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Taking the matter into one's own hands – Women's experiences of unassisted homebirths in Sweden

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ABSTRACT

Objective: There are no national guidelines or financial support for planned homebirths in Sweden. Some women choose to give birth at home without the assistance of a midwife. The objective of this study was to describe eight women's experience of unassisted planned homebirth in Sweden.
Design: Women who had the experience of an unassisted planned home birth were interviewed. The material was analysed using a phenomenological approach.
Results: The essential meaning of the phenomenon giving birth at home without the assistance of a midwife is understood as a conflict between, on one hand, inner responsibility, power and control and on the other hand insecurity in relation to the outside, to other people and to the social system. A wish to be cared for by a midwife is in conflict with the fear of not maintaining integrity and respect in this precious moment of birth.
Conclusion: Some women may be more sensitive to attitudes and activities that are routinely performed during pregnancy and childbirth and therefore choose not to turn to any representatives of the medical system. The challenge should be to provide safe care to all women so that assistance from a midwife becomes a reality in all settings.

Introduction

In many parts of the world there is a severe shortage of skilled birth attendants and women suffer from inadequate care. In high-income countries a midwife or an obstetrician is present at almost all births. However, there are problems related to the practice of high-technological care including rising rates of caesarean sections and interventions during birth [1]. For some women the increasing use of technology is a reason for their search for alternatives [2–6]. In Sweden, as in most high-income countries, few women give birth at home. Less than one in a thousand births in Sweden is a planned homebirth [7]. There are no guidelines regarding planned homebirths and the health care system does not provide economic support for homebirths [8]. Prenatal care and birth care are publicly funded in Sweden. However, a woman who chooses to give birth at home has to find a midwife willing to assist her and usually must pay for the service herself [8]. There are about 20 midwives in Sweden who assist planned home births on a regular basis. Most of them are also employed in a hospital and are therefore only available for a home birth when they are not on duty. Thus, due to financial and organizational factors, one in five (n = 20, 20%) of the planned homebirths is not assisted by a midwife or other skilled birth attendant [9].

Lundgren [10] describes the women's experiences of requesting a homebirth in a system where homebirths are not accepted. According to the women this involves feelings of dealing with a contrast between the inner and outer image of giving birth. Giving birth is seen as a natural process from the pregnant woman's perspective while she perceives that concern with the potential risks characterizes the perspective of those in the health care system. Sjöblom [11] investigated the attitudes towards the plans to give birth at home and found that Swedish women experience negative attitudes from health care staff, who find the woman's choice provoking and risky. Nevertheless, some women choose to give birth at home in spite of the perceived attitudes and the lack of midwives willing to assist them. The objective of this study was to describe eight women's experience of unassisted planned homebirth in Sweden.

Methods

A reflective lifeworld research method developed by Dahlberg et al. was used [12]. This method is based on Husserl and Merleau-Ponty's phenomenological philosophy, transformed into an empirical

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epistemology that serves as guiding principles in research [12]. The focus lies in the description of a phenomenon, which is an object as a subject experiences it. The phenomenon studied in this study was unassisted homebirth. From a phenomenological perspective it is not possible to describe an object without reference to the subjects, in this study the women who have this experience. With an open mind the researchers in this process approach the material in order to identify phenomena and their variations [12]. During the whole process it is essential to employ critical reflection and to bridle the understanding of the phenomenon. Openness is central for lifeworld research, in line with Gadamer's [13] concept of scientific openness, described as a wish to see and understand something in a new way.

Participants and data collection

The Regional Ethical Review Board at Karolinska Institutet, Stockholm approved the study. Eight women who had the experience of an unassisted planned home birth in the last five years (2009–2014) were interviewed. The two researchers IL and HL carried out the interviews in Swedish. Half of the participants had responded to the advertisement on the website for planned homebirths in Sweden, and the others were recruited through a consumer group in Sweden. An appointment was made after information was given about the aim of the project and informed consent was achieved. All interviews took place in the participants' homes and they varied between 50 and 105 minutes. For one woman the unassisted homebirth was her first birth; the other seven had given birth to between one and three children previously. The multiparous women had experience of both hospital and homebirths. All women had their partners present at birth and five also had a doula or friend by their side. Six had tried to find a midwife willing to assist them but had not succeeded and two had deliberately chosen an unassisted birth during the pregnancy. The interviews started with an opening question addressing the experience of giving birth at home without the attendance of a midwife. Follow up questions were asked in order to capture the details of the stories.

Data analysis

The data were analysed in accordance with the procedures described by Dahlberg et al. [12]. During analysis, the researcher moves from understanding the interview text as a whole, through understanding the single meaning units of the text, to a new whole, in which the essential meaning of the phenomenon is illuminated [12]. All interviews were audio recorded and transcribed verbatim. First all interviews were read separately by the researchers. The interviewers IL and HL read the interviews together identifying meaning units. From the meaning units, clusters were formed that captured the variations of the phenomena. This was a cyclical process whereby the researchers moved back and forth between the whole text and segments of the text to gain some understanding of the phenomena being explored. The clusters were then abstracted to a higher level and grouped together. The essential structure of the phenomenon was formulated from the different clusters. Constituents were created from the essential structure to describe all possible variations in the phenomenon.

Collaborative reflective discussions, as described by Van Manen [14], then took place with the whole research team to generate deeper insights and understandings. Two of the researchers (IL and HL) are midwives and familiar within the field of study, this enabled them to share their views of the way the description did or did not resonate with their own experiences. The third author (KN) has experience as a nurse and is well known in the field of anthropological studies.

Findings

The essential meaning of the phenomenon giving birth at home without the assistance of a midwife was understood as a conflict between, on one hand, inner responsibility, power and control and on the other hand insecurity in relation to the outside, to other people and to the social system. The woman was outside the social *boundaries* of accepted behaviour and her own power during birth was like "climbing in the Himalayas, not only without oxygen but also all by myself". It was understood as a way to maintain a sense of the self being protected within its field of power. The home was seen as a protected area where the woman's own power was not threatened by foreign interruptions or interventions. The home is where the baby was made in the first place and it was considered the place for birth with the same intimate feeling of love. Giving birth was described as part of the sexuality and as such "it should not be conducted in front of people I do not have trust and confidence in". To be fully open and safe in this situation was essential for the women and they create the environment ahead of the birth so that they were prepared to "go-with-the-flow" when labour started.

The women had trust in their own ability to give birth. However, as they were outside the *social boundaries* of acceptable behaviour they felt insecurity in relation to the society and other people outside their own protected field of power. The women did not want to be judged or objectified by others and they perceived the presence of a midwife as a potential threat to the intuitive process the birth may be. They feared that external principles come with a midwife who is not only their support but also the representative of a medical paradigm they do not agree with as long as the birth is proceeding normally. A wish to be cared for by a midwife was in conflict with the fear of not maintaining the integrity and respect they need in this precious moment of birth. On the other hand, when they succeeded in making the birth of the baby into a sacred process, they experienced a sense of hanging on the edge of a cliff and they felt added confidence in the new role as a parent. Three constituents contributed to the understanding of the lived experience of having an unassisted homebirth. The inter-related constituents are presented below and quotations from the stories illuminate each constituent.

Taking on the responsibility by oneself and not delegating any responsibility to the health care system

During and after birth there are practical arrangements that need to be done and medical aspects that must be considered. When the women find themselves in a situation where the support from a midwife was not available they tried to find another solution for the forthcoming birth. They displayed resistance towards the routine management provided by the hospital; but they still saw the need for some arrangements to make the birth safe. In order to identify situations that could be complicated they studied the literature about the birth process and educated themselves with help from midwives, friends and the Internet.

> I had done that with my first two children (both born in the hospital), and that was just fine but at the same time (now with the third child) I had a feeling that something had been taken from me that I had experienced when I was pregnant with (my first two) X and Y. If we had had our own midwife who had said to us that I must go to the hospital I would have done that since I relied completely on her since she knew us and she knew what was important for us. In that case I would have found out most of what I really needed to know.

Choosing a planned home birth was the result of having little confidence in the healthcare system, due to previous experiences or knowing about the experiences of others. All but one of the