within the birth space. The specific objectives were to explore, describe and compare birth spaces with different domestic characteristics and subsequently, how laboring women worked within these spaces during the labour process. This project was situated within a larger ongoing body of work exploring birth unit design.
Method: a qualitative approach, using the techniques of video ethnography and reflexive interviewing, was used. Video data consisted of films of the labours of six Australian women who gave birth in 2012. Filming took place in two different tertiary hospitals in Sydney NSW (n=5 women), as well as a stand-alone Birth Centre (n=1 woman). Video footage of a woman labouring at home was used to compare and contrast women's experiences. Latent content analysis was used to analyse the data set. In addition there were 17 one-hour video-reflexive interviews that were audio-taped and fully transcribed (nine interviews with women and/or their support people and eight with midwives). Field note data accompanied both the video recording as well as the reflexive interviews.
Findings: in general, women labouring in conventional hospital labour and birth rooms acted and interacted with the environment in a passive way. The spaces clearly did not resemble homely or 'domestic' spaces. This forced women to adapt to the space. In essence all but one of the women labouring and birthing in these spaces took on the role of a 'patient'. One participant responded quite differently to the conventional hospital space. 'Domestication of the space' was the mechanism this woman used to retain a sense of ownership within the birth space. In contrast, in the domestic birth environments (Birth Centre and home) women effortlessly claimed ownership of the space, expressing their identity in a myriad of ways. In these domestic spaces, women were not required to change or modify their birth spaces as the design, furnishings and semiotics of the space openly encouraged them to be active, creative and take ownership of the space.
Conclusion: the findings of this study add to the existing literature on birth unit design and more specifically contribute to an understanding of how the features of domesticity within the birth setting may shape the experience of labouring women and their care providers. The evidence gained from the study will assist in the ongoing movement to humanise birth spaces and develop further understandings of how home-like birth spaces should look. Those designing, building, furnishing, managing, accessing and working in Birthing Services could all benefit from the consideration of how environments designed for the care of birthing women, may be affecting the outcomes and experiences of women and their families.

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Introduction

In the early 1970s a number of health services, particularly in the United States and Australia, started to redesign their maternity services and facilities to meet the growing demands from childbearing women for a more humanised approach to birth (Fannin, 2003). Women were seeking a birth ambience characterised by compassion, warmth, nurture and love. In the intervening years some effort has gone into better understanding aspects of the environment that may facilitate the type of experience that women and their families want and need (see for example Davis-Floyd, 2001; Newburn and Singh, 2003; Fahy et al., 2008; Hauck et al., 2008; Hodnett et al., 2009; Stenglin and Foureur, 2013). As a result, in a variety of resource rich countries institutional maternity care settings have been reconstructed to reflect a sense of domesticity, characterised by the concepts of: 'reflecting home life', 'home making', 'to make domestic', 'to adapt', 'to train/tame', 'to make homely' (Collins, 2002; American Heritage, 2016). Some contain 'home-like' bedrooms within hospital labour wards; others have 'home-like' birthing units adjacent to the labour wards, usually referred to as 'birth centres'.

Newburn and Singh (2003) asked 4000 women to describe features of a birth space that facilitated a positive birth experience. Predominantly, women said they wanted spaces that were homely, comfortable, personal and adaptable. These same findings were later replicated by Rudman et al. (2007) in their survey of 2600 women exploring women's satisfaction with intrapartum care and the relationship to birth space. Building on these concepts Shin et al. (2004) examined a set of design principles believed to attribute a sense of 'hominess' to the birth space. They found that women responded positively to spaces that facilitated family comfort and engagement and where they had control over their own privacy. Likewise Walsh (2010) argued that the development of the home-like or domestic birth space was integral in the facilitation of the 'nesting instinct'. Nesting is said to be experienced by all mammalian species during pregnancy and most importantly, in the early phase of labour and birth. Walsh (2010) described these behaviours as intuitive and therefore, somewhat problematic for women and their carers to articulate in terms of what facilitates them.

Birth environments that engender a feeling of being 'at home' – a comfortable and familiar environment - have been identified as providing women with a strong sense of their own identity (Williams, 2002). Some time ago Sixsmith (1986) described 'home' as an emotional reference point for a sense of self. Exploring this further Williams (2002) theorised that places that facilitate a strong construction of the self-assist in the maintenance of health and wellbeing. Other theories connect the spaces we inhabit or encounter with either calming or arousing emotions, each with neurophysiological consequences that may alter the course of a woman's labour and birth (Fahy et al., 2008, 2011; Foureur, 2008; Buckley, 2015).

Maria Fannin (2003) however, challenges us to consider the possibility that the home-like hospital environment is a construct of a popular representation of home as a site of safety, security, autonomy and domesticity; a situation that is not necessarily the case for a significant proportion of the population. As Michie (1998) pointed out some time ago, "Home does not signify autonomy and bodily control for all women, nor is the domestic space always the safest for women" (p. 262).

As a consequence of better understanding the association between environment and health (Ulrich et al., 2008) there has been a growing interest in exploring how design of birth spaces may also influence the neuro-physiology and behaviour of labouring and birthing women, their supporters, their midwives and other care providers (Fahy et al., 2008; Foureur et al., 2010; Hammond et al., 2013a, 2013b; Hammond et al., 2014). There remains, however, a dearth of research exploring how characteristics such as those of domesticity or home like qualities may influence women's labour and birth experience (Foureur et al., 2010; van Lonkhuijzen et al., 2011).

Aim

The aim of this project was to explore, describe and compare birth spaces with different domestic characteristics and how labouring women responded and/or worked within these spaces during the labour process. This paper presents the findings specifically related to women's sense of identity and/or ownership within these spaces. The project was situated within a larger ongoing body of work exploring birth unit design.

Method

The data used in this study were drawn from the Birth Unit Design (BUD) Project. This was a large qualitative study using video ethnography that aimed to provide evidence about the birth environment and the ways in which it may influence communication, behaviour, socio-cultural experiences, the physiology of labour and birth and, ultimately, women's experiences of maternity care. A detailed account of the BUD research design has been published (Davis Harte et al., 2014).

Study participants were recruited from a purposive sample of women giving birth in two urban maternity units in an Australian capital city. One participant gave birth in an alongside midwifery-led birth unit in one of these hospitals, three in standard hospital labour rooms with ensuite shower/toilet and two women birthed in rooms that contained a large bath/birth pool as well as ensuite facilities. Three of the six women received midwifery-led, caseload, continuity of care.

All women were low risk for complications at recruitment and remained so. Three women were primiparous. One multiparous woman received a social induction of labour at term. The remaining women experienced a spontaneous onset of labour at term with a singleton vertex presentation. Four women experienced a spontaneous vaginal birth and two primiparous women had an assisted vaginal birth with forceps. All women and their partners/supporters had visited the birth unit prior to labour onset.

The dataset used in this study consisted of video recordings depicting selected time periods during six women's labour experiences. Women could stop the filming at any time but none did so. For each woman the same two midwife researchers undertook the filming, collection of field notes and conducted the video-reflexive interviews. The midwife researchers were not employed in the study settings and had familiarised themselves with the environment by undertaking a (filmed) scoping activity prior to commencing the filming of the labours. The women and their partners met the midwife researchers during a home or clinic visit prior to commencing the study, when consent to participate was obtained (Harte et al., 2016).

The average length of the video recordings was 90 minutes (range 42 minutes to 3 hours). These were each edited to an average length of 35 minutes (range 15 minutes to 1 hour) with associated field notes. In addition there were 17, one-hour video-cued interviews that were digitally recorded and then fully transcribed (nine interviews were with women and/or their support people and eight with their attending midwives). These involved playing back the edited video footage and asking participants to reflect on their experiences and comment on how the environment was affecting what was happening in the birth space at the time. Field note data accompanied both the video recordings as well as the interviews. Each participant's dataset (video, audio, field notes) was colour coded (red, green, yellow, orange, blue) to facilitate data management. Ethical approval for the study was granted from the participating health care authorities and the university.

To enrich the analysis, video footage from a home-birth attended by private midwives was also used. This labour and birth were filmed before the commencement of the BUD project by one of the BUD research team when attending the birth with another privately practi-

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