

https://dspace.org/

Investigating childbirth choices in a Group of Childfree Women in South Africa

Edginton, Christina

2019
https://hdl.handle.net/10539/29403

Downloaded from a DSpace repository. https://dspace.org/

Investigating Childbirth Choices in a Group of Childfree Women in South Africa

By Christina Edginton

Supervised by Professor Carol Long

Student number: 800214



This is a research report submitted in partial fulfilment of the requirements for the degree of Master's in Social and Psychological Research by Coursework and Research Report in the faculty of Humanities, University of the Witwatersrand, Johannesburg.

Declaration

I, Christina Edginton (Student number: 800214) am a student registered for the degree of Masters in Social and Psychological Research by Coursework and Research Report in the academic year 2019/2019.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature: _____ Date: _____

Table of Contents

Title Page ……..1

Declaration…….2

Table of Content……3

Abstract …….5

Chapter 1

1.1 Introduction ……...6

1.2 Research Aims……7

1.3 Research Rationale ……7

1.4 Structure of Report…….9

Chapter 2

2.1 Literature Review

2.1.1 The medicalization of childbirth……..11

2.1.2 Choice in childbirth ……12

2.1.3 Factors influencing childbirth choices ……14

2.1.4 South African Context ……16

2.2 Research Questions …….18

Chapter 3: Methods

3.1 Research Design ……..19

3.2 Sample and Sampling ……..19

3.3 Procedure …….20

3.4 Ethical Considerations …….22

3.5 Analysis ……...……23

3.6 Reflexivity ……...24

Chapter 4: Analysis and Discussion

4.1 Characteristics of the sample ……..26

4.2 Theme 1: Anxiety around childbirth ……...27

4.2.1 Pain of vaginal birth ……29

4.2.2 The safety of the medical setting ……32

4.2.3 Physical changes ……34

4.2.4 The influence of the media ……37

4.3 Theme 2: Caesarean sections as a point of reference for childbirth choices ……..38

4.3.1 Caesarean sections as a medical necessity ……..38

4.3.2 Caesarean sections as the easy way out …….……..41

4.3.3 Socio-economic factors ……...43

4.4 Theme 3: Childbirth and Motherhood ……44

4.4.1 Pressure to have children ……44

4.4.2 Safety of the baby ……45

4.4.3 Childbirth choices affecting motherhood ……46

4.5 Theme 4: The influence of other women's stories ……..48

Chapter 5: Conclusion

5.1 Overview of research findings ……52

5.2 Strengths and limitations ……55

5.3 Recommendations for future research …….……56

5.4 Conclusion……57

Reference List …….…..…59

Appendix A: Interview Schedule …….…..……..62

Appendix B: Participant Information Sheet …….……...64

Appendix C: Participant Consent Form …….…….65

Appendix D: Supervisor Contract ……...66

Appendix E: Ethical Clearance Certificate ……67

Abstract

In South Africa women have a variety of choices to consider when faced with birthing decisions, ranging from elective caesarean sections to drug-free vaginal birth at home. While these choices may seem straightforward, there are a range of views and beliefs about the 'ideal' birth influencing women's choices. This study aimed to conduct an in-depth investigation of the views and ideologies surrounding different childbirth choices in a group of childfree women in South Africa, as well as to explore their prospective choices and the reasons behind these choices. The research further aimed to explore how their views regarding different methods of childbirth link to their understanding of motherhood and femininity as well as to common feminist debates on childbirth and motherhood. The sample of this study consisted of 9 female postgraduate students, with ages ranging from 21 to 28, attending the University of the Witwatersrand, who had not yet given birth and were not pregnant at the time this research was conducted. The participants each completed a face-to-face in-depth semi-structured interview. A thematic analysis found four themes which emerged from these interviews, namely anxiety around childbirth, the use of caesarean sections as a point of reference for childbirth choices, childbirth and motherhood and the influence of other women's stories. The findings of this study further revealed that the media and the stories of other women have served as the main sources of information for this group of women concerning different childbirth choices.

Chapter 1

Introduction

In today's society women have a variety of childbirth choices and options to consider when faced with birthing decisions, ranging from elective caesarean sections to drug-free vaginal birth at home. Childbirth most often occurs either at home, in a hospital or in a birth centre. Home births are vaginal deliveries without medical interreference, usually assisted by midwifes or doulas. Water births are a type of birth whereby the mother gives birth, or goes through some stages of birth, immersed in water (Oberg, n.d.). In a hospital setting women have the option to give birth vaginally, with or without medication, or to have a caesarean section. Caesarean sections can be elective or non-elective in the case of medical complications and involve delivery through an incision across the abdomen (Oberg, n.d.). The idea of choice with regards to childbirth, though it may seem straightforward, is a complex notion with many different views and beliefs about the 'ideal' birth influencing women's choices (Crossley, 2007; McAra-Couper, Jones & Smythe, 2012). Since the 1970's the literature on childbirth choices has focused on arguments surrounding the medicalization of childbirth and its effects on motherhood and femininity (Beckett, 2005). On the one hand there are those who critique the medicalization of childbirth and encourage 'natural childbirth' and on the other hand there are those who critique this 'natural childbirth' movement and view it as regulatory rather than empowering for women (Beckett, 2005; Brubaker & Dillaway, 2009). With caesarean section rates rising globally, and in South Africa specifically, it is increasingly important to understand women's childbirth choices and the social and cultural contexts in which they are made (Betrán et al., 2007). Furthermore the high levels of maternal mortality in South Africa, which are often associated with rising rates of caesarean sections and their increased surgical risk, highlight the importance of exploring childbirth choices further (Gebhardt, Fawcus, Moodley & Farina, 2015).

This study aimed to conduct an in-depth investigation of the views and ideologies surrounding different childbirth choices in a group of childfree women in South Africa. It is important to note that the terminology available to refer to women who have not yet given birth and are not pregnant is problematic. The word 'childless' is often used however it could be seen to place women who do not have children as missing, without or 'less' something, and hence frames the absence of a child in a negative way. The word 'childfree' offers an alternative which could be seen to frame the absence of a child in a more positive way,

placing women who do not have children as being ‘free’ of something. Alternatively the term ‘nulliparous’ is often used in the medical field to define women who have never given birth. Given that there is limited terminology available, the word ‘childfree’ will be used in this study to refer to women who do not have children, are not pregnant and have yet to give birth.

Research Aims

The aim of this study was to conduct an in-depth investigation of the views and ideologies surrounding different childbirth choices in a group of childfree women in South Africa. This research aimed to understand the views and opinions of these childfree women regarding different childbirth choices as well as to explore their prospective choices and the reasons behind these choices. The research further aimed to explore how their views regarding different methods of childbirth link to their understanding of motherhood and femininity as well as to common feminist debates on childbirth and motherhood.

Research Rationale

In 1985 the World Health Organisation (WHO) declared that the ideal rate of caesarean sections for any region should be 10 to 15%. Based on a systematic review done in 2014 the WHO supported these rates by concluding that at the population level “caesarean section rates higher than 10% are not associated with reductions in maternal and new-born mortality rates” (World Health Organization, 2015, p. 4). Based on these conclusions they argue that caesarean sections should ideally be performed only when medically necessary due to the possible risks associated with this surgical intervention (World Health Organization, 2015). This position taken by the World Health Organization (2015) has become controversial with many arguing that women should simply be allowed to choose to have a caesarean section. Some argue this position as they believe caesarean sections have become safer while others believe that it is a patient’s right to choose their form of medical care (Beckett, 2005). According to Betrán et al. (2007) the average rate of caesarean deliveries in Africa is 3.5% with South Africa holding the highest rate at 15.4%. Additionally there are studies which have been conducted comparing these rates in private and public hospitals in South Africa and shown that while they are between 15 and 20% in the public sector, the private sector

rates can range from 40 to 82% (Naidoo & Moodley, 2009; Tshibangu et al., 2002, as cited in Chadwick & Foster, 2013). When looking at these rates provided by various authors it is clear that they do not align with the 10 to 15% suggested by the World Health Organization. While these rates could be argued to be high it is still unclear in South Africa what proportion of caesarean sections are performed for medical reasons and what proportion are elective caesareans (Chadwick & Foster, 2013; Naidoo & Moodley, 2009). Irrespective of the rates of elective and medical caesarean sections in South Africa it is important to further understand and explore childbirth choices in a South African context. Furthermore Chadwick and Foster (2014) have highlighted the lack of research that exist in South Africa regarding rates of births located outside of the medical setting.

In South Africa discussions regarding methods of childbirth should consider the high maternal mortality rates which are often associated with rising rates of caesarean sections and their increased surgical risk (Gebhardt et al., 2015). The National Committee for Confidential Enquiries into Maternal Deaths in South Africa (2018), which publishes triennial reports of maternal deaths has highlighted that the lack of access to safe caesarean sections in South Africa has largely contributed to the rates of maternal deaths in this country. This report has indicated that the lack of appropriately trained doctors and nurses as causes of maternal mortality with regards to caesarean sections is concerning (National Committee on Confidential Enquiries into Maternal Deaths, 2018). Despite the fact that South Africa has seen a decline in maternal mortality since 2009, deaths associated with caesarean sections have been highlighted as an area which still requires attention and improvement (Moodley, Fawcus & Pattinson, 2018). Moodley et al. (2018) argue that the main factor affecting this decline in maternal mortality has been the success of the antiretroviral treatment programme for HIV-positive women as opposed to improvements in the availability of safe caesarean sections. They further emphasize that caesarean sections are “an underlying factor in other causes of maternal deaths such as puerperal sepsis, thromboembolism and eclampsia” (Moodley et al., 2018, p.7).

This research aims to explore childbirth choices in the South African context by focusing on the views and ideologies surrounding different childbirth choices in a group of childfree women, and further investigate how these views relate to women’s understandings of motherhood and femininity. While many studies have looked at women’s retrospective reasons for making childbirth choices, recent studies have taken a different approach by focusing on the perspectives of women who do not yet have children (Cappell & Pukall,

2017; Malacrida & Boulton, 2012; Stoll et al., 2009; Stoll & Hall, 2013). These studies have suggested that the views of childfree women on different childbirth choices often differ from the views of women who have had children, with some research indicating that childfree women hold stronger beliefs of normative ideologies of motherhood than women who have already given birth (Malacrida & Boulton, 2012). The literature has further highlighted that childbirth choices are strongly influenced by and linked to the social and cultural contexts in which they occur (McAra-Couper et al., 2012). The idea that childbirth choices are strongly influenced by context highlights the importance of conducting this research in South Africa given that there is a limited amount of literature in the South African context which has focused on childfree women. This research aims to explore this further by investigating how the views of this group of childfree women are linked to or influenced by their social and cultural contexts. Furthermore focusing on women who are not yet mothers may also provide insight as to how motherhood and the medicalization of childbirth are constructed within childbirth choices.

In South Africa medicalized births are becoming increasingly popular with 96% of women giving birth in a health facility, home births and elective caesarean sections are often seen as uncommon choices for South African women (Chadwick & Foster, 2014; South African Demographic and Health Survey 2016, 2017). Previous research has highlighted that fear of childbirth has been an important factor influencing women's childbirth choices and has been related to more positive views of medical interventions (Stoll & Hall, 2013). Although it is not one of the main aims of this research it is also important to explore women's sources of information regarding different childbirth choices, as previous research has emphasised that these sources may perpetuate misconceptions regarding different methods of childbirth (Cappell & Pukall, 2017; Saroli-Palumbo, Hsu, Tomkinson & Klein, 2012). This research has the potential to shed light on the factors influencing birth preferences of childfree women in South Africa as well as investigating these sources of information regarding different methods of childbirth.

Structure of the Report

Chapter one has introduced the importance of exploring childbirth choices in South Africa as well as outlined the aims of the research. It has provided a broad understanding of the importance of investigating childbirth choices and the rationale for conducting this research

in South Africa with childfree women. Chapter two consists of the literature review. This section discusses feminist debates regarding the medicalisation of childbirth, literature discussing the idea of choice in childbirth, studies which have considered different factors influencing childbirth choices and lastly the state of existing literature in South Africa regarding childbirth choices. This chapter ends with an outline of the research questions. Chapter three outlines the methods employed in this study by discussing the research design chosen for this study, providing an explanation of the sample and methods of sampling used and outlining the research procedure and ethical considerations followed. This chapter further discusses the use of thematic analysis, steps followed for the analysis and reasons for the choice to conduct a thematic analysis. The chapter ends with a discussion of reflexivity and recognition of the position of the researcher within the research. Chapter four presents the analysis and discussion of the findings of the research. This chapter begins with a discussion of the characteristics of the sample. The four themes identified through the thematic analysis and presented in this chapter are anxiety around childbirth, the use of caesarean sections as a point of reference for childbirth choices, childbirth and motherhood and the influence of other women's stories. Lastly chapter five provides an overview of the findings of the research, discusses the strengths and limitations of the research and ends with a discussion of the possible recommendations for future research.

Chapter 2

Literature Review

This chapter aims to explore the existing literature related to childbirth and childbirth choices in order to identify the existing gaps in the literature and provide context for the study which has been conducted and discussion to follow. This chapter will explore the different feminist arguments regarding the medicalization of childbirth, the complexities of making childbirth choices both before and during the childbirth experience, attitudes towards different childbirth choices and different factors affecting these choices. The chapter will also include a section discussing the literature on childbirth choices in the South African context and highlight the need for more research to be done in South Africa in different contexts.

The medicalization of childbirth

A large body of the research that exists concerning childbirth and childbirth choices has focused on feminist arguments regarding the medicalization of childbirth. The feminist critique of the medicalization of childbirth emerged during the period of second wave feminism in the 1970's and is often referred to as the 'natural childbirth' movement (Beckett, 2005). The argument put forth by advocates of the 'natural childbirth' movement is that the shift which occurred from birth being viewed as a home centred event to birth being viewed as a medicalized event has resulted in childbirth becoming a passive, impersonal and isolated experience for women (Beckett, 2005).

Brubaker and Dillaway (2009) discuss three core themes that they have identified within this feminist critique of the medicalization of childbirth, namely issues of control, the birth setting, and the use of medical technology. The issue of control is related to the argument that the medicalization of childbirth results in control being taken away from women giving birth and given to medical practitioners and their technologies. This issue of control is strongly linked to arguments concerning the birth setting. It is argued that when women give birth in a medical setting the control that they would have is given to medical practitioners and regaining this control would require removing the act of birth from the hospital setting. Lastly Brubaker and Dillaway (2009) identify the use of technology as a central theme emerging in this feminist critique of medicalized childbirth. The argument is that birth in a hospital setting or 'technocratic birth' removes women's control and ability to participate in their own

childbirth experiences. These arguments are characterised by a strong resistance to medical interference in the childbirth process and their use of the words ‘natural’ and ‘normal’ can be understood “as a response to the medical profession’s pathologization of birth, as well as to the use of technology and application of norms that render birth a ‘high risk’ event” (Beckett, 2005, p. 254).

On the other hand there are also a number of feminist scholars who disagree with the arguments put forth by advocates of the ‘natural childbirth’ movement. According to Beckett (2005) one of the main critiques of the ‘natural childbirth’ movement is centred around the use of the word ‘natural’ in that it discredits women whose childbirth experiences involve medical interference. They argue that this idealisation of the ‘natural’ and ‘normal’ can be viewed as regulatory as opposed to empowering for women as it creates the idea that births which don’t conform to these ideals are ‘unnatural’ (Beckett, 2005; Brubaker & Dillaway, 2009). According to these critics birth in a medical setting or birth which involves some form of medical intervention is as much an empowering experience for some women as ‘natural childbirth’ is for others. The idea of pain in the experience of childbirth has also been a recurring topic in these arguments. According to Beckett (2005) during the period of first wave feminism women played a role in the medicalization of childbirth by fighting for the right to use pain killers during childbirth. The rejection of pain medication which is often advocated by the ‘natural childbirth’ movement can thus be seen as restricting the agency of women and creating a system where they may be judged for requesting pain medication during childbirth (Brubaker & Dillaway, 2009).

Choice in childbirth

Linked to these arguments on the medicalization of childbirth are discussions on the idea of choice in childbirth. Crossley (2007) uses an in-depth case study to create the argument that choice in childbirth is not as straightforward as it appears to be when discussing ‘natural’ and medicalized births. Through the exploration of this case study Crossley (2007) proposes that the idealization of ‘natural’ childbirth can create expectations for women which often do not align with their actual childbirth experiences. Crossley (2007) uses her own birthing experiences as the case study in this paper and explains how although she had originally been strongly motivated towards a non-medicalized ‘natural’ home birth, there were difficulties and possible risks which arose which made medical intervention necessary in order to ensure

safe delivery. The idea of choice in this case was not as straightforward as Crossley (2007, p. 559) had expected as she felt that she "could not argue against the medical professionals with regard to the risks posed" as she had less knowledge than them from which to do so.

In a study done in Canada with 22 recent mothers, Malacrida and Boulton (2014), highlight the complexity of choice in childbirth and the tensions between women's planned childbirth and their actual childbirth experiences. They conducted narrative interviews with these recent mothers about their expectations and choices before childbirth and their actual childbirth experiences. Similar to Crossley's (2007) experience of childbirth they noted that while many of these women had planned and chosen to have a 'natural' or vaginal birth, when faced with the decision about medical intervention they felt that they were not able realistically evaluate their options. Malacrida and Boulton (2014, p. 13), conclude that "faced with this ambiguity, mothers often trusted experts' knowledge and acquiesced to medical pressure, hoping for the best".

While Crossley's (2007) study and the findings of Malacrida and Boulton (2014) highlight the complexities of choice in women's actual birthing experiences, McAra-Couper et al. (2012) discuss the idea of choice in childbirth in relation to the social and contextual factors influencing women's childbirth choices. Their study of 33 'lay' women in New-Zealand highlighted that choice is often influenced and shaped by different social and contextual factors. Some of the factors they identified and discussed in this study which influenced and constructed women's choices were "social change, the gendering of women, the power of control and organization, the normalization of surgery, convenience and the role of technology" (McAra-Couper et al., 2012, p. 7). They argue that through social changes the power of decision making in childbirth has shifted from being entrusted to the medical professions and experts to the belief that "a woman's 'informed' choice is always the right choice" (McAra-Couper et al., 2012, p. 8). They propose that childbirth choices and even behaviour during childbirth are influenced by the way women are gendered in any given society. They further explain that the ability to control and regulate certain aspects of the childbirth experience, such as pain or the date and time of the birth, affects their choices depending on the level of value they place on control (McAra-Couper et al., 2012). Linked to the ability to control the childbirth experience they argue that the normalization and perceived safety of surgical interventions, as well as the trust in technology, result in women favouring caesarean sections over vaginal birth as the safer option for both them and their children (McAra-Couper et al., 2012). The notion of choice in childbirth choices is clearly a

complex topic both during women's experiences of childbirth and in the stages of making a decision on their prospective choices.

Factors influencing childbirth choices

Given that the concept of choice within childbirth is extremely complex and has multiple power structures operating within it, the next body of literature that will be discussed are studies which have moved beyond debates on the medicalization of childbirth to investigate attitudes towards different methods childbirth and factors influencing the different childbirth choices that women make. Stoll et al., (2009) conducted a mixed methods study on a male and female sample of childfree Canadian university students in order to understand if students would prefer caesarean or vaginal delivery for them or their partner and if their confidence in vaginal birth was related to, or rather a predictor of, these choices. This study found that only 9% of their sample of university students preferred caesarean delivery as opposed to vaginal delivery, and that for women specifically this was linked to low confidence in vaginal birth and fear of childbirth (Stoll et al., 2009). The most common themes they found to emerge for participants who displayed a preference for vaginal delivery were centred around what is considered 'normal' and 'natural'. For participants who displayed a preference for caesarean delivery the most common themes identified were fear of pain and damage to the body (Stoll et al., 2009). Although this study utilised a mixed-methods approach, the use of an online survey and the nature of their qualitative data as short-answers limits their ability to explore respondents answers further with probing and follow-up questions.

In a study done later in Canada by Stoll and Hall (2013) the attitudes and preferences of childfree university women towards childbirth choices was explored further. This study looked at female university students who showed low and high levels of fear of childbirth. They found that women who displayed low levels of fear of childbirth saw medical interventions more critically than women with high levels of fear of childbirth, who saw medical intervention as more helpful during childbirth (Stoll & Hall, 2013). Although the focus of this research was to examine how these women's preferences and attitudes were linked to levels of fear of childbirth, the authors did note some interesting findings that emerged irrespective of women's fear scores. Some of the themes they found emerging in their data were linked to common feminist debates about childbirth choices, such as women's

autonomy in the birthing process. The authors report that they found little evidence related to feminist debates that the medicalization of childbirth reduces women's autonomy in the birthing process (Stoll & Hall, 2013). Given that investigating how these women's preferences and attitudes link to feminist debates was not the aim of this research it is understandable that the authors did not focus on these conclusions. Their findings do however highlight that themes of feminist debates are often present in discussions of childbirth choices and could be explored further (Stoll & Hall, 2013).

Saroli-Palumbo et al. (2012) conducted a study among 359 male and female pre-university students in Canada in order to examine these students' beliefs regarding different methods of childbirth and the sources of these beliefs. Through the use of a survey they found that most students indicated they would prefer to have a vaginal delivery in a hospital setting and showed scepticism and a lack of confidence in births outside of a hospital setting (Saroli-Palumbo et al., 2012). They found that no male students would choose for their partner to have an elective caesarean section and 9.3% of the female students would choose to have an elective caesarean. While the number of female students that would choose to have an elective caesarean is low, their study showed that 71.2% of these women viewed caesarean sections as a standard method of childbirth (Saroli-Palumbo et al., 2012). They found that the female students in this study also had varied opinions about pain-relief during childbirth. Almost half of the women felt that pain is a necessary aspect of the childbirth experience and that pain-relieving drugs should be avoided while others disagreed (Saroli-Palumbo et al., 2012). This study further revealed that these students' main sources of information regarding different methods of childbirth and their childbirth beliefs were family members and the media (Saroli-Palumbo et al., 2012).

Malacrida and Boulton (2012) conducted a study investigating both childfree women and recent mother's perceptions of childbirth choices in Canada. The use of these two groups was to allow for the comparison of recent mothers' experiences of childbirth and childfree women's expectations regarding childbirth. This study revealed many tensions regarding femininity, sexuality and motherhood and concluded that "women's choices are not freely made but instead are enacted within a limiting range of disciplining and competing framings of ideal femininity, sexuality, and sacrifice" (Malacrida & Boulton, 2012: pg.769). They found that it was mostly the childfree women in their study who highlighted the tensions between viewing normative femininity as 'dignified' and 'tidy' and the perceived messiness of vaginal birth which contradicts this view of femininity, whereas most of the recent mothers

in their study viewed this messiness of birth as a rite of passage to motherhood (Malacrida & Boulton, 2012). They further stated that all of the women in their study acknowledged the tensions that surround vaginal birth and the belief that women's bodies should be 'tight' and 'sexually available' (Malacrida & Boulton, 2012). Malacrida and Boulton (2012) revealed that childfree women expressed stronger beliefs that pain, sacrifice and selflessness are necessary in order to experience motherhood. The differences identified in this study between childfree women's perceptions and recent mothers' perceptions of childbirth choices highlight the need for further research into childfree women's perceptions of childbirth choices. The fact that the childfree women in this study held stronger beliefs of normative ideologies of motherhood than women who have recently given birth suggests that their beliefs need further investigation and exploration. Furthermore given that childbirth choices can be seen to be influenced by different social and contextual factors and that the authors of this study noted significant racial, ethnic, and cultural limitations to their sample, it is important to investigate these views of childless women in different contexts.

Cappell and Pukall (2017) also focused on childfree women's perceptions in their study, however this research focused on assessing perceptions of childbirth related to sexuality and the common misconceptions that exist regarding childbirth and sexuality in a sample of Canadian childfree women. This study found that there were several factors which led individuals to believe that vaginal childbirth was harmful to future sexuality as opposed to caesarean delivery. They further emphasised that reliance on the media as opposed to medical professionals as primary sources of health care information perpetuated these misconceptions regarding vaginal birth and caesarean birth and their effects on future sexuality (Cappell & Pukall, 2017). Given that this study was quantitative in nature and the authors conducted the data collection by means of an online survey with Likert-type questions, it could be argued that the understanding of the perceptions of these childfree women towards childbirth choices and sexuality is limited.

South African context

In the South African context there is very little work exploring women's childbirth choices, however Chadwick and Foster's (2013) study which was conducted with a sample of white, middle-class pregnant women reveals the need for more work to be done in a South African context with more diverse groups. Their study looked at how women make childbirth choices

with gender as a form of disciplinary power driving these choices. Through this study they highlighted the need for looking at childbirth as part of a complex gendered process of both femininity and motherhood (Chadwick & Foster, 2013). Their study found three central themes emerging which they argue shaped and regulated women's choices, namely a patriarchal optics of childbirth which emerged in their study as a form of gendered power influencing women's childbirth choices, the 'natural childbirth' ideal and the 'good mother' imperative (Chadwick & Foster, 2013). They found that women who had chosen vaginal childbirth viewed hospitals as an unnecessary feature of the childbirth experience while women who had chosen to have caesarean sections viewed the female body as "uncontrollable and horrible" (Chadwick & Foster, 2013, p. 327). When discussing the 'natural childbirth' ideal they found that both women who chose to have vaginal deliveries and women who chose to have caesarean sections often used the 'natural childbirth' ideal to justify their choices. They stated that some of the women who had previously given birth in a hospital setting, have chosen to have home births as they viewed their previous hospital births an 'unnatural'. They also noted that women who had chosen to have caesarean sections often justified their choice by constructing vaginal birth as a "horror-story" and placing emphasis on the safety of the hospital setting in an attempt to divert from what is seen as 'natural' (Chadwick & Foster, 2013).

Drawing on the data from this study, Chadwick and Foster (2014) further explored how these pregnant women constructed and negotiated risk in relation to their respective childbirth choices. Using a social constructionist form of discourse analysis the authors aimed to understand how these women positioned themselves in relation to risk and their choice to either have an elective caesarean section or give birth at home (Chadwick & Foster, 2014). They found that women who chose to have caesarean sections viewed their choice as a form of risk management as they believed this was a safer option than vaginal delivery, whereas some of the women who chose to give birth at home viewed caesarean sections as an unnecessary intervention and highlighted the possible risks associated with this intervention (Chadwick & Foster, 2014). They concluded in their study that "expert knowledge and biomedical definitions of risk served as over-arching interpretative frameworks in which women negotiated the uncertainties of birth" (Chadwick & Foster, 2014, p.14).

As well as looking at the existing literature on childbirth choices in South Africa, it is also important to discuss the state of the health care facilities which are available to women giving birth. In a study looking at 48 women's childbirth stories in public maternal health facilities

in the Western Cape, Chadwick (2014) raises concerns about the quality of care available to women giving birth in South Africa. Utilising a thematic analysis Chadwick (2014) found that only 14 of these women reported having a positive childbirth experience, 32 of these women reported having a negative childbirth experience and most of these women described their experience as very bad. The thematic analysis conducted found that "themes of abuse, petty aggressions, dehumanisation, disrespect and neglect unfortunately continue to dominate some women's childbirthing stories" (Chadwick, 2014, p.133).

The literature regarding childbirth choices has pointed to a shift from focussing on the medicalization of childbirth and instead focusing on other factors and power structures influencing childbirth choices. There is still however a strong need for work in different social and cultural contexts. McAra-Couper et al. (2012) emphasize that childbirth choices are strongly influenced by the social and cultural contexts in which they occur. In South Africa there is clearly a need for a further understanding of women's childbirth choices and the various underlying factors that influence these choices. Furthermore it can be seen that there is a need for an in-depth investigation of the views and ideologies surrounding different childbirth choices and how views relate to these women's understandings of motherhood and femininity. By focusing on a group of women who have yet to experience childbirth and motherhood, this research aims to contribute to understanding these views that these women hold and how their views link to broad feminist debates on childbirth and motherhood.

Research Questions

The main aim of this research was to explore how a group of childfree women in South Africa understand and view different childbirth choices. There are three further sub-questions which have been identified which are:

1. What are their prospective choices and the reasons behind these choices?
2. How are their views on childbirth choices related to their understandings of motherhood and femininity?
3. How do their views and understandings link to common feminist debates on childbirth and motherhood?

Chapter 3

Methods

The following chapter will provide an outline for the research methods utilised in this study. This chapter provides a description of the research design supporting this study, the sample and sampling methods used, the procedure followed and the consideration of ethics. Lastly the chapter will end with a discussion of reflexivity and recognition of the position of the researcher within the research.

Research Design

A qualitative research design was chosen for this study. Qualitative research is an approach used mainly for understanding and exploring the meanings of individuals within a given social or human area of interest (Creswell, 2013). According to Ritchie, Lewis, Nicholls and Ormston (2013, p. 3) the aims of qualitative research "are directed at providing an in-depth and interpreted understanding of the social world of research participants by learning about their social and material circumstances, their experiences, perspectives and histories". A qualitative design was appropriate for this study since the aim of the study was to conduct an in-depth investigation of the ideologies and tensions surrounding, and embedded in, childfree women's views of childbirth choices, motherhood and femininity. Given that the purpose was to explore and understand and was therefore highly inductive, a qualitative research design was suitable for this study. It is also important to note that this research has been approached in an interpretive way. This is due to the fact that the main aim of the research was to rely on participants' views and perspectives as much as possible and was concerned with understanding childbirth choices from the subjective experiences and perspectives of the participants (Creswell, 2013).

Sample and Sampling

The sample of this study consisted of 9 female students attending the University of the Witwatersrand, who had not yet given birth and were not pregnant at the time this research was conducted. Ritchie et al. (2013) provide reasons for the use of smaller sample sizes in

qualitative research. They argue that there will be a point in qualitative research where an increasing sample size no longer contributes to the findings of the study. Furthermore given that qualitative studies are usually rich in detail, sample sizes should be fairly small to allow for the researcher to manage the data (Ritchie et al., 2013). The participants in this study were all postgraduate students with ages ranging from 21 to 28. Postgraduate students were sampled as they are older than undergraduate students and possibly more likely to have thought about different methods of childbirth. Of the 9 women interviewed for this study there were 5 Black, 3 White and 1 Indian student. All of the participants spoke English, as had been assumed since the University of the Witwatersrand is an English based university, hence all of the interviews were conducted in English.

The participants were selected using non-probability convenience and snowball sampling. These methods of sampling are non-random, meaning that the sample was selected by the researcher based on specific sampling criteria, hence there was no guarantee that all members of the population had an equal chance of being included in the sample (Ritchie et al., 2013). The sample was chosen based on convenience and availability and also included snowballing sampling, which involved asking participants who volunteered to identify others they know who fit the selection criteria (Ritchie et al., 2013). Participants were approached during lectures and asked to participate in the study, additionally flyers were placed on campus requesting participation in the study. Once the participants had completed their individual interviews they were asked by the researcher if they could reach out to any students that they knew who fit the research criteria, if these students were interested they could be given the contact details of the researcher. The researcher was further put in contact with potential participants through colleagues based on the sampling criteria. These colleagues were other students completing their MA in Social and Psychological Research who reached out to students they knew personally who fit the sampling criteria and asked them if they would be interested in participating in the research.

Procedure

Once ethical clearance had been obtained from the University of the Witwatersrand's Human Research Ethics Committee (HREC Non-Medical), the participants were approached and invited to participate in the study. With permission from the relevant staff, participants were

approached during lectures and asked to participate in the study. Additionally flyers were placed on campus requesting participation in the study. The participants were all contacted, either through the flyers, during lectures or via text message, with the same message which said,

> My name is Christina Edginton and I am a student completing a Master's degree in Social and Psychological Research at the University of Witwatersrand. I am investigating childbirth choices in a group of South African women who do not have children. The interview will take no longer than an hour of your time. Your responses to the questions will be kept confidential. Each interview will be anonymised, and your identity will be protected during the analysis and written report. If you are interested in participating, please contact me and we can arrange a day and time that suits you to conduct the interview. If you have any questions, please do not hesitate to ask.

Once the participants had agreed to participate in this study, the researcher explained the purpose of the study and what their participation would entail. The researcher arranged to meet the students on campus at a time that was suitable for them and it was explained that the interview would take no more than an hour of their time. The participants were given an information sheet (see Appendix B) outlining important aspects of the study and were required to sign a consent form (see Appendix C) before the interview began. Before the interview was conducted the participants were required to sign the consent form and they were given both an information sheet and a verbal explanation detailing what participation in the study would entail. They were also given the opportunity to address any questions or concerns that they may have had. The consent form was kept by the researcher and included a section pertaining to the recording of the interviews and the storage and use of the anonymized transcripts for further studies. The participants were made aware that if they had any questions or concerns during or after the data collection process, they could contact the researcher or her supervisor, however none of the participants made contact after the data collection process.

The participants in this study completed individual face-to-face semi-structured in-depth interviews (see Appendix A), which were recorded and transcribed by the researcher and took no longer than an hour to complete. A semi-structured interview style was chosen in order to allow the researcher more freedom to deviate from the determined interview schedule with

the use of follow-up questions or rephrasing of questions if necessary (Creswell, 2013). The interview schedule was compiled by the researcher based on the aims of the data and existing literature on the topic. The first two interviews conducted for this study were used to pilot and evaluate the interview schedule, which resulted in a few questions being added, however these interviews were still analysed in the study given that they added value to the data collected. To initiate the conversation the participants were asked what different methods of childbirth they were aware of, if they had ever thought about giving birth in the future and to describe what their ideal future childbirth experience would look like. They were also asked about their views on different methods of childbirth, their fears and expectations of the childbirth experience, the way childbirth is portrayed in the media, their description of the ideal mother, and were asked about the childbirth experiences of women in their social circle. These questions were asked with the aim of understanding how they view different methods of childbirth and to explore the reasons behind their prospective childbirth choices. The researcher ended the interviews by asking about how the participants experienced the interview and how they experienced the discussion of childbirth given that it was not something in their immediate future.

Ethical Considerations

Due to the fact that the individual interviews were conducted face-to-face the participants could not be guaranteed full anonymity in the data collection process, however they were guaranteed confidentiality by the researcher and were made aware that in the final write up they would be assigned an anonymous code/pseudonym. Participants were aware that the interviews were going to be recorded and that only the researcher would have access to these recordings. This data has been stored on a password protected laptop and the recordings will be deleted after the completion of the degree. The participants in this study were all over the age of 18 and did not constitute a sensitive sample, hence their consent was obtained through the use of a consent form and their participation in this study was voluntary. The participants were made aware that they were free to withdraw from the study at any point during the data collection process without any penalty for leaving the study, however once their transcript had been assigned an anonymous code/pseudonym they would not have been able to withdraw. None of the participants requested to withdraw at any stage of the research process. Lastly the participants were informed that the results of this study may be published

and would be given to them upon request, they were provided with the details of the researcher and her supervisor on the information sheet.

Analysis

This study utilised thematic analysis as per Braun and Clarke's steps (2006) to explore emerging themes and patterns in the data collected. According to Braun and Clarke (2006) a theme "represents some level of patterned response or meaning within the data set" (p. 10), and researcher judgement was the main tool for identifying these themes within the data set. This was a suitable analysis for the data collected given that interviews are considered one of the most appropriate and commonly used data sources in a thematic research (Joffe, 2012). As per Braun and Clarke's (2006) steps there were 6 phases to the analysis of the data collected in this study. The first step involved familiarization with the data, this was done during the transcription process where the researcher became familiar with the data by creating the transcriptions and reading the data multiple times. During this first stage the researcher also made notes of initial ideas of possible themes. The second step involved generating initial codes from items in the data which were seen to have repeated patterns. Once all the data had been coded and collated the next step involved searching for broader themes within these codes, once these broader themes were identified a thematic-map was created which depicted the main themes and sub-themes that emerged in the data. The next phase involved refining and reviewing the themes previously identified, after which the themes were defined and named. Once the themes identified had been finalised, defined and named the researcher produced the final report of the thematic analysis.

In order to ensure trustworthiness and rigour of the research, the researcher aimed to satisfy four criteria namely credibility, transferability, dependability and confirmability (Shenton, 2004). These criteria will be discussed based on provisions suggested by Shenton (2004) to meet these criteria. With the goal of ensuring credibility the researcher used a recognized method of qualitative research to analyse the data, aimed to constantly evaluate the project as it developed and examined previous research findings in order to compare the results to these studies. The use of a supervisor was helpful in evaluating and examining the project as it developed and hence played an important role in achieving credibility. Shenton (2004) further suggests that using tactics to ensure honestly from the participants may assist in ensuring credibility, in order to try meet this criterion the researcher used tactics such as

probing, establishing rapport and encouraging the participants to speak freely during the interviews. Transferability has been seen to be difficult to attain in qualitative research as not the main goal of this type of research to generalise findings to other situations (Creswell, 2013). The researcher did however detail the data collection procedures and has not generalised findings to other contexts. In order to try ensure dependability the researcher has detailed procedures of the study in order to allow the researcher to understand and evaluate their effectiveness (Shenton, 2004). Lastly in order to ensure confirmability the researcher used direct quotations from the participants and acknowledged her own position and how this might have affected the research, which has been discussed further in the section to follow.

Reflexivity

Reflexivity is the process of self-evaluation and recognition of the position of the researcher and how this position might affect different aspects of the research, including the "setting and people being studied, questions being asked, data being collected and its interpretation" (Berger, 2015, p. 220). Richie et al. (2013) further highlight the importance of reflexivity in obtaining objectivity and acknowledging the bias that might exist in the research a result of the background beliefs of the researcher.

I will start by acknowledging my position. I am a 23-year-old, white, middle class, cisgender female, furthermore similar to the participants in this study I am a childfree woman with views of my own regarding different childbirth methods and my ideal childbirth experience. As a result of this I had to be conscious of how my views compared to those of the participants and ensure that I remained as objective as possible throughout the research process. It is also important to note, similar to the participants in this study, that I am also a postgraduate student at the University of the Witwatersrand. These characteristics are all important to consider as they may have shaped the nature of the relationship between myself and the participants, and in doing so shaped the information they were willing to share during the interviews. While I do feel that being a student and peer of the participants allowed them to feel more comfortable during the interviews, I did also observe that some of the students who were considering pursuing their master's degrees would ask me questions after the interviews regarding the interview process and work load. It is important to note that this might have been a motivation for some of the women to participate in this study. I feel that it is also important to discuss how I came to choose this research topic and the effect that this

might have had on the research itself. While I have always believed that I am open to experiencing both vaginal birth in a hospital setting and possibly a caesarean section in the future, I don't believe that I had ever thought in depth about my future childbirth choices, or the reasoning behind those choices. However after reading Malacrida and Boulton's (2012) study titled *Women's perceptions of childbirth "choices" competing discourses of motherhood, sexuality, and selflessness*, I was intrigued by the views of the childfree women in this study and how some of their views seemed to differ from my own. It was the views of the childfree women in this study that inspired me to conduct similar research in a South African context and I believe that this is important to acknowledge given that during the research process I often found myself comparing the views of the women I interviewed to the views of the women in the previously mentioned study. Finally I believe that my experience as an interviewer is important to acknowledge. During the beginning of the data collection process I became aware that I do not have a lot of experience as an interviewer which I feel resulted in a lack of probing and exploring in certain areas during the first few interviews. I believe that transcribing the interviews as I was conducting them was particularly helpful as I became aware of areas where my interviewer skills needed improvement and was able to improve on this as the data collected process progressed.

Chapter 4

Analysis and Discussion

This chapter will explore 4 broad themes which have emerged from the 9 interviews conducted with childfree women at the University of the Witwatersrand. In order to aid the exploration of these themes a table has been provided outlining the age, race and preferred method of childbirth of each of the participants (see Table 1), as well as a discussion of the characteristics of this sample. The 4 themes that will be explored in this chapter include anxiety around childbirth, caesarean sections as a point of reference for childbirth choices, childbirth and motherhood and the influence of other women's stories.

Characteristics of the sample

This sample consisted of 9 women who had not yet given birth and were not pregnant during the time of this study but were open to the possibility of experiencing childbirth in the future. At the time of this study all of the participants were postgraduate students at the University of the Witwatersrand with ages ranging from 21 to 28.

PARTICIPANT ID	AGE	Race	IDEAL METHOD OF CHILDBIRTH
Sarah	21	White	Vaginal birth with epidural at a hospital
Lesedi	21	Black	Vaginal birth with epidural at a hospital
Caitlin	28	White	Vaginal birth with epidural at a hospital
Megan	24	White	Vaginal birth with epidural at a hospital
Lethabo	23	Black	Vaginal birth at a hospital (open to with or without epidural)
Omphile	25	Black	Vaginal birth with epidural at a hospital
Amahle	24	Black	Elective caesarean at a hospital
Rethabile	24	Black	Elective caesarean at a hospital or water birth
Michelle	23	Indian	Vaginal birth with epidural at a hospital

Sarah (21; White) indicated that her preferred method of childbirth would be vaginal birth with an epidural in a hospital setting. Sarah mentioned during her interview that she would ideally give birth in a hospital setting due to the possibility of medical complications however she did find the idea of home births interesting. Lesedi (21; Black) also stated that in the future she would ideally prefer to give vaginal birth in a hospital setting. Lesedi mentioned that she was concerned about experiencing postpartum depression after giving birth as she currently suffers from anxiety and depression. Caitlin (28; White) explained that she would ideally prefer to give vaginal birth with an epidural in a hospital setting as she felt that this was a safer option than a home birth and was concerned about bonding with her future child if she chose to have a caesarean section. Megan (24; White) initially stated that if she could she would choose to have an elective caesarean section, however as the interview progressed she stated that she would rather have a vaginal delivery in a hospital setting with an epidural. Lethabo (23; Black) stated that she would ideally prefer to give birth vaginally in a hospital setting. She further explained that she would take the advice of the medical professionals before deciding whether she would have an epidural or not. Omphile (25; Black) explained that she would ideally like to give birth vaginally in a hospital setting but was interested in water births as a possible option. Amahle (24; Black) stated that she would ideally prefer to have an elective caesarean in a hospital setting as she was concerned about possible complications during vaginal birth. Rethabile (24; Black) stated that she would ideally prefer to have an elective caesarean and was also interested in possibly having a water birth. Michelle (23; Indian) explained that she would ideally choose to have a vaginal birth in a hospital setting with an epidural.

Theme 1: Anxiety around childbirth

Throughout the interviews when discussing the possibility of giving birth in the future, irrespective of the method of childbirth being discussed, all of the participants expressed some level or fear, anxiety or nerves regarding different aspects of the childbirth process. It appeared that most of the anxiety these women experienced was centred around the pain of vaginal childbirth, the use of medical drugs, the setting of the childbirth experience and the possible physical changes associated with childbirth. While high levels of fear of childbirth have been related to more positive views of medical interventions (Stoll & Hall, 2013), most of the women in this study who displayed fear or anxiety towards childbirth still indicated

that they would prefer vaginal birth over having a caesarean section. All of the women in this study did however favour giving birth in a medical setting, and in doing so displayed that they trusted and favoured some form of medical interventions in the childbirth process, which Stoll and Hall (2013) found to be related to high levels of fear of childbirth.

When discussing vaginal birth, Lethabo and Michelle expressed concern about the length of the childbirth experience. Lethabo said "*I think I've heard a lot of horror stories about how long it is, people go into labour for like 18 hours*". Lethabo, who stated that she ideally would prefer a vaginal birth, is exhibiting fear towards the childbirth experience by referring to stories she has heard about the length of some childbirth experiences as "*horror stories*". When Michelle was discussing the length of the childbirth experience and the possibility of being in labour for many hours she stated, "*it just seems stressful*". While Lethabo and Michelle's concerns are more general in the sense that any woman may be concerned about being in labour for a long period of time, Lesedi and Caitlin expressed fear about situations, more personalised and specific to their lives. Lesedi expressed concern that she might suffer from postpartum depression after giving birth. She expressed that she suffers with anxiety and depression and believed that these might be a contributing factor to the possibility of her experiencing postpartum depression in the future. While this anxiety is not centred around the actual childbirth process it may still have an influence on Lesedi's childbirth choices and future experiences of childbirth. On the other hand Caitlin, who was 28 years old and stated that she would ideally prefer to give vaginal birth in a medical setting, expressed concern about the possibility of needing a caesarean section in the future. She stated

> *There's like stories about if you give a natural birth then it's better for the child. So there's like a pressure that I should do that, but then I also realize that I'm 28 now and still studying so I might end up having children in my 30s in which case there is a higher chance of complications. So then I think that it's possible that I'll have to get a c-section, and then I've heard scary stories like that they take all your insides out and put them next to you on the table and that kind of thing. So just those possibilities are anxiety provoking.*

For Caitlin her anxiety about childbirth is centred more around her age and the possibility of her age preventing her from having a vaginal birth. Through discussing stories she's heard about caesarean sections and describing the surgical intervention as taking "*all your insides out*", Caitlin is expressing her fear towards the medical aspect of having a caesarean section,

possibly justifying her choice to ideally give vaginal birth in the future. The fear and anxiety that Caitlin is displaying appears to be linked to her confidence in the surgical intervention involved in having a caesarean section. While previous research has shown that the normalization of surgical interventions and the trust in the safety of these interventions has resulted in women favouring caesarean sections over vaginal birth (McAra-Couper et al., 2012), Caitlin's favouring of vaginal birth can be seen as a result of her lack of trust in the safety of surgical interventions. Her anxiety about the possibility of having a caesarean section may reflect her views on the perceived safety of this method of childbirth, resulting in her viewing vaginal birth as the safer option for her and her child. While Caitlin stated that she would like to give birth in a medical setting, and in doing so supporting some level of medical interference, her use of the word 'natural' in this case may be used to distinguish her ideal childbirth experience from that of a highly medicalized one and justify her decision of choosing vaginal childbirth over a caesarean section (Chadwick & Foster, 2013). According to Beckett (2005), the words 'natural' and 'normal' have often been used as a response to the normalization of medical interventions in childbirth in order to resist medical interference in the childbirth experience.

1.1: Pain of vaginal birth

A main sub-theme to emerge regarding these women's anxiety about the childbirth experience is that of the pain of vaginal birth. Most of the participants who stated that their ideal preferred method of childbirth would be vaginal birth mentioned that one of their fears about this method was the pain experienced during this type of birth. For the participants whose ideal method of childbirth was not vaginal birth, the pain of vaginal birth was used to justify their own childbirth choices. Given that none of these women had experienced giving birth themselves they often mentioned that their fear stems from stories they have heard from other women or from the way birth is portrayed in movies and on television.

When asked about her fears of giving birth Sarah stated that she has "*a very low pain threshold*", which is why the pain experienced during childbirth is a major fear of hers. Michelle also discussed this fear of the pain involved in vaginal birth. When asked about her fears regarding childbirth she stated,

> *Definitely the pain, definitely the pain and like the things that you hear about giving birth naturally like vaginally. Yeah, definitely like things that can go wrong with you, your body, you know, like things can tear and yeah, painful experience.*

While Michelle is also touching on the physical changes associated with vaginal birth she is emphasising that the pain of giving birth vaginally is her main concern. While studies have shown that the fear of pain and damage to the body are often used in order to justify the choice to have a caesarean section (Stoll et al., 2009), Sarah and Michelle have stated that they would ideally prefer to give vaginal birth despite these fears. These results indicate that while fear of pain and fear of damage to the body might drive some women to choose to have caesarean sections over vaginal birth, this is not the case for all women. This might be related to the levels of fear of pain experienced by these women, as Stoll and Hall (2013) have argued that women who displayed lower levels of fear of childbirth saw medical interventions more critically than women who displayed higher levels of fear of childbirth. Sarah and Michelle might be displaying lower levels of fear of pain and damage to the body as these fears are not influencing their decision to give vaginal birth.

Although there were only two participants who stated that their ideal method of childbirth would be an elective caesarean section, they still mentioned pain as a major concern for them. Rethabile stated,

> *My fears with natural. It just seems so intense… I don't understand how a head can come out of a vagina and it just seems so painful, and also the, all the complications, just now you faint while trying to give birth or if you don't dilate… if the child isn't like positioned properly, I just think natural birth is very complicated.*

Unlike Sarah and Michelle, Rethabile is using her fears about the pain of vaginal birth to rationalize her decision to have an elective caesarean section as opposed to vaginal birth. She is not only referencing the pain involved in vaginal birth but also the possible complications involved with this method of childbirth, further validating her decision to have an elective caesarean section in the future. Similarly to the findings in this study, Stoll et al. (2009) found that of the few women in their study who would prefer to have a caesarean section as opposed to vaginal birth, their reasons were mostly related to a low confidence in vaginal birth, pain and damage to the body. Rethabile is echoing here that pain and low confidence in vaginal birth are reasons for her choice to have a caesarean section. Furthermore McAra-Couper et al. (2012) have shown that the ability to control certain aspects of the childbirth

experience, such as pain, may affect childbirth decisions, hence Rethabile's desire to control or regulate the pain associated with vaginal birth may be a contributing factor in her future childbirth decisions. Furthermore by framing vaginal birth as complicated Rethabile is emphasising her trust in medical interventions as the less complicated and safer option when it comes to childbirth, which McAra-Couper et al. (2012) believe results in women favouring caesarean sections over vaginal birth.

When discussing the pain involved in vaginal birth, some of the participants also discussed their concerns regarding the use of an epidural as a pain-relieving drug during vaginal birth. Most of the women who stated that their preferred method of childbirth would be vaginal birth also stated that they would prefer to have an epidural to avoid the pain involved in this method of childbirth. For example Megan said, "*I have a very high pain tolerance, but I don't quite fancy shoving a baby out without some medical interference*". Megan uses the idea of the pain associated with vaginal childbirth in rationalizing her decision to have an epidural however she also justifies this decision by referencing her own personal medical history. She said, "*I also have like lower back problems so I'm, I'd rather have some sort of pain medication*". The ability to control the pain associated with vaginal birth seems to be influencing these women's decision to have an epidural as a form of medical invention, which has been discussed by McAra-Couper et al. (2012) as a factor constructing women's childbirth choices. While Megan was confident that she would have the epidural during vaginal birth Lesedi and Michelle appeared to be more conflicted. Michelle stated,

> *I'm kind of in two minds about like epidurals and stuff like that. Uhm because like on one hand, I would, if I were to give birth I would like to have the epidural, but then on the other hand there is like implications for the child… But I think that like as, as the person that's actually going through the birthing process, I don't want, me myself, I don't want to feel pain. Yeah, so I think I have that like right not to feel pain because I am the one going through it.*

While she showed concern about the implications of having an epidural, Michelle emphasised that felt as though she had the right to avoid the pain involved in vaginal birth, as this was her childbirth experience. Lesedi similarly stated that she would ideally prefer to be "*natural*" and "*authentic*" by not having the epidural however she had heard stories from other women who had done this and "*they said that they never experienced pain like that in their life*". Lesedi's use of the word 'natural' here can be linked to the arguments surrounding

the natural childbirth movement as the use of the word natural when discussing childbirth can be understood as a resistance to the normalization of medical intervention in childbirth (Beckett, 2005). Chadwick and Foster (2013) also highlight that the natural childbirth ideal is often used by women in order to justify their choices, both for the choice to give vaginal birth and to have a caesarean section.

Although Michelle and Lesedi and were sceptical about the use of drugs during vaginal birth, they both leaned more towards using drugs because of the pain they feared during the childbirth experience. Previous studies have shown that fear of pain and the desire to control this pain is often linked to the choice to have caesarean section (McAra-Couper et al., 2012; Stoll et al., 2009), however these results suggest that while fear of pain might drive some women to choose to have caesarean sections over vaginal birth, this is not the case for all women. Interestingly while other studies have noted that some women believe pain is a necessary part of the childbirth experience (Malacrida & Boulton, 2012; Saroli-Palumbo et al., 2012), none of the women in this study echoed this belief. Although some of the women in this study have stated that despite the pain involved they would still choose to have vaginal birth over a caesarean section, they are accepting some form of medical invention through the use of an epidural. Furthermore Lesedi and Michelle's scepticism of using pain medication during their childbirth experiences could be linked to the arguments surrounding the 'natural childbirth' movement, as Brubaker and Dillaway (2009) argue that the rejection of pain medication can be seen as the result of a system where women may be judged for requesting pain medication during childbirth.

1.2: The safety of the medical setting

Throughout the interviews conducted it became clear that the idea of giving birth outside of the medical setting was anxiety provoking for the women in this study. Of the nine women interviewed for this study only Rethabile indicated that she was open to the possibility of giving birth outside of the hospital setting. Almost all of the women mentioned that they felt that giving birth in a hospital setting with the presence of medical professionals would be safer for themselves and/or their children. For example when asked why she wouldn't consider having a home birth Lesedi said,

> *Because I don't think it's safe. I don't like it. I don't think I would trust it. Even though people are more modernized now and they have doctors come in and stuff. I just want*

> *to do it in a sterilized environment where I know, like uhm, the chances of my child getting sick, or of me getting sick are as low as possible… there are so many things can go wrong when you give birth. So I want to be able to like get the help that I need, uhm as quickly as possible and as easy as possible. So yeah and I think like maybe the comfort of having a room of experts who know what is happening constantly is probably, uhm, why.*

Lesedi is discussing both her own safety and the safety of her future child and emphasising that she places trust in the medical professionals and sterility of the medical setting. She is justifying her choice to give birth in a medical setting by referencing the possible complications involved in the childbirth experience and the anxiety that these possible complications may provoke. Lesedi's idea of the hospital setting as being a better option due to the sterile environment and immediate access to medical professionals was echoed by other women in this study. Similar to Lesedi, Megan and Lethabo also highlighted the importance that they placed on the availability of medical professionals. Megan stated that she would prefer a hospital setting as "*all people in the hospital are trained to deal with this situation that you're going through*". When discussing the setting of her ideal birth Lethabo said,

> *I'd want my child to be delivered professionally I guess, I'd want someone that knows if there's something wrong, or if there's something wrong with the baby, or something wrong with me.*

When discussing water births Michelle displayed concerns about the lack of medical professionals that would be available in this setting. She said, "*the lack of medical personnel, lack of like technological stuff. Yeah, it's just like, it seems like the more risk involved, where more things can go wrong*". These women are justifying their decision to give birth in a medical setting by referencing the safety of themselves and their future children and placing their trust in the medical professionals and technology available in the medical setting.

The lack of confidence that the women in this study have shown towards birth outside of the medical setting has been observed in previous research. Saroli-Palumbo et al. (2012) found that most of the students in their study would choose vaginal birth over a caesarean section and showed scepticism towards births outside of the hospital setting. The participants in this study have shown this same scepticism, often referring to births outside of the medical settings as unsafe or untrustworthy. Similarly the trust placed on medical professionals has

been noted in previous research, Malacrida and Boulton (2014) found that recent mothers emphasised the trust they placed in medical professionals during their childbirth experiences. This trust plays an important role in childbirth decisions as it results in women favouring medical settings as opposed to home births (McAra-Couper et al., 2012). The trust that the women in this study have shown towards the medical setting and medical professions further emphasises the complexity of childbirth choices. McAra-Couper et al. (2012) have argued that through social changes the power of decision making in childbirth has shifted from being entrusted to the medical professions to being entrusted to the women giving birth. It can however be argued that medical professionals do have power in the decision-making process during childbirth because they are often seen to have more knowledge and expertise with regards childbirth (Crossley, 2007). Advocates of the 'natural childbirth' movement have often critiqued the medicalization of childbirth for this reason. They argue that the medicalization of childbirth results in control being taken away from women and given to medical practitioners. They further argue that regaining this control would require removing the act of birth from the hospital setting (Brubaker & Dillaway, 2009).

1.3: Physical changes

Many of the women in this study further displayed some level of fear or anxiety regarding the possible physical or bodily changes that may occur after giving birth. Lesedi and Omphile expressed fears about the changes that might occur during vaginal birth. When discussing giving birth vaginally Omphile said, "*I don't want to stretch my vagina*" and Lesedi said,

> *I think I'm more afraid of, I think it's my vanity that always gets to me like, how my body will change. Not even change like internally but how it will look. It's like what if I don't look the same anymore and what if I don't like the way my body looks.*

Both of these women are expressing fear about the possible physical changes that may occur after vaginal birth. Lesedi's concerns seem to be focused more on her weight and how her body will look after having a child, whereas Omphile is expressing concern about how giving birth might affect her sexually. Although Omphile's comment was mentioned briefly while she was discussing the pain involved in vaginal childbirth, she did mention later in the interview that she has seen many videos of women giving vaginal birth. When discussing some of these videos she described them as being "*icky*", "*scary*" and "*terrifying*", and it is possible that these videos may have influenced her fears about giving vaginal birth. Although

Omphile was one of the only women in this study to express concerns about vaginal birth affecting her sexually, Cappell and Pukall (2017) found that there were several factors which led women to believe that vaginal childbirth was harmful to future sexuality. They also emphasised the role of the media in these misconceptions, they argue that reliance on the media as opposed to medical professionals as primary sources of health care information perpetuates these misconceptions regarding vaginal birth and their effects on future sexuality (Cappell & Pukall, 2017). Although she raised these concerns about vaginal birth, and how this type of birth might affect her physically and sexually, Omphile still stated that she would prefer to have vaginal birth in the future. She added, "*I think society pushes more natural birth and I think people get frowned upon if you do caesarean because like ah you're taking the easy way out*". Similarly, although Lesedi showed concern about bodily changes after having children, she too stated that she would still prefer to give vaginal birth in the future as she saw caesarean sections as a "*last option*".

While Lesedi and Omphile were concerned about the bodily changes that might occur giving birth vaginally, Amahle and Rethabile expressed concerns about the effect that having a caesarean section might have. Amahle first mentioned that she felt that women who give birth vaginally may be able to "bounce back" to their previous weight faster. She further stated,

> *There is also the pressure I think after women give birth, is like to get back to what she looked like before. So then I think that also influences like your birthing choices because some people go for the or would want to go for the natural birth that they can, like I was saying, get back to their weight quicker. As with caesarean you have to think about the scar and how long it's going to take to heal and all of that. So I think it's like a twofold. There's also like, I don't want to be like really graphic, but then… So it's like also I guess with men like, I guess they'd also prefer if like, you would still be the same down there if you had a caesarean, but at the same time it's like, and if you don't then it's like the six weeks, and it's like ah I have to get back and like please my husband or whatever. So there's so much pressure with women from each other and then from men as well.*

Amahle, who ideally would prefer to have an elective caesarean section, is echoing the fears of Lesedi and Omphile, by referencing possible weight gain, vaginal changes and the sexual consequences associated with giving birth vaginally or through a caesarean section. Although

Amahle raises concerns about both vaginal birth and caesarean sections, her concerns about vaginal birth affecting her sexual relationships may be one of the reasons she would prefer to have a caesarean section in the future. Similarly to Amahle, Rethabile, who also stated that she would ideally prefer to have an elective caesarean section, expressed concern about the scar associated with having a caesarean section. She mentioned her mother's scar from her caesarean section and stated, "*luckily now unlike when she gave birth like the scar isn't as big*". She added that if the scar was as big as when her mother gave birth she would probably choose not to have the caesarean section. Rethabile further stated,

> *What I know about caesarean sections, is that like unlike after natural birth, I don't know if you guys do this but in African cultures you, you strain your stomach so that it goes back to its normal shape. So when you have an operation, you can't exactly do that. So by defaults you, you probably are inclined to have that that excess skin.*

It is interesting to note here that this was one of the only instances where cultural influences have been mentioned. The participants were asked during the interviews if they knew of any cultural influences or shared beliefs in their culture concerning the ideal way to give birth, however most of the participants felt that culture played a small role in childbirth decisions. Some of the participants, like Rethabile, did however mention behaviours after childbirth which are culturally specific. In this case Rethabile is highlighting the influence that culture has on the way she views bodily changes or physical consequences, which are often a result of childbirth. The participants discussed above have all expressed concerns about different aspects of both vaginal birth and caesarean sections and how each of these methods of childbirth have different physical consequences. Lesedi, Amahle and Rethabile expressed concerns about their weight and way their bodies will look after giving birth, be it vaginally or through a caesarean section, however when discussing vaginal birth specifically the women seemed to focus on the sexual consequences for both them and their potential partners. By emphasising the physical consequences of childbirth these women are expressing their aspirations to remain 'unscarred' or 'undamaged' physically after the childbirth experience as this might have consequences for them as women. Although previous research has shown that damage to the body has been identified as a reason for some women choosing to have caesarean sections as opposed to vaginal birth (Cappell & Pukall, 2017; Stoll et al., 2009), this study has shown that damage to the body is a theme which emerged in discussions of both vaginal birth and caesarean sections. The women in this study

displayed fear of bodily changes after giving birth irrespective of their preferred method of childbirth.

1.4: The influence of the media

When discussing their fears about different aspects of the childbirth experience, the women in this study often referenced social media, movies or television shows they had seen which show different childbirth experiences. The anxiety and fear of different aspects of the childbirth experiences emerged when the women were discussing how they had seen childbirth being portrayed on these different media platforms. When asked about the way she has seen childbirth being portrayed in the media, Lethabo stated that what stood out to her most about vaginal birth was the "*screaming*", "*pain*" and "*anger*" that women giving birth often seem to express. Omphile said that the way childbirth is portrayed in movies seems "*extremely painful*". Rethabile also felt that pain was an important aspect of the way birth is portrayed in the media. She said,

> *I think it's always the same, painful and you tell your husband that you hate them, then it's always the same narrative for natural birth that you go in so much pain and anguish… So it always makes it seem like it's this emergency, high-pain.*

When discussing how she had seen childbirth being portrayed in the media Michelle said,

> *I think the obvious way that they sort of represent it is that is vaginal birth being a lot more stressful than a caesarean… Uhm just because of like the levels of activeness and passiveness in each method, you know.*

Given that the women in this study had never experienced childbirth, these media representations of the childbirth experience may play an important role in their future childbirth decisions. The anxiety and fear towards different aspects of the childbirth experience may be linked to the way these participants have seen childbirth being portrayed in the media. The extreme pain and stress of vaginal birth depicted on these different media platforms has also been referenced by these women as an important fear they have of the childbirth experience. Previous research has revealed that for many women, and particularly childfree women, the media often serves as one of their main sources of information regarding childbirth, as well as their family members who have had children, and although the influence of the media may be unavoidable it has been seen to create misconceptions

regarding different aspects of the childbirth experience (Cappell & Pukall, 2017; Saroli-Palumbo et al., 2012). Reliance on the media as a main source of childbirth information would then bring the idea of informed choice into question. For some the women in this study the media seems to be one of the main sources of anxiety in the way different methods of childbirth have been portrayed, which has influenced their beliefs about their ideal childbirth experience.

Theme 2: Caesarean sections as a point of reference for childbirth choices

Despite the fact that only two of the participants in this study stated that they would ideally prefer to have an elective caesarean section, many of the women interviewed had strong beliefs about caesarean sections which may have influenced their decisions regarding their ideal childbirth experience. Irrespective of their ideal preferred method of childbirth, the women in this study often used their views of caesarean sections as a method to justify their childbirth choices. Some of the women who stated they would ideally prefer to have vaginal birth justified their decision by stating that they believed caesarean sections should only be used in situations where there is a medical emergency. When discussing how childbirth is portrayed in movies and on television, some of the participants noted that caesarean sections are often only portrayed in the media in situations where there is a medical necessity. Some of the participants also stated that having an elective caesarean section is often seen as taking the easy way out, as opposed to going through the pain and struggle often associated with vaginal birth. Three of the participants also identified that socio-economic factors may play a role in whether or not a woman chooses to have a caesarean section.

2.1: Caesarean sections as a medical necessity

When discussing caesarean sections, the women in this study often felt that this choice should be or is often seen as a medical necessity. Sarah, Lesedi and Michelle, who all stated that they would ideally prefer to give vaginal birth, stated that they would only have a caesarean section if it was medically necessary for themselves or their baby. Michelle said, "*I feel like if you have a caesarean there should be a reason like a medical reason*". Lesedi said,

> *I've only ever thought of a caesarean as like a last option when you definitely have no other option. Like I said if your baby is breached and you kind of have to give it, or like if it's early, or there is a complication.*

Sarah also stated that she felt caesarean sections should be a medical necessity and further emphasised the medical nature of caesarean sections. She said,

> *I think I think a caesarean is something that you do when it's necessary when you have to, there could be potential complications. But I mean the process of having a caeser. They cut into your body. They cut through like your muscle and then into your uterus so it's much more than kind of just giving birth and kind of being fine the next day. So you have a new baby and all of those kind of like things and then over and above that you actually recovering from what is like major surgery.*

These women's views regarding caesarean sections may be linked to their preferred method of childbirth. Given that they view caesarean sections as a medical necessity it makes sense that their ideal preferred method of childbirth would be vaginal birth. Sarah highlights the fact that in her opinion having a caesarean section is a "*major surgery*" which is why she believes that it should be a last resort. She also compares the recovery of vaginal birth to the recovery of having a caesarean section and states that with vaginal birth women are usually "*fine the next day*". Lesedi also mentions that caesarean sections should be used when it is necessary for the baby's safety, placing an importance on the needs of the child over the needs of the mother. These women have justified their choice to have vaginal birth by highlighting the assumed high-risk nature of caesarean sections as a form of surgical intervention. This can be seen to reveal a lack of trust in the safety of surgical interventions and the medical setting, as the perceived safety of surgical interventions, as well as the trust in technology, has been seen to result in women favouring caesarean sections over vaginal birth as the safer option for both them and their children (McAra-Couper et al., 2012).

While these women spoke about caesarean sections as a way of justifying their own childbirth choices, Rethabile, who said that she would ideally prefer to have an elective caesarean section, felt that she might not be able to as caesarean sections are often seen as a medical necessity. After stating that her ideal childbirth would be an elective caesarean section, Rethabile said,

> *I'd have to give birth naturally, even with like the C-section I say I want to C-section but at the end of the day you go into C-section because of if your child is too big, or if*

> *they have complications or whatever. They try you out with natural birth first, so it's probably something that I would have to make peace with anyway.*

At a later point during the interview Rethabile also said,

> *I think childbirth, it's not it's not a matter of choice really. It's something that it's it's prescribed. It's like you having a child, you're pregnant. You'll go for your, your prenatal care whatever. Yeah, then your first choice is to go the natural way, if you can't you go C-section, like a it's like a script. Yeah, it's never really been a matter of choice.*

Although Rethabile stated that she would prefer to have an elective caesarean section, she felt that this might not be an option as she believes that caesarean sections are often associated with being a last resort in an emergency situation. She further emphasised that she felt that she didn't necessarily have a choice when it comes to making decisions about her childbirth experience, she felt that her first choice would have to be vaginal birth and she would only be able to have a caesarean section if there were complications during the childbirth process. The fact that Rethabile felt she didn't have the authority to choose to have a caesarean section highlights the complex nature of childbirth choices and the tensions that exist between women's ideal childbirth choices and actual childbirth experiences, which has been observed and discussed in previous research (Crossley, 2007; Malacrida & Boulton, 2014).

Some of the women in this study also mentioned that they had often seen caesarean sections being portrayed in movies and on television as a medical necessity as opposed to a choice. For example when discussing how birth is portrayed in movies and on television Rethabile, who felt that she would have to try give birth vaginally first although she would prefer to have a caesarean section, stated:

> *With the caesarean they never show a caesarean as a matter of choice, but as a default as to when you can no longer breathe or when you need to save a baby.*

Given that she had never seen caesarean sections being portrayed as a choice in the media it is understandable that she believes that she would not be able to have an elective caesarean section. Similarly when discussing how she has seen childbirth being portrayed in movies Caitlin said, "*I've always seen caesareans as being emergency like operations… It's never, I've never noticed it being portrayed as a choice, so then in my mind it's an emergency*

thing". Michelle also expressed that the media portrays caesarean sections in a specific way, she said,

> *I think I think also caesarean, the way that it's been represented as a lot more like the person giving birth. It's not like, like a caesarean birth is not it's not like you're giving birth. Yeah, you know not like you're giving life. Yeah, it just seems like it's less involved. It's very, the person, the mother is a lot more disconnected yeah from from the child.*

Caitlin and Michelle, who would both prefer to give birth vaginally, have seen caesarean sections being portrayed in very specific ways in movies and on television which may have an influence on their future childbirth choices. Caitlin stated that she associated caesarean sections with an emergency situation because of the media's representations of this type of childbirth and Michelle sees caesarean sections as a method of childbirth which is more passive and where the mother is less involved in the childbirth process. The idea of caesarean sections being a more passive and disconnected method of childbirth has often been used as a critique of the medicalization of childbirth (Brubaker & Dillaway, 2009). The argument is often made that medicalized births in a hospital setting remove women's ability to participate in and control their childbirth experiences which results in childbirth being a more passive experience (Brubaker & Dillaway, 2009). Although Michelle is not expressing that she views caesarean sections in this way, the media's representation of caesarean sections as passive and disconnected may still have an influence on her childbirth choices as the media has been found to be one of the main sources of childbirth information for women who have not yet given birth (Cappell & Pukall, 2017; Saroli-Palumbo et al., 2012). Additionally recent studies with childfree women have found that they often don't agree with these feminist debates that the medicalization of childbirth reduces women's autonomy and control of their childbirth experiences (Saroli-Palumbo et al., 2012; Stoll & Hall, 2013).

2.2: Caesarean sections as the easy way out

As well as viewing caesarean sections as a medical necessity some of the participants also felt that having an elective caesarean section was a way for mothers to take the easy way out. When justifying her decision to have a vaginal birth Lesedi said that she associated caesarean sections with many "*negative things*" and she felt that some women choose to have a caesarean section in order to get the childbirth "*over and done with*". Lesedi further stated

that she would prefer to have a vaginal birth as she didn't want to rush the process. Caitlin echoed these beliefs and further expressed that she saw a connection between the way women give birth and what that says about the type of mother that they are. Caitlin stated,

> *I associate a mother electively getting a caesarean section as being maybe less willing to go through struggle or something… Like they are trying to have it feel easy, so that's, that's not something that I would stand by.*

Caitlin is expressing that in her opinion going through the pain or struggle of vaginal birth is imperative to becoming a good mother. For both of these women having a caesarean section is being portrayed as taking the easy way out, instead of going through the pain of vaginal birth which they view as an important aspect of the childbirth process. The fact that these participants view elective caesarean sections in this way may also have influenced their ideal preferred method of childbirth, which for Lesedi and Caitlin was vaginal birth.

Amahle, who stated that she would ideally prefer to have an elective caesarean section, also mentioned that this choice is often viewed in a negative way. When comparing how women who give vaginal birth are viewed as opposed to how women who have elective caesarean sections are viewed Amahle said,

> *It's like, okay, she did it the natural way and then there's the oh you went and decided okay I want to give birth on such a date and then you had your procedure, it's like you just took the cop out way. So I think there's that kind of pressure.*

Amahle is acknowledging that although she would prefer to have an elective caesarean section she feels a pressure to have vaginal birth as she understands that women who choose to have caesarean sections are viewed as taking the "*cop out way*".

By framing elective caesarean sections as taking the easy way out, these women are emphasising that childbirth should be difficult and that going through the struggle of giving birth vaginally is imperative in being a 'good mother'. Malacrida and Boulton's (2012) study similarly revealed that childfree women often expressed stronger beliefs that pain, sacrifice and selflessness are necessary in order to experience motherhood. Given that all of the women in this study who would ideally prefer to give birth vaginally also indicated that they would prefer to have pain-relieving drugs during childbirth, it could be argued that they don't see pain as an imperative during childbirth. They have however still stressed that there is a sacrifice involved in giving birth vaginally which needs to be experienced in order to be a

'good mother'. Similar to the findings of Chadwick and Foster (2013), the women in this study who would choose to have vaginal births have used the 'natural childbirth' ideal in order to justify their decisions. Additionally Amahle who stated she would ideally prefer to have a caesarean section showed scepticism about this decision as a result of the natural childbirth ideal. The strong beliefs about caesarean sections held by the women in this study can thus be seen as a result of the idealisation of the 'natural', which has shown to be a strong influence on these women's prospective childbirth choices, irrespective of their ideal preferred method of childbirth.

2.3: Socio-economic factors

Three of the women in this study further mentioned that they felt that elective caesarean sections are not a practical choice as they understood that they are often expensive. When asked if she knew of any shared beliefs in her culture concerning the ideal way to give birth, Rethabile said,

> *Well if you're giving birth, uhm because most people can't like afford medical aid and stuff. So you are inclined to give birth naturally or sometimes give birth at home… So I wouldn't say it's cultural but socio-economic, like sometimes makes a decision for you.*

Rethabile is highlighting that the idea of choice is often limited by socio-economic factors, although as previously stated she would ideally prefer to have an elective caesarean section, this might not be a practical option for her. Lesedi also mentioned the fact that socio-economic factors might play a role in limiting one's choice when it comes to childbirth decisions. She mentioned that from what she knows of elective caesarean sections they are "*quite costly and expensive*", and further expressed that someone's choices might be limited if they "*don't have the money to do it*".

While Rethabile and Lesedi highlighted that one's socio-economic status might play a role in limiting a woman's choice, Michelle felt that one's childbirth choices may also be influenced by the idea of "*striving to be a certain socio-economic status*". Michelle said

> *I think now we're getting to a point where nobody cares anymore and I think a lot of it is to do with the fact that rich people are giving birth in a certain way… but now it's like people are doing it the way they want to, yeah… provided that you have the*

> *money… I think it's also like it's also like, like striving to be a certain socio-economic status the way you give birth. You know because I feel like the more the more medical it is, the more drugs you use, the more technology you have is associated with high socio-economic status. Yeah, so I think people are striving towards that.*

Michelle's views of childbirth choices being used as a way to strive to be a certain socio-economic status still emphasises the socio-economic factor involved in making childbirth choices. The more medical the childbirth experience, the more likely it is that this process will be costly and the limited to women who can afford it. While previous research has highlighted that the idealisation of the 'natural' can be viewed as regulatory for women in that it positions births which don't conform to the 'natural' in a negative way or as 'unnatural', Michelle's comments highlight a shift from the idealisation of the 'natural' to an idealisation of the medical, which may be a result of the normalisation of medical interventions in childbirth (Beckett, 2005; Brubaker & Dillaway, 2009).

Theme 3: Childbirth and motherhood

Most of the women in this study showed that they believe there is a connection between the childbirth experience and motherhood. This was expressed by some of the participants through their willingness to place the safety of their future children above their own preferences during the childbirth process, and in doing so positioned themselves to be seen as a 'good mother'. Additionally some of the women simply expressed how they believed that different types of childbirth experiences can affect the motherhood experience in different ways.

3.1: Pressure to have children

While most of the women did not feel that there is any pressure in society to give birth in a certain way, many of the women mentioned that they felt pressured to have children, irrespective of their preferred method of childbirth. For example Lethabo said,

> *I think there's no pressure to give birth in a certain way. I don't think people actually like care about that, but I think that is pressure to, well in the black society, like as a black person I know that there is a lot of pressure to have children. Uhm if you don't*

> *have children, they think there's something wrong with you. Even with some men they believe that if a woman can't have kids then she's not worth marrying. So I think there's pressure to have children but not so much pressure as to how you give birth.*

Lethabo is referencing her experiences with both societal and cultural pressure and emphasises that she feels there is no pressure regarding birthing choices but rather to become a mother. The women in this study often expressed that they felt no societal pressure to give birth in a specific way, emphasising that the normalization of caesarean sections has resulted in them often seen as a standard method of childbirth (Saroli-Palumbo et al., 2012). Sarah and Lesedi further echoed that they felt pressure to have children and be a mother. Sarah mentioned that people often expect that "*most women want to have kids*" and although she made it clear that she does want children in the future she emphasised that this is often not the case for all women. Similarly when discussing societal pressure Lesedi said, "*everyone just expects all of us to just want to be moms. Which is not the same for all women*". The idea that women in South Africa feel societal pressure to have children has been observed in previous research (Bimha & Chadwick, 2016). In their study exploring South African women's decisions to not have children, and the way they negotiate this choice in the context of societal pressures, Bimha and Chadwick (2016, p.6) found that their study did "corroborate previous studies which point to the pervasive stigma and disapproval childfree women experience in pronatalist settings".

3.2: Safety of the baby

Some of the participants in this study expressed that they placed the safety of their future children above their own preferences during the childbirth process, and in doing so positioned themselves to be seen as a 'good mother'. When discussing different methods of childbirth Lethabo stated that her priorities are more about the safety of her baby. She said, "*I'd be open to whatever type of birth allows my child to come out safely*". Similarly when discussing the setting of her ideal childbirth experience Lesedi said,

> *I just want to do it in a sterilised environment where I know like uhm the chances of my child getting sick or of me getting sick are as low as possible.*

Lethabo and Lesedi are adopting the maternal role by placing the emphasis on the safety of their children as opposed to their own preferences about their ideal childbirth experiences. Similarly when discussing her fears about having a water birth Megan said,

> *I like the concept of a water birth, it looks so cool and stuff and everything but then I don't know why in my mind I think the baby's going to drown so I'm like no.*

At a later stage in the interview when discussing the possibility of having an emergency caesarean section, she stated

> *I think it's like a matter of like what's good for the baby because as much as you'd want to give birth naturally and whatever if that's not a possibility, I don't think it's going to be a shameful thing to have gone and had a caesarean… I think it just matters about like if the baby's fine and if the mom is fine.*

By emphasising the importance of making good birthing choices for the safety of the baby, the participants have created a connection between being a good mother and making good decisions regarding childbirth. Megan is once again touching on the idea that many women view caesarean sections as a standard method of childbirth and do not believe that it is a 'shameful' thing to have had a caesarean section as long as the safety of the baby is prioritized (Saroli-Palumbo et al., 2012). By prioritizing the safety of the baby above their own preferences during childbirth, the women in this study have shown that the 'good mother' ideal drives and shapes women's childbirth choices (Chadwick & Foster, 2013). This 'good mother' ideal emphasises that when making decisions regarding childbirth women are expected to be selfless and sacrifice for their children above their own wishes or desires (Malacrida & Boulton, 2012).

3.3: Childbirth choices affecting motherhood

Some of the participants in this study also expressed how they believed that difficult childbirth experiences can affect motherhood in different ways. For example Lesedi said,

> *If you have a bad birthing experience it might sort of, affect the way you see motherhood, it might make you not want to do it again, it might make you feel sort of, uhm I don't want to say hostile but like it might make it harder for you to connect with a child.*

Rethabile and Michelle also mentioned that they thought that having a negative childbirth experience could potentially affect motherhood. Rethabile felt that having a traumatic childbirth experience could potentially lead to post-partum depression or possibly resentment of the child, whereas Michelle used her mother's experience with childbirth as an example of how the childbirth experience may affect motherhood. Michelle said,

> *I think the way you mother has a lot of, it ties a lot to the way you give you gave birth. Because I know that. If I think about my mom, when she had my older brother, he was in distress, so she had to have an emergency C-sections and because, because he was in distress. He was born with fluid in his lungs so like that I think the whole process of her not knowing what was happening when she was under the anaesthesia. It made her want to be more hands-on, it made her want to be more involved just because that, that part of the birthing process was taken away from her, yeah. And even now you know, she still very like involved as a mom so I think yeah, definitely like they are definitely some carryovers from the birthing process to the way a person mothers. If not, if not, like for the next 18 years, then definitely in the first year.*

While Lesedi and Rethabile focused on how the childbirth experience may affect a mother's ability to connect with her child, Michelle focused more on the effect on a mother's parenting style by drawing on her mother's negative childbirth experience. Omphile also discussed how the childbirth experience could affect motherhood however instead of looking generally at how a negative childbirth experience could affect the motherhood experience she focused specifically on caesarean sections and the possible effect of this method of childbirth. Omphile said,

> *I've heard like when you have a caesarean you can't really like touch the baby so it might be difficult to bond with the baby. I don't know you might, I'm not saying like this will cause you to have, what is that post-partum depression. I'm not saying that. But like maybe it would be difficult for you to like attach to the baby. Not that you would resent the baby, but I don't know if they would go as far as to resent their decision if they chose the caesarean or not but I think yeah in that way I think it could influence the way we experience motherhood.*

Omphile's comments reflect her belief that having a caesarean section might make it difficult for a mother to form a healthy attachment with her child. She further mentions that she feels the experience of motherhood may be affected by the resentment of one's childbirth choices.

In making this connection between caesarean sections and attachment in motherhood, Omphile is framing caesarean sections in a more negative way and emphasising the disconnect that she feels is involved in this method of childbirth. This disconnect that Omphile is emphasising might be a result of the belief that highly medicalized births remove women's control and ability to participate in their own childbirth experiences (Brubaker & Dillaway, 2009). While this has been highlighted in some of the feminist debates regarding the medicalization of childbirth, it goes against the recent suggestion that most women view caesarean sections as a standard method of childbirth (Saroli-Palumbo et al., 2012). Similar to the women in this study prioritising the safety of their baby above their own needs, the 'good mother' ideal can be seen to be a strong motivator when discussing how childbirth choices can affect motherhood (Chadwick & Foster, 2013). They are emphasising that good birthing choices involve thinking about the effects that different methods of childbirth have on motherhood and the connection between the mother and the child after childbirth.

Theme 4: The influence of other women's stories

Throughout the interviews it became clear that many of the participants' prospective childbirth choices have been influenced by the stories of women in their social circle. These stories have played a role in their decisions regarding their potential future childbirth choices. These stories, as well as the media, have served as significant sources of information that these childfree women have regarding different methods of childbirth, which has been observed in previous research (Saroli-Palumbo et al., 2012). Lesedi, who stated that she would ideally prefer to give birth vaginally, emphasised the importance of the medical setting and justified her reasons for not opting for a home birth with a story of one of her family members' experiences. Lesedi said,

> *I think it was in like the 80s, the early 80s, she had given birth to a child. And I think that's why I don't want a home birth actually, is, she had given birth to a child in like the house. In my grandma's house… And so people tried to like, so they didn't take her to a hospital after she gave birth and everyone like sort of came in. And they were supposed to cut the cord but they cut the cord with an unsterilized scissor. And it gave the baby an infection, and died like two days later. And then, that was just like, for me, I think after that home births just became super weird.*

When discussing the childbirth setting earlier in the interview Lesedi stated that she would prefer to give birth in a hospital as she believes that it is a "*sterilised environment*". Given that this story of a home birth from someone in her family had terrible consequences, with the loss of the baby, it is understandable that Lesedi places an important role on the medical setting and the professionals in this setting. Lesedi is using this story of a home birth to emphasise her trust in the medical setting, its technologies and surgical intervention. This trust and the normalisation of the medicalisation of childbirth has been seen to result in women favouring medicalised births as the safer option for them and their children (McAra-Couper et al., 2012). Furthermore through the use of this story Lesedi is justifying her decision to not have a home birth by positioning this type of childbirth as unsafe and risky for the baby and in doing so positions herself to be seen as a 'good mother' by focusing on the safety of the baby (Chadwick & Foster, 2013).

Megan spoke about her mother's childbirth experience and how this affected her decision to have vaginal birth. She described how her mother's experience has affected her own choices,

> *So my mom, I was an emergency caesarean because my umbilical cord wrapped around my neck. I didn't feel like getting out of the womb. So my mom had to get an emergency caesarean. And then she had to have my sister with a caesarean as well. So I suppose if I could choose I'd rather have natural so that if I have two children I don't have to go through a caesarean again.*

Megan's links her decision to have vaginal birth to her mother's childbirth experience and the fact that her mother was not able to make a choice with her second child as she had previously had a caesarean section. In her own words she stated, "*it would be nice to have the choice*". Although Megan is using this story of her mother to explain why she might want to choose vaginal birth over having a caesarean she is also referencing a situation where the medical setting played an important role the childbirth experience of someone close to her. Megan has previously emphasised the value she places on the medical setting and professionals in this setting, she stated that she would prefer a hospital setting as "all people in the hospital are trained to deal with this situation that you're going through". This value placed on the medical setting and professionals in this setting could be a result of the important role they played during her mother's childbirth experience. This trust of medical professionals and the medical setting plays an important role in childbirth decisions as it has been seen to result in women favouring medical settings as opposed to home births (McAra-

Couper et al., 2012). The women in this study often displayed a lack of trust towards and scepticism towards births outside of the medical setting which could be a result of the stories they have told of women close to them having positive experiences in a medical setting or negative experiences outside of a medical setting. This scepticism towards births outside of the medical setting and trust in medical professionals has been identified as a major factor contributing to women's different childbirth choices (Malacrida & Boulton, 2014; Saroli-Palumbo et al., 2012).

Amahle, who stated that she would ideally prefer to have an elective caesarean section, highlighted the painful aspect of vaginal birth in the stories she told about the women she knew who had been through childbirth. She mentioned her aunt who has had three children, "*she's like you think it gets better but it was actually just as painful every single time*". Additionally when asked if she thinks that the stories of the women close to her have influenced her views about the ideal childbirth experience, she responded,

> *Uhm maybe not the ideal, but then maybe like a realistic thing of childbirth because as much as like I was telling you like they went through the pain and then afterwards you're excited to have the baby but then they don't like gloss over the fact that it's painful.*

Amahle stresses that the stories she has been told have given her a more realistic view of the childbirth experience, which may be the reason she placed importance on avoiding the pain of vaginal childbirth. While other participants have been seen to place more value on safety in the medical setting Amahle is emphasising that the ability to control pain in childbirth is a driving factor in her decision making, which may be a result of the way pain in childbirth has been experienced by the women close to her. Amahle's fear of pain in childbirth could be seen to be related to her choice to have a caesarean section as previous research has highlighted that fear of childbirth and pain in childbirth is often related to positive views of medical interventions in the childbirth process (Stoll et al., 2009; Stoll & Hall, 2013).

Unlike the examples discussed above, Lethabo told a story which could be seen as a cautionary tale however did not seem to affect her decision regarding her childbirth choices. She told the story of her aunt who had a negative experience giving vaginal birth,

> *She gave birth, uhm I can't believe I'm saying this (laughs), but her vagina tore to uhm anus and she was just, like it was just a really tough birth for her. And after that, she was very disconnected with the child. Uhm she did see a psychologist and it was*

> *because of the fact that it was such a hard and long. I think it was almost. I think an 18 hour something that long birth so after that she was very disconnected with the child. She's like almost, angry at the child. I don't want to say that but yeah, there was a disconnect. So I think that contributed. The trauma, the pain, the how long it was. So I think it definitely has a lot to do with the process and how, how that goes.*

Although she mentioned negative physical consequences and the pain that her aunt experienced, Lethabo still stated that she would prefer to give vaginal birth and would be open to not having an epidural. While this story didn't seem to affect her childbirth decisions Lethabo did mention that her sister-in-law, who has had three children, has never had her water break as an indication that she was going into labour. When asked about her ideal childbirth experience earlier in the interview Lethabo said, "*the typical water breaking, as a warning at least, because I'm worried about my water not breaking and me not knowing if I'm supposed to be giving birth*". It is clear that although the story about her aunt didn't seem to affect her childbirth choices, her sister-in-law's experiences with childbirth have influenced her concerns and fears about the childbirth process.

Throughout the stories told by the women in this study it is evident that the childbirth experiences of the women close to them and stories told by these women have affected their views on different methods of childbirth, but more importantly contributed to their fears of childbirth in different ways. Lesedi's story of a home birth which resulted in the death of the child can be seen to be linked to low confidence and fear of births outside of the medical setting. Similarly Megan's story of her mothers' emergency caesarean section resulted in her placing value in the medical setting and professionals in this setting and further emphasised the value she places in the ability to make her own childbirth decisions. She expressed the fear of not being able to make these decisions as a result of an emergency or previous surgical intervention. Amahle highlighted that for the women close to her pain was important part of the childbirth experience and her fear of pain during childbirth can be seen to be related to her decision to have an elective caesarean section in the future. Lastly although Lethabo's story regarding the tough vaginal birth of her aunt did not seem to affect her decision to have a vaginal childbirth in the future, her fear of not knowing when she is in labour or not having her water break seems to be a fear which has resulted from her sister-in-law's childbirth experiences.

Chapter 5

Conclusion

The following concluding chapter will provide an overview of the research findings, focusing on the four main themes identified by the thematic analysis. This chapter will further provide an outline of the various strengths and limitations of the study as well as possible recommendations for future research related to childbirth choices.

Overview of Research Findings

The aim of this study was to conduct an in-depth investigation of the views and ideologies surrounding different childbirth choices in a group of childfree women in South Africa. This research aimed to understand these views as well as to explore these women's prospective choices and the reasons behind these choices. The research further aimed to explore how their views regarding different methods of childbirth link to their understanding of motherhood and femininity as well as to common feminist debates on childbirth and motherhood.

The results of this study have indicated that one of the main factors influencing these women's prospective choices has been the anxiety that they have towards different aspects of the childbirth experience. It could be argued that this anxiety is heavily informed by the media and the stories of other women which have served as the main sources of information for these women regarding childbirth. The pain of vaginal birth was identified as a fear for most of the participants in this study. The participants who stated that they would ideally prefer to have an elective caesarean section often used their fear of the pain of vaginal birth to justify their decision to have a caesarean section. This finding is similar to that of previous studies which have shown that fear of pain is a major factor influencing women's choices to have caesarean sections as opposed to vaginal birth (Stoll & Hall, 2009). The women in this study who stated that they would ideally prefer to give birth vaginally have also identified the fear of pain as a major concern however this fear did not impact their decision to have vaginal birth. This might be a result of the levels of fear they are experiencing as previous research has indicated that women with lower levels of fear of pain view medical interventions, such as the surgery involved in having a caesarean section, more critically than women with higher levels of fear (Stoll & Hall, 2013). An alternative explanation for this finding may be that these women's views of caesarean sections as a high-risk method of

childbirth have a stronger influence on their prospective choices than their fears towards the pain of vaginal birth. Most of these women did however express that they would prefer to have an epidural in order to control this pain. Furthermore unlike previous research (Malacrida & Boulton, 2012; Saroli-Palumbo et al., 2012) none of the women in this study expressed that they believed pain is a necessary part of the childbirth experience. This might be a result of the normalization of medicalized births which often involves the use of pain medication or surgical intervention. Although these women have shown trust in the use of pain medication during vaginal childbirth, many of them have expressed scepticism towards the surgical intervention involved with caesarean sections. This may be a result of the way caesarean sections are portrayed in the media and by other women or it may be an indication of their levels of trust towards the healthcare available to them. The women in this study further expressed fear towards giving birth outside of the medical setting, often referencing the safety of the medical setting for themselves and/or their children. When discussing childbirth outside of the medical setting, such as home and water births, the women in this study often referred to their concerns regarding lack of access to medical professionals and technologies in these settings. These results have indicated that the trust that these women have placed in the medical setting will play an important role in their future childbirth choices and has strongly influenced their views of home and water births as unsafe childbirth choices. Although these findings suggest that these women trust the safety of the medical setting the participants have also expressed that they view caesarean sections as a high-risk method of childbirth. This may suggest that the strong shift towards the medicalisation of childbirth has resulted in these women favouring the medical setting while still showing scepticism towards the safety of complex surgical interventions in this setting. An alternative explanation for this finding may be that these women have mostly seen or heard about caesarean sections being performed only when there is a medical emergency, and thus view them as a high-risk or last resort during childbirth. Lastly the results have indicated that the fear of physical or bodily changes, which have been associated with different methods of childbirth, has influenced the views and prospective choices of the women in this study. With regards to vaginal childbirth the participants expressed fear towards the way their bodies will look after giving birth vaginally and how this method of childbirth might affect them sexually. Previous research has indicated that the media has played an important role in women believing that vaginal childbirth is harmful to future sexuality (Cappell & Pukall, 2017). This fear of damage to the body that these women have expressed has not however resulted in them favouring caesarean sections. On the other hand with regards to giving birth

via caesarean section, the women in this study often mentioned concern about losing weight after childbirth and the scar associated with this surgical invention. While previous research has indicated that fear of damage to the body often results in women favouring caesarean sections (Cappell & Pukall, 2017; Stoll et al., 2009) the findings of this study have shown that these women expressed fear of damage to the body for both caesarean sections and vaginal birth. These findings may once again be the result of their views of caesarean sections as taking the easy way out or only an option in the case of medical emergencies, and thus their fears of vaginal birth affecting their bodies and affecting them sexually have not resulted in them favouring caesarean sections. Alternatively since the women in this study expressed fear of damage to the body for both vaginal birth and caesareans sections, these findings may simply be a result of what type of damage to the body these women fear most.

The findings of this study have further indicated that the way these women view caesarean sections has strongly influenced their prospective choices in various ways. Women who stated that they would prefer to give birth vaginally often justified their decision by framing caesarean sections as a high-risk method of childbirth which should only be performed in the case of medical emergencies. Previous research has found that the perceived safety of surgical interventions results in women favouring caesarean sections over vaginal birth (McAra- Couper et al., 2012). It is understandable then that these women's lack of trust in, or high-risk view of, surgical interventions has resulted in them favouring vaginal birth, despite their overwhelming preference for giving birth in the medical setting. The idea that caesarean sections should only be performed when medically necessary was found to have been reinforced by the media as many of the women in this study explained that they had only seen this method of childbirth being depicted in emergency situations. While this view of caesarean sections as a high-risk method of childbirth may be a result of the way the media has portrayed this method of childbirth, it could also be a result of the stories of other women. If these women had never heard of anyone close to them or in their social circle having an elective caesarean section they may only view caesarean sections as a last resort during a medical emergency. Alternatively their lack of trust in surgical interventions may be a result of the way these women view the healthcare available to them, which may have influenced their views of caesarean sections as a high-risk method of childbirth. Furthermore although the participants have expressed that they did not believe that pain is a necessary part of the childbirth experience, they did believe that elective caesarean sections are often seen as taking the easy way out. This belief that going through the struggle of vaginal birth is

imperative in being a ‘good mother’ has been observed in previous research (Chadwick & Foster, 2013; Malacrida & Boulton, 2012). These views of caesarean sections may be a result of the idealisation of the ‘natural’, which has shown to be a strong influence on their prospective childbirth choices irrespective of their ideal preferred method of childbirth. The findings of this study have also highlighted that socio-economic factors may strongly influence childbirth choices, as the women in this study often associated caesarean sections and highly medicalised births with a high socio-economic status. These findings suggest a possible shift from the idealisation of the ‘natural’ to the idealisation of the medical, which may be a result of the normalisation and acceptance of medical interventions (Beckett, 2005; Brubaker & Dillaway, 2009).

The results of this study have further emphasised the connection between childbirth choices and motherhood. The women in this study often highlighted the safety of their children as an important factor to consider when making childbirth choices, thus positioning themselves to be seen as a ‘good mother’. By prioritizing the safety of their babies above their own preferences during childbirth the women in this study have emphasised that the ‘good mother’ ideal shapes women’s childbirth choices and emphasises the role of selflessness and sacrifice in childbirth choices (Chadwick & Foster, 2013). They further expressed that they believed the experience of childbirth may affect motherhood in different ways, the women in this study mostly emphasised that different methods of childbirth may affect the connection with their child. They emphasised that good birthing choices should involve thinking about how a method of childbirth may influence the connection between the mother and the child, which again emphasised the ‘good mother’ ideal shaping their childbirth choices (Chadwick & Foster, 2013). This belief that childbirth experiences affect motherhood could be seen to be linked to the stories these women told of the childbirth experiences of the women in their social circle. It is clear that these stories as well as the representation of childbirth in the media have served as the main sources of childbirth information for these childfree women.

Strengths and Limitations

One of the main strengths of this study is the contribution it makes to the existing body of knowledge on childbirth choices in South Africa. As the review of previous literature has highlighted there is very little work exploring women’s childbirth choices and the reasons behind these choices in a South African context. Although the findings of this study cannot

be generalised, the results do align with the understanding that medicalized childbirth in South Africa is becoming increasingly popular, with home births and elective caesarean sections often being seen as uncommon choices for South African women (Chadwick & Foster, 2014; South African Demographic and Health Survey 2016, 2017). Furthermore the qualitative design of this study allowed for a more in depth and detailed examination of childfree women's views of different childbirth choices. The semi-structured nature of the interviews allowed the researcher to guide and redirect the interview when necessary resulting in greater depth of the data collected. Lastly the racial diversity of the sample of this study can be seen as a strength as it appears that diversity has not been a main priority in previous studies on childbirth choices both in South Africa and internationally. In South Africa specifically, Chadwick and Foster's (2013) study which was conducted with a sample of white, middle-class women highlighted the need for more work to be done in a South African context with more diverse groups.

With regards to the limitations of this study, sampling university students poses limitations for the educational diversity of the sample. The use of face-to-face interviews can be seen as a limitation given that the quality of the data gathered is dependent on the skills of the interviewer. The researcher of this study had limited experience conducting interviews which could be argued to have impacted the quality of the data. Furthermore in qualitative research the position and biases of the researcher might influence different aspects of the research. The researcher did however aim to remain as objective as possible throughout the research process and remain aware of her own position and the possible effects of this position. Although the use of thematic analysis was suitable for this research and the aims of the research it can be limited. Lastly the participants were asked during their interviews about possible cultural influences on childbirth choices, these questions yielded limited responses and hence a theme could not be generated exploring this further. While this can be seen as a limitation is could be an opportunity for future research to explore.

Recommendations for Future Research

Although the sample of this research is racially diverse there is still the opportunity to explore childbirth choices further with women from different groups, social circles and educational and economic backgrounds in South Africa. It could be beneficial for future research to further explore childfree South African women's sources of information regarding different

methods of childbirth given that the media has been seen to perpetuate misconceptions (Cappell & Pukall, 2017; Saroli-Palumbo et al., 2012). Additionally the use of triangulation and different data collection methods in future research may be helpful in addressing some of the shortcomings of using individual interviews as the only method of data collection.

While previous research has found that the perceived safety and normalisation of surgical interventions often results in women favouring caesarean sections over vaginal birth (McAra-Couper et al., 2012), this study has highlighted the lack of trust in surgical interventions which has resulted in most of the women in this study favouring vaginal birth. These findings may highlight the need for further exploration on the way South African women view health and maternity care. Furthermore future research could further explore the connection between childbirth choices and motherhood, which has been identified in the findings of this study. The 'good mother' ideal has been found to have been a strong factor influencing these women's prospective choices. Given that exploring the influence of the 'good mother' ideal on childbirth choices was not one of the main aims of this study there is a gap for future research to explore this further. The findings of this study have also shown that these women have used the stories of other women as one of their main sources of information regarding childbirth, these stories have shaped and influenced their views in different ways. The idea that childbirth choices are policed and shaped by other women could be explored and unpacked further in future research. Lastly although the participants in this study were asked about possible cultural influences on their childbirth choices these questions yielded limited responses. This may suggest that childbirth choices are influenced more by other factors, such as gender or educational and socio-economic background, which could be explored further.

Conclusion

This research has shown that there are a variety of factors shaping and influencing childfree women's views on different childbirth choices and their own prospective childbirth choices. One of the main factors found to be influencing their prospective choices is the anxiety that they have towards different aspects of the childbirth experience. The women in this study expressed strong fears towards the pain of vaginal birth, giving birth outside of the medical setting and the physical or bodily changes which have been associated with different methods of childbirth. These women's views of caesarean sections have also influenced their

prospective choices in various ways. Most of the women in this study have expressed that they view caesarean sections as a high-risk method of childbirth which should only be performed in the case of medical emergencies and although they do not necessarily agree with these views they have indicated that caesarean sections are often seen as taking the easy way out. These results show both a trust and a distrust in the medicalisation of childbirth. On the one hand these women have shown a strong preference for more medicalized births and lack of trust in births outside of the medical setting, however they still have shown scepticism towards the safety of caesarean sections and view this method of childbirth as a high-risk option. The results of this study have also emphasised the influence of the 'good mother' ideal. The women in this study often highlighted the safety of their children as an important factor to consider when making childbirth choices, thus positioning themselves to be seen as a 'good mother'. Lastly the influence of other women's stories has been found to be an important factor influencing these women's prospective choices. The childbirth stories of the women in their families and social circles have served as one of their main sources of information regarding childbirth. Investigating the views of childfree women on childbirth choices offers a window not only into their opinions and the ways these are shaped by various dominant ideologies, but also a window more generally into the complexities of reproductive choice. This study has demonstrated that choice in childbirth continues to be a site of contestation. In a country with huge disparities between the public and private healthcare system, a very high caesarean section rate and a very high infant mortality rate related to the birthing process, further interrogation of childbirth choice is indeed warranted.

Reference List

Beckett, K. (2005). Choosing Caesarean: Feminism and the politics of childbirth in the United States. *Feminist Theory*, 6(3), 251-275.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative research*, *15*(2), 219-234.

Betrán, A. P., Merialdi, M., Lauer, J. A., Bing-Shun, W., Thomas, J., Van Look, P., & Wagner, M. (2007). Rates of caesarean section: analysis of global, regional and national estimates. *Paediatric and perinatal epidemiology*, 21(2), 98-113.

Bimha, P. Z., & Chadwick, R. (2016). Making the childfree choice: Perspectives of women living in South Africa. *Journal of Psychology in Africa*, *26*(5), 449-456.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Psychology*, 3(2), 77-101.

Brubaker, S. J., & Dillaway, H. E. (2009). Medicalization, natural childbirth and birthing experiences. *Sociology Compass*, 3(1), 31-48.

Cappell, J., & Pukall, C. F. (2018). Perceptions of the effects of childbirth on sexuality among nulliparous individuals. *Birth*, *45*(1), 55-63.

Chadwick, R. (2014). Raising concerns: Quality of care in maternal health services in South Africa. *African Journal of Midwifery and Women's Health*, *8*(4), 177-181.

Chadwick, R. J., & Foster, D. (2013). Technologies of gender and childbirth choices: Home birth, elective caesarean and white femininities in South Africa. *Feminism & psychology*, 23(3), 317-338.

Chadwick, R. J., & Foster, D. (2014). Negotiating risky bodies: childbirth and constructions of risk. Health, risk & society, 16(1), 68-83.

Creswell, J. W. (2013). Research design: Qualitative, quantitative, and mixed methods approaches. Sage publications.

Crossley, M. L. (2007). Childbirth, complications and the illusion of choice': A case study. *Feminism & Psychology*, 17(4), 543-563.

Department of Health, Medical Research Council. 2017. *South African demographic and health survey 2016*. Pretoria: Department of Health, Medical Research Council.

Gebhardt, G. S., Fawcus, S., Moodley, J., & Farina, Z. (2015). Maternal death and caesarean section in South Africa: results from the 2011-2013 saving mothers report of the national committee for confidential enquiries into maternal deaths. *South African Medical Journal*, *105*(4), 287-291.

Joffe, H. (2012). Thematic analysis. Qualitative research methods in mental health and psychotherapy: *A guide for students and practitioners*, 1, 210-223.

Landman, M. (2006). Getting quality in qualitative research: A short introduction to feminist methodology and methods. *Proceedings of the Nutrition Society*, 65(4), 429-433.

Malacrida, C., & Boulton, T. (2012). Women's perceptions of childbirth "choices" competing discourses of motherhood, sexuality, and selflessness. *Gender & Society*, 26(5), 748-772.

Malacrida, C., & Boulton, T. (2014). The best laid plans? Women's choices, expectations and experiences in childbirth. *Health:*, *18*(1), 41-59.

McAra-Couper, J., Jones, M., & Smythe, L. (2012). Caesarean-section, my body, my choice: The construction of 'informed choice' in relation to intervention in childbirth. *Feminism & Psychology*, 22(1), 81-97.

Moodley, J., Fawcus, S., & Pattinson, R. (2018). Improvements in maternal mortality in South Africa. *South African Medical Journal*, *108*(3), 4-8.

Naidoo N and Moodley J (2009) Rising rates of Caesarean sections: An audit of Caesarean sections in a specialist private practice. *South African Family Practice* 51(3): 254–258.

National Committee on Confidential Enquiries into Maternal Deaths. (2018). Saving Mothers 2014-2016: Seventh triennial report on confidential enquiries into maternal deaths in South Africa: Executive summary. *Pretoria: National Department of Health*.

Oberg, E. (n.d.). Childbirth Types: Natural Childbirth, Water Birth, Home Birth. Retrieved from

https://www.medicinenet.com/7_childbirth_and_delivery_methods/article.htm#what_are_assisted_births

Patton, M. Q. (1980). Qualitative evaluation methods. In *Qualitative evaluation methods*. Sage.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). Qualitative research practice: *A guide for social science students and researchers*. Sage.

Saroli-Palumbo, C. S., Hsu, R., Tomkinson, J., & Klein, M. C. (2012). Pre-university students' attitudes and beliefs about childbirth: Implications for reproductive health and maternity care. *Canadian Journal of Midwifery Research and Practice*, *11*(2), 27-37.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), 63-75.

Stoll, K., Fairbrother, N., Carty, E., Jordan, N., Miceli, C., Vostrcil, Y., & Willihnganz, L. (2009). "It's all the rage these days": university students' attitudes toward vaginal and cesarean birth. *Birth*, 36(2), 133-140.

Stoll, K., & Hall, W. A. (2013). Attitudes and preferences of young women with low and high fear of childbirth. *Qualitative health research*, 23(11), 1495-1505.

World Health Organization. (2015). WHO statement on caesarean section rates.

Appendix A: Interview Schedule

1. How old are you?
2. What do you know about different methods of childbirth?
3. Have you ever thought about giving birth in the future?
4. Do you have an intention to give birth in the future?
5. How do you feel about giving birth in the future?
    - What are you looking forward to?
    - What are your fears?
6. If you were to try imagining your ideal birth giving what would that experience look like?
    - Why this option over others?
    - What factors do you think have influenced these choices?
    - How do you feel about other choices that have not been mentioned?
7. Would your potential partner be involved in this decision with regards to the method of childbirth you would pursue?
    - What if they wanted the opposite of what you wanted?
8. How would you feel if you weren't able to give birth this way?
9. How do you feel towards different childbirth options?
    - Natural birth without any medical interference?
    - Natural birth with epidural?
    - Emergency caesarean?
    - Elective caesarean?
    - Water births?
10. There are often scenes in movies and tv shows that show women giving birth, if you've ever seen any that you could remember could you share how you experiences them?
11. Do you feel that there is any pressure in society to give birth a certain way?
12. Do you think that there are shared beliefs in your culture concerning the ideal way to give birth?
13. Do you think that the way women give birth can influence their experience as mothers? Why? In what way?
14. How would you describe the ideal mother? What do you think this role entails?

15. Can you tell me about the childbirth experiences of women in your family or social circle?

    - Probe with “can you think about any more stories”

16. Do you think these experiences, or the views of these women close to you have influenced your views about your ideal childbirth experience discussed earlier?
17. What was it like for you talking about different childbirth methods when it’s not in your immediate future?
18. Did anything that you spoke about in the interview surprise you?
19. Are there any questions that you’re left with now after having thought about different childbirth methods?

Appendix B: Participant Information Sheet

SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

FACULTY OF HUMANITIES

UNIVERSITY OF THE WITWATERSRAND

Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

Good day,

My name is Christina Edginton and I am a student completing a Master's degree in Social and Psychological Research at the University of Witwatersrand. As part of my studies I have to undertake a research project, and I am investigating childbirth choices in a group of South African women who do not have children. I am interested in understanding women's opinions and views about different childbirth choices and how these views link to their cultural context as well as to their understanding of motherhood and femininity.

I would like to invite you to participate in this study.

If you agree to participate you will be requested to do an individual interview with me, which should take no longer than one hour of your time. With your permission the interview will be audio-recorded, however only myself and my supervisor, Professor Carol Long, will have access to these recordings. They will be kept in password protected files on the researchers' computer.

Participation in this study is completely voluntary. You may choose not to answer questions or to completely withdraw from the study, without negative consequences, at any point before the analysis of data begins. There are no foreseeable benefits or harms in participating in this research. Although fellow members of the focus group will know your identity, I will protect your identity in the written report by using a pseudonym and disguising or deleting any other identifying information.

Results from this study will be written in a research report and may also be published. A summary of results will be available to you upon request. Anonymised transcripts of your interview may also be included in future related studies conducted by myself and/or my supervisor.

If you have any queries, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (non-medical), telephone + 27(0)11 717 1408, email hrec-medical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za.

Should you have any further questions please do not hesitate to contact me or my supervisor.

Thank you for considering taking part in the research project.

Yours sincerely,

Christina Edginton 800214@students.wits.ac.za 072 014 6752

Professor Carol Long Carol.Long@wits.ac.za 011 717 4510

Appendix C: Participant Consent Form

Investigating Childbirth Choices in a Group of Childfree Women in South Africa

Christina Edginton

800214@students.wits 072 014 6752

I _____(name and surname) consent to participate in the research study on childbirth choices, motherhood and femininity, conducted by Christina Edginton and supervised by Professor Carol Long. The research has been explained to me and I understand what my participation will involve.

Please circle if appropriate:

I agree that my participation will remain anonymous with the use of an anonymous code or pseudonym (false name)	YES	NO
I agree that the researcher may use anonymous quotes in his research report	YES	NO
I agree that the interview may be audio recorded	YES	NO
I agree that my anonymized transcript may be stored for possible future research use	YES	NO
I agree that the results of the study may be reported in the form of a research report for the partial completion of the degree, Masters in Social and Psychological Research Psychology	YES	NO
I agree that the research may also be published	YES	NO

Name of Participant: _____

Signature: _____

Date: _____