Abstract

Problem and background: Despite a generally affluent society, the caesarean section rate in Switzerland has climbed steadily in recent years from 22.9% in 1998 to 33.7% in 2014. Speculation by the media has prompted political questions as to the reasons. However, there is no clear evidence as to why the Swiss rate should be so high especially in comparison with neighbouring countries.

Aim: To describe the emerging expectations of giving birth of healthy primigravid women in the early second trimester of pregnancy in four Swiss cantons embracing three languages.

Methods: Qualitative individual interviews with 58 healthy primigravid women were audio recorded, transcribed and subjected to thematic analysis. Recruitment took place through public and private hospitals, birth centres, obstetricians and independent midwives. The main ethical issues were informed consent, autonomy, confidentiality and anonymity.

Findings: The three main themes identified were being in limbo, experiencing a continuum of emotions and planning the birth.

Discussion: Being pregnant was part of a project women had mapped out for their lives. Only three women in our sample expressed a wish for a caesarean section. One of the strongest emotions was that of fear but in contrast some participants expressed faith that their bodies would cope with the experience.

Conclusion: Bringing together the three languages and cultures produced a truly "Swiss" study showing contrasts between a matter of fact approach to pregnancy and the concept of fear. Such a contrast is worthy of further and deeper exploration by a multi- disciplinary research team.

Kewords: caesarean section, Switzerland, expectations, thematic analysis, decision making in pregnancy.

Statement of significance

Problem: one third of births in Switzerland, a land of high living standards and with good health care facilities, are by caesarean section.

What is already known: There are good antenatal and intrapartum services in Switzerland but primarily provided by medical practitioners. Additionally, there are low perinatal and maternal morbidity and mortality rates.

What this study adds: healthy primigravid women enjoy normal daily work and social routines. They neither expect not desire a caesarean section at the mid point of pregnancy.

Introduction and background

In recent years, the caesarean section rate in Switzerland has climbed steadily from 22.9% in 1998 to 33.7% in 2014[1]. One third of all babies in Switzerland are therefore born by caesarean section although no corresponding decline in perinatal mortality has been noted. Caesarean section is now generating considerable interest from the media which are questioning its necessity, its associated costs and its longer term effects on women's and children's health in the country. Likewise, political interventions on the topic are taking place both at national and regional level. While such trends are not unique to Switzerland but parallel those in other developed and developing countries, Switzerland's caesarean section rate has climbed higher and faster than neighbouring countries and is now one of the highest in Europe [2]. In contrast, countries such as Finland and the Netherlands have a 50% lower caesarean section rate.

The systematic review carried out for the World Health Organisation (WHO) suggested that there was no justification for caesarean section rates over 15% in developed countries [3]. While the specialist literature generally agrees that the increasing caesarean section rate is due to medical indications [4], the caesarean section rate recommended by WHO to ensure optimal maternal and infant health outcomes remains 10-15% [5,6]. In cases such as maternal fear of giving birth, other forms of intervention may be possible to achieve the best outcomes.

The constantly increasing rate in the industrialised countries is a hotly debated topic in both public and professional fora. Some see birth by caesarean section as a safe, predictable and effective preventive alternative to unpredictable vaginal birth, while others claim it as economically-driven, with unacceptably adverse effects on the health of both mother and infant. Indeed, there is increasing evidence that the negative health consequences of caesarean section without a clear medical indication are underestimated, and that the increase is not associated with improvements in perinatal mortality and morbidity [7,8]. Thus, a widespread theory that the rise in caesarean sections could be attributed to an altered maternal risk profile has not been confirmed [9]. In Switzerland large regional differences in caesarean section rates particularly illustrate this point [10]. Comparable effective alternatives to surgery, such as focused pelvic floor exercises to prevent

incontinence [11] or psychological interventions to relieve women's fears of birth are often cited [12]. The findings of research into short-and long-term health consequences of caesarean sections, such as postoperative pain and complications in subsequent pregnancies often are not available to the women [9,13]. Healthy newborns born at term also have a significantly increased risk of developing respiratory distress syndrome [14], after a caesarean section. There is also some work suggesting that Infants' gut microbiome development may be disturbed by caesarean section because the babies do not come into contact with microbes of the mother's vaginal tract. These may become further inhibited by antibiotic prophylaxis given to the woman before the skin incision [15] . Compared with vaginal birth, the composition of the intestinal microbiota of infants born by elective caesarean section show persistence of low amounts of bifidobacteria and bacteroides and over-representation of enterococcus and clostridium which has been linked to diabetes mellitus and other childhood diseases such as asthma. [16] . Thus, caesarean section as a safe alternative to vaginal birth is questionable [7,17]. This was confirmed in a multi country study carried out for WHO in which 24 countries and 373 health facilities, representative of the global picture, participated [18] . A total of 286,565 births was analysed. 27.5% of births were caesarean sections of which 1% had no stated medical indications. Compared with spontaneous births, these showed increased risk of death, admission to intensive care units, blood transfusion and hysterectomy. Gibbons et al [5], using a statistical modelling scheme, also showed in a background paper for WHO how the much higher costs associated with unnecessary caesarean sections contribute to the global burden of health inequality. The authors' definition of "unnecessary" appears somewhat unclear but appears to be where the best known estimate of expected numbers of 15% from previous WHO studies is exceeded. Using this approach, they concluded that in 2009, Switzerland carried out 10,147 unnecessary caesarean sections at a cost of US$ 20,277,952.

Action plans are in place in some countries, including Switzerland, to reduce the high rates of caesarean section and associated costs. The Swiss action plans, however, remain somewhat vague with a lack of clarity as to why and when the decision is made to undertake a caesarean section and which factors influence this process. This

raises the related questions of the expectations of pregnant women of their birth, how the decision is made for the particular mode of giving birth and women's experience of giving birth in relation to the decision making processes. Several reviews on the topic have been published . Kingdon et al's systematic review of nulliparous women's views of planned caesarean section in national surveys and one randomised controlled trial found inconclusive results and methodological problems, stating a need for good qualitative research as a foundation for future research [19] . Likewise, McCourt et al, whose inclusion criteria were wider, concluded in their critique of 17 studies concerning women's preferences or request for elective caesarean section that rigour is almost always questionable and "well conducted studies focusing on women's views were lacking" [20,p. 78]. Mazzoni et al's systematic review and meta-analysis of women's preferences for caesarean section analysed 38 observational studies globally [21]. While more systematic than Kingdon et al's review, this review was restricted to quantitative studies and the authors highlighted the need for more and better research into the subject.

Other studies with a similar focus not included in the reviews were carried out in Germany [13], Australia[22], Sweden[23] Norway [24]and the USA [9]. Most of them offered cross sectional pictures of women's expectations using predetermined questions. Fenwick et al [25] used a descriptive qualitative design to explore Western Australian women's expectations of childbirth. These were represented by five themes depicting both positive and negative views. However, their stated aim of discovering women's reasoning for choosing a caesarean section was not really addressed.

A further issue of particular relevance to the present study is the expectations that women have of birth and how their own experiences influence this. No reviews but a few studies were located in this field. A study undertaken in Switzerland[26] questioned how 251 participants' views of their birth experiences changed in the first two years of their child's life and sought to identify whether any particular groups were at risk of negative birth experiences. Data were collected at 72 hours post-partum and again in the second year after giving birth. The study is very useful but the effect of the varying parity of the participants and the lack of focus on their expectations leaves some unanswered questions as to the study's validity.

Despite reports in the popular media, the limited research findings show evidence that very few women have the expectation of a caesarean section without any obstetrical or psychological indication, preferring to focus on active participation in labour and birth. While there is a growing body of research in this area reflecting the importance of the topic, as yet there are limited well executed and reported studies that examine the context in which the mode of birth is chosen. Few studies used a longitudinal approach to explore the expectations of the mode of birth and the influencing factors. Those cited above have used structured approaches which may have limited the opportunity to explore how women's expectations might change during the maternity experience. While the cited research reports have considerable bearing on the present study, none of the results located are directly transferrable to Switzerland although that of Wiklund et al [27] is relevant. In this, however, participants were unable to voice their own opinions but had to match these to questionnaires developed by health professionals. The present study aims to address this deficit and create new knowledge in the field.

Aim

To describe the emerging expectations of giving birth of healthy primigravid women in the early second strimester of pregnancy in four cantons (administrative areas) in Switzerland.

Methods

Setting

Four cantons in Switzerland formed the setting for this study. Zürich and St Gallen are German speaking cantons, Vaud French speaking and Ticino Italian speaking .

Participants

Participants were 58 healthy women pregnant for the first time recruited from the above cantons. All have been allocated pseudonyms. One woman who initially agreed to take part dropped out because of work pressures.

Recruitment

Recruitment took place through gatekeepers in public and private hospitals, birth centres, obstetricians and independent midwives. Information about the study was given in writing and verbally by one of the researchers and 48 hours later women

who had tentatively indicated an interest in participating were contacted by phone to discuss the project and what their participation would involve. Those who agreed to participate made an appointment to meet the researcher at a place and time of their choosing. At the first meeting more questions were answered and a consent form signed.

Ethical considerations

The main ethical issues were informed consent, autonomy, confidentiality and anonymity. Primary permission to undertake to study was given by the Ethics Commission for Zürich (KEK-ZH-2014-0367). Secondary permission was granted by the ethics commissions of each of the other three cantons.

Data collection

Qualitative semi-structured interviews were chosen as the most appropriate method for data collection. Interviews were open but a few key questions generated by the whole team served as prompts. Data were collected at a place of each participant's choice. Interviews lasted between 45 and 75 minutes. Interviews were audio-recorded, transcribed verbatim using the programme F4.

Data analysis

Analysis was carried out in accordance with the method of Braun & Clarke [28]. Transcripts were entered into the MaxQDA software package from which codes were initially generated from each interview by the researcher who had collected the data. These codes were recorded in the language of the interview. Memos pertaining to relevant codes and to every completed interview as a whole, as well as significant codes were written in English and summarised the interview. The interview memos then formed the first point of discussion amongst the team as to commonalities and differences among participants. Out of this discussion themes were generated in each canton. These were then compared by the senior researchers on each site and combined themes allowed to emerge. As a final member check these were discussed by the complete team and the quotes which provided the best illustration determined.

Trustworthiness

Interviewers (authors 3-6) were experienced, female researchers based on two sites, Lausanne and Zurich. Three were midwives, one a psychologist and one a sociologist.

Three had given birth. All were fluent speakers in the language in which they collected the data and in English. All could read the three national languages. Prior to commencing this project the researchers sat together and discussed their own thoughts and ideas about giving birth to be aware of their own viewpoints and potential biases. These thoughts were audio recorded or written down so that they could be considered part of the data. At certain points during the study these thoughts were revisited, checking to ensure that individual biases did not influence the overall findings. All emergent codes were discussed in the teams on each site and cantonal themes were compared between sites. The senior researchers in each site also held monthly meetings ensuring consistency between the two sites, the three languages, and the English translations of themes and quotes. Finally, the whole team participated in agreeing final themes in accordance with the method.

Findings

Three major themes emerged and are discussed next. Where possible the participants' own words have been used. An overall theme or category, such as found in Grounded Theory studies, was not sought, but underpinning the three themes was the notion that becoming pregnant and thus giving birth was part of a lifelong project mapped out in advance. As Ronja stated:

> It's simply a new, yes new, new thing, something that I have never experienced before.

Likewise Verena noted that:

> You need to have a stable basis in the relationship [with the baby], then the birth can be built up like lego blocks.

Being in limbo: taking or avoiding decisions

At approximately this midway point in their pregnancies, participants all acknowledged the magnitude of the change their pregnancies could bring about but had differing responses. Claudia for example felt that:

> At the beginning it wasn't the best because of the nausea, and then once you're past that it's putting on, piling on weight, I only could work half time because of that. Then eventually around the 19th week it slowly stopped. And now we're a bit better, I'm enjoying life again. I can do

more but I'm still really tired as well as working and there isn't room for much more. So my focus is really the nausea and not so much on looking forward to the baby and what's to come.

Claudia's views were supported by Nadine who stated:

…at the beginning I wasn't looking forward to it at all. There's other mothers who tell me that it wasn't any better for them in pregnancy. So for me it was a bit like 'I must get through it'. So I really don't enjoy my pregnancy even though I don't have the same complaints now.

However, the decision to start a family was seen by others as:

I'm a bit pragmatic because I think you just take it a month or even a week at a time, it'll be ok or if not you need to rethink (Katja).

Scarlet noted that, as a self-preservation measure, she did not want to think too much about being pregnant at the beginning of the pregnancy. But now in her second trimester she started to acknowledge her pregnancy, and allowed herself to think about the baby.

During the first three months, I really…I forced myself not to build up any emotional relationship with this "egg". I called him "egg" at the beginning because I was really scared of having a miscarriage.

Hearing predominantly negative feedback about childbirth from friends and relatives, some women perceived themselves as outsiders when thinking that birth might be a positive experience. Feeling confident that the process may be not be as difficult, painful and risky as predicted, Violette preferred not to speak about her vision to avoid justifying herself or feeling marginalised.

Yes, I do not talk so much about it apart from with my family and my close friends. This is something I do not speak about because I feel like… yes a bit different.

The magnitude of change also affected participants' views as to where and how they would give birth, all being aware that these were elements to consider. Most participants aimed for a vaginal birth, but two suggested that elective caesarean section was the best choice in relation to their life needs and their views of their medical needs, Mia articulating it:

> To deal with this, it is better to choose a date, and thereafter we can organise meetings or work. Then I know that this week and then the two or three weeks after I am booked… well not really booked…but having a pause and then it is the best way to organise my diary.

Perceived maternal or infant risks in relation to place of birth were felt strongly by the participants, those who chose alternatives to hospitals feeling compelled to justify their choices to disparaging friends and family members. Such discussions were sources of stress, as the women who elected to give birth at home or in a birth centre often heard negative comments about these settings. They were said to be irresponsible and to take great risks to their own and their babies' health. Some participants felt the need to discourage such negative discourses that intensified their fears or to question their decisions.

> The gynaecologist told me that I would die in a birth centre. She told me, 'you'll have a haemorrhage and then you have to act fast and at the hospital there's a neonatologist'. She said a lot of things which have also frightened me although I tried to laugh about it because I knew she was just stupid, trying to justify her job in the sense that she wants me to give birth in her hospital because she makes money out of it. Anyway it's her job and she believes in her job but still she managed to scare me [Lana]

Continuum of emotions: ideals/fears/faith

Although few of the women had unplanned pregnancies and the notion of them being a project was to the fore, it did not mean that they were immune from emotions when considering their births. For some participants, the main emotion was fear:

> I think it's simply that I didn't have any trust. Until now nothing has come easily so the fear of….'why should it work first time'. Since then you hear all these stories from round about...like someone lost it [the baby] in the seventh week and someone in the 12th. However I'm not usually a timorous person. (Barbara)

While Barbara's fears appeared related to every aspect of her pregnancy, Rojna's fears focused on the birth itself:

> Fear of the birth is already there, well fear of the pain. Or maybe we'll do this but not this or this…. uncertainty maybe about when this little baby is here. Because now it's easy, I carry it around with me. And birth is another situation when you really have absolutely no idea what's happening then, And after the birth all is changed. I just can't put words to it.

Rojna fears related primarily to uncertainties and these was also addressed by Freya who felt a lack of control and worried about how to be proactive.

> Yes, so I worry about when I have to go into the hospital. Because my partner might not be here if he's abroad. Oh well...that's the way it goes. But I do worry about what my role is, how I should prepare myself or is it all right. I don't do any preparation now, will I have enough support from the people there? Or what will really happen in the birth; how will it go, how will I know it's begun? There is nothing to make me totally certain, I have absolutely no idea. On the other hand I say it can't be too big a deal because billions of women have done it, but like I say, I want as much tuition as possible.

The fear of having to cope with such a frightening experience made participants think about possible approaches to birth with which they think they will be able to cope.

> Well, I understand the desire to find a balance and have a birth that's as serene as possible even though in my opinion anyway it's war, especially the first time when you don't know what to expect. So whatever you may imagine, read or have been told it will be 10,000 times worse or different or better than anything one can imagine or read but anyway I think it will be WAR. [Julia]

Such negative representations might also impact on how participants envisaged birth. When they felt that their physical integrity was threatened by the baby passing through, or that their fear of childbirth is so intense, caesarean section was initially contemplated as a simpler alternative.

> There are some women who feel less torn after a caesarean section in comparison with a vaginal delivery…There are some women who experienced issues and have flash backs. [Mia]
>
> People are scared to suffer… we hear sometimes women who say 'well, me, I certainly do not want to give birth … I would like to be put to sleep completely and waken up when the baby is there' or things in the same line, and I tell myself, well it's not like that that life functions. [Audrey]

Other representations of childbirth were more balanced, and relied on faith that childbirth was a natural process traditionally achieved by giving birth vaginally. Some women considered childbirth as a natural process which can be successfully achieved. These women tended to feel confident in their own capacity to give birth and cope with pain. Lucie reflects this:

> From my point of view we are made for this, women, therefore, I do not see why there could be a problem or anything else. So it's true, I am quite laid-back about that.

Finally, some participants visualised that natural birth was the outcome of personal preparation. Those women felt responsible for the outcome of childbirth and thus envisaged caesarean section as a personal failure.

> If I can avoid a caesarean section, it would be really, really nice because I will be really disappointed if I go for a caesarean section; really absolutely, absolutely disappointed. I will take it personally like I would have badly managed, like I would have done something wrong even if it is not the case. I try to convince myself before childbirth but…. For me I think it would difficult… psychologically, to accept. [Violette]

Some women who considered vaginal birth as in the natural order of things and those who felt a personal responsibility to achieve natural birth planned to give birth outside of a hospital. All referred to hospital in negative terms, revealing representations suffused with fear of being submitted to protocols.

> I feel like in the hospital, lots of things are done which are not necessary, in order to reassure healthcare providers and so they do not miss anything or so we cannot reproach them for anything. But I say there are

lots of things that happen in hospital that are not necessary… yes…and I do not want to suffer from that [Florence]

Women felt the need to know as much as possible about pregnancy and childbirth. It could be seen as a means of understanding their body changes and reducing the fears of forthcoming childbirth.

I like to be informed if I can. It calms me down. I have more control of the situation if I already know things. Then, I can know the details as time passes but I have more or less an idea of how things will progress. This makes me feel calmer. I'm not wondering now how badly I'm going to do. I say to myself that I know these possibilities now and afterwards we'll see. [Mina]

Several participants were active in seeking information. They used different sources e.g: books, TV, films, conferences or meetings of groups promoting physiological childbirth. Some of them accessed multiple sources of information to obtain a satisfactory answer.

I, like a big girl, looked a bit for information elsewhere and then… to determine what the risk factors of tearing etc were…and then ….. what to do, so I am curious about that. Let's say I do not stop after one version, even from my mum. After that I'll make my mind up on the topic. [Juliette]

In some cases, seeking information led women to change their vision of childbirth and to consider a different birth plan. It was especially true for those who got in touch with groups promoting physiological birth.

I have attended lots of conferences from the association. They had lots of events recently, I got informed, on well…well what the choices are. Because at the end, it's a world we discover, actually I did not know my options in relation to childbirth [Sacha]

Most of the women did not initially consider giving birth in a birth centre, midwife led unit, or at home. Some participants were unsure about the services provided there or considered that the nature of the service provided did not fit their clinical situation or needs. (e.g: lack of epidural, remote from the hospital, specialist service).

> The birth centre. I don't know… I have heard about that but I do not know really what it is… so for me, hospital is the traditional thing, but I have enough confidence in the traditional system, so I would say no. For me a private hospital is something more exclusive which costs a bit more, and is for the higher social class. I associate them with plastic surgery or rehabilitation. [Scarlet]

Planning the birth

Many participants, as part of their projects, had given careful consideration as to how they would deal with labour and birth. Primiparous women, however, often considered that the healthcare providers are the birth specialists so they relied on them in the early antenatal period. Some women used them to validate or reject their choice of mode of childbirth or to pursue options and make choices.

> Regarding birth I've never really asked myself what it would be like. Instead, with my midwife I have really built this idea. Perhaps right from the start I built a new idea. She didn't really make me change my mind because before I didn't really have a true idea, but let's say that I developed it with her help. [Lana]

Other women seemed to look for advice from health care professionals before making their own decisions regarding mode or place of birth. They expected to find an opportunity to discuss or discover complementary aspects of important decisions.

> I think that now I am influenced a bit by the people I met in the association and now I have to have the same discussion with the obstetrician on the same subject and get another point of view, get something different. [Sacha]

However, regarding making decisions during labour and specifically if something went wrong, women relied on their health care provider to make the final decision about mode of birth.

> [I must] have somebody in whom I have confidence, I can rely on, and then it is this person who tells me…. Well, I have enough confidence to tell myself that if she thinks that this or that has to be done, then I will follow her. [Florence]

Several participants showed profound confidence in the hospital system or in their obstetricians; one preferring to let him choose her mode of birth. For another woman, it was the opposite, she insisted that there could not be a stronger influence than herself, and it was your personal thoughts, supplemented with information that would help her to make her choice.

> I think… it is not a question of…. I want to get rid of the decision making. I think that the decisions belong first of all to the health care providers, to the doctors, not the patients [Nora].

> It has to do with your own responsibility to get informed… well an adult who is pregnant, it has to do a little with the person's responsibility to get informed and even more to have the will to get informed, but after all everybody is different [Scarlet]

Tajna appeared to have some clear paths in her mind while acknowledging that nothing could be entirely certain:

> So before labour, I need to know what happens, like that is A and B that I need to do. And of course I want it all to go smoothly without complications, that it just goes perfectly and I hope that until the due date there's not too many problems so that I can get myself orientated. Then I know it depends on each case and if everything doesn't go smoothly there's the chance of an epidural.

A few participants described their ideal images of childbirth during the interview. Childbirth can be seen as a moment when mother and baby help each other or a difficult moment but one which strengthen the women in her future life. In each of these cases, the guarantee of the ideal vision of childbirth is only possible if the birth happens a birth centre or at home, where the women feel like they really listened to.

> I'd like to see my childbirth a little *ROMANTICALLY*. That is, to think that it really is a journey my baby and I do together and that we help each other [Lana]

> You read or you hear about these women who somehow after an hour or even less have given birth. That would be great, a complication free normal birth. Yes and not a long and unending painful labour leading to complications. That would be good. I'm also against a caesarean but

wouldn't say no if it was necessary on medical grounds. Also I really hope simply for a lot of support from the medical staff. [Freya]

Many women expressed their needs for continuity of care provider. Having a known carer was linked to a feeling of security especially in such an unfamiliar experience as the first childbirth.

I expect somebody to follow me from A to Z. [Léanne]

Being known by their care provider throughout pregnancy and childbirth was also perceived as a guarantee that their desires would be respected.

The principles of safety and confidence are very important. And then it is the advantage of the birth centre, in the fact that we have somebody whom we have met who supports us, and knows our way of thinking. [Juliette]

Some participants argued their wish for continuity of care provider in relation to institutional organisation of care. Based on testimonies or on their knowledge of the system, they anticipated potential difficulties in securing continuity with their lead provider and looked for the best way to answer them.

The hospital system, I think I would be stressed with…all the comings and goings that might exist around me, I heard…Furthermore, lots of people told me that often during and after childbirth… there are lots of people who come round, we do not have necessarily one person who looks after you. Then, we can have lots of different advice and this… yes I would be anxious and unsettled because of all the different advice [Lucie]

For women, it was particularly important to give birth where their HCP in the institution where their HCP was working.

I didn't choose the hospital but simply my obstetrician works at this facility and therefore I've known for the past five or six years that I would have given birth there if I didn't change my physician. I already liked the idea anyway so the choice has somewhat been influenced by the obstetrician. [Nina]

Discussion

In the previous section some carefully selected quotes have been presented to allow key responses of the participants to be presented in their own words. Hence, this section simply highlights and develops a few of the major points in relation to other published literature.

While all of the participants acknowledged there had been a huge change in their lives, their responses showed no unanimity, some being too busy with other issues to deal with it and others immediately deciding upon their place and mode of birth. The metaphors expressed by women such as likening pregnancy and birth to building with lego blocks suggest that being pregnant was simply part of a project they had mapped out for their lives. This tied in with the responses of several participants who appeared to have given the subject little thought but when asked about how they would like to give birth all responded that they aimed for a vaginal birth. However, for some, it appeared to be a question reflected back to the researcher as if to say “what else would we do?” Only three women in our sample expressed a wish for a caesarean section at the midway point of the pregnancy thereby supporting previous findings [20, 21] but contradicting the current popular belief that many women wish to have a caesarean section.

One of the strongest emotions expressed by participants was that of fear. As shown in the preceding section for one participant the fear was so great she refused to allow herself to build up a relationship with her developing baby to the extent of calling it an “egg”. This is contradictory to the trend experienced in recent years whereby health professionals have sought to use language which is considered in keeping with the language that health service consumers might use. A key example of this is the tendency to use the word “baby” rather than “fetus” throughout pregnancy, not simply in discussion with women but in clinical records. Less uncommon is the fear of pain or loss of control during labour which appeared to be a major concern for many participants. While this has been described in recent studies, [29, 20] the depth of emotions reported by some of the participants showed extreme imagery such as “war” or “being put to sleep” suggested that such fears are deeply embedded and may be a previously unarticulated phenomenon. It also suggested that for some women the total passivity experienced in birth 70 years ago

when they were actually anaesthetised and the cervix manually dilated may have been welcomed here. [31]

In contrast to fear some participants expressed faith that their bodies would cope with the experience but that they could not simply stand back and let this happen. This contrast is also expressed in other studies [32, 33] Here, participants were proactively considering various options but at the same time, still having fears that alternatives to state run hospitals were perhaps lacking in essentials. For a country that has a comprehensive midwifery service, funded by all major insurance companies, this is a somewhat surprising finding. It, however, ties in with the feeling expressed by most participants that when they became pregnant the obvious thing to do was to go to their obstetricians, thus receiving most of their information from them. In Switzerland, regardless of insurance packages, every woman has the right to have a gynaecologist and many do so and from when they are teenagers. Thus, in the present study some participants had built up relationships with their gynaecologists over a period of years, so turning to them for obstetric services. While research literature has shown the unique relationship midwives have with women by continuity of midwifery care over a long period of time, in the present study what continuity was sought varied amongst participants.

Conclusions, limitations and recommendations

The results have generally supported other research findings but they have also generated new knowledge which is relevant and worthy of further exploration. In particular the notion of pregnancy as a project underpinned by strong emotions appears to be a new development. The feeling of limbo is also new as participants were healthy and other “projects” such as work ,sport or other social activities were still being given higher priority at this point of the pregnancy.

It is the first such study to be carried out in Switzerland. While a relatively small country, it represents a microcosm certainly of mainland Europe and possibly of other areas in that it contains three major language regions, from four cantons, each with its own culture and customs. In bringing together the data the plan was not to compare and contrast the regions but to consider the “Swiss” experience and the results of the analysis have focused on the commonalities. Nonetheless, it could also be of value to consider the similarities and differences between the different regions

of the country so that institutions such as insurers which cover the whole country can ensure they cover the most appropriate services.

The sample in this study was “healthy primigravid women”. Regardless of this, an unexpected finding was the matter of fact approach to pregnancy articulated by many of the participants. Given the time and energy invested in antenatal care and more particularly the different childbirth education and parentcraft classes on offer, these are something that health care providers might like to reconsider. Likewise, midwives, wishing to provide the complete range of services throughout the pregnancy continuum, need to give much higher consideration as to how their services can become more visible, mainstream and acceptable.

The concept of fear was a major issue. While it is neither unrealistic nor unhealthy to express a fear of the unknown, the emphasis placed on this was much higher than expected and also presented a conundrum when considered alongside the matter of fact approach that the same women appeared to express. Such a contrast is worthy of further and deeper exploration by a multi- disciplinary research team.

This study provides the basis for further data collection and longitudinal comparison at later points in the pregnancy and post natal period. Such work is ongoing. While the sampling strategy was intended to be as appropriate as possible, and a vast amount of data was generated, qualitative research can never be truly representative of the population as a whole. Therefore it is planned that the results of this study together with those from the later time periods be used to generate a questionnaire for testing in a larger sample of women giving birth in Switzerland.

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