

# The safety-net: what influences New Zealand first-time mothers' perceptions of safety for self and unborn child?

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### ABSTRACT

**Background:** Pregnancy, labour and birth are times when a mother wants to ensure both her, and her developing baby's, safety. An objective of the present study was to investigate New Zealand (NZ) primiparous mothers' perceptions of what contributes to a sense of safety for themselves and their unborn babies.

**Method:** A qualitative method was used to obtain an insight into childbearing experience and new mothers' concept of safety. Ten New Zealand first-time mothers aged 24 to 38 years (median 31.5 years) participated. These women took part in a semi-structured face-to-face interview within 11 days to 16 weeks of giving birth (median 13.5 weeks). The interviews were audio-recorded, transcribed verbatim and then analysed using thematic analysis informed by Interpretive Phenomenological Analysis (IPA).

**Method:** A core theme identified across transcripts was designated 'safety-net'. This theme incorporated the four subthemes: care of self and unborn child; the importance of midwife skills; the availability of a hospital facility and its resources; and the availability of medical expertise and intervention.

**Conclusions:** The present study highlights what influences first-time mothers' perceptions of safety for self and unborn baby. Women sought out relevant information and managed important lifestyle changes. They took care over selection of a midwife. Additionally, the availability of a local tertiary care facility with highly skilled obstetricians, obstetric registrars, anaesthetists, paediatricians and hospital support staff increased

participants' perception of safety and gave them the confidence to select birth options suited to their needs.

### KEY WORDS

Birth, labour, midwife, pregnancy, safety

### INTRODUCTION

An important requisite of motherhood is keeping self and baby safe (Rubin, 1984). In the New Zealand Maternity Services Consumer Satisfaction Survey, 203 mothers who had recently given birth identified feeling safe as the "best [thing] about women's maternity care" (Ministry of Health, 2007, p. 72) in New Zealand, but what contributed towards a mother's sense of safety was not explored. When the outcome, or actual birth experience matches, or is better than, a woman's expectations of how her labour and birth will progress, her satisfaction with her birth experience is enhanced (Howarth, Swain, & Treharne, 2010; Manning & Wright, 1983). However, unexpected medical interventions or the necessity of admitting the newly born infant to an intensive care unit are challenging outcomes, which lead to women perceiving their birthing experiences negatively (Waldenstrom, Hildingsson, Rubertsson, & Radestad, 2004). This raises an important question. What do women need to enable them to feel safe during pregnancy, labour and birth? This study seeks to determine what behaviours, environments and care options women perceived as creating a sense of a safety for themselves and their unborn child.

In the words of Smythe (2003):

*Understanding the meaning of being safe ... would be of no consequence if childbirth were always safe. Experience teaches us, that even with the best of intentions, childbirth is not always safe. Things go wrong. Death is always a possibility. (p. 202).*

New Zealand mortality rates for mothers and babies are low (Oza, Cousens, & Lawn, 2013; Statistics New Zealand, 2011; 2012). However, this offers little consolation to those mothers who experience the loss of a baby. Most women are aware that labour and birth are an unknown journey which may not always go as planned.

Safety and feeling safe is an 'interpretative act' (Smythe, 2010). Therefore feeling safe is affected by cultural, emotional, social, psychological and spiritual aspects which vary from person to person, situation to situation. All these factors must be considered in a discussion of an issue as complex as the perception of what is safe and what is not (Dahlen, 2012).

In New Zealand, a woman has choices over who provides care and where she will give birth. These choices may be guided in part by a woman's perceptions of safety (Boucher, Bennett, McFarlin, & Freeze, 2009). Most will choose a case load midwife as their Lead Maternity Carer (LMC) (91.6% of pregnant women who register with an LMC in this country do

so) (Ministry of Health, 2012). Perceptions of safety may be influenced by the relationship of trust and partnership she builds with her midwife (Howarth, Swain, & Treharne, 2012). Perceptions of safety may also be affected by media reports of those few situations when midwifery care resulted in complications, and by magazine articles which unjustifiably sensationalise such events (Newick et al., 2013). As yet there is minimal research into the influences of media reporting of adverse outcomes and women's perceptions of maternity care.

In a review of relevant literature, Howarth, Swain and Treharne (2010) identified a lack of New Zealand studies examining what influences New Zealand women's perceptions about what constitutes a sense of safety for self and unborn child during pregnancy, labour and birth.

## METHOD

A phenomenological approach informed by IPA was used to examine the birthing experiences of ten first-time mothers living and giving birth in New Zealand, to gain an insight into what makes them feel safe during pregnancy, labour and birth.

### Participants

The inclusion criteria were: 1) primiparous mothers (with singleton pregnancies) who had given birth to a healthy baby within the 4 months prior to the interview; 2) being aged 18-42 years; 3) having registered with and received care during pregnancy from an LMC who was a midwife; 4) living in a stable relationship; and 5) having the prerequisite English language skills.

### Procedure

Ethical approval for this study was given by New Zealand Lower South Regional Ethics Committee (reference number: LRS/08/22/EXP). Posters, newspaper advertisements and snowballing (information passed from person to person) were used to recruit participants. A total of ten first-time mothers self-selected to participate in a semi-structured face-to-face informal interview at a place of their choosing. Information sheets, consent forms and study questions were emailed to participants prior to the interview. While the questions were useful in commencing the interview, participants were encouraged to tell their stories in their own way, allowing them to cover the relevant questions in ways that made sense for them. This allowed the interviewer to explore pertinent issues further.

Informed consent was obtained at the beginning of the interview at which time participants were asked if they had any questions. Interviews lasted between 57 minutes and 106 minutes (mean 76 minutes). The recorded interviews were transcribed verbatim. For each participant, a birth story that aimed to encapsulate the essence of the woman's experience was compiled and sent to her so she could check for errors or omissions. Once it was clear the interviewer had captured each woman's experience as she herself saw it, analysis began. Each participant was assigned a pseudonym and other identifying material was removed or altered to protect anonymity of individuals and organizations. Participants were provided with a \$20 petrol voucher for taking part in the study.

### Data Analysis

Thematic analysis informed by IPA was used to examine the data (Smith, 1995; 1996; Smith, Flowers, & Larkin, 2009; Smith, Jarman, & Osborn, 1999). By using this technique women were given the opportunity to bring up and explain topics of importance to them and which may have remained hidden in a questionnaire approach. This methodology allowed for themes to emerge from the data (Reid, Flowers, & Larkin, 2005).

Three major core themes emerged from the interviews across all transcripts. These core themes were isolated along with subthemes and their relationship to the core themes. A full description of the analysis process is given in Howarth, Swain, & Treharne (2011). The core themes were named: 1) taking personal responsibility; 2) relationship issues; and 3) the 'safety-net'. This article will focus on the core theme 'safety-net'.

## RESULTS

### Demographic characteristics

Participants were aged 24-38 years (median 31.5 years). The mean age in New Zealand for women giving birth to their first child was 28 years for the year ending March 2008 (Statistics New Zealand, 2008). The babies were born between the beginning of April 2009 and the end of September 2009 at between 36 and 42 weeks gestation. Seven of the 10 births were within one week of estimated due date. Three babies were born at home; all babies were born vaginally.

One baby suffered bruising during a forceps birth. Two early and small babies spent a few days in the neonatal intensive care unit where they were monitored for jaundice. No baby was considered to have had serious issues. Difficulties establishing breastfeeding and two instances of the mother requiring further care accounted for the longest hospital stays. All babies and mothers had been discharged from hospital by the end of eight days.

Educationally, participants varied from being school leavers through to university post-graduates. Three participants were recent immigrants (within the past six years) of European or Australian origin. Three participants identified as both Māori and New Zealand European. The four remaining identified as New Zealand European. Eight participants lived within a 10 minute drive to the local tertiary care public hospital; the other two participants lived within a 30-40 minute drive. All participants were in stable relationships. At the time of the mother's interview, babies were aged 11 days to 16 weeks (mean age 11.5 weeks) and all mothers were confident their babies were breastfeeding successfully and were thriving.

### The safety-net theme

Feeling safe was a concern for all ten participants. Their perceptions of what felt safe influenced their behaviours and decisions at every stage of pregnancy and birth. The theme of creating a 'safety-net' incorporated the subthemes: care of self and unborn child; the importance of midwife skills; and the availability of a hospital facility with resources, medical expertise and intervention.

#### Safety-net: Care of self and unborn child

All ten participants used the internet and books to inform their decisions regarding risk related behaviours, for example, drinking alcohol or smoking is risky to fetal development (Einarson & Riordan, 2009; Flynn & Chermack, 2008; Henderson, Gray, & Brocklehurst, 2007). They also consulted with their midwives about keeping their unborn baby safe. They made changes to their then current behaviours to ensure the safety of their developing babies. No woman in the study smoked cigarettes and all participants stopped consumption of alcohol once pregnancies were suspected and confirmed, because of their concern that alcohol could damage the developing fetus:

*I wasn't a smoker but I used to drink quite a lot. [...] [I] gave up the drinking from the day that I found out I was pregnant. (Sara)*

Special care was given to nutrition and exercise regimes so women kept healthy and fit as this was seen as pro-actively supporting the baby's health and thus giving the baby the safest possible environment in which to develop and grow:

*My midwife [...] recommended having a really balanced diet [...] we'd have fish twice a week and steak. (Wendy)*

*I'd stayed pretty active [...] I tried to carry on walking as much as I could. (Carol)*

Women in the study who suffered issues such as morning sickness sought out information about 'cures' on the internet. Ngairé was deeply concerned that her frequent vomiting was having a severe impact on her own health and that this could mean her baby would be starved of essential nutrients. As well as checking for information on the internet, she also sought assistance from her midwife:

*My midwife was a naturopathic midwife sort of, um, for homebirth and she was awesome and she, we tried so many different things [...] because I*

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## Participants in this study were satisfied that the care they received from their midwives made them feel their care was safe for themselves and their unborn babies..

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*wanted to do everything natural [...] I had ginger tea and, what else was I using? I was using all kinds of stuff.* (Ngaire)

When these products did not bring relief and her midwife suggested she try prescription medicines when the naturopathic options were unsuccessful. Ngaire responded:

*She even suggested something along the lines of (propriety brand) [...] and I was really anti that.* (Ngaire)

This concern to do 'everything natural' during pregnancy, driven by a need to keep self and baby safe, was common to all ten of the women in the study. While so-called 'natural remedies' were perceived as safe to take, potential side effects from prescribed medication were regarded as potentially dangerous to the developing fetus, and considered best avoided at all times if at all possible.

### **Safety-net: The importance of midwife skills**

Participants and their partners were concerned that their midwives had the professional skills to ensure safe and responsible antenatal care and they asked probing questions. While none of these women expected to have any issues, they were aware that sometimes things did go wrong, and they wanted assurance that their midwives would act in a timely and appropriate manner if a problem developed. This was an important quality in a midwife if her client was to feel safe and secure:

*I think the professional skills, um, because knowing if, if something went wrong she knew.* (Beth)

All these women wanted their partner included and kept informed, and they also wanted him to feel confident his partner was being appropriately and safely cared for. In particular, Ngaire's partner was very anxious because he felt a hospital birth was a safer option than the homebirth she planned:

*My partner and I were just battling over my decision to have a homebirth.* (Ngaire)

Ngaire had very clear ideas about the type of environment she wanted her baby to be born into. She viewed with disquiet what she regarded as the unnatural environment of the hospital and was concerned for her baby's future emotional development and stability if she gave birth in any other space than the gentle and calm home environment she had planned for. While she felt that the birthing suite at the local hospital could give her the conditions she required, she knew that it was in demand and there was no guarantee it would be available when she needed it. Consequently, Ngaire was only prepared to consider going to hospital if the labour and birth deviated from the normal and medical intervention became essential for her baby's health. Ngaire discussed her problem concerning her partner's anxiety with her midwife:

*In fact it was quite a healing journey that all three of us went on, because he was really, really resistant to my homebirth and he fought pretty much all the way and, um, she, yeah she helped turn him around.* (Ngaire)

Ngaire's midwife took special care to address his need to feel Ngaire was in safe hands during her labour at home by explaining to him as she laid out her equipment what it was for, and what she was doing. Consequently, he felt reassured that the midwife had the necessary resources and knew when and how to use them to ensure that Ngaire would receive whatever emergency care she might need appropriately and skillfully at home, or she would be safely transferred to hospital if the need arose:

*[The midwife] had also laid out all her [equipment], like the oxygen and all this medical stuff, really professionally [...] Cos he was like, "She looks really professional".* (Ngaire)

As a consequence of her partner's confidence in their midwife's ability to keep their baby safe, Ngaire and her partner then went on to have the birth that she had planned for:

*They [midwives] knew that it was his and my journey and they were just going to guide us [...] I pushed her out [...] And then when he brought her up she just kind of did a little tiny bit of a wab and then, um, he passed her to me and I just breastfed her straight away, um, in the water [...] In the days after that, he was blown away. He was like, he was like "Oh I respect you so much now, thank you for standing strong with your beliefs," and, um, like he still goes on about that day.* (Ngaire)

All participants wanted to feel confident that their midwives could monitor the progress of their labour and take appropriate action if required, even though it was not explicitly part of the birth plan:

*I was absolutely exhausted [...] it was my midwife actually who said, "I think you need an epidural".* (Vinnie)

If specialist care was required, women wanted to feel that their midwives were still involved and able to support them during labour, even though obstetricians had taken over care. These women had developed trusting relationships with their midwives and their presence increased the women's sense of safety in the midst of an unexpected and often frightening situation amongst people who were usually strangers. The midwives' continued support and continuity of care gave reassurance and greater confidence in a safe outcome:

*One of them (the obstetricians) did the forceps birth and the other one did the delivery of the placenta [...], but [midwife's name] was really good in that she [...] told me what to do and when I needed to do it and, um, and she, and she told [partner's name] what he needed to be doing as well and, cos I think he, at times he was quite concerned about me.* (Sara)

This continued for the first six weeks after baby was born when the reassurance midwives gave helped the mothers develop confidence in their own abilities to keep their baby safely cared for:

*I used to hang out, even though things were good for those six weeks, I used to hang out for [midwife's name] to come visit [...] it was just the whole reassurance that we were doing a good job.* (Carol)

Participants in this study were satisfied that the care they received from their midwives made them feel their care was safe for themselves and their unborn babies. Beth and her partner had returned from overseas for her to give birth in New Zealand, because they held the New Zealand model of midwifery care in so high regard and she was not disappointed. Her midwife acted promptly when, in early labour, an issue developed with the baby's heart rate. The midwife gave good advice which enabled Beth to make informed decisions and feel she and her baby were safe throughout labour and birth:

*We came back to New Zealand from [other country], um, to have [baby's name] here, [...] because we knew that midwives were so big, [...] It's [New Zealand] an amazing place to have a baby.* (Beth)

### **Safety-net: The availability of a hospital facility, with its resources, medical expertise and intervention**

Having a tertiary care hospital facility close at hand was an important safety consideration for all participants. Participants were confident that surgical

facilities and medications were available if they became necessary for a safe birth. Five participants chose to give birth in the hospital because they felt the hospital was the safest place to give birth:

*I was actually pretty keen on having a hospital birth, [...] just so that there was always help there. (Carol)*

For the other five participants, the closeness of the hospital gave them the confidence to feel safe enough to try for a homebirth. They felt that if difficulties developed, they had time to get to the hospital for any specialist care they or their babies needed. The closeness of the hospital gave them a sense of a 'safety-net':

*I knew the prep time for the, for a caesar is approximately 40 minutes. And I live five minutes from the hospital; I'm going to get there before they're ready for me. [...] So if I needed to go, I knew I was well within a time frame that was gonna be fine. [...] I think had I lived further away it would've been a harder decision. (Anita)*

When complications developed for Beth, the distance she lived from the hospital (a 30 minute drive) influenced her decision to abandon her plan to attempt a homebirth. She chose to remain at the hospital after the midwife's check-up indicated her baby may have required continuous monitoring. While this was a very difficult and disappointing decision for Beth to make, she and her partner both felt that safety of mother and baby was the priority and better served by being close to the resources needed just in case an emergency arose:

*It was just new terrain, you know, [...] and [we] didn't quite expect it, that there would be complications [...] then I felt much more aware of the fact that [suburb] was a half hour drive from the hospital [...] in the winter. (Beth)*

Whenever complications arose, participants were grateful for the 'safety-net' provided by obstetricians, obstetric registrars, anaesthetists, paediatricians and hospital support staff. While the ten women hoped to have uncomplicated births, they had faith that, in the event of an emergency, the expertise of local medical personnel would ensure that they and their babies would be safe. Those who required assistance were grateful for the care that they felt kept them safe and brought their babies safely into the world:

*He [the obstetrician] pulled him out, just one, one, um, gentle pull and while I pushed [...] I really appreciate what he did, in that he did, you know, he got, got [baby's name] out very efficiently and very safely and, and very, you know, no damage to him and no damage to me. (Beth)*

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Their midwives supported the women's sense of safety by keeping them and their partners included in choices about care and by keeping them both fully informed throughout pregnancy, labour and birth.

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In contrast, Sara's baby was severely bruised by his forceps delivery. One of her friends asked if she was going to make a complaint about the extent of his bruising. While Sara was distressed by the bruising and found it very difficult to accept that this had happened to her baby, her reply illustrates her awareness that her baby could have suffered much more if medical expertise had not been available when she and her baby needed it. She herself had required emergency treatment for the removal of her placenta and she was overwhelmingly grateful that she and her baby were both alive and well because the obstetricians had the skills to keep them safe:

*And I said, "Well, no, I'm not, because the, the, the [obstetrician] that delivered him was only doing what [obstetrician][...] thought was best and safest [...] So, yeah, I'm just really grateful and really thankful that, that [...] everything worked out and everything was fine. (Sara)*

The women who required medical assistance to give birth felt that they and their babies had been kept safe in circumstances which were not straightforward.

## DISCUSSION

Feeling safe was a central issue identified by participants in this study of first-time mothers' birthing experiences in New Zealand. The women took the following steps to increase their perception of safety. They modified their behaviours to optimise health once they knew they were pregnant. They took care in selecting a maternity care provider. They explored birth setting options which reflected their cultures and expectations and, in choosing, revealed the importance of the proximity of a well-equipped and staffed hospital that they felt ensured their choices were safe.

This finding was consistent with previous NZ research where feeling safe ranked sixth on the mothers' list of what was best about NZ maternity care (Ministry of Health, 2007). For the ten first-time mothers taking part in this study, pregnancy, labour and birth were new terrain and they were not sure what to expect. They were aware that there are instances when things can go wrong at any stage (Smythe, 2003). As a result, once pregnancy was confirmed, each woman interpreted what safety of self and unborn child meant for her (Smythe, 2010). Each woman took the steps she considered necessary to feel she and her developing baby would be as safe as was humanly possible.

Participants in this study were aware of findings that alcohol consumption could damage a developing fetus. All ten women were already non-smokers. To further safeguard their health they made changes to diet and exercise, took vitamin and mineral supplements and used herbal remedies. All participants wanted the best for their babies and were prepared to modify their behaviours to ensure this.

Participants wanted to feel confident in their midwives' professional expertise. When engaging their midwives women had also wanted assurance that their partners would be fully included. Their midwives supported the women's sense of safety by keeping them and their partners included in choices about care and by keeping them both fully informed throughout pregnancy, labour and birth. This became especially important if one partner was not sure about the choices made, or if changes to the birth plan became necessary.

Five women needed assistance from obstetricians in the form of forceps or ventouse births; two of these women had planned homebirth. In these situations the women felt that their midwives had kept them and their babies safe by not delaying in seeking assistance once concerns arose, thus confirming the women's faith in their midwives' ability to provide a 'safety-net'. Although clinical responsibility for care many have been transferred to the medical team the women wanted their midwives to continue to be there for them. The midwives' presence, support and awareness of their needs and wishes, increased the women's emotional sense of being in safe hands. Their midwives were expected to advocate for them in unfamiliar and often scary situations. The continuity of care women received from their midwives, and the trust women placed in their midwives' abilities to do all of this, gave the women a sense of safety that they relied on during pregnancy, labour and birth and in those first weeks of post-birth care.

The availability of highly skilled obstetricians, obstetric registrars, anaesthetists, paediatricians and hospital support staff, in conjunction with the availability of the local tertiary hospital facility, provided an essential part of the woman's 'safety-net'. It enabled these women to feel they had a greater range of choices they could safely make. The knowledge that the hospital was not far away gave some mothers the confidence to feel safe in choosing the homebirth option. There was apprehension expressed by these women that obstetricians could be too quick to offer interventions while there was still a possibility of an unassisted vaginal birth. There is research to suggest that, in some cases, this may be a valid concern. Maassen et al. (2008) found that birthing women, who were considered low risk, had a significantly higher rate of medical intervention when they birthed in a secondary care facility when compared to other low risk women birthing in a primary care facility with the support of a midwife. While most births are likely to take place without complications, it is not possible to predict with absolute certainty that any birth will be complications free (Olsen & Clausen, 2013). Those mothers who chose a hospital birth did so because for them a hospital birth felt like the safer option.

There are several limitations immediately evident in this study. Interviews were conducted retrospectively. The sample was self-selected and included only ten first-time mothers. Consequently, such a small sample is not representative of all women who live in and give birth in NZ. Participants came from one urban area in New Zealand and their perspectives reflect the conditions of that area only. While one woman had a 40 minute drive to the hospital, women living in isolated rural areas may have very different perspectives regarding safety of self and baby. Women who have already experienced childbirth may have different perspectives of the birth experience and safety as they give birth to subsequent children. There are a variety of differing situations and experiences that have not been explored in this study and that merit further research. This study describes these women's perspectives only and the authors acknowledge when others are involved, including professionals, there may be other perspectives that could be considered.

## CONCLUSIONS

For these ten women, throughout their pregnancies and during their labours and births, what made them feel they and their babies were safe was an important motivator for behavioural change and an important influence in the development their birth plans. How they interpreted what would make them feel safe, and the actions they took based on these interpretations, provided them with a 'safety-net' which enabled them to make the choices they made. Firstly, the women were aware of changes they needed to make to support both their and their babies' health and well-being. The women chose their midwives carefully, needing to feel confident in the midwives' professional skills. Also important to these women birthing in New Zealand was the availability of a tertiary care facility within close proximity to their homes staffed by highly skilled maternity health professionals. This availability increased their sense of safety and gave them the confidence to select birth options (e.g. home or hospital birth) suited to their own particular needs. This all contributed towards the women's confidence that both they and their babies would safely negotiate pregnancy, labour and birth, resulting in a good outcome – a healthy baby and a healthy mother.

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