Home as a place for giving birth - A circumpolar study of the experiences of mothers and midwifes

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Abstract:

This article explores what home birth mothers and midwives say about the birth experience and the interaction between mother, partner and midwife. It is based on an explorative empirical study of the narratives of seven home birth mothers and the experiences of five midwives. The authors examine how these subjective experiences can help us to understand the phenomenon of home birth. The article is grounded in a philosophy of place and feminist theory, understood within a health promotion framework. Home birth manifests itself as a place-based aesthetic experience characterised by gender, body, nature and culture. The participants spoke of the significance of giving birth at home. The authors discover that giving birth at home involves celebration, togetherness and ontological security. It also encompasses a broad understanding of risk, power structures, responsibility and co-determination. Openness about the challenges of home births can boost the position of home birth among both clinicians and the general public.

Keywords:

Circumpolar health, home birth, health promotion, aesthetic experience, interaction, feminism.

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In this article, the authors will explore what home birth mothers and midwives narrate about the birth experience and the interaction between mother, midwife and partner. All the partners in the study were biological fathers of the new-borns. The purpose is to understand the phenomenon of 'home birth' in light of feministic theory and health promotion ideology, rooted in a philosophy of place. The aim is also to highlight empirical knowledge of what a home birth can mean for the mother and her family in terms of health and quality of life.

Norwegian studies reveal that with appropriate selection of mothers home birth can be a safe alternative (Blix, Huitfedlt, Øian, Straume & Kumle, 2012; Blix, Kumle, Kjærgaard, Øian & Lindgren, 2014). However, it is not always easy to predict complications (Johansen, Høgsve, Iversen, & Broen 2017). Even though very few Norwegian women give birth at home in comparison with other countries, the number of home births in Norway is rising (Johansen, et al 2017). According to "National Guidelines for Home Birth" (The Norwegian Directorate of Health, 2012) women offered the option of home birth should not have diseases or other conditions that can affect the birth outcome. Any previous birth must have been without complications.

Context and culture

Every birth can be conceptualized as a subjective existential journey that is coloured by both setting and culture (Hanson, Hermansen, Schmidt, & Henriksen, 2011). People should be

allowed to define what they consider culturally unsafe in healthcare (Hanson et al., 2011). Choosing home birth may be a question of rejecting what the mother feels is culturally unsafe. A minority of women in Norway choose home birth, however, minority is not defined by ethnicity or language, but can be guided by a personal conviction to choose something other than the mainstream. "/…/whatever women's reasons for wanting to birth at home, the right to give birth in the place of one's choice is a fundamental feminist issue" (Shaw, 2007, p. 268). The feminist discourse purports that women are naturally capable of giving birth (Fage-Butler, 2017). Reiger and Demsey (2006) have highlighted inconsistencies related to the low rate of home births and gender equality:

> A decline in cultural and individual confidence in women's birthing capacity seems paradoxical in view of women's increased social power and achievement in the modern west, along with their improved health and living conditions (Reiger & Dempsey, 2006, p. 364).

This empirical study was conducted in Norway, a country that is recognised for focusing on gender equality. Our research was carried out in a circumpolar region with harsh winters, long distances and the traditional co-existence of Norwegian, Kven and Sami cultures.

A home

To understand 'home birth', it is necessary to comprehend the phenomenon of 'home'. A home is based in a dwelling, whether in a city or on a mountainside. The sense of belonging to a place prevents alienation: "The word alienation expresses precisely that one no longer has a foothold in life; one belongs nowhere and has become alienated" (Norberg-Schulz, 1978, p. 16). A home is a place to find shelter, take root and open up to life. To choose the home as a place to give

birth can be synonymous with Norberg-Schulz's (1985) understanding of home as a place to gain strength, an anchor in life in a particular place.

Women need to experience safe maternity care and the quest for security can be understood with Norberg-Schulz' metaphor that we are "/ ... / placed in the cradle of the home (Norberg-Schulz, 1985, p. 108) that a home is. Receiving a baby in a safe place is therefore the essence of home birth. The home can be understood as a secure and protected space (Martinsen, 2015). Being received and receiving is the contextual interaction between baby, mother, midwife and partner.

A health promotion perspective

The tradition of health promotion (WHO, 1986), is based on a broad understanding of health involving participation, dialogue and context. Health is created where people live, love, work and play (WHO, 1986). The home has always been a place where nurses, midwives, public health nurses and health visitors work, but it has not been regarded as a classical setting for health promotion (Mahler et al., 2014). Public health researchers must realise the importance of context, culture and tradition in early life (Whitehead, 2011). Working in another person's home involves different working conditions from a hospital. It is important that professionals respect the spoken and unspoken rules of place (Martinsen 2006).

The midwife has to work professionally while also establishing and maintaining relations with the family members. When a woman chooses home birth, it is not necessarily on her own terms, but on those of medical science (Johannesen, 2009). According to Johannesen (2009), the pregnant woman can lead her project (pregnancy and planning a home birth), but will have to follow healthcare guidelines if clinicians are involved. The midwife supports the woman according to government recommendations for a safe birth. Both mother and midwife have a

joint mission: safeguarding the health of mother and baby. The midwife must deal with medical risk factors while facilitating well-being, security, and respecting the ethics of place.

A feminist perspective

Home birth in a feminist perspective recognises the voices of the mothers and highlights their feelings and values related to emotional and embodied birth experiences (Yuill, 2012, Bortin, Alzugaray, Dowd, Kalman, 1994). Feminism can be defined as gender equality (Nochlin, 2002); the belief in social, economic and political equality of the sexes. A feminist perspective is rooted in the principles of justice and diversity (Yuill, 2012, Butler, 2002). It often dwells on reproductive rights and career opportunities, but has largely ignored the important process of childbirth (Satz, 2017). Home birth has been regarded as an act of resistance (Fage-Butler, 2017). Through feminism, we reflect on cultural diversity among women and acknowledge female values in a traditional patriarchal society (Gosden & Noble, 2000, de Beauvoir, 2010). Empirical studies on women's experiences of homebirth illustrate why women choose to give birth at home. Previous traumatic hospital birth, wanting to avoid medical interventions and wanting to be in a familiar environment and have control over decision-making are some of the reasons given (Shaw, 2007). Home birth in a feminist perspective, recognises the partner in addition to the mother and midwife, as an important actor in the birth event. The reason for an explicit feminist perspective in home birth research is the belief in the importance of promoting values such as 'home' and 'family'.

Research method

This is a hermeneutic phenomenological study, exploring lived experience (Van Manen, 1997). The hermeneutic phenomenological design was chosen, as the aim was to gather experiential material. According to Van Manen (2014) when carrying out a hermeneutic phenomenological study it is important to stay close to the experience as lived. The authors' interest was not in opinions or technical procedures but in the experience of home birth as lived through. We studied seven mothers' stories about their home birth experience, their interaction with the midwife and partner, and the experiences of five midwives from their professional perspective.

Recruitment

We recruited participants in the arctic region of Norway, above the Arctic Circle, by contacting midwives with an active home birth service. They informed women with previous home births about the study. Five midwives and seven mothers participated. The sampling was purposeful. We wanted to recruit participants from both urban and rural areas, with challenging weather and transportation conditions.

The study had twelve participants; one of the midwives was male. One participant group consisted of three women with one or more previous planned home births. The other group consisted of four midwives with more than five years home birth experience. Participants could choose between participation in a focus group interview or giving individual written responses to questions. This was due to challenges related to geographical distance and work rotation. One midwife and five mothers responded in writing.

Written narratives

Asking individuals to write down stories that describe their lived-experiences is a feasible method for collecting experiential material (Van Manen 2014). The purpose is not to access events factually and chronologically but to capture feelings, mood and emotions. Five mothers and one midwife wrote free, individual texts describing their experiences from the births. The written narratives were between one and two pages long. The purpose of these written narratives was to ensure the participation of those who wanted to contribute and to gather include individual memories that emerged in retrospect. In the words of Van Manen (2014 p 365) "Phenomenological reflection is writing".

Focus groups

Two focus group interviews were conducted; one with the midwives that lasted one hour and 40 minutes, and one with the mothers that took one hour and 33 minutes. The interviews were conducted in calm settings at the university or in the hospital. The second author, a researcher with two home birth experiences acted as moderator. This provided the possibility of an intimate conversation based on a common frame of reference. The participants acted as co-researchers and decided the direction, commitment and temperature of the conversation. The moderator ensured that the discussion was in keeping with the research focus. A focus group has a common topic or theme (Morgan, 1997). The main theme was the home birth experience. In a hermeneutic phenomenological interview study, the process of analysis begins during the interview (Van Manen, 2014). The following sub-themes emerged during the interview: Motive for the home birth choice and sensory experiences during home birth; thoughts on co-determination and on health & risk in relation to the birth situation. Interaction & communication between mother, partner and midwife and the role of the partner during the

birth also were also thematised as well as the significance of the family unity and the meaning of place and home.

Analysis

The study aimed to reveal the unique personal experience of home birth of mothers and midwives. Van Manen (1997) writes about researching lived experience to gain access to information that provides a deeper and richer understanding of a field. Our approach was to be as open as possible to the participants' stories to prevent blocking important experiences we had not considered and to ensure rich descriptions of their experiences of home birth**.** The transcribed interview texts and the written narratives were read by each researcher independently. A selective 'highlighting approach' was chosen as the analysis tool (Van Manen, 1997). This implied that sentences, phrases or words that that could give meaning to the participants' experiences were highlighted. The selected quotes were sorted and thematised into themes. Further processing led to three main themes: *security, peace* and *participation* and six subthemes further detailed in the findings and discussion section.

Ethical aspects

The study was approved by the Norwegian Social Science Data Services. However, prior approval is insufficient as ethics is an intrinsic part of the whole research process (Clancy, 2011). In the interviews, the moderator was attentive and considerate. Doubts and uncertainties in interpretation and the selection of themes were discussed by the authors in order to address the ethical aspects of this phase.

Findings and discussion

Interpretation of the participants' responses revealed that *security, peace* and *participation* were core concepts. These concepts comprised six sub-themes: 'home as a safe haven', 'giving birth is risky', 'birth as celebration and togetherness', 'participation and responsibility', 'host or guest' and 'nature and everyday activities as a sensory approach to birth'. These subthemes guide the presentation of findings and are further elucidated and reflected upon using the philosophy of place, as well as health promotion, and feminist ideologies. These perspectives permeate the findings and help evoke meaning from, and give depth to the experiences without losing the essence of the stories.

Home as a safe haven

The participants recalled the feeling of *security* during labour as it was experienced from within, as a bodily emotional experience that gave them *peace.* As one mother said:

> Being allowed to be at home felt nice and secure for me. It would have meant more stress for me to have to go somewhere, to a hospital - in such a vulnerable situation / ... / feeling secure inside myself and the feeling of being able to concentrate fully on my body (Participant 2).

This woman was glad she did not have to travel. She did not view her home as a particular place, but as an 'existence'. This existence can be defined as a 'taken-for-granted' life experience, or as a 'here-and-now' frame for the woman's life. Her home as a 'place' was thus experienced as a 'safe haven' that enabled her to focus on herself and the birth. She also stated:

> It was important for me to be able to focus so much on my own inner experience that I wasn't so sensory or outward-looking / ... / For me it was wonderful to be at home. I relaxed so well.

> It felt nice and secure, and I'd say I recovered very quickly from the birth because I didn't have to go anywhere soon, just be with my baby and get to know her.

Health is created where people live work and play (WHO, 1986). The mothers present a picture of the home as a health promoting setting for giving birth. A home birth can contribute to well-being and empowerment (Fage-Butler, 2017) and the importance of the home as a *safe haven* is evident in the mother's stories. Described as follows:

> My husband did the vacuuming and cooking, while I rested and breathed through the contractions. The midwives knitted and chatted, and observed my breathing. It felt safe and warm. I was in my own bubble. I was surprised how simple it really was, my body did the work, all I needed to do was let go (participant 3).

The woman's words illustrated security, peace and presence - the *here and now* aspect of place. The mother also observed that her husband did not play the traditional gender-stereotype-game, but a more caring housekeeping role during the homebirth process. Another mother (participant 7) presented the contrast between hospital and home births:

> So on the way I had to hurry, there wasn't much time. I was reminded of the time. Compared to when I was [gave birth] at home, then it was completely unimportant. It didn't matter whether it was night or day. And that's how it is - a stress factor.

This comment indicated the lack of peace and presence in the hospital space. The hospital was experienced by four of the informants as an instrumental, patriarchal and busy place where issues of time dominated. The critical sociologist Hermut Rosa (2010) reminds us to be aware of structures related to time and space, because these affect our being-in-the-world (Rosa, 2010, p. 42). We see this in the participants' stories. Rosa writes about speed and alienation in late

modern society. Everything has to go quickly and the increasing acceleration in society makes people feel alienated (Shaw, 2012). According to Rosa (2010) as speed increases, one's physical and existential space becomes constrained and the natural priority of place over time is reversed. The experience of presence disappears. "Here, now" becomes "soon, later". Time becomes a confined space and place loses its identity and security.

The mothers in our study said that when giving birth at home they felt calm, secure and experienced a sense of community not alienation. Some participants who had previously given birth in hospital were not necessarily dissatisfied, as one mother (participant 3) said: "My first birth in hospital was a nice, safe experience!" They appreciated having the hospital's expertise in the background if anything went wrong. But hospitals were still perceived as urgent and impersonal places, institutions where they could feel alienated. A mother (participant 7) said:

> "I felt the hospital birth was lots of stress, I was almost kicked out of the maternity ward straight after the birth because there were so many mothers-to-be and little space. Not much personal contact with the midwife".

Participants (3 and 7) who had given birth both at home and in hospital tended to compare the experiences. They concluded that home birth provided an experience of mastery, the ability to listen to their own bodies, an alternative time experience and security in a familiar world. They reported perceiving the hospital framework as rigid, defined by others and inflexible to women's needs. Pollard (2011) writes about the medicalisation of birth: that /…/ can be conceptualised as a gendered process: in many countries, legislation gives medical practitioners power over childbearing women" (Pollard, 2011, p. 5). When women tend to feel alienated in the world it can be because they feel that they do not fit in:

> /…/ what really matters for women is access to the information that will enable them to participate fully in the birth experience, whether it occurs at home, in hospital or in a birth centre (Kitzinger, 2002, p. 8).

Giving birth is risky

Giving birth involves risks and the women mentioned this, but their descriptions also included a different kind of risk than what is normally associated with childbirth. They spoke of 'risking the stress' of giving birth in hospital. One mother (participant 2) said:

> Risking the journey, discomfort, waiting, unnecessary interventions, constant interference, strangers, unfamiliar smells, other patients, uncomfortable beds, authority and abuse of power, hospital food, sharing a room and not being able to have the father always present - well, it doesn't tempt me.

Good places embrace you, protect you and give you courage, while places that infringe upon you are places where you can lose your foothold (Martinsen, 2006). One mother (participant 5) explained that in hospital, important medical needs could be addressed, but not necessarily the personal, social and cultural needs. She explicated further:

> So it meant so much to me that my first son was born in my childhood home, the farm where we've lived for eight generations. The expression "generations follow generations" makes sense, and I feel part of many generations. It gives a meaning, security and responsibility. The actual part of the house where the baby was born didn't matter so much. The first one was born when I was sitting on the living room floor, the second one in the bed in the bedroom.

A home can be experienced as a harmonious space, a place where the occupants can feel free from the distractions and disruptions of a strange place (Mahler et al. 2014). The respondents

talked of harmonious experiences during labour, using expressions like “being in a bubble”, “going deep into yourself” and “being concentrated and present, there and then”. These words can be interpreted as expressions of “flow (Csikszentmihalyi, 2016). Flow occurs when one becomes oblivious of time and place and devotes oneself completely to the moment of the experience (Csikszentmihalyi, 2016). Everything feels in place.

Mothers and midwives used the terms *natural* and *normal* when describing giving birth. The midwives discussed the medical understanding of a so-called “normal birth”. They concluded that what home birth midwives consider a “natural” and thus “normal” birth differs from a traditional institutional understanding of a “normal” birth. The mothers also spoke of a *normal* birth in hospital, and their expectations for a *natural* birth at home. Their stories can illustrate that a *natural* birth allows one to follow one’s own rhythm and everyday routines performed in familiar surroundings, where one can calmly decide who can be present. In Pollards study: “All the midwives distinguished between holistic midwifery dealing only with ‘normal’ women, and midwifery involving extended skills and caring for women with complications” (Pollard, 2011, p.12). The female body in medical science has been seen by feminist researchers as a faulty machine, always in a danger of breaking down (Bortin et al., 1994**. p. 146).** Technology is used during pregnancy and birth to regulate and control the procedure and avoid risky situations in order to produce a healthy newborn (Bortin et al., 1994. p. 146). The terms *normal* and *natural* seem unsuitable in connection with childbirth (Shaw, 2007), because people with very different births can refer to their births as normal despite minor or moderate medical interventions. The idea that there are natural and medicalized models of childbirth has been criticized, as some women use technological aids and still regard their births as a natural process (Shaw, 2007). Listening to voices in their context has illustrated that place and tradition influence

understanding. As, Coxton, Sandall & Fulop (2014), write, each culture defines what is natural and normal.

Birth as celebration and togetherness

Home is not only a physical place, but also a place loaded with symbolism rooted in the past, present and future (Frank, 1995). When a woman gives birth at home, every moment, including the moment of birth, is part of a greater historical narrative and the experience of belonging to a place. Formerly in Norway, births were a family matter, an experience for the whole family, involving rituals, celebrations and commemorations (Hanson et al 2016). Such practices still exist. Several participants reported that their births culminated in a gathering with food, celebration and intimacy as essential elements. As one mother said:

> For the children it feels secure, they're a product of their parents, and can be reassured that this is a good healthy home. We're strong people, you know. We don't need, in case the worst should happen, to have the greatest expertise at hand **(participant 6).**

These words demonstrated how the birth was an expression of the whole family's identity and strength. Another participant, who had given birth in four different houses, said: "This suggests that the shell of the house doesn't mean that much. What's most important is that *we* live there and everything is *ours* and familiar". Further: "All four births were experienced as great moments for 'us' and 'ours' " (participant 5). Bortin et al (1994) emphasize the importance of studying the births impact on relationships and the woman's sense of empowerment. A mother explained:

> The attitude you indicate: we can do it, or the woman giving birth - I can handle this just as well as anyone else, that's healthy. Very often it's not how you feel, but your attitude. It's the signal you send to the rest of the family. It's very reassuring **(participant 1).**

This participant linked the reassuring feeling of the birth to the understanding of strength, celebration and togetherness. Home birth empowers (Fage-Butler 2017). Food on a festive table with candles, and grandparents and siblings present to meet the baby the same evening that he arrives. The mother (participant 5) elaborated further: "There was wealth around the table". The birth was thus experienced as culturally safe. It can be interpreted that the mother trusts herself, her bodily strength and cultural harmony. Norberg-Schultz (1978) writes about the power of place to give strength just as Martinsen (2006) recognises how certain places can sap energy. Research shows that many lose faith in their own cultural knowledge and practices with regard to giving birth (Hanson, et al., 2011, p. 92).

Participation and responsibility

It was important for the mothers to be active participants. One aspect they highlighted as vital was personal chemistry, avoiding conflict and creating a good birth experience. It was absolutely essential that the chemistry was right between the woman and the midwife. Just as power can be linked to roles, titles and uniforms, it can also be linked to an individual's behaviour and personality (Frich, 2015). The midwives we interviewed emphasised that a midwife must be aware of her power of definition. Martinsen (2005) reminds us how our vulnerable dependence on others cries out for respectful care. One mother said, "I had quite clear views on the birth positions I wanted, late umbilical cord clamping, soft music and candlelight". Another mother (participant 4) stated:

> I think it's extremely important that the woman feels she's the one who decides. I'd want that at least, not just being involved, but having co-determination. It sounds a bit like a top-down approach: the patient may be involved in the decision. For me it's important that the woman decides, no-one else. If you have co-determination, you go from being passive to active. You control things yourself. That's why it's so important to tell pregnant women that they have co-determination, and what they can decide. I think that with first pregnancies the woman too often just does what the clinicians recommend, thinking they're the experts and know how to do things. But women are experts about their own bodies. That's why information is important, not only when you're pregnant, but also that the midwife gives the woman control during the birth.

This mother also said that a high degree of self-determination implied responsibility for the decision to give birth at home:

> I wasn't just advised by clinicians not to give birth at home. I felt intimidated, labelled as an irresponsible "child murderer" and pressurised not to give birth at home. These weren't clinicians I met in connection with the birth or the pregnancy. It was more other clinicians who'd heard I wanted to give birth at home.

The mother feels responsible and stigmatised and expresses doubt about the ethical aspects of her choice. Choice can lead to feelings of accountability and blame (Coxton et al., 2014). Active participation by the woman in decisions about the birth can change the power relationship between the woman and the midwife. One participant made this point:

> In any case, it's a situation you don't control completely, as your body and the circumstances take control of you and your will, but it's all the more important that you can be involved in deciding what's needed to make the best of a situation like that **(participant 6)**.

A high degree of co-determination does not necessarily mean that the clinician has less power (Beedholm & Fredriksen, 2015). Power can appear in new ways. The midwife's duty may be to support the woman to succeed in her role. If health services are to promote health, clients must gain control of factors that have a positive, not a negative, effect on their health (Vallgårda, 2009). According to the midwives, the mother can decide to some extent, but the midwife will always be in the background ready to step in and take over if the mother or child's life or health is in danger. The midwife and the mother have a joint project to preserve life and health, which must have a balance in power relations and a focus on life-world care. Dialogue and participation are important factors in promoting health (WHO, 1986). A life-world approach to healthcare can help promote participation and avoid a focus on self-determination, understood as self-interest (Galvin and Todres 2013; Todres, Galvin, & Dahlberg, 2007). A life-world approach seeks to maintain basic human values in high-tech healthcare, and encompasses more than self-interest and the healthcare focus on efficiency. The mothers described objectification in an impersonal hospital world, and demonstrated their need for more than efficiency when they give birth. These women's stories are worth listening to when future healthcare decisions are made. A mother spoke about an undesirable incident during a home birth with regard to co-determination and responsibility. The woman described it as follows:

> Health and quality of life are two words that go hand in hand / ... / I think my bleeding would have been handled better in a hospital than at home. I fainted some days after the birth, and my blood count was never taken./.../ not until years after the birth did a doctor find out my iron deficiency / ... / The midwife said I mustn't talk loudly about my bleeding to gynaecologists, maybe she was joking, but I feel I wasn't treated adequately because of attitudes to the dangers of giving birth (participant 4).

The woman believed that speaking about her experience of inadequate care and lack of treatment for her bleeding could be interpreted as a possible criticism of home births. However,

openness about the challenges of home births can promote trust and boost the position of home birth among both clinicians and the general public.

Host or guest

During a home birth, one is master in one's own house and shares the experience with one's partner (Bortin et al., 1994). "The midwife becomes a guest and the woman and the father the hosts," one participant emphasised. This alters the whole symmetry in the relationship. At home, the partner is free to decide his own actions. One midwife described the partners's role:

> He's more active around his wife without taking over. It's his birth too / ... / food, drink, massage, towels / ... / he arranges it / ... / The father gains most from it. He gains in every way when it's at home. Much more involved and included.

The mothers remembered their partners going into the garage, painting the living room, gardening, cooking and fetching basins, towels and warm water for the midwife. One of them said, "He knows me best and knows my body language and can pass on information to the midwife if I can't." Here we see that the woman's partner combined the roles of host, facilitator and translator. His role was important for the mother, the midwife and the newborn. The importance of being assigned a valuable social role in everyday life is widely recognised. The sharing of roles described here can lead to a more participatory role for the partner and should be the subject of further research in an emancipatory family and public health perspective. The whole family was clearly affected by a situation where the midwife was a guest and not the host. "The child gets a more peaceful start. Fewer sharp sounds, breastfeeding starts more readily. No breastfeeding problems or supplements of water or milk," said one midwife. He elaborated:

> Brothers and sisters don't have to visit like in hospital. Avoid the trauma of being separated from the mother and new baby. Often with their grandparents and come home once the baby is born. There's a strong sense that this is idyllic and not stress.

The women and midwives agreed on the strong synergy effect for mother, partner, siblings and the baby, and of the parents' role shift from being guests in a hospital to being hosts in their own home. This inclusive approach is seen in feminist literature as having an overall health promotive effect on the whole family.

> /…/ the feminist approach would define health from the viewpoint of the woman and assess her within her social, environmental, and biological context. Health promotion encourage behaviors conductive to the woman's well-being throughout her life-circle (Bortin et al., 1994, p. 144).

Nature and everyday activities as a sensory approach to birth

Giving birth at home gave access to nature. Several participants were keen to be part of nature, also in the birth process. The early stages of birth are compatible with experiences of nature. A hospital building can discourage contact with the outside world. At home, the participants can open a window, breathe fresh air, step outside and listen to the chirping birds, howling wind, crackling snow or see the midnight sun. Several participants had strong aesthetic narratives that helped to shape a great family story about the new baby. As one mother said:

> I thought it was a very beautiful night to come into the world! / ... / At an early stage of the birth, I watched the Kon-Tiki film. The last obstacle for the raft before they reached Polynesia was to get over the coral reef to the island. They dropped anchor and waited for the thirteenth and biggest wave to surf over the reef. This became a kind of mantra for me as

> the contractions got stronger. I counted waves and threw myself over the contraction on the biggest wave - and then drifted into calm waters on the other side (participant 6).

Giving birth was an aesthetic experience of place. The women remembered that "the sofa was beige" or "had a rough texture". Furniture, pictures or objects that surrounded them during the birth were remembered and could leave a mark that jolted their memory in later life. These sensory experiences gave the participants peace and calm to give birth, and the confidence to deal with the contractions naturally. 'Air' and 'fragrances', 'sounds' and 'music', 'touch' and 'movement' are mentioned as important experiences during the birth process. Movement is important for the progress and outcome of the birth, according to a midwife:

> Movement and activities that get the birth going, I think they affect you in these phases. So when you get to the point of giving birth, it isn't just chance. I think they get where they want to be, without necessarily being conscious of it. They land where it's best to be.

Another midwife said: "The atmosphere that fills the home is quite unique in a home birth". She reflected on the calm, the light, the sounds and feelings in the room and pointed out that it is the totality that has an aesthetic value. This can be linked to Dewey's (1934) interest in how everyday activities create meaningful aesthetic experiences. One of the women (participant 7) said she would choose home birth again because she recalled the experience of "devoting myself completely to my body and the feeling of privacy in an intimate part of life". Stories about going from room to room, cooking, wallpapering, cleaning the stairs or listening to the radio, were highlighted by the participants as important memories of participation in the birth. Both parents spent time during the birth doing everyday things, rather than having to leave home for a hospital where they had to concentrate solely on the arrival of the baby and wait for instructions from the midwife.

Limitations

The scope of the study is small and cannot be generalised to other regions in Norway or other countries in the world. However, as a hermeneutic phenomenological study and in keeping with feminist and health promotion ideologies it does have relevance. The study recognises cultural diversity and the importance of listening to the voices of women and highlighting their feelings and values. It can be argued that the perspectives of both midwives and mothers portray a romantic one-sided picture of home birth. There were only three participants in the group of mothers. This can limit variation in experiences. However, as Morgan (1997) has outlined, a small group is very useful when the researcher wants a clear sense of each participants experience as it gives each participant more time to talk. The participants in the study share their views on home births without complications. One mother did however hint at the possible dangers of home birth and of being encouraged by the midwife not to mention complications to the hospital gynaecologist. This gives a glimpse of underlying structures of power and resistance amongst home birth professionals that are not discussed in depth in this article and that should be investigated further.

Conclusion

Mothers and midwives have shared their experiences about the home birth experience. Home birth presents itself as a place-based aesthetic experience involving body, nature and culture. Giving birth at home can promote feelings of strength, participation and dialogue. The shared experiences also revealed other understandings and underlying power structures. Home is not always a safe haven, nor is birth always a celebration of togetherness. Giving birth also involves

risk, pain and unforeseen events. A home birth means that the professionals must have a broad understanding of risk and safety, responsibility and co-determination. The medical model of childbirth care is dominated by risk analysis and cause and effect discourses. The home birth discourse needs to be unfolded. This study has shown the need for further research on home birth using other methodologies. Dominant and latent discourses and underlying power structures in home birth warrant further study.

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