

# How Baloch Women Make Decisions About the Risks Associated With Different Childbirth Settings in Southeast Iran

Zahra Moudi<sup>1,\*</sup>; Zhila Abed Saeedi<sup>2</sup>; Mahmoud Ghazi Tabatabaie<sup>3</sup>

<sup>1</sup>Faculty of Nursing and Midwifery, Zahedan University of Medical Sciences, Zahedan, IR Iran

<sup>2</sup>Faculty of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, IR Iran

<sup>3</sup>Department of Demography and Population Studies, Faculty of Social Science, University of Tehran, Tehran, IR Iran

\*Corresponding author: Zahra Moudi, Faculty of Nursing and Midwifery, Zahedan University of Medical Sciences, Zahedan, IR Iran. Tel: +98-9153411005, Fax: +98-5433442481, E-mail: zz\_moudi@yahoo.com

**Received:** October 30, 2014; **Revised:** December 25, 2014; **Accepted:** December 27, 2014

**Background:** In Zahedan City in Southeast Iran, some women prefer to give birth at home despite the availability of the equipped hospitals and expert advice that hospital births are safer.

**Objectives:** This study explains how Baloch women make decisions regarding the risks associated with childbirth at home versus a hospital. This study identifies and defines the factors that influence the choice of the place of delivery by Baloch women.

**Materials and Methods:** The article draws on data from a grounded theory. In particular, on in-depth interviews with 25 Baloch women, 21 of whom had planned home births and 4 planned hospital births in their most recent childbirth.

**Results:** Six categories emerged from the data as follows: 1) deliberation and risk assessment; 2) obstacles to hospital births; 3) preference for hospital births; 4) obstacles to homebirth; 5) preference for homebirth; and 6) risk management. The core category was deliberation and risk assessment. Our interviews showed that Baloch woman weighed the negative and positive aspects of each option when deciding on a childbirth setting. In this process, their assessment of risk included physical wellbeing and socio-cultural values. Furthermore, their assessment of risk can, in some circumstances, result in delays or avoidance of having hospital childbirth.

**Conclusions:** Managers and service providers need to know an ordinary woman's perception of risk to address the gap between current and desired childbirth services and encourage women to use current hospital services.

**Keywords:** Risk Assessment; Risk Management; Child; Decision Making; Iran

## 1. Background

In developing countries, the complications surrounding childbirth are a major threat to a woman's health and a cause of preventable deaths (1). The World Health Organization has consistently emphasized the importance of professional care for child delivery by involving skilled birth attendants and having access to comprehensive emergency obstetric care that enables appropriate care for when complications arise (2). However, it is difficult to predict when and where complications will arise (3, 4). Following from this view, it is generally assumed that hospitals are the safest place for childbirth, because medical technology and medical interventions are available that minimize the risks of child delivery (5, 6). Therefore, women are encouraged to give birth in hospitals under medical supervision. However, in most developing countries, the response to such encouragement has been limited and many women continue to give birth at home (7-12).

As in most developing countries (13), the Iranian government has accepted expert advice that hospitals are the safest place for women to give birth and the Ministry of Health and Medical Education (MOHME) of Iran has encouraged all women to give birth in hospitals. In

most areas of Iran, this hospital birth policy has been successful with an estimated 95.3% of all births in hospitals. In contrast, in Southeast Iran, in the provinces of Sistan and Balochestan, another trend is visible. According to MOHME, in these provinces still 10.8% of all births in urban areas occur at home (11).

## 2. Objectives

The present study explains how Baloch women make decisions regarding the risks associated with childbirth at home or in hospitals. This study also identifies and defines the factors influencing the choice of the place of delivery by Baloch women.

## 3. Materials and Methods

### 3.1. Setting

We undertook the study in Zahedan City, the capital of Sistan and Balochestan Province, located in south-eastern Iran along the Pakistan border (population: 613,572 in 2011). The rate of home births in the city was substantially

higher than in other cities. There are two main ethnolinguistic groups in Zahedan: the Baloch and the Sistani. The focus of the present paper was on the Baloch group, because the highest percentages of home births are reported in this group. The Baloch stand out as a distinctive social group that spreads across Pakistan, Iran, and Afghanistan.

The area is reasonably well provided with medical facilities. Zahedan has four Comprehensive Emergency Obstetric Care (EOC). Zahedan, also has trained traditional birth attendants (TBA) who are trained by and work under government supervision. In addition, Zahedan has untrained TBA who lack formal training but have acquired their skills by delivering babies and by apprenticeships with other TBAs. The fee that midwives and birth attendants receive is negotiated and agreed with the mother or her family and is lower than the fees charged by hospitals. However, insurance companies will not reimburse home birth fees. Therefore, women who have health insurance coverage and choose homebirth must pay for it themselves.

### 3.2. Study Design

A grounded theory approach was used. Grounded theory as a qualitative approach can potentially help scholars to explain the unique, diversity-related problems of society (14). The women who had chosen to have home births were invited through purposive sampling to explore how and why they had made this decision through in-depth semi-structured interviews. The present study is exploratory and designed to provide an opportunity for a small group of women to talk about their birth choices and to create enough data to enable us to understand why the women made the choices they did.

### 3.3. Sampling

We used purposive sampling to identify potential cases for our study (15). Since, we were interested in why some Baloch women chose to give birth at home, we interviewed women who gave birth at home and women who gave birth in a hospital. We decided to talk to women who just had a baby (within the previous 6 months), as the issues and concerns would still be fresh in their minds. Women who chose to have home birth could also choose different types of support. Eight were supported by trained TBAs and four were supported by untrained TBA. Additionally, we included in our study nine women with a home birth who were supported by medically educated midwives. In addition, four Baloch women were included in the study who had chosen to have hospital births.

### 3.4. The Interviews

The interviews took the form of a guided interview. Since all the women were bilingual in Persian and Baloch, we conducted the interviews in Persian. Although the main participant in the conversation was a mother in

most cases (22 out of 25), other household members contributed to the conversation. Generally, these other participants were female members of the household such as the women's mother, mother-in-law or sister-in-law and only in two cases the women's husbands also participated in the interviews. The presence of a relative also helps to prevent anxiety and embarrassment for the mother and to motivate her to take part in the discussion (16). The interviews took place in homes of the participants. All interviews were taped by the main scholar.

We started the conversation by asking an open question about how they chose the place of birth: How did you come to a decision about the place of childbirth? As the women talked about their choices and experiences, we guided the conversation by seeking additional information or clarification; for example, "Please explain more?" or "Why was that?" Most conversations lasted about an hour and a half with the shortest an hour and the longest two hours.

### 3.5. Data Trustworthiness

First, living in the same city (Zahedan), working as a midwife, and long-term presence in the field that comes with going to the homes of mothers with a traditional birth attendance helped the main scholar to establish a relationship of trust with Baloch mothers and midwives. Second, the use of multiple data sources (different types of midwife), member checks, and peer researcher support group helped the quality of research. Finally, rich descriptions were made to help readers to generalize the findings of the present study to other settings.

### 3.6. Ethical Considerations

We gained approval for the study from the ethical committee of Shahid Beheshti University of Medical Sciences, Tehran, and the relevant local authorities of Sistan and Balochestan Province in Southeastern Iran. The study was based on informed (oral) consent, because asking for a signature could compromise anonymity and made participants reluctant to talk (17). The midwives and birth attendants identified potential participants and act as intermediates between researchers and participants. The researcher telephoned each woman to reconfirm their previous given informed consent and if their answers were satisfactory, an appointment was made for an interview. In the first visit, the objectives of the study were clearly explained and asked if we could tape record the conversation. The anonymity of all participants was respected.

### 3.7. Data Analysis

Data were analyzed using Strauss and Corbin's approaches (18). We started our analysis of the data as soon as we had completed the first interview. All interviews were transcribed verbatim and then they were coded line by line by the primary researcher (a midwife) and a counseling psychologist simultaneously. These coders

discussed and agreed on the codes that were labelled on significant words and sentences. This initial open coding (19) was repeated with each subsequent transcript and in this way we built up a list of all the codes in all the interviews (a code book). To validate our emerging findings, we shared them with some of the participants to review the transcripts, to ensure that interpretation was appropriate, and reflected the reality of the participants and not the expectations of the researcher (20). We also invited two of the women who supported home births (a medically educated midwife and a TBA) to help with the interpretations.

Consequently, a constant comparative method was used and data were classified as belonging to particular clusters to form categories (18). In the next stage (axial coding), the primary researcher, a social research methodologist and a medical anthropologist worked together to interpret and identify relationships among the categories, and link them together in a new form. Scholars used a coding family that consists of underlying conditions, the contextual condition, intervening conditions, the action/interactional strategies by which the phenomena was managed, and consequences of them to understand the relationship between the categories (20). Consequently, the numbers of categories were reduced to five major new categories. We found that women mainly used these categories to make decision about childbirth setting.

Finally, the core category was developed, “deliberation and risk assessment”. This was the process of choosing one category and relating all the other categories to that. This core category explains how Baloch mothers weighed the negative and positive aspects of each option in relation to their main concern “(objective and subjective) risks”; and actions that they did to manage

their perceived risk and finally decide about childbirth setting. As well, “diagram was used to show the relationship between categories that arise during axial and selective coding. Actually it is a simplified version of paradigm model”(21) (Figure 1).

#### 4. Results

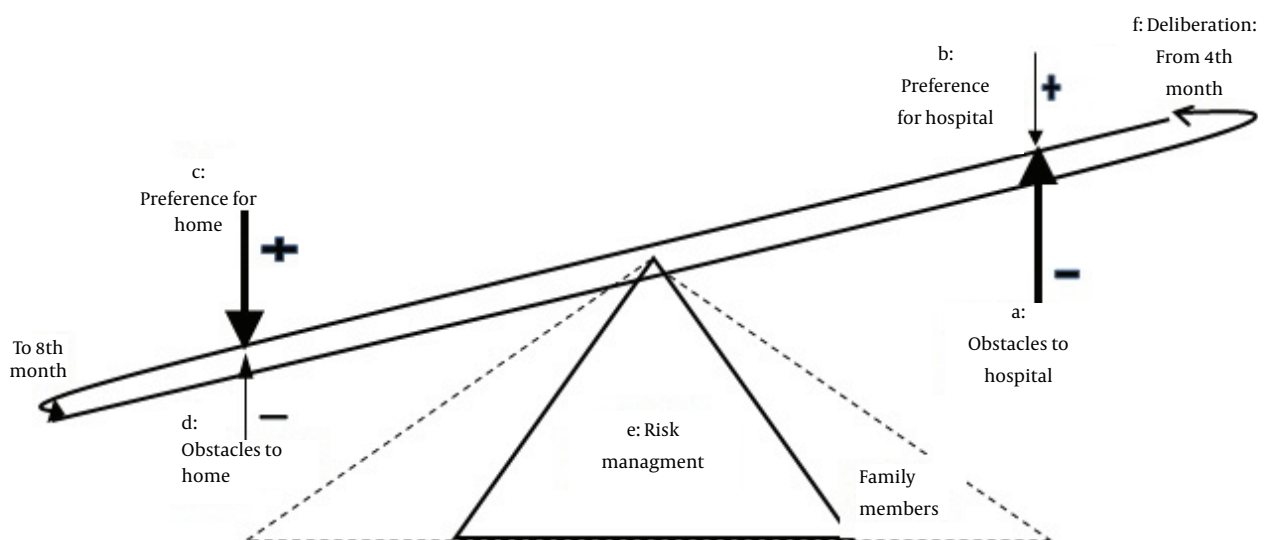
We interviewed 25 Baloch women who had a planned homebirth (n = 21) or planned hospital birth (n = 4). The planned homebirth women were between 13-39 years old. One woman could not read but the rest had educational levels varying from elementary school to high school (National Diploma). The planned hospital birth women were between the ages of 18-25 years old. Two were first time mothers. The education level ranged from secondary school to bachelor’s degrees (see Table 1).

Extracted concepts or themes were grouped into six main thematic or conceptual categories as follows: 1) deliberation and risk assessment, 2) obstacle to hospitals birth, 3) preference for hospitals birth 4) obstacle to homebirth, 5) preference for homebirth, and 6) risk management. “Deliberation and risk assessment” was found to be the main category.

##### 4.1. Deliberation and Risk Assessment

Deliberation is the process of gathering, analyzing, and evaluating information as well as risk assessment about available places for giving birth by considering a woman’s preferences; and the final decision made about the place of delivery. One of women stated:

“We calculate the hospital’s facilities. We are calculating and we are the ones who think and say that this/or that is better for us” (hospital birth, age 25).



**Figure 1.** The Conceptual Framework Explaining How Women Come to a Decision about the Homebirth

**Table 1.** Demographic Characteristics of Women Participated in the Study

| Demographic Characteristics               | Place of Last Childbirth |                 |
|---|--------------------------|-----------------|
|   | Home, n = 21             | Hospital, n = 4 |
| <b>Previous place of birth</b>            |                          |                 |
| Home                                      | 7                        | -               |
| Hospital                                  | 7                        | 2               |
| First baby                                | 7                        | 2               |
| <b>Midwife</b>                            |                          |                 |
| Biomedically educated midwife             | 9                        | 4               |
| <b>Traditional Birth Attendance (TBA)</b> |                          |                 |
| Trained                                   | 8                        | -               |
| Untrained                                 | 4                        | -               |
| <b>Type of previous birth</b>             |                          |                 |
| Normal delivery                           | 11                       | 2               |
| Cesarean section                          | 3                        |                 |
| Without previous delivery                 | 7                        | 2               |
| <b>Insurance coverage</b>                 |                          |                 |
| Yes                                       | 10                       | 4               |
| No  | 11                       | -               |

Since hospital births are the only options that were introduced to women formally, the mother, along with her family, primarily began gathering information about the advantages and disadvantages of the place of interest. Women told about how, they relied on the lived experiences of others and themselves: "My sister who had delivered an only child in the maternity hospital, told me that: If I knew, I would never enter to the maternity hospital. And I understood that hospitals were not good" (homebirth, age 21).

Another one commented: "For my second child I wanted to go to the hospital, and then I remembered the difficulties that I suffered for my first child in the hospital. I said to myself I will never go to the hospital again" (homebirth, age 23). What remain after analyzing are negative emotions and the perceived risks that act as barriers to utilize an available hospital.

One of women stated: "I have done three deliveries in the hospital. However, that environment has become terrible for me. There is fear, as I entered the door of the hospital, something happens to me, as if my body is shaking" (homebirth, 37). Women explained their evaluation based on the preference for (positive aspects) and obstacles to (or negative aspects of) hospital or home births (Figure 1A and 1b).

#### 4.2. Obstacles to Hospital Birth

Obstacles to hospital births refer to hospital services

that are not compatible with the women's requirements and preferences. The quality of the hospital care and the cost of maternal services were two main negative attributes that have been stated by the mothers to explain why they avoided choosing the hospital setting. Mothers expressed the quality of maternal care according to ethics, conduct, and technical aspects of care.

One of the most important and annoying issues for the mothers was being separated from their relatives when entering the strange and unfamiliar environment of the hospital. A number of women noted, "From the beginning of labour admission to the delivery, they won't let you meet anyone" (homebirth, 19).

Lack of privacy: A shared labor room, crowdedness, and the lack of adequate physical coverage were among the major concerns that caused mothers not to prefer a hospital. As one woman stated, "Everyone sees you, they see you naked, we're afraid of this, too" (homebirth, 23). One of the women presented her opinion about cesarean section in this way: "In hospital, if the childbirth lasts only for a short time, doctors will rush into cesarean section" (homebirth, 35). One woman commented, "(Episiotomy and) stitching is important to me. When I was stitched after my first childbirth, it became infected, I had too many problems" (homebirth, 35).

The inability to prevent invasion of their bodies (e.g. frequent vaginal examinations) was another problem that all of the women complained about. As one of the woman explained, "I heard students saying: the midwife told me (student) to examine her, don't mind her, let her shout, examine her, there's no problem" (homebirth, age 19).

At lower economic levels, hospital costs are a major obstacle to using hospital services in the absence of insurance coverage. One woman commented, "At home I pay one-tenth of the hospital cost. Since I could have a normal delivery at home, it's impossible to go to the hospital, even if all the facilities of the hospital would be with me", (homebirth, age 28).

#### 4.3. The Preference for Hospital Birth

The preferences for hospital birth are mainly related to the attributes (Figure 1 B) that have been clustered in a main category: medical preparedness to deal with unpredictable risks. From the Baloch women's point of view, the main advantage (or positive attribute) of the hospitals was access to medical specialists and medical and surgical services to face with potential risks. However, among the women who chose to give birth at home, hospital delivery was commonly accepted in the case of medical complications. One woman said, "For those who have a problem, the hospital is very good and necessary" (homebirth, age 30).

After separate evaluation and weighing the benefits and obstacles of the hospital option, then the women began to evaluate a home birth. Two major categories emerged from the mothers descriptions about their evaluation of home birth: the preference for and obstacles to home birth (Figure 1 C and 1D).

#### 4.4. The Preference for Home Birth

The preference for home birth is mainly related to desirable (technical and ethical) attributes of homebirth. The evidence of this study showed that for the mothers who gave birth at home, the positive attributes of home childbirth were much greater than the positive ones resulting from the medical services available at the hospital. One woman commented, "The house is a better and easier place of childbirth, there's more comfort and peace at home" (homebirth, age 29). In other words, mothers who chose home birth forgone some hospital gains to reach a broader target; which means they gain both the positive aspects of home delivery (emotional support, sense of control, avoidance of hospital routines and interventions) and hospital specialized services to confront with unpredictable complication.

#### 4.5. Obstacles (or Perceived Risk) to Home Birth

Obstacles to home birth are fears of medical risks that prevented mothers from actualizing the decision for home delivery.

One woman stated, "My family members are afraid of giving birth at home, they are afraid of problems that may occur" (hospital birth, age 18).

One woman recalled her relative's experiences as follows: "her husband said that he won't let her give birth at home and she must go to hospital, so we took her to the hospital" (home birth, age 25)

Also, mothers concern about unpredicted complications could prevent them from homebirths. One of mothers said: "If I give birth at home, what would happen if my baby needs oxygen, or maybe I need a Cesarean section at that moment, then all of the equipment is there" (hospital birth, 21). These mothers did not accept any interruption to their access to the operating room facilities and medical and surgical facilities of the hospitals. As one Baloch woman noted, "If serious bleeding takes place, to reach the hospital, till they'll admit her, she may finish while she's on the way, maybe something happens to the baby" (hospital birth, age 25).

#### 4.6. Risk Management

Whenever the mother's assessment of the medical risks for home births were much greater than the perceived hospital risks, they eventually proceeded to give birth at a hospital. The evidence from our study revealed that Baloch mothers used different strategies to cope and come to terms with hospital risks to exploit the positive aspects of hospital services (Figure 1 E). The Baloch women, depending on their family background and SES, personality, and the support of their significant others used diverse ways to cope with the risks associated with childbirth by means of hospital services. One primiparous mother explained that her husband suggested cesarean section for the following reasons: "My husband said, if you really are afraid (of the delivery room environment),

do Cesarean section" (homebirth, age 19). In this way, women with Cesarean section avoid going through the delivery room atmosphere about which they had negative emotions

However, mothers who chose to have normal vaginal delivery and at the same time suffered from fear of possible problems throughout childbirth had to use different mechanisms to cope with the unacceptable hospital childbirth care services. A number of the mothers tried to avoid the negative aspects of the hospital services by delaying referral to the hospital. "They were saying that in hospitals, they rush into performing Cesareans. Then, I went to the hospital at the last moments (near the time of delivery)" (hospital birth, age 25). Two other strategies are also used. First, some hired a private midwife as a supporter or guard: "When there are several patients, they go to visit the other patients and we will be left alone. Usually, we go to the hospital with a private midwife. Therefore, no other midwives, no students, no doctors were allowed to come close to us" (hospital birth, age 25). Second, mothers who could not afford to hire a private midwife used the "ignoring" method: "We generally put away the bad aspects of hospitals and just see the equipped hospitals" (hospital birth, age 21).

Opposition to hospital childbirth services can lead mothers to give birth at home when those mothers mentally were not able to accept the provided services. This group of mothers remembered hospitals as a -back up to dealing with biomedical and surgical complications whenever there was no solution for them in the context of their home. "If I have a problem, I go to the hospital, if it is harmful for my baby or me. For example, if there is bleeding, we are forced to go to the hospital" (homebirth, age 35). As well, we have explained how women who choose to give birth at home manage the risks related to childbirth elsewhere (22).

### 5. Discussion

The findings of this study showed that some mothers, despite the geographical accessibility to an equipped hospital, prefer to give birth outside a hospital. Based on normative theories, women who chose homebirth are not concern about risk and safety (23). This study revealed the ways that women knew and managed risks and other implications of their decisions.

All decision-related actions include some form of comparative processes regarding the risks of two different options or expectations of undesired events in an uncertain future. As noted in the present study, Baloch mothers evaluate home and hospital childbirth services with respect to desirability of their attributes (e.g. ethical considerations, technical care, and financial issues) to make an optimal decision.

Women weighed up the home and hospital childbirth care services, and women who choose homebirth considered homebirth safer than hospital birth (23, 24). Risks are understood as expected or observed negative outcomes to

decisions (25). In this regard, risks have a scientific (objective) and a socio-cultural (subjective) aspect (26). In this way, as the present study showed, sometimes women and families prioritized social variables and/or their value over biological ones (26, 27). This behavior arises from contextual differences in the meaning and use of the concept of risk (28), by individuals who are influenced by a wide range of psychological, socio-cultural, and institutional forces (29).

In the same way, Baloch women used home birth, which is relevant to their situational context, as a defensive strategy to reject the technocratic model of childbirth care and protect themselves from the perceived risks that have arisen from high technologies (22). However, according to Abed Saeedi et al. (22) and the present study, Baloch mothers do not often reject hospital childbirth services without the inclusion of good options or manage medical risks. When women finally chose to give birth in a hospital, they were exploring a coping style to manage perceived risks and make the process more desirable. Many experts recommend that we must turn to a model of childbirth care in which values, concepts (like love), and effective relationships as well as respect for cultural differences in the childbirth care process (12, 30-34).

Additionally, the present study showed women who had a planned homebirths expressed her feelings toward the childbirth process in hospitals as, "horrible scary" and "terrifying". Individual decisions, like childbirth setting, cannot be explained merely by rational theories, as everyone has different past or lived experiences and other specifics (35, 36). The current study along with previous studies showed that child birth experiences contain psychological processes that extended beyond the physical aspects of child birth (37, 38).

The limitations of this study were the small group of women in the planned hospital birth group. Additionally, the study was performed in Zahedan, and Baloch women within this city. Therefore, it may not reflect the experiences of women who are living in other areas of Sistan and Balochistan Province or in other parts of Iran. Despite these limitations, the study is among the first to explore the role of perceived risks in developing decision-making models about the setting of childbirth. Moreover, the findings of this study potentially have implications for reproductive health policies and programs in Iran by giving voice to women.

Managers and service providers need to understand a lay people's perception of risk and the way in which they manage them. In addition, this knowledge helps midwives, as the main childbirth care providers, to address the gap between the current and desired childbirth services. In this manner, they can contribute to more positive childbirth experiences that respond to the expectations of local people.

## Acknowledgements

We would like to express our appreciation to all women who participated in the study. As well, we thank the local

executives at Zahedan University of Medical Sciences for their support. We would like to thank the Shahid Beheshti University of Medical Sciences for financial support.

## Authors' Contributions

Zahra Moudi wrote the proposal, collected data, analyzed them, and wrote article. Zhila Abed Saeedi and Mahmoud Ghazi Tabatabaie guided her in writing and collecting and analyzing data.

## Funding/Support

We would thank the Shahid Beheshti University of Medical Sciences for financial support.

## References

1. Koblinsky M, Conroy C, Kureshy N, Stanton ME, Jessop S. Issues in programming for safe motherhood. *Arlington, Virginia: MotherCare, John-Snow, Inc.* 2000.
2. W.H.O. In: PMNCH fact sheet: maternal mortality. World Health Organization, editor. 2011.
3. Jordan RG, Murphy PA. Risk assessment and risk distortion: finding the balance. *J Midwifery Womens Health.* 2009;54(3):191-200.
4. Jomeen J. *Choice, Control and Contemporary Childbirth: Understanding Through Women's Stories.* Radcliffe Publishing; 2010.
5. Pairman S, McAra-Couper J. Theoretical frameworks for midwifery practice. In: Pairman S, Pincombe J, Thorogood C, Tracy S editors. *Midwifery.* Sydney: Churchill Livingstone Company; 2006. pp. 238-70.
6. Nolan M. *Home Birth: The Politics of Difficult Choices.* London: Routledge; 2011.
7. Navaneetham K, Dharmalingam A. Utilization of maternal health care services in Southern India. *Soc Sci Med.* 2002;55(10):1849-69.
8. Gleib DA, Goldman N, Rodriguez G. Utilization of care during pregnancy in rural Guatemala: does obstetrical need matter? *Soc Sci Med.* 2003;57(12):2447-63.
9. Gabrysch S, Campbell OM. Still too far to walk: literature review of the determinants of delivery service use. *BMC Pregnancy Childbirth.* 2009;9:34.
10. Anson O. Utilization of maternal care in rural HeBei Province, the People's Republic of China: individual and structural characteristics. *Health Policy.* 2004;70(2):197-206.
11. Ghazi Tabatabaie M, Moudi Z, Vedadhir A. Home birth and barriers to referring women with obstetric complications to hospitals: a mixed-methods study in Zahedan, southeastern Iran. *Reprod Health.* 2012;9:5.
12. Gabrysch S, Lema C, Bedrinana E, Bautista MA, Malca R, Campbell OM, et al. Cultural adaptation of birthing services in rural Ayacucho, Peru. *Bull World Health Organ.* 2009;87(9):724-9.
13. Fordham S. Women's views of the place of confinement. *Br J Gen Pract.* 1997;47(415):77-80.
14. Bryant A, Charmaz K. Introduction Grounded theory research: methods and practices. In: Bryant A, Charmaz K editors. *The SAGE Handbook of Grounded Theory.* Los Angeles: SAGE Publications; 2007.
15. Coyne IT. Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *J Adv Nurs.* 1997;26(3):623-30.
16. Morse JM. Sampling in grounded theory. In: Bryant A, Charmaz K editors. *The SAGE Handbook of Grounded Theory.* London: SAGE Publications; 2007.
17. Barbour R. *Introducing Qualitative Research: A Student's Guide to the Craft of Doing Qualitative Research.* Los Angeles: SAGE Publications; 2007.
18. Bernard HR, Ryan GW. *Analyzing Qualitative Data: Systematic Approaches.* Thousand Oaks: SAGE Publications; 2010.
19. Gibbs GR. *Analyzing Qualitative Data.* Los Angeles: SAGE Publications; 2008.

20. Limb M. Grounded theory. In: Bassett C editor. *Qualitative Research in Health Care*. London: Wiley; 2004.
21. Rodon J, Pastor JA. Applying grounded theory to study the implementation of an inter-organizational information system. *Elec J Bus Res Method*. 2007;**5**(2):71-82.
22. Abed Saeedi Z, Ghazi Tabatabaie M, Moudi Z, Vedadhir AA, Navidian A. Childbirth at home: a qualitative study exploring perceptions of risk and risk management among Baloch women in Iran. *Midwifery*. 2013;**29**(1):44-52.
23. Boucher D, Bennett C, McFarlin B, Freeze R. Staying home to give birth: why women in the United States choose home birth. *J Midwifery Womens Health*. 2009;**54**(2):119-26.
24. Catling-Paull C, Dahlen H, Homer CS. Multiparous women's confidence to have a publicly-funded homebirth: a qualitative study. *Women Birth*. 2011;**24**(3):122-8.
25. Zinn JO. Risk as discourse: Interdisciplinary perspectives. *CADAAD*. 2010;**4**(2):106-24.
26. Sjoberg L, Moen BE, Rundmo T. Explaining risk perception. An evaluation of the psychometric paradigm in risk perception research. 2004.
27. Berry NS. Kaqchikel midwives, home births, and emergency obstetric referrals in Guatemala: contextualizing the choice to stay at home. *Soc Sci Med*. 2006;**62**(8):1958-69.
28. Sjoblom I, Idvall E, Radestad I, Lindgren H. A provoking choice-Swedish women's experiences of reactions to their plans to give birth at home. *Women Birth*. 2012;**25**(3):e11-8.
29. Oltedal S, Moen BE, Klempe H, Rundmo T. Explaining risk perception: An evaluation of cultural theory. *Trondheim: Norwegian University of Science and Technology*. 2004;85:1-33.
30. el-Nemer A, Downe S, Small N. 'She would help me from the heart': an ethnography of Egyptian women in labour. *Soc Sci Med*. 2006;**62**(1):81-92.
31. Wiegers TA, Van der Zee J, Kerssens JJ, Keirse MJ. Home birth or short-stay hospital birth in a low risk population in The Netherlands. *Soc Sci Med*. 1998;**46**(11):1505-11.
32. Kruske S, Kildea S, Barclay L. Cultural safety and maternity care for Aboriginal and Torres Strait Islander Australians. *Women Birth*. 2006;**19**(3):73-7.
33. Morgan DL, Slade MD, Morgan CM. Aboriginal philosophy and its impact on health care outcomes. *Aust N Z J Public Health*. 1997;**21**(6):597-601.
34. Anyait A, Mukanga D, Oundo GB, Nuwaha F. Predictors for health facility delivery in Busia district of Uganda: a cross sectional study. *BMC Pregnancy Childbirth*. 2012;**12**:132.
35. Marquis BL, Huston CJ. *Leadership Roles and Management Functions in Nursing: Theory and Application*. Philadelphia: Lippincott Williams & Wilkins; 2006.
36. Dessler G. *Management: Leading People and Organizations Into the 21st Century*. Prentice Hall; 2001.
37. Morison S, Percival P, Hauck Y, McMurray A. Birthing at home: the resolution of expectations. *Midwifery*. 1999;**15**(1):32-9.
38. Viisainen K. Negotiating control and meaning: home birth as a self-constructed choice in Finland. *Soc Sci Med*. 2001;**52**(7):1109-21.