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(Celia Bell)**

**An Experiential Assessment of the *Gentle Birth Method*
during Pregnancy from an Ayurvedic Perspective**

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ABSTRACT

This study investigates the experiences of six post natal women who consistently used the Gentle Birth Method (GBM) during their pregnancy. The principles underpinning the GBM are derived from Ayurveda, the traditional system of medicine originating in fifth century India. In the UK, Ayurveda is now considered within the health care system as a complementary and alternative system of medicine (CAM). In the context of conception, pregnancy, childbirth and maternal postnatal care, Ayurveda emphasises the importance of diet, lifestyle regime and mental and emotional preparation.

This is a small scale qualitative study the aim of which is to investigate the experiences, motives, perceptions and rationale of women who had recently given birth having consistently used the GBM during their pregnancy. The study is based on two forms of data collection: (1) a retrospective audit of existing postnatal follow up forms (PNFUF) from GBM clients; (2) semi-structured face-to-face interviews with postnatal mothers. The study employed a purposive sampling strategy to select six women for the interviews with a view to gaining in-depth insights into their pregnancy and birth experiences.

The interviews were carried out in central London – in most cases at the participant's home. The transcribed interviews were analysed using Mauthner and Doucet's Voice-Centred Relational Method to identify themes. The four themes that emerged across the interviews were:

- (1) Fear and anxiety of an uncertain or unknown event.
- (2) Feeling of autonomy and active participation – a sense of control.
- (3) Women helping each other.
- (4) Truly believing in what you are doing.

With respect to the PNFUF, the data collected was limited in scope as very few GBM clients had completed the forms. With respect to the interviews, although the sample size of six was adequate for a qualitative study in the field of healthcare it is unlikely that the results are representative of pregnant women across the UK as the women interviewed represented a limited social demographic range: educated professionals from higher than average household income families.

Nonetheless, the research approach facilitated an exploration of the experience of women who had consistently used Ayurvedic Medicine, as embodied within the GBM, to support their pregnancy and birth experience. Such a study has not previously been conducted and in this way the project adds to the body of knowledge pertaining to the GBM, Ayurveda and CAM. Moreover, the insights and ideas uncovered by the study may provide the author with the basis for a research question in the context of PhD studies.

Finally, the report will help to identify recommendations to Dr Motha for improvements, additions and modifications to the GBM and in so doing will support the ongoing development and success of the GBM.

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
AM	Ayurvedic Medicine
AH	Vagbhata's Astanga Hrdayam
AS	Vagbhata's Astanga Sangraha
CAM	Complementary and Alternative Medicine
CD	Compact Disk
CI	Cikitsasathanam
CS	Caraka Samhita
HIV	Human Immunodeficiency Virus
GBM	Gentle Birth Method
KS	Kasyapa Samhita
MDX	Middlesex University
MN	Madhava Nidana
MSc	Masters of Science
N=	Number of Subjects
NHS	National Health Service
NSESC	Natural Sciences Ethics Sub-Committee
PNFUF	Post Natal Follow-up Forms
RCT	Randomised Control Trails
RMS	Recurrent Miscarriage Syndrome
SA	Sarirasthana
SS	Susruta Samhita
SU	Suthrastana

1. Introduction and Aims

This study assesses the experiences of six post natal women who consistently used the Gentle Birth Method (GBM) during their pregnancy. The GBM was developed by Dr Gowri Motha, who in practising as a gynaecologist and obstetrician found that she was becoming an expert in crisis management on the labour wards of her hospitals.

I have always been bemused by the fact that, as pregnant women, we spend longer preparing the nursery for the baby, than our bodies. We sigh over wallpaper swatches, pore over name books and coo over cots without once thinking about conditioning ourselves for birth (Motha and MacLeod 2004, p xiii).

The principles and methods underpinning the GBM derive from Ayurveda, which originated in fifth century India and means ‘science of life’ in Sanskrit (Sharma and Bhagwan Dash 2006, p xxi). Ayurveda is a holistic medical system that treats the underlying disease aetiology rather than providing symptomatic relief. It is one of the branches of the Vedas, the ancient Indian sub-continent texts (Sharma and Bhagwan Dash 2006, p xxi). In the UK, Ayurveda is considered a complementary and alternative system of medicine (CAM). Ayurveda dictates the importance of diet, lifestyle regime and mental and emotional preparation for conception, pregnancy and maternal post natal care.

This project was undertaken on the basis of the researcher’s belief that there existed a gap in the research relating to the “experiences” of pregnant women who used CAM therapies and herbs during their pregnancy. Further, other qualitative studies researching the childbirth experience have focussed on specific groups of women such as “Professional Chinese Canadian women” (Brathwaite and Willims 2003, p748) or “Women’s lived experiences of fear of childbirth” (Nilsson and Lundgren 2007, p2) rather than assessing the CAM modalities such as Ayurveda. In addition, there were no studies that had evaluated a pregnancy and birth-fitness programme such as the GBM in the context of its Ayurvedic perspective. As such, the question that this research project sought to answer was:

What are post natal mothers' experiences, motives and rationales for using the GBM?

The aim was to investigate the specific experiences, motives, perceptions and rationales of six women who had recently given birth and had consistently used the GBM during their pregnancy. The research design chosen to answer the question was a qualitative study comprised of (1) a retrospective audit of post natal forms and (2) six semi-structured, face-to-face interviews with post natal mothers who had consistently used the GBM during their pregnancy.

The structure of this report follows the recommended format for an MSc dissertation report for Middlesex University (MDX) per the module handbook (Traynor 2010, p14), which is the standard IMRaD style for scientific papers. The literature review aims to contextualise the project from both a theoretical and methodological standpoint - reviewing current journal articles, ancient Ayurvedic text books and the GBM. The methods section explains the methodology for the project particularly the Voice-Centred Relational Method used to analyse the face-to-face interviews and the rationale for choice of methods. The results section presents the key findings of the project as well as a characteristic of the sample interviewed. Two pen portrait summaries of the transcribed interviews are included in Appendix 8. The discussion analyses the four themes that emerge from the research in the context of the literature review and assesses the implication of the findings, limitations of the study and options for future research. The conclusion summarises the results and makes recommendations for the enhancement of the GBM.

2. Literature Review

2.1 Search Strategy

The literature review is comprised of three aspects: (1) a review of classical and current Ayurvedic texts; (2) a database search for journal articles on subject content as well as appropriate research designs, protocols and methodology; and (3) other relevant texts relating to complementary therapy and research methods.

2.1.1 Ayurvedic Textbooks

Caraka Samhita is considered the first and most important “written” text of Ayurveda dating back 1500 years (Svoboda 1992, p9). Further classical Ayurvedic texts are divided into Brihatrayi (great triad) and Laghutrayi (smaller triad). Caraka Samhita (CS), Susruta Samhita (SS) and Vagbhata’s Astanga Sangraha (AS) constitute the great triad and Sharangdhara Samhita, Madhava Nidana (MN) and Bhavaprakasa form the smaller triad (Ranade and Deshpande 2006, p35-61). In addition, the author drew on Kasyapa Samhita (KS), the only available source book on Kaumarabhrtya (Ayurvedic paediatrics, obstetrics and gynaecology), Yoga Ratnakara and Vagbhata’s Astanga Hridayam (AH). The classical Ayurveda texts are difficult to mine in a logical, sequential manner as they were originally oral texts that were subsequently “written”. As such, they are written in question and answer format rather than by subject or topic.

Current Ayurvedic obstetrics and gynaecology texts include Ayurvedic Prasuti-Tantra & Stri Roga (Tewari), Kaumarabhrtya (Tewari) and Ayurveda for Women (Svoboda). These are modern interpretations, translations, commentaries and compilations of the classic texts. These sources were mined for relevant information.

2.1.2 Database search

Databases searched included the ISI Web of knowledge (<http://isiwebofknowledge.com2011>) and Ebscohost (<http://www.ebscohost.com> 2011). The former covers topical journals such as The Indian Journal of Traditional Knowledge and The Journal of Alternative and Complementary Medicine. The latter includes MEDLINE and AMED. Also searched were British Library Direct, Science Direct and Google Scholar. The author also made numerous research visits to the British library.

Keywords: childbirth, labour, pregnan*, gravid, anxiety, wellness, stress, tension, antenatal care, pregnancy care, prenatal care, antepartal care, childbirth experience, CAM, complementary and alternative medicine, complementary and alternative therapy, alternative medicine, alternative therapy. All keywords were searched individually as well as combined with OR and AND (see Appendix 9 – Sample Keyword Search Strategy).

Inclusion / Exclusion Criteria: Animal tests were excluded. The search was limited to articles written in English. No time limits or geographical locations were specified.

2.2 Pregnancy and Antenatal Care

Pregnancy, though not pathological, is a challenging time for the pregnant woman as she experiences anatomical, physiological and metabolic changes in her body to accommodate the growing foetus (Marieb and Hoehn 2007, p1133).

Traditional antenatal care (ANC), defined as the care of pregnant women from conception to the onset of labour (Myers 2006, p110), was developed from models used in the United Kingdom (UK) in the early twentieth century (Carroli, Rooney and Villar 2001, p1; Villar et al 1998, p28). Carroli, Rooney and Villar (2001, p1) denote maternal mortality as the greatest health indicator between industrialised and developing countries.

2.2.1 Changing Childbirth

In the UK, enormous improvements in infant and maternal mortality have been achieved during the twentieth century (Department of Health 1993, p1). Since 1983, the Department of Health has reformed its ANC through its expert maternity group called the “changing childbirth” - a policy document - which was a manifesto for change in the way maternity services were planned and provided (Department of Health 1993, p71). These reforms to maternity care reflect the belief that ANC must be “women centred care”, reflecting the pregnant woman’s unique medical, ethnic, cultural, social and family background and taking and ensuring that her “views and wishes and her desires for a safe outcome are important and respected” (Department of Health 1993, p5). The report addressed various aspects of the birth experience such as appropriate care, including consistency of ANC, place of birth, accessible care, effective and efficient services and action for change. Other industrialised nations have adopted similar programs which have been redesigned to address women’s needs and actively promote women’s participation in their ANC (Novick 2009, p2).

In the UK, the National Health Service (NHS) has established both a “patient led” and “evidence based” approach to appropriate care (Department of Health 1993, p9). Wye, Shaw and Sharp (2009, p323) explored how primary care clinicians balance these potentially conflicting goals. They completed a two site case study of NHS premises in England that offered CAM therapies. The study methodology included interviews, observations and reviewing collected documents and databases. The study found that when health care goals were in conflict evidence based findings would generally predominate. However, they reported that observed behaviour - during their study – suggested that perceived evidence of research predominated versus actual fact based evidence (Wye, Shaw and Sharp 2009, p328).

2.2.2 Childbirth Experiences

Several qualitative studies that explored women’s experiences of childbirth were identified. Gibbins and Thomson (2001, p302) used a phenomenological approach with eight first time mothers exploring their expectations and experiences of childbirth. The data was collected during two unstructured, face-to-face interviews, one in late pregnancy and the other two weeks post birth. Gibbins and Thomson (2001, p307) found that the women in their study wanted to take an active part in their labour and have the feeling of being ‘in control’. This control was expressed in three ways: (1) during the labour process, e.g. its duration, (2) participation in decision-making and management of labour and birth and (3) control over emotions and behaviour. The control gave the women confidence in their ability to cope with labour culminating in a more positive birth experience. These women found support for their desire for control through partners, positive attitude midwives who were caring for them during pregnancy and birth and information that they were given during pregnancy and birth to facilitate decision making and preparation for labour. The women further informed themselves through parent-craft classes, discussions with friends and family, birth plans, reading books and watching videos (Gibbins and Thomson 2001, p308).

Brathwaite and Willims (2003, p748) completed an ethnographic interview study with six professional Chinese Canadian women. The purpose of the study was to explore the connections between culture and expectations surrounding the childbirth experiences of these six women and the perceived need to educate and inform health care providers of

these beliefs, values and practices in both pregnancy and childbirth. The study found that the participants described adherence to many traditional values, beliefs and practices throughout pregnancy and childbirth. Examples of values, beliefs and practices during pregnancy were not lifting or reaching for objects overhead, not handling scissors on the bed, not attending funerals or sad occasions, not wearing all black or white, not eating certain foods and eating certain types of food that maintained yin and yang equilibrium in the body (Brathwaite and Willims 2003, p751). However, some of these practices were modified to accommodate functioning in a context that could not support full expression of cultural traditions. Also, the more recent immigrants to Canada tended to adhere less to Chinese rites and beliefs (Brathwaite and Willims 2003, p751).

Nilsson and Lundgren (2007, p2) conducted a qualitative study using phenomenological approach, collecting data via in-depth interviews. The objective was to describe women's lived experiences of fear of childbirth. Lived experiences were defined as: 'to lose oneself as a woman into loneliness'. The four main themes expressed by the participants were that they felt: (1) trapped, (2) on their own, (3) that they were going to be an inferior mother and (4) the danger was both appealing and threatening simultaneously (Nilsson and Lundgren 2007, p4). Key conclusions were that the women experienced self-doubt and felt insecure about their capabilities to bear and give birth to a child. Previous birth experiences related to care received relative to suffering was pertinent with women who were multiparous. These findings mainly concerned pain and negative experience with staff (Nilsson and Lundgren 2007, p7). The authors conclude that pregnant women who fear childbirth are an exposed group in need of support during pregnancy and childbirth. Nilsson and Lundgren note that fear has mainly been studied in Northern cultures specifically from a bio-medical perspective and recommend further research to "investigate cross-cultural differences as well as experiences from lifeworld-oriented perspective" (Nilsson and Lundgren 2007, p8).

2.3 Complementary Therapies for Antenatal Care

2.3.1 Market size

CAM is one of the fastest growing areas of healthcare for both consumers and practitioners (Tiran and Mack 2000, p1). The seminal study completed by Eisenberg et al (1993) in the USA on the market size for CAM found that the number of visits in 1990 to CAM practitioners exceeded visits to primary care physicians with 75% of the former paid for by the clients. Similar to the study by Eisenberg et al (1993); Lewith, Jonas and Walach (2003, p3) highlighted that the increasing demand in the UK for CAM practices is public-led. The Western European market is estimated at approximately US\$ 5 Billion in revenues for the period ending 2003/2004 (<http://www.themedica.com> 2011).

A survey conducted in the USA in 2005 specifically addressing pregnancy found that 62% of pregnant women surveyed were likely to use CAM therapies during their pregnancy for relief of minor ailments particularly lower back pain (Wang et al 2005, p459). Mitchell (2010, p109) agrees that the growing use of CAM during pregnancy and childbirth could be an indication of women's desire for fulfilment and need for autonomy and active participation in healthcare decisions especially in the "risk society" context. A "risk society" exists where the advancement of scientific and technological advantages are overshadowed by the risks and dangers in a world dominated by anxiety and uncertainty.

Adams et al (2009, p238) found that the profile of women who tended to use CAM during their pregnancies were generally older and possessing a higher degree of education and house-hold income and typically reported more physical symptoms. Other factors linked to an increased use of CAM therapies and herbs during their pregnancy were previous use of CAM, first time mothers, planning a natural birth and non-smokers.

2.3.2. Complementary Therapies used in Pregnancy

In the UK context, Tiran and Mack - in their book Complimentary Therapies for Pregnancy and Childbirth (2000) - review the following CAM therapies: Homoeopathy, Osteopathy, Chiropractic, Acupuncture, Herbal Medicine, Massage and Aromatherapy, Reflexology, Shiatsu, Hypnosis and Hydrotherapy with the conclusion that CAM can be useful as an add-on to conventional maternity care as it offers natural relief to common discomforts during pregnancy and fewer side effects than the pharmaceutical option (2000, p10).

Field (2008, p28) in her review of the literature over a five year period found that massage therapy, acupuncture, yoga, relaxation, hypnosis, music therapy and aromatherapy were the CAM therapies most commonly used by pregnant women. Massage or touch therapy for 20 minutes per week over a 5 week period was found to decrease depression, anxiety and leg and back pain. Biological indicators found were: decrease in cortisol levels, decrease in excessive foetal activity and lowered prematurity. Acupuncture had beneficial effects on back pain, pelvic pain, nausea and vomiting associated with pregnancy. Preventative effects were also noted for acupuncture for preventing nausea and vomiting (Field 2008, p29). A study comparing 60 minutes/day of yoga from 18-20 weeks of gestation until delivery were compared against 60 minutes of walking. The yoga group experienced fewer complications including: intrauterine growth retardation, pregnancy induced hypertension, higher foetal birth weight and lower incidence of preterm labour (Field 2008, p29).

Adams et al (2009, p238) in their critical review of the literature from 1999-2008 found the CAM therapies most often used during pregnancy were: acupuncture, acupressure/reflexology, aromatherapy, massage, yoga, homoeopathy and chiropractic care. The most frequently used herbal medicines were: ginger, raspberry leaf and echinacea.

2.3.3 Stress and Anxiety-Related Therapies

Some degree of stress and anxiety are commonly associated with pregnancy resulting from the enormous physiological, psychological and social changes taking place in a woman's life (Bastard and Tiran 2006, p48; Tiran and Chummum 2004, p163). Significant levels of increased stress have been known to lead to complications such as pre-eclampsia, intrauterine growth retardation, gestation diabetes and premature labour (Stenson 2003, p140). Similarly, antenatal anxiety has been linked to foetal development that can have lasting impact on the child's psychological development (Bastard and Tiran 2006, p48). A pregnant woman's fear of pregnancy, childbirth, previous loss of a baby, lack of support and unrealistic expectations can sometimes manifest as symptoms of anxiety (Cote-Arsenault 2003, p623; Melender 2002, p101). The relaxation qualities of massage have been known to extend from mother to baby. Massage is known to stimulate endorphins and decrease blood pressure through its actions on the parasympathetic nervous system thus potentially reducing maternal and foetal mobility and mortality (Bastard and Tiran 2006, p50; Cassar, 2001 p 12).

Pregnant women diagnosed with severe depression were given twelve weeks of massage therapy twice a week by their partners versus a control group receiving standard treatment. The massage group not only had reduced depression by the end of the therapy period but also exhibited reduced depression and cortisol levels during postpartum. Further, their babies were less likely to be born premature or have lower birth weight (Field, Diego, Hernandez-Reif, Deeds, Figueiredo 2009, p454). Beddoe and Lee (2008, p165), in their review of published literature on the effectiveness of mind-body interventions during pregnancy; found some evidence for efficacy especially with muscle relaxation therapies, yoga and meditation. Outcomes for the treatment group included higher birth weight, shorter length of labour, fewer instrument assisted births and reduced perceived stress and anxiety. Beddoe and Lee (2008, p165) found that some of the research reviewed had methodological problems – primarily absence of RCT and / or absence of adequate control. Beddoe, Yang, Kennedy, Weiss and Lee (2009, p310) in their seven-week study of prenatal mindfulness yoga based on the Iyengar method using sixteen healthy singleton pregnancies, found evidence to support reduction in both physical and psychological distress especially when the program was

started early in the pregnancy. However, the limitations of their study were the absence of a placebo group, small sample size and possible selection bias (Beddoe et al 2009, 317).

Bastani, Hidrania, Kazemnejad, Vafaei and Kashanian (2005, p36), in their RCT using one hundred and ten primigravid women for the effects of applied relaxation on reducing anxiety and perceived stress in pregnant women, found significant reductions in state / trait anxiety and perceived stress for the experimental group versus the control group after the intervention. Bastani et al (2005, p38) conclude that incorporating a relaxation technique into an ANC program could serve as a resource for improving maternal psychological health.

2.4 Ayurvedic Approaches to Antenatal care

Ayurveda's ANC program begins prior to conception. Caraka in his chapter on the method of procreation notes that both the man and the woman who have unimpaired semen and ovum, with the woman having a healthy uterus, the couple having the desire for an "excellent progeny can achieve their objective" (CS Sarirasthana (SA) VIII: 3; Sharma and Begawan Dash 2005, p463).

One of Ayurveda's fundamental tenets is that:

The cause of all disease is the morbid (increase) dosas (humors) and the cause for morbid increase of the dosas is indulgence in different kinds of unhealthy foods and activities (MN I:14; Murthy 2005, p5).

Both the man and woman need to eliminate excessive dosas from the body and mind through diet and regimens that include: oleation, sudation, herbs and the recommended method of expulsion of the dosa prior to the commencement of procreation. CS SA (IV:34; Sharma and Begawan Dash 2005, p405) explains that just as there are three dosa - Vata, Pitta and Kapha - that afflict the body there are two dosa - Rajas and Tamas - that vitiate the mind. "Vitiating of the body and mind result in the manifestation of disease there is no disease without their vitiating". The commentary of a similar sloka in

CS SU (I:57 Sharma and Begawan Dash 2006, p41) explains that Vata is the most prominent of the dosas as a result of its: “acuteness, variety and seriousness of the diseases caused by it”.

The body and mind must not only be balanced in dosas but the couple must also be physically fresh and clean, happy and be attracted to each other before coitus is performed. Further, the women must not have “fear, dejection, grief, anger or desire for another man during intercourse” (CS SA VIII: 4-8; Sharma and Begawan Dash 2005, p464).

The rationale for a wholesome diet (Table 1), regime and lifestyle (Table 4) is to balance the dosa, dhatu, mala and keep the agni firing with the objectives of:

1. Nourishing and sustaining the mother.
2. Facilitating the foetus’s growth and development.
3. Mitigating risk and ensuring a smooth labour and delivery.
4. Promoting the secretion of breast milk.

(Girija 2008, p40; Koppikar 2008, p37)

CS SA (VIII:21; Sharma and Begawan Dash 2005, p464) states that the mother must refrain from an unwholesome diet, regime, lifestyle and perform virtuous deeds to ensure a healthy and happy baby. Kasyapa explains the importance of the wholesome diet and lifestyle of the mother as the body habituates to the foetus. Kasyapa further specifies that the mother must use only “garments and ornaments which are meritorious, auspicious, new and intact”, live in a home that is well maintained, clean and free from insects and pests and listen to beautiful music (KS SA V:11-14; Tewari 2002, p141). KS CI (II:14-15; Tewari 2002, p165) further notes that pregnant women must be happy, be bathed daily adorning clean clothes, remain pious, sober and worship God; should not remain erect, flexed, hold heavy weights for long and avoid excessive, laughter, shaking and trauma.

SS SA (X: 3-4; Murthy 2004b, p152) states that a woman from the very first day of pregnancy must remain happy, clean, partake in auspicious acts, be devoted to the Lord, not exposing herself to unclean, mean or abnormal sights, sounds, odours including

visiting cemeteries / crematoriums or eat foods that are stale, dry or too moist and not remain alone in her home. She should avoid overexertion, penetrating massage, sitting on hard surfaces or places that are too high and should consume foods that are nourishing for her body and mind especially tastes which are sweet and unctuous processed with recommended herbs.

AS SA (2:36; Murthy 2005, p29) explains that the care of the pregnant woman is similar to the foetus. The mother needs to be looked after carefully with all pleasant and suitable things protecting her from causes of foetal abnormality. This is particularly as her strength will have a tendency to deteriorate as the foetus develops requiring more space and prioritising nutrition. In summary, all foods and drinks, which are difficult to digest, sharp in potency as well as heat producing, penetrating into the tissues and drying as well as activities that are strenuous should be avoided. Verse 38 says: “the pregnant woman should be protected just like a vessel filled with oil to the brim is protected, without any shaking” (Murthy 2005, p31).

Vagbhata’s AH SA (I:43) says:

The woman, who has conceived should be looked after affectionately by her husband and attendants, supplied with things that she likes and which are good for her health, nourished with more butter, ghee and milk, always (Murthy 2004, p368).

All the classic authors above have detail account of the embryology and month by month development of the foetus which is outside the scope of this study. However one aspect which is relevant is the desires, longing, cravings and wants of the pregnant women must be fulfilled as they are the desires of the foetus expressed by the mother.

AS SA 2:11-12 (Murthy 2005, p21) notes that even unhealthy desires of the mother must be fulfilled. He suggests combining unwholesome desires with healthy / wholesome ones to keep the woman satisfied. Unfulfilled desires of the mother lead to aggravated Vata, which can either destroy or deform the foetus and as such a pregnant woman whose desires are fulfilled will “beget a son endowed with valour and long life”.

2.4.1 Month by Month Diet Schedule for Ayurvedic Antenatal Care

Ayurveda dictates the importance of diet for the pregnant woman.

Table 1: Comparison of Month by Month Pregnancy Dietary Schedule Recommended By the Three Great Classical Ayurvedic Texts: Caraka Samhita, Susruta Samhita and Vagbhata's Astanga Sangraha

(CS SA VIII:32; Sharma and Begawan Dash 2005, p485; SS SA X: 3-4; Murthy 2004b, p153; AS SA 3:2-10; Murthy 2005, p33)

Months of Pregnancy	Caraka Samhita	Susruta Samhita	Astanga Sangraha
1	Wholesome food both in AM and PM complimented by milk	Foods which are sweet, cold in potency and liquid	Foods which are sweet, cold and liquid that she is accustomed to in the AM and PM. Milk, ghee with some herbs boiled in gold or silver pot followed by water
2	Milk boiled with herbs that have a sweet taste	Same as month 1	Milk with herbs that have a sweet taste
3	Milk with honey and ghee	Same as month 1 plus boiled red rice and milk	Same as month 2 plus ghee with honey
4	Milk with 12g of butter	Milk and butter with some meat and boiled rice in the way she finds appealing	Milk with 12g of butter
5	Unfermented Ghee taken directly from milk		Milk and ghee
6	Ghee with herbs that have sweet taste	Ghee with some herbs or thick gruel	Milk and ghee processed with sweet herbs
7	Same as month 6; vata pacifying diet without much fat or salt. Both food and water in small quantities.	Ghee with herbs; to satisfy the foetus	Same as month 6; eat small portions with sweet taste reduced fat and salt and follow with water
8	Milk and gruel with ghee	Thick gruel and meat soup	Gruel with milk and ghee
9			Gruel with fats and meat soup

Ayurvedic dietetics and energetics denote five active principles of all substances: rasa, guna, virya, vipak and prabhava (Murthy 2004a, p145). Further, there are six tastes: sweet, sour, salty, pungent, bitter and astringent. Caraka says that the proper utilisation of these tastes maintain the body while improper uses increase the dosas (CS VI I:4; Sharma and Begawan Dash 2005, p113). Caraka notes that a physician who is rigorous in his/her classification of rasa and dosa will rarely misdiagnose aetiology, symptoms and treatment of disease (CS SU XXVI: 27; Sharma and Begawan Dash 2005, p458). For instance, the sweet taste recommended in the monthly dietary schedule (Table 1) is not merely the consumption of sweets, sugars and chocolates but a more complex dietetic and energetic assessment of the sweet taste on the tongue and taste buds (Sastry 2004, p2) that is Vata and Pitta pacifying and anabolic in action and cooling in potency (Table 2).

Table 2: Ayurvedic Energetics – The Five Active Principles of All Substances

(Lad 2002, p249; CS SU XXVI: 14; Sharma and Begawan Dash 2005, p454; CS VI I:4; Sharma and Begawan Dash 2005, p113)

Rasa	Virya	Vipak	Actions	Dosa +	Dosa -
Madura Sweet	Cooling	Sweet	Anabolic	Kapha	Vata, Pitta
Amla Sour	Heating	Sour	Metabolic	Kapha, Pitta	Vata
Lavana Salty	Heating	Sweet	Anabolic	Kapha, Pitta	Vata
Katu Pungent	Heating	Pungent	Catabolic	Vata, Pitta	Kapha
Tikta Bitter	Cooling	Pungent	Catabolic	Vata	Kapha, Pitta
Kashaya Astringent	Cooling	Pungent	Catabolic	Vata	Kapha, Pitta

The sweet taste is especially important in the first trimester to maximise Pitta transformative and metabolic energy while mitigating over activity of Pitta through

bleeding and miscarriage. The priority in the first trimester is to ensure the viability of the pregnancy hence the importance of following a Pitta balancing diet in the first trimester. In the second trimester the foetus needs to develop and grow while maintaining its stability established in the first trimester. This is the Kapha phase of development of the pregnancy. The energy of Kapha is stability, lubrication and structure therefore a Kapha balancing diet would be suitable. In the third trimester managing Vata, which is the energy of movement, especially the sub-dosa of Vata downward movement of Apana Vayu (Table 3), is essential for a safe birth of the baby and mother hence Vata balancing diet is ideal (Girija 2008, p40; Lad 2002, p29).

Table 3: The Five Sub-Dosas of Vata, their Locations and Functions as described in Caraka Samhita

(CS CI XXVIII: 5-11 Sharma and Bhagwan Dash 2009, p20)

Sub-Dosa (sub-set)	Locations	Functions
Prana Vayu	Head, chest, throat, tongue, mouth and nose	Spitting, sneezing, eructation, respiration deglutition of food
Udana Vayu	Umbilicus, chest and throat	Manifestation of speech, effort, enthusiasm, strength and complexion
Samana Vayu	Pervades: Sveda vaha srotas, dosa vaha srotas and ambu vaha srota; located in the region of Jatharagni	Promotes digestion
Vyana Vayu	Pervades the entire body	Facilities movement of the body: motion, extension, sudden movement, winking of the eyes
Apana Vayu	Two testicles, urinary bladder, phallus, umbilicus, thighs, groins, anus and colon	Ejaculation of semen, voiding of urine and stools, elimination of menstrual blood and parturition of foetus

As noted, ensuring that the dosas are in a balanced state is an essential tenet of Ayurveda. Therefore, keeping Vata unimpaired throughout a pregnancy is essential as opposed to only in the third trimester. Vata is the most virulent of the three dosas and

can cause the most harm to mother and baby as it can cause “premature expulsion and undue retention of the foetus; and morbidity of the semen and foetus” (CS CI XXVIII: 34 Sharma and Bhagwan Dash 2009, p29). Moreover, Vata especially Prana Vayu which resides in the head and the brain pertain to cerebral functions (Lad 2002, 46) in addition to the physical functions listed in Table 3. Lad (2002, p48) explains that Prana Vayu “is movement of mind, thoughts, feelings, emotions, sensation and perception” therefore Prana Vayu imbalances can lead to fear, anxiety and nervous tension. At its essence, the ANC of Ayurveda’s primary focus is to manage and sustain Vata and its sub-dosas through the period of change for both the pregnant woman and foetus.

Datta (2011) explains that her clinical experience at the GBM clinic demonstrates that most pregnant women tend to show symptoms of Pitta, Kapha and Vata imbalances in the first, second and third trimesters respectively. Experiential knowledge or Pratyaksa is a valid source of knowledge in Ayurveda. These Padarta come to Ayurveda from Nyaya Philosophy, which is one of six branches of traditional Indian philosophy (Lad 2002, p11; Radhakrishnan 1999, p48).

2.4.2. Herbs Recommended for Ayurvedic Antenatal Care

CS lists a group of ten herbs called Prajasthapana (Table 4) that have traditionally been used to reduce the incidence of miscarriage by improving implantation and facilitating adhesion to the uterine wall (Sharma and Bhagwan Dash 2006, p100). CS lists additional categories of herbs that promote spermatogenesis, improve the quality of sperm and improve the production and quality of breast milk.

Table 4: Caraka’s Ten Herbs for Prajasthapana – To Improve the Implantation of the Foetus to the Uterine Wall – Reducing the Incidence of Miscarriage

(CS SU IV: 18 Sharma and Bhagwan Dash 2006, p100; CS SA VIII: 20 Sharma and Bhagwan Dash 2006, p474)

	Sanskrit Name	Botanical Name
1.	Indravaruni	Citrullus colocynthis
2.	Brahmi	Bacopa or Herpestis monnieri
3.	Satavirya	Cynodon dactylon
4.	Durva or Durvadwayam	Variety of Cynodon dactylon
5.	Amalaki	Embllica officianalis
6.	Guduchi	Tinospora cordifolia
7.	Haritaki	Terminalia Chebula
8.	Katuki	Picrorhiza Kurroa
9.	Bala mula	Sida cordifolia
10.	Preyangu	Callicarpa macrophylla

CS SA VIII:20 (20 Sharma and Bhagwan Dash 2006, p474) further recommends including the herbs of the Jivaniya group. However, most of these herbs are either extinct or on a list of endangered species.

Girija (2008, p41) suggests that milk boiled with Bala can be consumed from the first month although it is preferable to use it from the second month. Bala is sweet in taste, cold in potency, regulates Vata and pacifies Pitta. When taken during pregnancy, Bala has the potential to protect the woman from bleeding, strengthen her and improve her complexion (Pole 2006, p137). Other herbs that are freely available and not endangered are Satavari (*Asparagus racemosus*), Yashtimadu (*Glycyrrhiza glabra*) and Vidari (*Ipomomea digitata*). These herbs should be boiled in water and milk until the water has evaporated and are ideally consumed at room temperature or tepid warm (Girija 2008, p41). Satavari has an affinity for sukra dhatu supporting female fertility and increasing reproductive fluids enhancing both conception and reproductive strength as well as preventing miscarriage. Satavari also has affinity for increasing the flow and quantity of breast milk (Pole 2006, p271). Yashtimadu is known for its rasayana action; it is sweet in taste, cold in potency and sweet in post digestion. It has an affinity for sexual potency and is vitalising (Sastry 2005, p154). Vidari is a renowned rejuvenating tonic for the female and male reproductive system. It has an anabolic and diuretic action as well as an affinity to increase the production of breast milk (Pole 2006, 292).

Koppikar (2008, p38) similarly suggests Yashtimadu with white and red sandalwood powder (*Santalum album-Lignum*) taken in milk for the first month as well as Yashtimadu, Ksheerakakoli (*Lilium polyphyllum*) and Devadaru (*Cedrus deodara*). In the second month, Koppikar suggests Pippali (*Piper longum*), Manjishta (*Rubia cordifolia*) and Satavari decocted in milk in equal quantities. She also suggests Lotus stem (*Nelumbo nucifera*), Nagakeshara milk (*Mesua ferrea*), Bel fruit (*Aegle marmelos*), camphor and goat milk.

A decoction of Gokshura (*Tribulus terrestris*) can be taken from the sixth month to reduce water retention. The herb has an affinity for the urinary system, improves digestion and is sweet in taste. Vidari is recommended from the seventh month. It is a diuretic but also increases the secretion of breast milk; it is rejuvenating and improves fertility (Girija 2008, p43).

There are many herbs that have traditionally been used in Ayurveda to support pregnant women. However, it is important to consider the age of the pregnant mother, her constitution and digestive fire, the season and place as well as the relevant legislative restrictions (UK legislation in the case of this study) that govern the use of specific herbs. In this respect, caution should be taken to ensure the safety and purity of the herbs before they are prescribed to a pregnant woman (<http://www.apa.uk.com> 2008),

2.4.3 Regime and Lifestyle Suggested for the Pregnant Woman

Ayurvedic ANC recommends specific regime and lifestyle practices for the pregnant woman to follow (Table 5).

Table 5: Comparison Regime and Lifestyle Schedule Recommended By the Three Great Classical Ayurvedic Texts: Caraka Samhita, Susruta Samhita and Vagbhata's Astanga Sangraha

(CS SA VIII:32; Sharma and Begawan Dash 2005, p485; SS SA X: 3-4; Murthy 2004b, p153; Murthy 2004, p153; AS SA 3:2-10; Murthy 2005, p33)

Months of Pregnancy	Caraka Samhita	Susruta Samhita	Astanga Sangraha
1			Bath with leaves of bilva, karpasi, pappana patali, picumanda, agnimantha, mamsi, vardhamanaka or scented with perfumes
2			
3			
4			
5			
6			
7	To reduce stretch marks and reduce itching/burning sensation in the skin spread a paste of Candana with powder of sirsa and maduka or paste of kutaja, haridra and musta or past of nimba and manjistha or triphala		To reduce stretch marks and reduce itching/burning sensation in the skin spread a paste of Candana with powder of sirsa and maduka or paste of kutaja, haridra and musta or past of nimba and manjistha or triphala
8		Niruha basti to remove compacted faeces and Anuvasana basti to promote downward movement of vata	Niruha basti to remove compacted faeces and Anuvasana basti to promote downward movement of vata
9	Anuvasana basti with herbs that have a sweet taste Cotton swabs soaked in oil to be kept in virginal tract for oleation of uterus and genital tract		Cotton tampon soaked in oil to be inserted into virginal tract to lubricate the uterus and genital tract

Although not specifically mentioned in the pregnancy regime per se, Abhyanga is an essential component of Ayurveda's Dinacharya that is obvious that it does not need specific mention.

Vagbhata's AH SU (II:8) says:

Abhyanga (oil massage and bath) should be resorted to daily, it wards off old age, exertion and (aggravation of) vata; bestows good vision, nourishes the body, long life, good sleep, good and strong (healthy) skin. It should be done specifically to the head, ears and feet (Murthy 2004, p24).

However, Susruta has noted that a deep and penetrating massage is contraindicated during pregnancy (2.4 Ayurvedic ANC). As such, anything more than gentle touch with special oils should not be undertaken. The properties of oil used for the massage should be nurturing, caring and most importantly facilitating the pacification of vata and completed only after the foetus has established itself following the first trimester.

Caraka (CS SA VIII:21; Sharma and Begawan Dash 2005, p488) mentions that if this program for diet, herbs and lifestyle is followed from the first to the ninth month of pregnancy, the following can be expected:

1. Softening of the placenta, pelvis, waist, side of the chest and back.
2. Downward movement of vata.
3. Normalisation of urine, stools with easy elimination.
4. Softening of the skin and nails.
5. Promotion of strength and complexion.
6. Ease of delivery with a healthy baby at the appropriate time with excellent qualities

Koppikar (2008, p37) discusses a study conducted between October 1988 and February 1990 at Poddar Ayurvedic Hospital in Mumbai, India. Out of 1000 deliveries completed during this period:

- Low birth weight babies were less than 5.9%.
- Still births 3.1%.
- Lower section caesarean section (LSCS) 4.5%.
- Vaginal tears were negligible and notable reduction in prolonged delivery in women who used enemas and vaginal swabs.

She further explains that even though these practices were part and parcel of the culture and knowledge of midwives and women they have largely been lost and are only being used by classically trained Ayurvedic doctors (Koppikar 2008, p37). However, the results from the study are significant and she recommends wider use of the diet, lifestyle and regime that Ayurveda recommends for pregnancy (2008, p37).

Per Table 5 CS, SS, AS recommend a decoction enema (Niruha Basti) to eliminate compacted, old faeces to create extra space for the birth canal to expand into and oil enema (Anuvasana Basti) to lubricate the colon as well as encourage the proper downward movement of Apana Vayu (Table 3) to help deliver the baby easily and without complication. AS SA (3:7; Murthy 2005, p35) specifies the best position for the administration of the enemas to the pregnant woman. Further, AS explains how the picchu should be soaked in oil and inserted into the vagina to lubricate and prepare the birth canal as well as optimise the downward movement of Apana Vayu in preparation for the birth.

2.4.4 Labour Preparation and Onset of Birth

In addition to the regime recommended for pregnancy, Caraka specifies that the maternity home should be constructed prior to the commencement of the ninth month.

The maternity home should be constructed in a place cleared of bones, gravels and pieces of earthen vessels. The soil of the locality should have excellent colour, taste, and smell. The doors should face towards the east or north and the wood of bilva (*Aegle marmelos* Corr.)...should be used for the construction of this maternity home (CS SA VIII:33; Sharma and Begawan Dash 2005, p490).

Caraka details the herbs, physical instruments (including various surgical instruments that should be sharp and constructed of metal) and other equipment that should be stored in the maternity home. He further instructs that a “number of female attendants who are multipara, affectionate, constantly attached to the lady, well mannered, resourceful, naturally disposed to love, free from grief, tolerant of hardship and agreeable must be present in addition to the Brahmins (physician / teacher) well versed in the Artharva Veda” (CS SA VIII:34; Sharma and Begawan Dash 2005, p491).

The signs of the impending delivery as categorised by Caraka are:

1. Exhaustion of the limbs.
2. Feeling of depression in the face.
3. Looseness in eyes.
4. Feeling in the chest as if a knot is being untied.
5. Feeling as if something is coming down from the pelvis.
6. Heaviness in the lower part of the body.
7. Pain in groin, region of the bladder, pelvis, sides of the chest and back.
8. Onset of show from the genital tract.
9. Loss of appetite.

Caraka mentions that the above signs herald the true labour pains, which coincide with the excretion of the amniotic fluid. When these signs appear, the labouring bed should be prepared and the “female attendants having the qualities (specified) should remain all around her and console her with talks, which are comforting and consoling to her” (CS SA VIII:36-37; Sharma and Begawan Dash 2005, p492). In another sloka, Caraka mentions that whatever is needed and advised by the Brahmins should be prepared and “old ladies” should be kept in the maternity home (CS SA VIII:34; Sharma and Begawan Dash 2005, p491). This indicates the importance of women helping each other during the entire pregnancy process in addition to the presence of a qualified physician.

2.5 Gentle Birth Method

Dr Gowri Motha, obstetrician and gynaecologist, working at various NHS hospitals across London, found that she was becoming an expert in crisis management. She could do little to help the mothers she was seeing in the labour ward except with her forceps, ventouse and scalpel:

It saddened me and was not why I had entered this profession. Every birth is a miracle, and should be a personal triumph for every woman. Why was it so rapidly becoming something fewer and fewer women could achieve without help? I fully believed doctors and the medical establishment should be investigating preventative measures that would help women prime their bodies for birth before they went into labour...I needed to create a total birth fitness programme and to make the mothers birthfit so that they could have the gentle birth they wanted. (Motha and MacLeod 2004, p33).

Motha's experience as a practicing obstetrician was that even the more "women centred" ANC programs, though adequate for monitoring prenatal and maternal health, were inadequate for the most natural of human acts - that of birthing a baby. Her conclusion was that a supplementary pregnancy preparation was required to complement the established ANC programs offered by the NHS and private maternity hospitals.

Motha drew from her cultural roots, Sri Lanka, where she was born, and India, where she completed her medical training, and was drawn toward Ayurveda. One of the eight branches of Ayurveda is Kumara Bhritya, which means "how to take care of the child – drawing a clear link between mother's well-being and health of the embryo, including its impact on the implantation process, early foetal development and the whole pregnancy" (Motha and MacLeod 2004, p15). The importance of the mother's preconception health and happiness as stated in Ayurvedic Approaches to ANC (2.4) resonated with Motha:

Ayurveda expounds that the character, physical attributes and health of a child begins with the mother and her pre-conception status - how well nourished, rested and emotionally prepared she is for the pregnancy and motherhood. It also emphasises the great need for the mother to be surrounded by love and care of her partner. These values all align very closely with my own instinct about how we should care for expectant mothers and it is for these reasons that I allude to Ayurvedic wisdom throughout the programme (Motha and MacLeod 2004, p15).

Combining her Eastern and Western background and training, Motha developed a holistic birth preparation plan that hones the body, mind and emotions during pregnancy for the impending birth. “The physical condition, aiming to detoxify and decongest the body...the mental attitude addresses any resistance or fear about the birth (both expressed and latent)...emotional level extending a loving welcome to the unborn baby and learning how to bond with the baby in the womb” (Motha and MacLeod 2004, pxiv).

Motha’s book The Gentle Birth Method: The Month-by-Month Jeyarani Way Programme details her method. Some therapies such as the enema and specific herbs have been added since the publication of her book and were discussed in meetings with Motha as well as Datta. In keeping with Ayurvedic ANC, the wellbeing of the body, mind and emotions are addressed throughout the GBM. The mother’s happiness and sense of being cared for and in contact with other women are integral components of the program.

2.5.1 Physical Preparation

The diet and lifestyle components of the GBM can commence as early as week 5 of the pregnancy (Motha and MacLeod 2004, p139). However, the comprehensive program should ideally commence after 12 to 16 weeks when the pregnancy is well established and the chance of miscarriage has reduced (Motha and MacLeod 2004, p239). The initial consultation would explain the program and commence with reflexology and a creative healing session at the clinic (Table 6).

Table 6: Gentle Birth Method Physical Preparation - Touch Therapies Suggested for use during Pregnancy

(Motha and MacLeod 2004; Motha and Datta 2010; Datt 2011)

Component	Indication	Frequency
Creative Healing	Clears congestion	Every 1-2 weeks
Reflexology	Cleanses body	Every 1-2 weeks
Bowen	Treat acute pain	Week: 21, 22, 34,35, 39, 41
Cranial-Sacral	Releases blockages	Week: 17, 25,27,29, 37
Picchu (virginal swab/tampon)	Preparation of the lower vaginal tissues	Commence at the end of week 35 and continue
Pelvic Release	Prepare birth canal	Week 36
Vaginal and Perinea stretch massage	Stretches and softens vaginal tissues for birth	After 36 weeks on a daily basis
Enema	Clear colon and increase space	30 mL 3x/week from 37 weeks

The importance of touch is well documented especially its effects of increasing endorphins, improving the immune system, dulling the response to pain and contributing to increased life expectancy (Motha and MacLeod 2004, p35). The therapies in Table 6 have been included in the program as they have been found to mitigate many of the problems arising during pregnancy such as back pain, nausea, heartburn and fluid retention (Motha and MacLeod 2004, p33). The picchu, vaginal massage and enema are to prepare the birth canal for the impending birth and inherent component of the Ayurvedic Approaches to ANC (Section 2.4.3, Table 5) (Motha and MacLeod 2004, p69).

In keeping with Susruta's contraindication (2.4.3 Regime and Lifestyle Suggested for Pregnant Woman) the GBM recommends avoiding a deep body massage throughout the pregnancy (Motha and MacLeod 2004, p145). The oils suggested for use during pregnancy and labour by the GBM is listed in Table 7.

Table 7: Gentle Birth Method Physical Preparation – Oils Suggested for Use during Pregnancy and Labour

(Motha and MacLeod 2004; Motha and Datta 2010; Datta 2011)

Component	Indication	Frequency
Ayurvedic anti-stretch mark oil	Nourish skin's collagen	Week 18 onwards
Aromatherapy anti-stretch mark oil	Nourish skin's collagen	Week 18 onwards
Ayurvedic Picchu oil	Preparation of lower vaginal tissue	Oil soaked swab inserted into vagina and kept for 4 hours
Extra virgin olive oil	Enema	Week 37 onwards
Aromatherapy labour oil	For use during labour	For massage during labour

In keeping with Ayurveda's ANC (2.4), diet is an integral component of the GBM, which suggests a variety of grains such as rice, millet, quinoa, amaranth, buckwheat, lentils and vegetables excluding wheat, sugar, gluten and dairy from the diet to both support the body and keep it clear of toxins. An Ayurvedic consultation at the second appointment will prescribe an individual dietary plan for each client after a thorough diagnosis of dosa, dhatu, mala and agni. Further, Motha reminds the client that it is important to grow a baby that is in keeping with the mother's frame; the adage regarding "eating for two" is obsolete - a pregnant woman only needs an extra 200 calories a day (Motha and MacLeod 2004, p6). As discussed in Ayurvedic approaches to ANC (2.4.1) Datta's (2011) clinical experience shows a pattern of Pitta, Kapha and Vata imbalances in the first, second and third trimesters respectively. As such, she prescribes a customised diet and herb plan to mitigate the dosa that she observes in the individual mother at a specific point in time.

Table 8: Gentle Birth Method Physical Preparation – Individualised Dietary Suggestions made during Ayurvedic Consultation for the Pregnant Mother

(Motha and MacLeod 2004; Motha and Datta 2010; Datta 2011)

Components	Indications	Frequency
Ayurvedic Consultation	Consultation with Ayurvedic doctor: prakriti, vikriti, pulse and tongue diagnosis and prescription of individualised diet and herbs	Either at first or second visit to the clinic with a follow up to review Ayurvedic diet each trimester or every four weeks as required
Ayurvedic Digestives		
Piece of fresh ginger, rock salt and lime juice	Improve digestion	30 minutes prior to meals
Fennel Tea: 2 tablespoons of in 2L of water boiled for 10 minutes	Improves digestion	Fill thermos and sip through the day

Datta may further prescribe herbs to the client. Some of these herbs described are in Table 9. Some herbs such as Bala choorna and Danwantari vati (pills) are suggested in the GBM book and can be purchased from the website <http://www.jeyarani.com/>.

That said, Ayurvedic herbs - though natural - should not be self-prescribed and supervision by a qualified practitioner is recommended by the GBM (Datta, 2001).

Table 9: Gentle Birth Method Physical Preparation – Herbs prescribes to Pregnant Women

(Motha and MacLeod 2004; Motha and Datta 2010; Datt 2011)

Components	Indications	Frequency
Bala Choorna	Vat and Pitta balancing	Every evening
Danwantari Vati	Improves digestion	1 pill/day
Shatavari	Female support	2 capsules 2x/day
Triphala	Relieves constipation	2-4 capsules at night no more than two weeks
Haridra	Anti-inflammatory	500mg 2x/day
Purvanava	Lymphatic drainage	500mg 2x/day

Other supplements recommended by the GBM book and therapists including those in Table 10.

Table 10: Gentle Birth Method Physical Preparation – Supplements suggested during Pregnancy and Labour

(Motha and MacLeod 2004, p11; Motha, and Datta 2010; Datta 2011)

Components	Indications	Frequency
Homoeopathic Tissue Salts	Salt support for mother and baby	1 tablet 2x/day
Pre-labour & Postnatal Homoeopathic kit	Prepare baby and cervix for birth	As directed in kit
Probiotics	Digestion and absorption	2x/day 30 minutes before meals
Omega 3: fish oil, flaxseed or hemp oil for vegetarians	Foetal brain development	1-2 capsules/day
Digestive Enzymes	Prevents bloating	One with breakfast and one with main meal
Pregnancy Vitamins	Overall pregnancy health	As indicated

In addition to the above supplements, an herbal tea comprised of Nettle leaf (*Urtica dioica* fol), Cramp Cut Bark (*Viburnum opulus*), Raspberry leaf (*Rubus idaeus*) and Squaw vine leaf (*Mitchella repens*) is suggested. The tea detoxifies and tones the uterus (Motha and MacLeod 2004, p11).

Maintaining physical activity especially a regular exercise program is recommended as part of the GBM. Motha reminds each client of the physical fitness that is required for pregnancy and birth. Even though the first trimester may require some rest to ensure the establishment of the pregnancy, during the second trimester a regular exercise can be resumed. Table 11 lists the exercise recommended by GBM (Motha and MacLeod 2004, p72). However, similar to Susruta’s contraindication (2.4 Ayurvedic ANC), excessive exercise at any stage of a pregnancy is contraindicated by the GBM.

Table 11: Gentle Birth Method Physical Preparation – Exercise suggested Post 13 Weeks of Pregnancy

(Motha and MacLeod 2004, p11; Motha and Datta 2010; Datta 2011)

Components	Indications	Frequency
Yoga	Increase strength and flexibility	20 minutes/day after week 16
Swimming	Helps foetal positioning	2x/week
Walking	Encourage head to engage	30 minutes/day building up in last few weeks
On all fours and funny walks	Optimal foetal positioning	Regularly from 32 weeks onwards

In addition to Yoga, gentle pranayama is suggested particularly nadi shuddhi or alternative nostril breathing (Motha and MacLeod 2004, p78). If Pitta is very high, breathing from the left nostril in a sequence of pranayama is recommended by the GBM (Datta, 2011).

2.5.2 Mental Preparation

As much as the physical fitness required for pregnancy and childbirth, GBM recognises the importance of mental factors especially those that relate to one's values and beliefs:

In principle, the mental preparation of the program requires just as much commitment – cleaning, toning and exercising the mind like a muscle. But for many mothers, this is the hardest part of the program. A body can be cleaned of toxins, stress and anxieties far more easily than the mind. The laying of hands onto flesh is instant balm, but it takes more than cuddles and massage to console and encourage the mind, especially in our western culture where the media and, let's be honest our family and friends regale us with birth horror stories...The body instinctively knows what to do. It's the fear and anxiety lodged in our minds that gets in the way and causes our bodies to tense up. However, by reconditioning your attitudes towards birth...you can view your mind...as another muscle in your body that you can flex, tone and control (Motha and MacLeod 2004, p87).

Motha further explains the importance of self belief, power of positive thinking and practicing self hypnosis daily to ensure that it become “normal” daydreaming that can consciously be harnessed (Motha and MacLeod 2004, p90). The history of hypnosis is closely linked to obstetrics and was used in the field since the 1830s (Motha and MacLeod 2004, p89). Motha explains that fear is the greatest barrier to experiencing a gentle birth, as fear releases the fight or flight hormone – adrenalin - which causes tightening of muscles and can prevent the cervix from opening and the uterus from contracting effectively. Motha's Pratyaksa is that fear and anxiety can be minimised by the following guidelines in Table 12.

Table 12: Gentle Birth Method Mental Preparation – Guidelines to Minimise Fear and Anxiety during Pregnancy and in Preparation for Birth

(Motha and MacLeod 2004, p88)

Activity	Rational
Deep muscle relaxation	Where physical exercise necessitates the mental capability of escaping and letting go as the physical body releases resistance and labours in the most efficient and effective manner
Self-hypnosis	Enacting the power of positive suggestion towards birth, making the mother feel she is capable of a natural birth hence she feels more in control of the birth process
Safe place	Visualising a safe place to which the mind can escape to mitigate pain during the worst part of the contraction cycle
Visualisation	Seeing the changes taking place in the body during both pregnancy and birth reducing the fear of the unknown
Birth rehearsals	Preparation for meeting the baby and hastening the progress through labour

Mental preparation can commence as early as 12 weeks and ideally no later than 20 weeks by listening to the GBM CD daily supplemented with classes at the clinic for both parents. Motha stresses that the key to mental preparation is practice to ensure that the self-hypnosis becomes instinctive (Motha and MacLeod 2004, p90).

2.5.3 Emotional Preparation

Emotions are the seat of the soul and Ayurveda believes that the soul enters the zygote at the point of conception:

When a man with unimpaired sperm and a woman with unaffected genital tract, ovum and uterine bed cohabit during the period of fertilisation, the jiva (Soul) along with the mind descends into the zygote lodged inside the uterus. This results in the formation of the embryo. It grows unaffected being nourished by wholesome rasa and being managed with proper regime (CS SA III:3; Sharma and Begawan Dash 2005, p366)

Similarly, the GBM promotes bonding with the baby from the moment the mother knows she is pregnant as there is a soul present in her body, which means there is someone to love (Motha and MacLeod 2004, p119).

From day one, when a pregnant women registers with me, I call her a mother, and her partner, a father. By encouraging her to consider herself a mother even before the baby is born, the mother earns to accept her new role and extends a welcome to the baby. Her role as nurture, life-giver and provider has already begun and it is during her pregnancy that she is given the opportunity to cherish this in an emotional capacity. Once the baby is born, the parent's role becomes much more physical – the act of feeding, changing nappies, cradling to sleep and so on. It is tiring and hectic time, but without exception, it is always so much more joyous when the emotional groundwork is already in place (Motha and MacLeod 2004, p119).

Some of the ways suggested in the GBM to build an emotional bond during pregnancy with the foetus are listed in Table 13.

Table 13: Gentle Birth Method Emotional Preparation – Suggestions to Commence Bonding with the Foetus during Guidelines Pregnancy

(Motha and MacLeod 2004, p120)

Suggested Activities
Humanise the baby – don't call it, him/her, 'it' give it a nick name that is loving, fond and intimate and does not need to reflect real name choice
Lather and hug the bump in the shower
Stroke the bump at every opportunity especially during ANC and GBM appointments when you have opportunity to locate the babies hands, feet, face, bottom etc
Gently hum favourite songs, tunes or lullaby
Send love hormones – constant interchange of endorphins between mother and baby can communicate warmth, love and safety. Consider yourselves a little team looking out for each other and working together
When deeply relaxed – visualise baby floating in your tummy bathed in glorious white light – feel the pure light as the baby flourishes inside you
Pore over scan photos – it's uncanny how newborn babies look like their 20 plus week scan photos
Try to have a new thought about the baby every day – imagine first walk together, delight of first smile, first bath etc
Birth rehearsal part of the self-hypnosis and visualisation is bringing the baby a step closer and closer to the mother and father as such the mental and emotion preparation in connect together.

2.6 Research Gap

Novick (2009, p1) highlights that there is still a research need to better understand women's experiences, requirements and preferences in ANC to improve pregnancy outcomes for mothers and babies. Adams et al (2009, p237), in their critical review of the literature for the use of CAM products and therapies, found 24 published papers that met their search criteria under four themes: "user prevalence and profile, motivation and

conditions of use, perception and self-reported evaluation and referral and information sources”. However their review found several gaps in scientific research: use of large scale samples, use of lived-experience studies where women speak about their uses of CAM during pregnancy (rather than survey design) and examining pregnant women’s experiences and perceptions of the benefits and risks associated with the use of CAM therapies and herbs during their pregnancy (Adams et al 2009, p244). Other qualitative studies researching the childbirth experience have focused on specific samples of women such as “Professional Chinese Canadian women (Brathwaite and Willims 2003, p748) or Women’s lived experiences of fear of childbirth” (Nilsson and Lundgren 2007, p2) rather than a specific method of childbirth. Especially not a specific CAM modality of health such as Ayurveda or birth preparations method based on Ayurveda such as the GBM and the experience of those women using the program.

Given the above, there is a need to better understand the “experiences” of pregnant women who use CAM therapies and herbs during their pregnancy. Further, the improvements needed in ANC are not merely the deployment of routine ANC biomedical markers, but rather the need to compliment the medically directed ANC program with stable complimentary programs that will support pregnancy and prepare the body for childbirth. Addressing the gap, the present study – through six interviews - assessed the following question:

What were post natal mothers’ experiences, motives, perceptions and rational for using the GBM?

3. Methods

3.1 Research Design and Approach

This study is a small scale qualitative research project comprised of (1) a retrospective audit of exiting post natal follow-up forms and (2) six qualitative semi-structured face to face interviews with GBM clients.

A qualitative methodology and semi-structured interview technique for data collection and analysis (Hart 2005, p314) was considered optimal for answering the research question as it enabled the researcher to gain in-depth insights into the experiences, motives, perceptions and rationale of the GBM participants. The relatively informal, theme based semi-structured style and interactive interview approach was deemed consistent with the ontological position of gaining insights into the participant's experiences, views and knowledge of the GBM and its underlying AM modality (Mason 2002, p63). Further, the semi-structured interview format was chosen to encourage each interviewee to speak freely, openly and comfortably regarding their experience of pregnancy and the use of the GBM.

Mason (2002, p55) explains a few approaches of qualitative research such as: ethnography, discourse analysis, psychoanalytical and interpretive approaches. An interpretive epistemology was chosen over an ethnography approach as the latter was considered too invasive during a particularly vulnerable period in a woman's life.

Blaikie (1993, p96) explains interpretivism as follows:

Human experience is characterised as process of interpretation rather than sensory, material apprehension of the external physical world, human behaviour depends on how they interpret the conditions in which they find themselves.

Mason (2002, p56) adds that what is unique about interpretivism is that it sees "people, their interpretations, perceptions, meanings and understanding as the primary data source". Unlike an ethnographic approach, first hand experiences are not required; rather, the participants' everyday understandings and perceptions are the required data source making interpretivism an ideal candidate for this study's interview format (Mason 2002, p56).

As discussed, the study is based on interviews with six postnatal mothers and focus is on the interest of women. However, this is not considered a feminist method as it does not address the issues of men's power and a patriarchal regime in the context of

women's pregnancy and birth time. Rather, it assumes a self-evidently gendered approach (Brown and Gilligan 1992, p24).

Measuring validity (internal and external), reliability and objectivity with respect to qualitative or flexible research sparks much philosophical debate: whether it is even needed in creative, open flexible study or why qualitative measurements cannot replicate standard criterion as do quantitative studies (Bowling 2009, p162; Robson 2002, p168; Seal 1999, p34). However, there appears to be broad agreement that some measure to judge the quality of the research must be in place (Seal 1999, p43). Both Seal (1999, p43) and Robson (2002, p168) seem to agree that trustworthiness amplifies the essence of validity and reliability in qualitative research. Seal (1999, p43) points to the work of Lincoln and Guba (1985, p290) as asking the right questions to assess trustworthiness of qualitative work:

1. Trust value – establishing confidence in the ‘truth’ of the findings especially the context in which the inquiry was carried out.
2. Applicability – determining the extent to which the findings of one study are applicable to another.
3. Consistency – determining whether the findings can be replicated in another study.
4. Neutrality – establishing the degree to which the findings are determined by the respondents and the setting of the study versus biased by the motives, interests and perspective of the researcher.

Robson (2002, p174) suggests that the support and peer group should be actively involved in the research project. In this study, the researcher had two supervisors with whom meetings were regularly held and the supervisors were actively involved in the design, sampling, data collection and data analysis for the study - thus mitigating research bias. In addition, a fellow AM student peer reviewed the all aspects of the research project.

3.2 Sampling Strategy and Setting

3.2.1 Strategy

The sampling strategy for the face-to-face interviews was based on a theoretical or purposive sampling. This strategy did not aim to generate a random, probability based group of respondents as it is a small scale qualitative study. However, the study was systematic and rigorous in its depth, complexity and understanding of the participant's: experiences, motives, perceptions and rationale for choosing and consistently using the GBM during their pregnancy (Mason 2002, p121). The birth outcome (natural, assisted or caesarean section) was not considered in sampling. Rather, the key factor was that the client had consistently adhered to the GBM program during their pregnancy as this could in turn be generalised against a larger universe to draw conclusions about whether there is a benefit derived from the GBM as its underlying AM modality. In this respect, six interviews were considered adequate to achieve interview saturation given the scope and scale of this research project. Crabtree and Miller (1991, p145) suggest that it is adequate to use a sample size of 6-8 participants in exploratory qualitative studies in the field of healthcare.

3.2.2 Setting

Five of the six interviews were conducted at the participants' home; the sixth interview was held at a local coffee shop. An hour was set as the maximum duration of each interview to respect the participants' time and for the researcher's practical and economic reasons. Screening included an initial phone call, participation information sheets and follow-up phone calls. Participants were reassured that they could leave the study at any point if they felt uncomfortable and their written consent was gained prior to commencement of the interview.

3.3 Data Collection Methods

Completed PNFUF (Appendix 4) for the year previous to the study were audited with three objectives: (1) analyse the forms, (2) develop a semi-structured interview guide

and (3) generate a short list of prospective interviewees for the study. The audit was conducted over a five-day period at both GBM clinics (St John's Wood and South Woodford). As there were so few completed PNFUF, the researcher asked the GBM therapists for names of clients who had consistently used the method in the past year and then reviewed the clients' treatment records for prospective interviewees matching the inclusion criteria.

The researcher used her field notebook to record data collected from the PNFUF. Questions were evaluated on a cross section basis as well as from beginning to end. Forms were analysed between clients - generating data across each question in terms of percentages. However, as the base was small ($n = 5$), it was deemed misleading and absolute numbers were presented (5 Results).

Initially the study was only open to women who (1) had given birth in the past three months and (2) were within the 31-40 age range. However, this did not generate adequate numbers for a short list of participants and the inclusion criteria were extended to (1) six to eight months and (2) 31-45 years of age. Further, during the design phase, the size of the participant short list was expected to be 24 clients whereas during the data collection phase the short list was reduced to 15 clients.

Prospective interview participants were pre-selected based on the inclusion criteria and seven of the fifteen participants were initially telephoned to assess their interest and availability and gain their permission to review their post natal form and client records. Once this permission was granted and interest assessed, participant information sheets (Appendix 5) were emailed to them with a further follow up phone call or text message to confirm participation in the study and set an interview date, time and location. Six out of the seven participants who were initially contacted agreed to be interviewed and interview dates and times were scheduled in the following two weeks. The seventh participant had left the country.

Interviews were confidential and participant names and data was protected (participants were assigned a simple code and all data pertaining to each participant will remain secure and separate). The semi-structured interview format and questions were approved by both study supervisors prior to being used in the face-to-face interviews.

Following the six interviews, the recorded interviews were transcribed and analysed. The other nine individuals from the shortlist were kept on file in case one of the six participants dropped out of the study. Consent forms (Appendix 6) were signed prior to holding each interview.

3.3.1 Inclusion Criteria

The participants were clients of GBM who had given birth within the previous six to eight months, were first time mothers between the ages of 30-45 and had consistently adhered to the GBM during their pregnancy. Further, they were comfortable to speak openly and honestly about their GBM experience, willing to make available an hour for the interview and able to read and understand the participation information and consent forms as well as articulate thoughts and views in English.

3.3.2 Exclusion Criteria

Excluded from the list of potential participants were GBM clients who were having their second baby, outside the inclusion age range, unable to attend an interview or unable to read, comprehend and converse in English.

3.4 Data Analysis Methods

Four sources of data were used in this study: (1) data from PNFUF; (2) field notes made before, during and after the face to face interviews; (3) tape recorded interviews; and (4) transcribed semi-structured interview transcripts.

The researcher reviewed the section of Mason's (2002) book on analysing interview data specifically her method of reading transcribed interview text: literally, interpretively and reflexively (Mason 2002, p148). However, as the interviews had a natural narrative flow, Mauthner and Doucet's (1998) Voice-Centred Relational Method as detailed in their chapter in the edited works of Ribbens and Edwards (1998) was judged more appropriate for the analysis of this study. Similar to Mason's method of

reading the interview transcripts several times, Mauthner and Doucet suggest reading the transcripts four times:

Reading 1: For plot and researcher's reflexive response to the narrative.

Reading 2: For the voice of "I".

Reading 3: For relationships.

Reading 4: For cultural and social contexts.

(Mauthner and Doucet 1998, p126-132)

Mauthner and Doucet (1998, p131) explain that the first and second reading are typical of a researcher analysing qualitative data. The third and fourth readings were versions of readings as conducted by Brown and Gilligan (1992). Mauthner and Doucet (1998, p130) explain that a key differentiator of the Voice-Centred Relation Method versus Grounded Theory in data analysis is reading for the personal pronoun, which facilitates the process of reflection and decision-making versus the action and interaction of grounded theory. Brown and Gilligan (1992, p25) explain that they were guided by a voice sensitive method and 'listened' to a person's story at least four times.

In this way, we begin to sort out different voices that run through the narrative...we used the term "listening" to describe our way of working because it joins our conversations with the girls with our listening to the audio-tapes and reading over interview transcripts. Our voice-centred approach thus transforms the act of reading into an act of listening as the reader takes in different voices and follows their movement through the interview (Brown and Gilligan 1992, p25).

The second part of the analysis was to break down transcripts, which have been read four times, into a number of over-lapping themes and sub-themes.

It also involved a dialectical process of moving between different ways of organising or representing the data, and between the details and particularities of each one of the individual respondent's experiences and the overall picture of the sample as a whole (Mauthner and Doucet 1998, p136).

Mauthner and Doucet (1998, p134) explain that four readings of the transcripts “emphasizes the multilayered nature of the narrative” tracing the voice of the participant both within and across a particular transcript. It delayed the reductionist data analysis approach of cutting up the interview data into themes and sub-themes immediately, which traditionally is completed by coding the transcripts into pre-existing sets of categories. The four reading approach is lengthy and intellectually complicated for the researcher while better maintaining integrity of the participant’s individual response. Mauthner and Doucet (1998, p135) feel it is a more robust approach to truly listen to the participants - extricating data from the interviews that is new and not simply confirming information that the researcher already knows to be true, which would defeat the purpose of the research study.

3.4.1 Specifics of the readings – stage 1

First reading of the interview text was to listen to the plot and sub-plot specifically the: who, what, why, when and how of the narrative and the story participant is narrating. Most of the analysis was completed manually and coloured pencils were used for each reading / each voice. After completing each reading, the research moved to a worksheet comprised of two columns, which recorded the participant’s words in one column and the researcher’s interpretation of the narrative in the other column. Ideally each of the interviews would have been summarised. However, due to time constrains, two interviews were chosen to create a pen-portrait summary (Appendix 8).

The second part of the first reading was to gain a sense of how the researcher placed herself, how her own experiences, background and history related to the participants. The researcher could not be considered an objective “outsider” as she had herself used the GBM during her pregnancy and is an Ayurvedic Practitioner. Therefore, she was considered an “insider” on both of these counts.

The research found the second reading to be most useful in understanding how the participant spoke about her experiences and how she spoke and felt about herself. The instances where the participant shifted between ‘I’, ‘we’ and ‘you’ during the same

question / thought to express varied experiences, motives, perceptions and rational were particularly insightful.

The third and fourth readings tended to be quicker. Nonetheless, these reading revealed lapses that had occurred during the prior two readings and in this way yielded new insights / information. These readings also shed further light on relationships and cultural and social contexts.

The researcher found the four readings and process of analysis that emerged from the readings more time consuming and intellectually challenging than she had anticipated.

3.4.2 Breaking down the transcripts into themes – stage 2

The themes from across the six interviews naturally emerged from the four reading approach. The researcher maintained a list of themes that she identified after each of the four readings from each interview and then compared them at the end of the process.

This was different from the research design that the researcher had conceived at the start of the project, which was that the interviews would be segmented and coded into pre-existing themes and categories that had emerged from analysis of the PNFUF and the literature review. What the researcher found was that the PNFUF were not that useful and the themes that emerged from the interview data analysis process were more subtle - relating to the mental and emotional aspects of pregnancy and birth preparation – than the physical aspects such as diet, touch, herbs, supplements, visualisation and the like that the PNFUF had initially identified. All physical, mental and emotional elements were present in the interview data. However, the participants' experiences and motives were more cerebral and subtle than physical.

3.5 Ethical Issues and Access

This study was presented for ethical committee review to the Natural Sciences Ethics Sub-Committee (NSESC), Middlesex University, School of Health and Social Sciences and was given final approval (see Appendix 2) prior to the commencement of any data

collection including the review of the post natal follow up forms. Written permission for the project was also obtained from Dr Gowri Motha (Appendix 3).

As discussed in the data collection methods section, an initial phone screening was completed to gain prospective recruits' permission and interest for the study. Participant information sheets were then emailed to them with a follow up phone call to explain the details of the study. Prospective participants were assured that they could leave the study at any time if they felt uncomfortable. Consent forms were signed prior to the commencement of face-to-face interviews and a summary of the findings of the study was mailed to participants who requested them.

3.6 Key Methodological Issues

GBM was chosen as the focus of the study because its underpinning modality is based on AM. Other antenatal programs offered by the NHS or private organisations were not considered relevant as they are not based on AM.

GBM is a private program paid for independently by its clients. One to one sessions with a GBM practitioner costs between £120-180 per visit and excludes the cost of herbs, oils, books, CDs, visualization and yoga sessions and other components of the program. The women using the GBM are therefore generally from a higher than average household income demographic and would not be representative of the national average pregnant women. Further, these women are highly motivated to care for themselves and their growing foetus and especially keen to do the "right thing" for their baby, which again may not fit within a national norm.

One of the key inclusion criteria of the study was to interview women who had had their first birth. This excluded women who participated in the GBM but had already had a child. From analysis of PNFUF, it was noted that women who had already had a child had joined the GBM for multiple reasons: they had experienced secondary infertility, wanted to have a natural birth the second time around or wanted to take more care of themselves and their foetus for the second pregnancy. The rationale for excluding this category was to maintain consistency between the participants and because of an

assumption that women were most concerned and anxious about their first pregnancy as they had not previously had the experience.

The other key inclusion criterion was that the participant had consistently used the GBM program. The rationale for this criterion was again to maintain consistency between the participants as well as to interview women who had had an opportunity to experience the GBM program in its fullest sense and therefore speak with particular focus about their experience, perceptions and motive. This, however, meant that most of the interview candidates were in some way biased to the benefits of the GBM as they would not have continued returning for treatments, herbs and visualization if they had not experienced and perceived some benefits from the program. In this sense, the researcher was in some respects “speaking to the converted”.

The study was somewhat constrained in its scope as it represented the author’s MSc dissertation and she was therefore the only researcher working on the project, had no external funding and was time bound.

4. Results

4.1 Retrospective Audit

The objective of analysing the PNFUF was to (1) develop a semi-structured interview guide and (2) generate a short list of prospective recruits for the study. A summary of these forms are available in Table 14. However, their usefulness for this study was limited as very few forms that had been completed (n=5). The receptionist / administrator at the clinic was of the view that a new resource was required to properly manage the forms and follow up on their completion as the existing process is ad hoc. Further, the forms (Appendix 4) are out of date and the purpose they serve is questionable

Table 14: Summary of Five Post Natal Follow-up Forms completed by Gentle Birth Method Client’s and/or Therapist over the Past Year that were Reviewed Retrospectively

Post Natal Follow-up Forms Reviewed	Form 1	Form 2	Form 3	Form 4	Form 5
Touch Therapies	Used all	CH, Reflex, SH &V	Used all	Used all	Reflex
Herbs/Supplements	Used all	Used all	Bala, Triphala	Probio	Bala, Vati, DE
Diet	Full compliance	Full compliance	Full compliance	Only from 37 weeks late joiner	Partial
Gestation at delivery	37 weeks	40 weeks	40 weeks	41 weeks	37weeks
Order of births	1 st child	2 nd child	1 st child	2 nd child	2 nd child
Induced	Yes	Yes	No	No	No
Hours in labour	3 ½	2	2	2 hrs & 17 min	1 hrs & 20 min
Pain relief	None (Gowri!)	None	None	Gas & Air	Gas & Air
Type of delivery	Natural	Natural	Natural	Natural	Natural
Sex of baby	Girl	Girl	Girl	Girl	Boy
Place of delivery	NHS	Private	Private	NHS	Home
Post natal issues	Jaundice	None	None	None	None
Thoughts on the GBM	Great	Excellent	Love it	Amazing	Wish known before

Notes:

Appendix 4: Full Post Natal Follow up form format

Therapies (Table 5): CH – Creative Healing, Refl – Reflexology

Herbs (Table 8): Bala – Bala Choorna, Vati - Danwantari Vati

Supplements (Table 9): Probio – Probiotics, DE - Digestive Enzymes

2.5.2 Mental Preparation: SH & V – Self hypnosis and Visualisation

Initially, when the researcher was discussing the project with the Motha, she believed that the forms would be a useful place to begin generating themes. However, that did not end up being the case. As Table 14 demonstrates, most of the information on the forms was similar with some minor variations. The forms did deliver one prospective recruit for the interview shortlist but the researcher had to speak to individual therapists, the GBM receptionist and read recent client records to compile the remainder of the shortlist.

4.2 Face-to-face Interviews

4.2.1 Characteristics of the Sample

As shown in Table 15, the six participants were between 32 and 41 years of age (with a mean age of 35.8), professional women with higher than average household incomes. Three out of the six delivered their babies at the Portland Hospital, a private hospital in London specialising in women and children. The other three delivered at NHS hospitals: St Thomas (south London), Chase Farm (North London) and Queen Charlotte (West London). None of the women planned to have a home birth. However, one of the participants scheduled to birth at the Portland ended up having her baby at home by accident. Three of the women had pre-existing conditions (RMS, HIV positive and endometriosis) that could have affected their fertility. The other three had experienced a miscarriage, a gynaecological operation and an idiopathic delayed conception. Four of the women had a doula or Motha present at the births; a fifth wished she had and the sixth was happy with her husband alone. Motha was present at two of the births. All of the women had vaginal births, with a minimum of pain relief (two women had epidurals and two women had gas and air).

Table 15: Characteristic of the Six Women Chosen Through Purposive Sample Strategy to be Interviewed Face-to-Face

Participants	Age	Profession	Conditions	Pregnancies	Started GBM
1	32 years	Marketer at Retail Bank	2 years to conceive – idiopathic	1: Live 1	27 weeks
2	34 years	Sales & Communications Manager	Removed cervical polyp 18 months prior	1: Live 1	22 weeks
3	32 years	Production Assistant	Graves Disease since 2002, RMS	4: RM 3 Live 1	18 months prior to birth
4	41 years	Editor, Counsellor	HIV + since 2000, Asthma	3: Term 2 Live 1	16 weeks
5	37 years	Singer and Musician, primarily for commercials	Mild case of Endometriosis	2: Term 1 Live 1	19 months prior to birth
6	39 years	Musician turned Music Therapist	Miscarriage	2: Mis 1 Live 1	16 weeks

Notes:

RMS – Recurrent Miscarriage Syndrome

HIV+ - HIV Positive

Live – Live Birth

Term - Termination

Mis - Miscarriage

4.2.2 Key Themes from the Interviews

The following four themes - generalised from the six interviews - emerged from the four readings across the data set.

(1) Fear and anxiety of an uncertain or unknown event

All of the women interviewed were first time mothers and thus had not previously experienced a full term pregnancy or childbirth. As such, they were anxious and fearful of the pregnancy and in particular the birth. Using the GBM was an important component of addressing these fears in preparation for the birth.

“I think it’s just that you hear so many horrendous birth stories just not wanting to be like that...It was a great pregnancy...I was looking for something that was going to help me manage a very frightening situation. I was very frightened at the beginning and I got less and less frightened and more and more excited about the idea of giving birth by the end and a lot of that was to do with Gowri and to do with the method.

I would never assume that I would have gone into my own labour without fear and I really didn’t have fear. Which actually nine months or six months previously that was my biggest fear – giving birth and I didn’t have fear.

Ok it was shit it was completely horrendous but I didn’t have fear, which was down to the Gentle Birth Method topped up with a bit of HypnoBirthing” (P6).

For participant six, the birth experience was difficult. She was in labour for sixty three hours as the baby was occipital posterior. However, the physical, mental and emotional preparation that she had consistently followed through the GBM had liberated her from

the initial fear and anxiety that she had felt in relation to the pregnancy and the birth process.

“I do believe in the law of attraction, I do believe in visualisation and all that but at the end of the day its childbirth, you have heard so much about it and you have heard so many horror stories in your life right! I mean it’s normal.

So in the back of my mind I always had this little tiny grain of doubt but after reading that book [Birth without Fear] I really felt like ‘do you know what I can do it’ so it was great. And I have to be honest since I started to go to Gowri’s clinic I never was scared of childbirth I was always excited... part of me wanted to see if I could do it.

So I was quite excited to see what is all this hype that everyone talks about [laugh]. I have heard some good stories as well of some easy births and I always felt I want to see if I can do it.

So it was always a very exciting time for me, even when my water broke we were just “YES” it was almost like when we were getting married I was just excited there was no nerves or anything it was just completely happy moment for me ” (P1).

The mental and emotional preparation helped participant one to become excited about her impending birth rather than fearful of it. She rationalises the normality of being fearful as she distances herself from these horror stories and switches from the personal pronoun I to you. She also switches from “I to We” in discussing the breaking of her waters to indicate that she and her husband were excited. The participant specifically uses the pronoun “I” to indicate instances when she took control of situations during her pregnancy and childbirth.

“I actually had an amazing labour it was five hours...I can’t say I enjoyed it [laugh] well I can I can say it was an amazing intense experience and I was never...its really important I was never scared, I

was never nervous about the actual labour and I think that's partly a combination of things. I think that's partly seeing Gowri and Debbie and also having an amazing pregnancy Yoga teacher who is also a doula and she accompanied me to the birth. So I just knew that...I was just never frightened and I think that was such a blessing not be frightened because then I just didn't worry, I wasn't worried about the pain so I had a really really good labour." (P4).

For participant four, the preparation with GBM as well as having a birth assistant or doula that she was familiar with helped to manage her nervousness and fear especially as she was worried about being in a medicalised situation such giving birth in a hospital.

"I was really focussed on doing whatever may help because I was very nervous about tearing that seemed to be in my head so anything we could do to help that was great. And I didn't tear at all, who knows if that was...who knows but I am going to credit all that stuff" (P2).

Participant two rigorously followed the physical preparation as she wanted to ensure minimum physical damage to her body. However, the underlying efforts made to physically prepare for the birth were ultimately made to mitigate her fear of the pregnancy and the birth process.

"Yes, I truly believe that it was very fast relatively un-traumatic experience because of all the preparation we done and because Gowri was there...To have a first labour be four hours...even at the hospital they were saying 'what you are doing that's unheard of'. But I think it is from all the preparation that we did, all the visualisation and all the treatments, definitely" (P 3).

Participant three had health issues related to maintaining her pregnancies so she naturally had a fear in relation to carrying her baby for the full term and also a fear of birth itself even though these elements were not explicitly vocalised.

“And it was an amazing moment because it gave me such a window into what my labour was going to be like because it don’t make the nightmare go away, not that birth is a nightmare but this kind of...pain and suffering of it didn’t disappear but I saw myself being able to look at it from an outside perspective and say ‘it is going to pass it is going to be OK this is just a moment’. My safe place gave me a distance from it which allowed me to experience it with less kind of tension which then made it much less horrible” (P5).

Participant five caught food poisoning during her pregnancy whilst on holiday with her husband. She was alone when it hit her so she had to work through serious symptoms alone and she ended up practising going to her safe place to mitigate the fear. This was the moment where she realised that she had tools that she could employ to deal with the fear during her impending birth experience and that there was no need to be fearful and anxious of the unknown event.

(2) Feeling of autonomy and active participation – a sense of control

All six participants were highly educated (a university degree at a minimum) professional women who wanted to have some control over their pregnancy and birth experience. Some of the participants expressed this desire during the interview whereas others did not overtly mention it but the sentiment could be inferred by their discussion during the interview.

“And I had a consultation with Debbie for the first time and it all sounded good and I thought alright I will try it for as many times as it seems to be working...I think my philosophy is probably to mix Western and Eastern together and kind of pull from both, and that seemed to work, from going to the Gentle Birth Centre to planning to have a birth at the Portland [laugh]...

Oh and the other thing I have not mentioned is I switched Obstetricians halfway through...I was interviewing different Obstetricians...And I had a list of questions that I asked him as well

as every other doctor from things about episiotomy to water births, rates of c-section blah, blah, blah...

No, I felt really positive to mix and match different things and I don't think that would work for everyone, but for me I was really open to a point from each practice what helped me and what made sense to me and I think it just all came together really well" (P2).

Participant two wanted to actively assess and evaluate all aspects of her pregnancy and birth preparation needing to feel in control of the situation. She interviewed and chose an obstetrician that she felt would facilitate her having a natural birth and also had a doula to support her birth. As she explains, she wanted to choose what she felt was "best" from various birth preparation programs thereby maintaining her autonomy, active participation and control of the pregnancy and birth.

"I was scheduled to have it at St Johns & Elizabeth but then that closed... everyone who was supposed to be there got transferred to the Portland which I felt very allergic to and did not want to do... I spoke to Yinka and Gowri and we decided let's go to the Portland because ultimately...we are a team and we are kind of using it as a hotel room we are renting it in a way because we will do it according to our method and we will just use their facilities.

So it was really distressing I really didn't want to have to take the antibiotics but I did, I had to do it. So every four hours I had to have a drip so that slowed things down. Also I was very pissed off about it and not happy just ahhh this is not what I wanted.

I just couldn't believe I wasn't dilating I was just determined and fierce and I knew that we were going to get there." (P 5)

Participant five knew the exact type of birth she wanted. She did all the preparation and planning and had assembled her team of experts to support her during the birth. She had planned to labour at home and come to the hospital for the birth. However, her

situation changed as the hospital insisted she have an antibiotic drip which changed her preferred environment. She could not believe that she was not dilating yet she persisted, supported by her team of experts. It took 38 hours but she had the natural birth that she wanted.

“And I had also done all the readings...from HypnoBirthing books and the Gentle Birth Method I also read books like What to Expect When You Are Expecting, I thumbed through that... I don't take it too seriously because they talk more about horror stories, I flip through those pages and I don't really pay attention.

Then we went to the hospital and you know we went with the idea that we were not going to come back, we were not going to be sent back home... So this woman is sitting there and I am having contractions obviously and she is asking me about drugs and all that, and I was: I told you I don't want this and that and she wasn't listening so at the end I just put on Gowri's CD and I ignored her [laugh] while I was having contractions. So she did whatever she wanted to do” (P 1).

Participant one had gone to great lengths to brief the midwives at the hospital and had written her birth plan. However, when she arrived at the hospital her notes had not been passed to the midwife on duty, she did not have a doula present at her birth and decided to ignore the hospital staff to maintain her “zone” – that is, stay in her safe place and ignore the unsympathetic, ill-prepared midwife.

“So there was a huge amount of research that we did flow charts and spread sheets of the pros and cons...we found so much research...I said I am going to be a pain again and they said we know you are going to be a pain again, we know you are a pain [laugh]...So I would challenge them the obstetricians.

Because I sort of was nervous about being in a hospital setting that suddenly things might get out of control and my partner and I might not know or being in labour might not sort of have the ability to say

hang on a minute. So that's why I think I having a doula there that is also just very clued up on the medical side of things just made me feel confident.

I knew I was going to be in a hospital setting where it was medicalised so sort of informing myself so that I felt more empowered I think ” (P4).

Participant four had underlying medical issues and she and her partner did extensive research to inform themselves such that they would have a sense of control at those points when the hospital staff sought to dictate the process. She specifically chose to have a trusted doula at her birth to help her manage the hospital protocol.

“And if I had stuck with Gowri's crawling on the floor...I didn't do the crawling at the end because every single antenatal thing had said that he was lying to tummy...And I think he turned back to back right at the end and I stupidly didn't follow through because I did so many things, the funny walks its quite a catalogue its like an exam, I had a whole exam timetable I swear to you I had like a revision timetable. I wish I hadn't thrown it away because you could have it as a hilarious appendix, it literally was every single day was on the horizontal axis and then on the vertical there was...how much wheat, how much glutton, how much sugar, how much fruit...whether you had done 20 minutes yoga...whether you done the enema, whether you done the vaginal stretching...I mean literally, and I ticked every single day in the last month I would tick every single day what I had done...I was meticulous” (P 6).

Participant six was fastidious in her planning and preparation for pregnancy and birth. She wanted autonomy and active participation in the process as a means of gaining control to contain her fear, anxiety and helplessness.

(3) Women helping each other

Four out of the six women interviewed had either Gowri or a Doula at their births to support them in addition to their partners. But it was not just during the birthing process but also during the pregnancy that the participants found it useful and nurturing to be supported and cared for by other women

“...Increasing so as the pregnancy continued it was extremely helpful in terms of support and in terms of calming me down. Because I am quite an anxious person and I was definitely neurotic in my pregnancy about mainly putting on weight and about the birth...Gowri and her team, at calming me down...Especially when you haven't got your family and you haven't got your community around you, you just need...but unfortunately you have to pay for it. Gowri is not money... she had got such a good heart and such integrity and that really came out through for me at the end when I was very anxious and needing...

My birth was absolutely horrific from start to finish unfortunately...but I am sure that if Gowri had been there or if I had more help then it would have been a lot better.

No it was just my partner and me. And Gowri was really anxious as well she said 'you really must have somebody with you' and I said No because my partner didn't want anyone there. But I wish I had because they would have been able to placate me and someone could tell me what was happening” (P6).

Participant six found the GBM program, particularly the treatments, useful as she felt cared for by other women. Not having other family in London it was useful for her to have this support network during her pregnancy. She wished that she had a birth assistant / companion in addition to her partner at her birth. She plans to have a doula present at her next birth.

“...but it was sort of doing the reflexology which was wonderful...I think Debbie is quite a good balance with Gowri because she seems a bit more pragmatic...Once I went there and I think there were three people doing treatments. I think Gowri was doing something, Dr Seems was talking to me and somebody else...was massaging me...And I thought ‘oh this is just so...I felt so pampered it was just’...Yes I think it’s a very nurturing environment there. And I did the HypnoBirthing class as well.

I thought I would like some support through the pregnancy and I like the idea of exercising, that whole thing about exercising, eating well, just the overall philosophy...chimed with me.

What was amazing was I felt this real connection to other women who had given birth such a deep connection to ancient women down the line it was so powerful and I just felt really...I felt surrounded by women who had done it before, where I was, and I just thought ‘gosh what an amazing thing we do really’ it’s amazing” (P4).

The various aspects of the GBM made participant four feel cared for, contained and pampered during her pregnancy. She had a doula during her birth (see quotes from above themes) and experienced a tangible sense of connection to the women both present and past in her life.

“Yes I think I had a great pregnancy and I wouldn’t have anticipated that I would be someone who would enjoy being pregnant...I would have thought that it would be a pain in the arse and I wouldn’t feel great...Yes I think it was a nice experience all around and I would say each element added to it. And then having the doula for me was something that was positive in the pregnancy because we had a few meetings with her leading up and I think I felt positive about going into the birth with her support. Because being our first baby to me having the doula was very important, to have someone who knew what was going on” (P2).

Participant two consistently followed the GBM program and visited the clinic regularly but also supplemented this with treatments from other women as she lived a relatively long distance from the clinic. She felt thoroughly supported by the women involved in her pregnancy and therefore was surprised at the extent to which she enjoyed the experience.

“So I was having weekly treatments of reflexology and cranial and visualisation, the whole experience. And I continued to have weekly treatments throughout my pregnancy...with Sarah or Kasia or Debbie. I did see Gowri quite often as well. We did quite a lot of visualisation stuff especially in the early stages of pregnancy...Yes and to sort of make sure that this one was a successful pregnancy...There was one session where I had three people doing stuff for me.

Gowri was at the birth which was wonderful and it was brilliant because it was complete chaos up there and they didn't believe I was in labour and they were going to send me home...I think I would have been in complete and utter panic if she hadn't been there” (P3).

Participant three has been diagnosed with RMS and Graves Disease. The support and treatments received from various women at GBM as well as visualisation provided her with the physical, mental and emotional resources to believe that the pregnancy was going to be work and that she was going to be able to carry the baby to term. Further, Gowri was present at the birth, taking care of the participant and providing her with a sense of confidence that things were as they should be.

“Gowri said we have a twelve week program... I think I followed it pretty religiously. There were a few times I fell off the wagon [laugh] I guess you could call it...But the ladies that I was working with...it was a rotation of Sarah, Debbie and Kasia and every time I had a massage I would chew their ear off and get lots of great advice about how to stick to the diet, alternatives I could do. And sometimes I

would be more stressed out and Debbie would give me a visualisation. It was great; they were really very very supportive.

I went weekly yes which was the highlight of my week [laugh] how can it not be when you have such great masseurs and great advice.

I had gotten myself in that zone and then my doctor came and I think when she came I finally let go and I felt like I could just relax. Because I really wanted her there because she give me tremendous amount of support and comfort and I know whatever she says is true and I have a lot of confidence in her” (P1).

Conception for participant one took approximately two years (idiopathic) and she decided when she fell pregnant to enjoy her pregnancy and do whatever was required to take care of herself and the baby and prepare for birth with women obstetricians she felt were competent and trustworthy.

“So Yehudi and Gowri were very much working together... I found very very helpful and I thought that was amazing that Gowri though she is very anti intervention on a kind of cellular level, she is also a doctor and understands the value...is very happy for that to be in conjunction when it is needed.

My husband and I took the course with Debbie...and then Sarah did lots of reflexology but she would always do it with Gowri.

The contrast in her [Gowri]... is so interesting because she come from this Western background her father was a doctor... she has got this grounding and intellectual scientific mind on one hand and on the other she is one of the most lateral thinking people I have ever met.

It just felt very impersonal to me and that was another reason why the Gowri factor was really important to me and I asked her early on if

she would be at the birth because I just was like I need my advocate with me or my compadre with me.

He [obstetrician] turned to Gowri and said ‘Gowri do your magic’. So Gowri...you can’t believe, I mean she is what 66 or something she did not leave my side for 38 hours. I know it makes me want to cry. She was just so incredible and she was alone she didn’t have anybody with her, she did cranial she did reflexology...she was on her hands and knees she was so unbelievable.

I felt really present...I know for a absolute fact that if Gowri or someone like her not been there it wouldn’t have...” (P5).

Gowri and her team at the GBM worked with participant five for nineteen months before she gave birth as she had a known case of mild endometriosis. Gowri was also with her during her birth as was part of her “team” – her team - as the participant wanted to feel that she was going through the process of pregnancy and birth with the same group of health care workers.

(4) Truly believing in what you are doing

Just as the GBM preparation encompasses physical, mental and emotional elements, believing in the GBM system and process is important for success even if it is merely a placebo effect. All of the participants believed in the system and the process. Moreover, they were paying for the service, which would not have been rational had they not felt the benefits of the program.

“But again I think it is the whole thing about just believing that you can have a good birth helps...And I listened to the CD But I only listened to it once. I had the CD and I felt...I don’t know whether it’s just a sense of trust, maybe for some of it, I don’t know if I was going to have a natural birth and some of it was just ‘oh it will be fine’...”(P4)

Participant four was HIV positive for nearly twelve years when she fell pregnant and she knew that her pregnancy would be complicated. She completed extensive research so that she could ensure that her pregnancy was managed correctly by her obstetric consultants. Further, she was unsure if she was required to have an elective c-section due to her medical condition. However, she felt that she wanted to trust the birthing process more intuitively rather than analyse it once again but she did believe that with all of the obstacles if she was still permitted by the hospital to try for a natural birth then it was all going to be OK.

“Because I had never heard of Gowri or the Gentle Birth Method...I met Gowri and we sort of clicked...we worked together. And there is always the sceptical part of you thinking ‘what is this’ but the ultimate goal was to have a happy, healthy baby and at that point I was willing to try everything. If someone had told me to take a bath in Yaks milk under a full moon I probably would have done so [laugh]. It was a happy coincidence that we were introduced and it was something that worked for me...

The only thing is that there is always a part of me that was always sceptical about you know any kind of dietary thing that were told to me. Because Dr Seema would tell me some really quite far out things to try and the visualisation...but I think having gone through it I can hand on heart say that everything that I was told to do worked...worked for me...but I think if you truly believe in what you are doing and why you are doing it...

I think Gowri’s belief in everything and the practitioners that work for her their belief in it helps it to work. I think if you are not going to embrace it fully then it’s not going to work for you...But I think you know was truly wonderful thing to discover and I truly believe that we won’t had our baby if it hadn’t been for Gowri and the Gentle Birth”
(P3).

Participant three desperately wanted to hold her pregnancy as she had three recurrent miscarriages. However, she was also a rational-minded professional coming from a family of medical doctors – her father was a consultant dermatologist – so she was inherently sceptical regarding approaches outside the conventional Western norm. Nonetheless, she could feel the benefits of the program particularly the mental and emotional preparation such as visualisation that she could carry her baby to term. During the interview, she confirms that she is a “picky eater” and found it easier to “eliminate” foods out of her diet than add new foods and herbs to her diet. However, she believed in Gowri, her team and the method and she was successful in her goal.

“Child Birth without Fear and what I love about this book...says that our ancestors never needed drugs and nobody was fearful of it...And so that gave me a lot of confidence that it’s not something that’s really required it’s just because society almost dictates it. And in general I believe in the Law of Attraction and I believe in all of this ermm thinking positively and visualising and if you visualise it enough it will come...So I was really able to follow the mental part of Gowri’s program pretty easily because I believe it, I really did believe that if I visualise it, it would all happen...

And another thing that I love about Gowri’s method is that it talks about...its almost like a partnership between her [baby] and myself ...I would always talk to her and say we are going to have a very big day and it’s a partnership and it’s our first thing we are doing together as a team” (P1).

Participant one inherently believed in the mental and emotional preparation aspects of the GBM. She is a South Asian living in the Diaspora and a vegetarian; she went for treatment on a weekly basis and really believed in the plan and followed it “religiously” as she stated during the interview. Not that one needs to be vegetarian and south Asian to follow the GBM program. However, her cultural roots made the follow-through more seamless. Further, it had taken her two years to fall pregnant and she made a commitment to enjoy her pregnancy.

“And then kind of when I realised that the epidural wasn’t going to work and I realised ‘oh fuck it, it hurts anyway’... so I REALLY went inside to the safe place and that really it was that moment that I employed that with every shed of energy that I had. And it was just like I have got to use that because it is the only thing I have got. And it really worked it really was amazing and also having my mother, my husband and Gowri there they were like this amazing team.

I actually really...it was like one of the most unbelievable magical experiences of my life and it really didn’t matter that it was so long” (P5).

Participant five’s birth was long and, in her words, required “perseverance on every level”. Yet she believed that she had done all the preparation - physical, mental and emotional - during her pregnancy to prepare for a natural birth. She has assembled her team; even though the location was not ideal for her (Portland) she knew that she had created an environment for success to the best of her abilities. By staying focused, she did have a natural birth even though it required 38 hours and the hospital machine was pushing her to have a c-section.

“...just that I think Gowri is quite a special person and I thinks she is very generous I thought initially that she was a but of a guru phenomenon and I am always a bit wary of that and I was also slightly worried about money. And all the homoeopathy I find really dodgy, I think it’s a dodgy thing that people pay for that actually is nothing, it’s just a pill of sugar...I went in very sceptically interestingly and actually the first time I went in there and I saw Debbie and she was lovely and it was just a really nice place, nice comfortable place to go back to” (P6).

Participant six has worked in research and was very analytical about the scientific basis for treatments and sceptical about the GBM program. However, after following the program during her pregnancy she could feel and notice the difference it made to her -

making her feel less anxious and nervous and calming her down. She even took some of the Homeopathic remedies during her labour that Gowri had given her.

4.2.3 Case Summaries

See Appendix 8 for two interview summaries.

4.2.4 Summary of Key Results

As discussed in section 4.1, the PNFUF did not yield many useful results. By contrast, the six semi-structured interviews identified the four key themes presented above:

- (1) Fear and anxiety of an uncertain or unknown event.
- (2) Feeling of autonomy and active participation – a sense of control.
- (3) Women helping each other.
- (4) Truly believing in what you are doing.

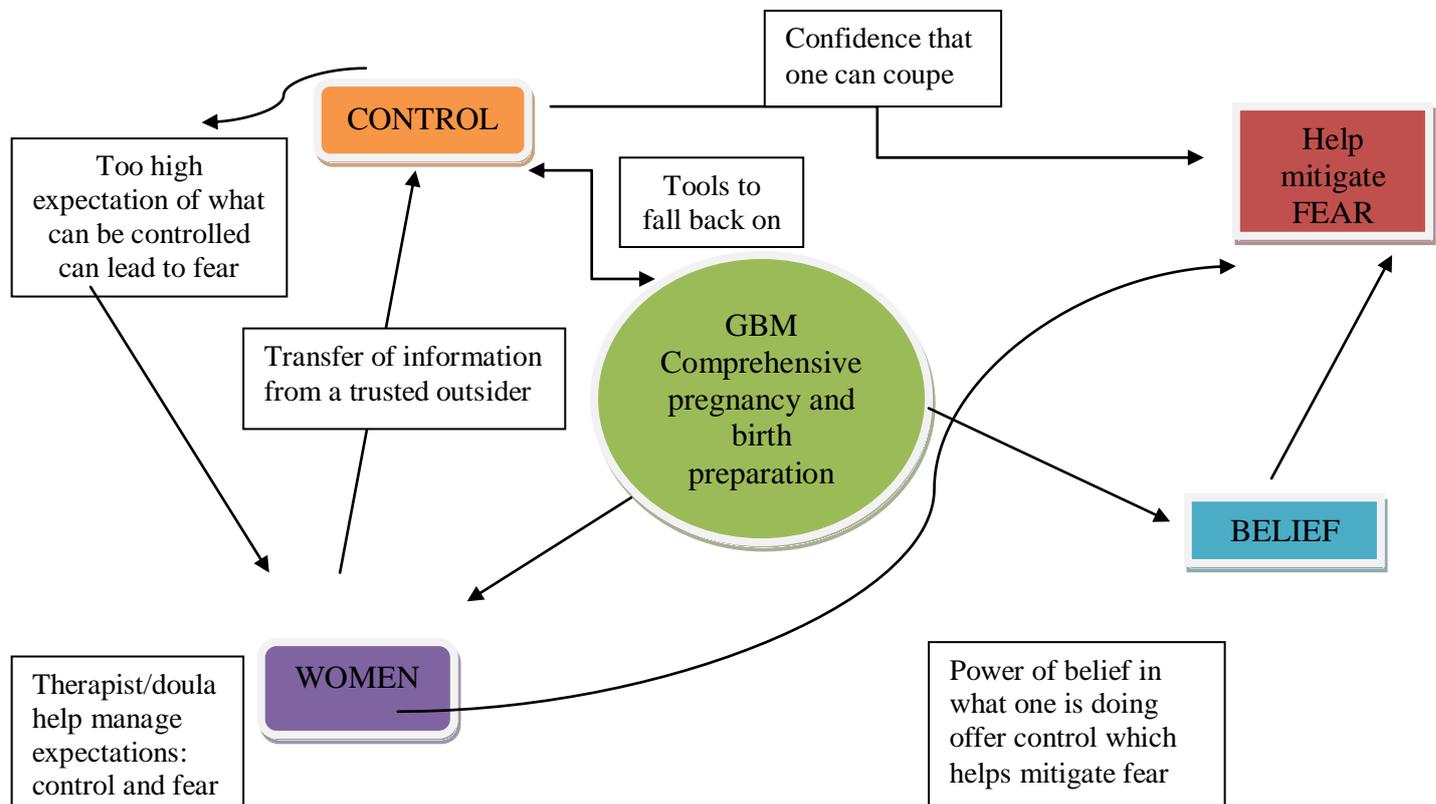
The participants believed that the GBM helped take care of themselves and their babies during pregnancy and gave them tools to assist with the birth process. All of the participants felt that the GBM prepared them physically, mentally and emotionally mitigating their fear of pregnancy and childbirth. It gave these professional women an opportunity to feel autonomous, participate actively and assume control of their pregnancy and birth experience. If nothing else, they felt well informed, well cared for – nurtured - and developed tools for the labour as well as beginning the initial bonding with their baby. The participants all noted that they would use the GBM again for subsequent pregnancies.

5. Discussion

This study is a small-scale qualitative research project interviewing six postnatal women who have consistently used the GBM. The sample size is adequate for use in a small-scale qualitative study in the field of healthcare (Crabtree and Miller 1991, p145). However, it is unlikely that the women are representative of pregnant women in the relevant geographical area (the UK) let alone the rest of the world. The aim of the purposive sampling strategy was to gain in depth insights into the participants' experiences, motives, perceptions and rationale for choosing and continuing to use the GBM during their pregnancy (Mason 2002, p121).

Figure 1 shows the connectivity between the four themes emerging from the study ((1) fear and anxiety of an uncertain or unknown event; (2) feeling of autonomy and active participation – a sense of control; (3) women helping each other; and (4) truly believing in what you are doing):

Figure 1: The Connectivity between the Four Themes That Emerged From the Face-to-Face Interviews with Six consistent Gentle Birth Method Participants



The GBM structure and acquisition of knowledge was comprehensive and helped the participants to feel in control of their pregnancy and birth experience. The control aspect helped the participants to mitigate their fear and anxiety of pregnancy and birth. The information and support provided by women helping each other also facilitated the participant's feeling more in control of their pregnancies and birth experiences, which again looped back to mitigate fear during pregnancy and labour. The women in the study had bought into the GBM and truly believed in the physical, mental and emotional birth-fitness program, which further offered them control of this unknown situation and helped to reduce their fears. In this way, the findings from the study link together.

5.1 Fear and anxiety of an uncertain or unknown event

This study found that the participants were initially fearful and anxious of their pregnancy and birth. These findings are in keeping with other research, which found that some degree of stress and anxiety was commonly associated with pregnancy and childbirth (Bastard and Tiran 2006, p48; Tiran and Chummum 2004, p163). Further studies have shown that antenatal anxiety has been linked to foetal development that can have lasting impact on the child's psychological development (Bastard and Tiran 2006, p48). Motha suggests that fear is the greatest barrier to experiencing a gentle birth as it releases the fight or flight hormone – adrenalin - that causes tightening of the muscles and can stop the cervix from opening and the uterus from contracting effectively (Motha and MacLeod 2004, p88).

The participants in the study found that the physical, mental and emotional preparation prescribed by the GBM enabled them to enjoy their pregnancy and anticipate the birth experience with excitement rather than fear of an uncertain event. The more comprehensively the participants followed the GBM the more they tended to enjoy their respective pregnancies and become less fearful of their impending births - even becoming excited about the birth event. Moreover, they maintained their happiness as the pregnancy continued, which supports the Ayurvedic belief that maternal happiness is a key ingredient for a healthy pregnancy (KS CI II: 14-15; Tewari 2002, p165).

Ayurveda stresses that the expecting mother must be looked after and kept happy so that the foetus is in turn happy and healthy (SS SA X: 3-4; Murthy 2004b, p152).

“The pregnant woman should be protected just like a vessel filled with oil to the brim is protected, without any shaking” (AS SA 2:38; Murthy 2005, p31).

The physical treatments involved in the GBM - a combination of massage, reflexology, picchu, enema, diet, herbs, supplements, yoga and walking - support women with a consistent program that in turn mitigates expecting mothers' fear. Studies have shown that massage increases the stimulation of endorphins that benefit not only the mother but also the foetus (Bastard and Tiran 2006, p50; Cassar, 2001 p 12). Other studies that used mind-body interventions such as meditation and yoga found that the treatment group had higher birth weight, shorter length of labour, fewer instrument assisted births and reduced perceived stress and anxiety. Four out of the six participants in the study had their babies at term; the other two babies arrived at 37 and 38 weeks, which is post requiring incubation and thus essentially a term delivery.

Kasyapa explains the importance of a wholesome diet and lifestyle for the mother as her body habituates to the growing foetus (KS SA V:11-14; Tewari 2002, p141). Similarly, the participants in the study followed in a consistent way the customised diet recommended by GBM. They did not consider it an inconvenience to their pregnancy but rather embraced it. Some of them admitted that there were times when they “fell off the wagon” yet they stuck to the program. During the research design phase of this study, the researcher had anticipated that the themes that would emerge would relate to the physical preparation for pregnancy and birth particularly following the customised diet, treatments and aspects such as utilising the enemas and picchu that may seem foreign to 21st century London women. However, the participants were very motivated to maintain these aspects of the program. It was as though the participants had bought into the physical preparation and were more interested in discussing the subtle mental and emotional aspects of the experience especially when recounting their birth stories.

Most of participants mentioned that they had heard horrendous birth stories from their friends or through the media. During the interviews, the participants tended to distance

themselves from these stories typically switching from the personal pronoun “I” to “you”. All of the participants believed that they were not ultimately fearful of the birth experience because they were birth-fit having followed the GBM. The mental preparation – particularly the visualisation of the birth experience - and practicing going to a safe place ensured the participants had tools, which they were able to utilise when the birth experience became difficult (Figure 1). Further, visualisation helped commence the emotional connection with the foetus.

These findings are in keeping with the literature in which Motha points out the close and long-standing connection between obstetrics and hypnosis. She states that self-hypnosis must be practiced daily to ensure that it becomes second nature to the pregnant woman, who will instinctively tap into her safe place or zone during the most challenging contractions (Motha and MacLeod 2004, p90). Further, the self-hypnosis and emotional preparation begin to build bonds with the foetus even before the child is born. Participant one mentioned that she often spoke to her baby during her pregnancy - referring to their “big day” (see quote on page 68 Section 4.2.2. Theme 4) which meant that she had already formed a close bond and partnership with her baby. Ayurveda states that the soul and the mind of the baby descend into the zygote at the point of conception (CS SA III: 3, Sharma and Begawan Dash 2005, p366) and thus the importance of appropriate diet and lifestyle practices for the baby as much as the mother. Moreover, mental and emotional preparation and happiness of the mother will ensure a healthy and happy baby (CS SA VIII:21; Sharma and Begawan Dash 2005, p464).

AS SA 2:11-12 notes that even the unhealthy desires of the mother should be fulfilled by combining the unhealthy desires with healthy / wholesome ones. The importance of fulfilling these desires, according to AS, is because they originate from the foetus and are expressed through the mother and not fulfilling them can lead to aggravation of the mother’s Vata (Murthy 2005, p21). As discussed in section 2.4.1 of Ayurvedic Approaches to ANC, Vata is the most virulent of the three dosas and can cause the most harm to a mother and baby as it can lead to “premature expulsion and undue retention of the foetus; and morbidity of the semen and foetus” (CS CI XXVIII: 34 Sharma and Bhagwan Dash 2009, p29). Further, diseases of Vata relate to the body’s nerves and imbalances in Vata especially Prana Vayu can lead to fear, anxiety and nervous tension

which are detrimental to a gentle, natural pregnancy and birth (Lad 2002, p48). At its essence, the primary focus of the ANC of Ayurveda is to manage and sustain Vata and its sub-dosas through the period of change for both the pregnant woman and the foetus.

5.2 Feeling of autonomy and active participation – a sense of control

The participants in the study felt that the GBM gave them a structure, process and program during their pregnancy that helped them feel empowered, giving them a sense of autonomy and active participation, which led to a sense of control over both their pregnancy and birth situation (Figure 1). The GBM informed them about what to expect during this “new” phase of their lives – none of the participants had carried a baby to term before. This information and knowledge was imparted by the GBM through multiple channels: the books and the website, during consultations at the clinic, speaking to the women therapists at the clinic during treatments, Ayurvedic diagnosis with Sema, consultations with Gowri, visualisation classes with Debbie and listening to Gowri’s visualisation CD daily. In addition to the GBM, the participants actively acquired knowledge themselves through reading pregnancy and birth preparation books and multi-media sources and through word of mouth - speaking to women friends, family members, doulas and obstetricians.

These findings are in keeping with other studies. Gibbins and Thomson (2001, p307) found that the women in their research on the labour experience wanted to take an active part in the labour process and have a greater sense of being “in control”. This was expressed in three ways: (1) control during the labour process, that is, its duration; (2) participation in decision-making and management of labour and birth; and (3) control over emotions and behaviour. Having control in these ways gave the women confidence in their ability to cope with labour - culminating in a more positive birth experience. The women found support for their desire for control through supportive partners, positive attitude midwives who were caring for them during pregnancy and birth and information that they were given during pregnancy and birth to facilitate decision making and preparation for labour. The women also sought information through parent-craft classes, discussions with friends and family, birth plans, reading books and watching videos (Gibbins and Thomson 2001, p308).

However, believing that one has control of the pregnancy and birth experience can be nebulous and lead to unrealistic expectations particularly regarding the labouring process, which can be unpredictable even with the best preparation, the most sincere of intentions and strong support during the birthing process - as Participant five experienced. She commenced her GBM program nineteen months prior to the birth, she had hand-picked her birth team, she had a good pregnancy but then discovered that she had a Strep B just as her waters broke and the hospital insisted she have an antibiotic drip (see quote on page 59 Section 4.2.2. Theme 2) which meant her team was no longer in control, the hospital was.

Other studies have found that women's fear of pregnancy, childbirth, previous loss of a baby, lack of support and unrealistic expectations can manifest as symptoms of anxiety for the pregnant woman (Cote-Arsenault 2003, p623; Melender 2002, p101). In the case of Participant five, her expectations of control could have led to a negative outcome of fear and anxiety during the birthing process. Her birth lasted 38 hours and she was dilating slowly which could have been a result of unexpressed fear and latent anxiety. However, the support she received from her mother, husband, Gowri and her obstetrician during the birthing process and the tools she had acquired during her pregnancy, particularly visualisation of her safe place, helped her to achieve her goal of a vaginal birth. Similarly, Participant one had a pre-existing view of how her birth would unfold:

“I read that not everybody's water breaks immediately and sometimes contractions start...So I had this romanticised ideal of how birth and labour should be and it would start with the water and then follow with contractions and then us going to the hospital and all that stuff”(P1).

However, when she and her husband arrived at the hospital the midwife had not been briefed about her birth plan (see quote on page 60 Section 4.2.2 Theme 2). Participant one's romantic view was dealt a swift blow. Yet with the support of her visualisation tools acquired from the GBM she was able to withdraw into her “zone” by listening to Gowri's encouraging voice long enough to facilitate dilation and arrival of her supportive obstetrician (see quote on page 65 Section 4.2.2 Theme 3)

5.3 Women helping each other

The participants in the study found weekly contact with a female therapist at the GBM clinic useful particularly given that most of them were living away from family and therefore lacked the sense of comfort and being cared for by family members. The women helping each other had multiple roles, which provide the participants with the feeling of being contained and looked after. Participant four recalls an appointment at the GBM clinic (see quote on page 63 Section 4.2.2. Theme 3) where three therapists were treating her simultaneously which meant she felt utterly cared for pampered and thoroughly nurtured.

This is in keeping with Ayurveda - Vagbhata's AH SA (I:43) states:

The woman, who has conceived should be looked after affectionately by her husband and attendants, supplied with things that she likes and which are good for her health, nourished with more butter, ghee and milk, always (Murthy 2004, p368).

Another role of the GBM was to pass on information about: pregnancy process, birth, GBM program, visualisation and self-hypnosis - going to that safe place, ideas and best practices to stay on: the diet, the regime and the lifestyle. As Participant one explained she would “chew” the therapist “ear off” during her appointment at the clinic see quote on page 64 Section 4.2.2 Theme 3). These findings are in keeping with other research that found that pregnant women informed themselves through ANC classes, discussions with friends and family, birth plans, reading books and watching videos (Gibbins and Thomson 2001, p308).

The participants in this study found the consistency and continuity of care and support essential as it helped develop a trusting bond with the GBM. In this context, asking one of the GBM members to be present at the birth was a natural extension of the GBM program and another instance of women helping each other. Participant five recounts how she found the NHS process of seeing a different midwife and obstetrician at each visit “impersonal” especially not knowing who was going to be present at her birth

inconceivable and assembled her personal birthing team (see quote on page 65 Section 4.2.2 Theme 3).

In this way, it was seen as important to have a trusted, non-judgmental third party – such as a doula or GBM team member - to support the participant during the labour process. This particularly relevant for the participants as they were experiencing their first birth – each navigating their way through uncharted personal waters. This was captured by Participant two (see quote on page 63 Section 4.2.2 Theme 3) who expressed how “important” it was for her to have her doula present at her first birth just so she had someone she trusted and someone who knew the process. The trusted, objective third party played another role – that of maintaining a familiar environment during the labour process as the labour was moved from the home to the hospital and thereby helping the labouring mother to feel a sense of control, which in turn helped to mitigate her fear and facilitated an easier, natural birth (Figure 1).

These findings are in keeping with Ayurvedic literature, which even specifies the character of the women who should be present at the birth. There should be “female attendants who are multipara, affectionate, constantly attached to the lady, well mannered, resourceful, naturally disposed to love, free from grief, tolerant of hardship and agreeable must be present” (CS SA VIII:34; Sharma and Begawan Dash 2005, p491).

5.4 Truly believing in what you are doing

All of the participants believed in the GBM system. They were all educated, professional women who were highly analytical and generally sceptical about “unusual things”. As Participant three mentions she was “always sceptical” (see quote on page 67 Section 4.2.2 Theme 4) which meant she believed in the validity of the GBM process and its proponents. In this sense, buying into the physical components of the GBM - diet, herbs, supplements, touch, enemas - was not the biggest challenge. The real obstacle was being able to believe and then to practice the mental and emotional aspects of the GBM – allowing one-self to enter the safe place and trusting that, during labour, this would suffice. The participants’ comments illustrated the importance of truly believing that the preparation they were doing during their pregnancy on the mental and

emotional as well as physical fronts would facilitate a gentle, natural birth. As expressed by Participant five who was required to access her safe place as her epidural did not take (see quote on page 69 Section 4.2.2 Theme 4).

In her writings, Motha emphasises the importance of self-belief, positive thinking and practicing daily self-hypnosis to the point where one has the capacity for “normal” daydreaming that can be consciously harnessed rather than remaining in the subconscious mind. She explains that the history of hypnosis is closely linked to obstetrics and was used in the field since the 1830s (Motha and MacLeod 2004, p89).

The interviews suggest that for the participants believing in themselves and believing in what they were doing empowered them and gave a sense of control and confidence that they can cope with the pregnancy and birth thereby mitigating fear (Figure1). This is in keeping with other research studies (Nilsson and Lundgren 2007, p4) and is significant given that one of the key themes drawn from the interviews was that fear of childbirth affects women, who experience self-doubt and feel insecure about their capabilities to bear and give birth to a child.

The authors of the Brihatrayi and Kasyapa, classic Ayurvedic texts discussed in the literature review, refer to the importance of maintaining the happiness of the pregnant woman as well as looking after her very well (2.4 Ayurvedic Approaches to ANC). Given that the historical and cultural context in which these books were compiled, the ideas would not have been cast in the guise of the importance of “believing” in the diet, lifestyle, herbs and practices that Ayurveda recommends because this was inherent in the AM medical system of that period, that is, belief in the approaches reflected in the GBM were an assumed part of the approach to medical care generally and pregnancy and child birth in particular. In addition, the researcher used English translations of the original Sanskrit texts and there may to a certain extent be a level of subtlety that is lost in the translation.

5.5 Implications for the practice of Ayurvedic Medicine and the Gentle Birth Method

The interviews revealed that many of the participants did not necessarily relate the GBM with AM even though most of them had had a consultation with Seem at the clinic or seen her during some of their treatment sessions and read about their dosa types in the GBM book. Four of the six participants had awareness of Ayurveda prior to their contact with the GBM and had consulted with an Ayurvedic Doctor or had Ayurvedic treatment during a holiday in India or Sri Lanka. Perhaps this was Gowri's intention when the GBM originally commenced as there would have been limited awareness of Ayurvedic medicine in the UK at that time. However, as awareness of Ayurveda has grown and with it becoming a legislatively-regulated CAM therapy in the UK (<http://www.apa.uk.com> 2008), it may be useful and of interest to prospective clients to make the links more explicit.

The results suggest that the GBM could more strongly promote its doula service or the service of one of its therapists being present at the birth – as this would offer the continuity that Caraka suggested during the birthing event (section 2.4.4) Moreover, it appeared from the results that it was mostly Gowri who attended labours. As participant five noted, this might become more difficult for Gowri in the future. Therefore, specifically promoting the services of the other members of the team would be useful. During the interviews some of the participants noted that the GBM and Gowri were synonymous. Gowri is intricately linked with the GBM and it would appear from this study that without Gowri's leadership the GBM would cease to exist. As such, it is important for Gowri to locate a successor for her practice who has the knowledge and credibility to maintain the GBM and who she can mentor well in advance of her retirement.

As discussed in Section 2.4.2, the ethics of prescribing herbs to pregnant women must be considered before they are recommended to clients of the GBM. Herbs given to pregnant women as part of the GBM must be administered with the utmost caution - ensuring their safety and purity as well as their appropriateness for the specific client. Further, Ayurvedic herbs should be prescribed by a registered Ayurvedic practitioner,

who considers all of the implication of the herbs and their suitability for the specific client before suggesting their use during her pregnancy (<http://www.apa.uk.com> 2008).

5.6 Limitations of Study and Future Research

As discussed in the results and discussion sections, this study is a small-scale qualitative research project involving interviews with six postnatal women who each consistently used the GBM during their pregnancy (purposive sampling – section 3.2). It is therefore unlikely that the women are representative of pregnant women in the UK given their levels of education and household income. However, the sample size and participant profile is adequate for use in a small-scale qualitative study in the field of healthcare (Crabtree and Miller 1991, p145) – specifically for the stated purpose of gaining in-depth insights into the participants experiences, motives, perceptions and rationale for choosing and continuing to use the GBM during their pregnancy which was achieved by this study.

Other limitations to this study were that the original design of using the PNFUF (section 4.1) to generate (1) semi-structured interview guide, (2) short list of participants was not realised as there were too few PNFUF completed. As such the researcher has to solicit the assistance of the GBM team and read client records to compile a short list of participants.

As discussed in section 3.1 of the methods section, both Seal (1999, p43) and Robson (2002, p168) agree that “trustworthiness” supports the essence of validity and reliability in qualitative research. Lincoln and Guba (1985, p290) segment trustworthiness into four components: (1) Trust value, (2) Applicability, (3) Consistency and (4) Neutrality.

The context of the present research study was that it represented the MSc dissertation of the author, who was the sole researcher of this study. The author was therefore limited by the scale, scope and timeline of the dissertation module these are additional limitation of this study. Further the researcher was not an outsider to the GBM or Ayurveda; however, she had no reason to bias this study towards a particular result therefore there should be high level of trust value and neutrality per Lincoln and Guba (1985, p290) definition.

The study sought to answer the following research question: what are post-natal mothers' experiences, motives, perceptions and rationale for using the GBM? This question was asked with a view to gaining insights into why GBM clients continued to use the GBM during their pregnancy and birth. The ultimate goal is to use these insights as a guide to more in-depth research into the use of the GBM and more generally Ayurveda during pregnancy and birth. As such findings from this study are applicable and consistent per Lincoln and Guba (1985, p290) definition (3.1 Research Design and Approach)

The research facilitated the exploration of the experience of pregnant women who consistently used AM, as embodied within the GBM, which has not been done before – thereby adding to the body of knowledge regarding the GBM, Ayurveda and CAM. In addition, the insights and ideas delivered by this study may provide the basis for a research question for the author to pursue in the context of PhD studies. Future research to quantify the findings from this study would be useful for example the extent to which consistent use of the GBM during pregnancy reduced fear and anxiety especially as these related to diseases of Vata. Or the use of the larger scale samples with several face-to-faces interviews with the same women to better understand the depth and complexities of pre/post natal experiences and perceptions of one of the themes identified in this study.

The report further identify recommendations to Motha for improvements, additions and modifications to the GBM and in so doing support the ongoing development and success of the GBM.

6. Conclusion

The key findings of the study were the four themes drawn from the interviews:

- (1) Fear and anxiety of an uncertain or unknown event.
- (2) Feeling of autonomy and active participation – a sense of control.
- (3) Women helping each other.
- (4) Truly believing in what you are doing.

The participants believed that the GBM supported them and their babies during pregnancy and provided them with tools to assist during the birth process. The participants felt that the GBM prepared them physically, mentally and emotionally - mitigating their fear of pregnancy and childbirth. All of the participants interviewed were pleased with the GBM and intended to use it for subsequent pregnancies.

Following from the study, the key recommendations for the GBM are the following:

- (1) Better link and identify the Ayurvedic underpinnings of the GBM particularly given that the latter is established in the UK as a legislatively-regulated system of CAM.
- (2) Actively promote the services of all established therapists at the GBM especially to accompany clients to their births as doulas and thereby continuing the support of the GBM therapist through to the birth experience.
- (3) Reduce the reliance on Gowri to attend births and spread this labour-intensive experience amongst the other therapists.
- (4) Reduce the perceived association of Gowri with the GBM so that the method will continue to prosper even after her retirement.
- (5) Recruit and mentor a suitable successor for the GBM, who can assume leadership of the practice after her retirement.
- (6) Critically evaluate the costs / benefits of the PNFUF.
- (7) ‘Pull’ prospective clients by having mini retreats and information events especially targeted at newly pregnant women looking to inform themselves about how to prepare for pregnancy and child birth.
- (8) Increase awareness of GBM by having stalls at CAM shows such as Camexpo and the Yoga Show.

- (9) Publish a new edition of the Gentle Birth Method book incorporating more of the Ayurvedic practices that are being used at the clinic but which are not included in the current edition.

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APPENDICES

APPENDIX 1: Glossary of Terms

Abhyanga: Full body massage with oil

Agni: Fire element in the body – it performs digestion, absorption and assimilation of ingested food and transforms food into energy

Amla: Sour taste – one of the six tastes of Rasa

Anuvasana or Sneha Basti: Therapeutic oil enema

Brihatrayi: The three great classical texts of Ayurveda – Caraka Samhita, Susruta Samhita and Vagbhata's Astanga Sangraha

Decoction: A method of extraction of herb/plant material

Dinacarya: Ayurveda recommended daily routine

Doula: Greek word meaning “servant or caregiver” - someone to help mother the mother

Dhatu: The seven elementary structural tissues that constitute the human body

Dosas: The five psycho-physiological humor of the body. Vata, Pitta and Kapha afflict the body. Rajas and Tamas - that vitiate the mind.

Guna: Attribute or quality

Jiva: Soul

Kapha: One of the three Ayurvedic constitutions – dominant in earth and water elements

Kashaya: Astringent taste – one of the six tastes of Rasa

Katu: Pungent taste – one of the six tastes of Rasa

Laghutrayi: The three smaller classical text of Ayurveda – Sharangdhara Samhita, Madhava Nidana and Bhavaprakasa

Lavana: Salty taste – one of the six tastes of Rasa

Madura: Sweet taste – one of the six tastes of Rasa

Mala: waste produced by the body generally eliminated by: urine, feces and sweat

Niru Basti: Decoction enema

Padarta: Sources of valid knowledge

Picchu: Cotton tampon soaked in oil that is inserted into the vaginal tract to lubricate

Pitta: One of the three Ayurvedic constitutions – dominant in fire and water elements

Prabhava: Unique or special effect which cannot be explained by the logic of rasa, virya and vipak

Prajasthapana: Improve the stability of early pregnancy; reduce the incidence of miscarriage

Pranayama: Breathing exercises pertaining to prana – breath of life – one of the branches of Astanga Yoga

Pratiyaksha: Knowledge produced through the contact of the senses with the objects of the world

Rajas: One of the qualities of consciousness – the principle of kinetic energy, active, mobile and responsible for all movement

Rasa: Taste usually the first experience of food in the mouth

Sub- Dosas: Five sub-sets of each of the dosas: Vata, Pitta and Kapha

Sukra Dhatu: the reproductive tissue of the body in both males and females

Tamas: One of the qualities of consciousness – the principle of darkness, ignorance and inertia

Tikta: Bitter taste – one of the six tastes of Rasa

Vata: One of the three Ayurvedic constitutions – dominant in air and space elements

Vati: Presentation of tablets usually in small sizes

Vipak: Post digestive effect of food

Virya: Potency or energy of a substance

Yoga: Union with God – generally used in the context of Astanga Yoga the eight branches of yoga

**APPENDIX 2:
Ethic Approval for Project**

APPENDIX 3:
Permission from GBM

APPENDIX 4
Post Natal Follow-up Form

APPENDIX 5
Participant Information Sheet

APPENDIX 6
Participant Consent Form

APPENDIX 7
Semi-Structured Interview Guide

Study Aim: Investigate the specific experiences, motives, perceptions and rational of six women who have recently given birth and consistently used the gentle birth method (GBM) during their pregnancy. The GBM is underpinned by Ayurvedic Medicine.

Research Question: What are post natal mother's experiences, motives, perceptions and rational for using the GBM?

Main Questions:

1. Tell me about your pregnancy story? (experiences, perceptions, views)
2. What were your motivations and rational for choosing the GBM?
3. Did you follow GBM program completely?
4. What do you know about Ayurveda?
5. Did you try any other complementary therapies during your pregnancy?
6. Given your preparation how do you feel your birth went?
7. Would you use GBM again?
8. Any other comments?

Back up questions:

1. Describe your experience and views of the GBM during your pregnancy
2. Which aspects of GBM did you use?
3. Which of these did you like/dislike and reasons why?

APPENDIX 8

Case Summaries of Two Interviews

Participant number 1

Delayed conception which subject attributes to poor nutrition as she was a vegetarian living in Hungary where there was a dearth of fresh vegetable – it took two years to conceive but a week after she moved to the UK it happened.

As a result of the delayed conception and she has lost 13 pounds over the time spent in Hungary – poor nutrition - she decided that she was going to really enjoy her pregnancy and do all she could for the baby and herself.

Heard about GBM at yoga classes that she was attending although in retrospect she recalls that her obs had mentioned Gowri. So after the pregnancy yoga class she went out and bought the GBM book and made an appointment at the GBM clinic this was at the beginning of the third trimester. But had bought book in second and started to look at it.

Did prenatal yoga at the Life Centre in Notting Hill and liked Tara Lee's classes but they were not convenient time for her as she was working so bought DVD and did it at home. Also walked 20-30 minutes each day.

When she saw Gowri in the 3rd trimester she mentioned a twelve-week program that she followed pretty religiously – few times she fell off the wagon – found it hard to give up wheat - but otherwise followed. Talked to the therapist at GBM about how to stay on the diet and when she was stressed Debbie gave her visualisation sessions. Saw Gowri twice at first appointment and then for vaginal stretch at 37 weeks. But when for touch therapies consistently every week from the third trimester, which was the highlight of her week. Also followed the other aspects of the program; nutrition, exercise, mental exercises and emotional bonding with the foetus. She been for four visualisation classes with her husband with Debbie and was listening to Gowri's CD every other day from the third trimester. She was listen to it at night and sometimes fall asleep to it so the therapist at the GBM asked her to listen to CD during the day as well so that it was both consciously and subconsciously absorbed. She loved the medical feel of Gowri's CD how they described the babies growth in an orderly step-by-step manner. Also the emotional connection with the baby especially the partnership of the birth preparation between herself and her little girl was amazing to her.

In addition to the GBM she also read other books, Marie Morgan on hypnobirthing and also saw another hypnobirthing expert but did not like her style. She really liked the book – Childbirth without Fear – especially its practicality and its historic perspective on childbirth without drugs, which gave her confidence that a natural birth was possible as she felt society, dictates otherwise.

She believes in the law of attraction and positive thinking – so that if you visualise it enough it will materialise. Thus she found Gowri's mental component very believable and bought into it whole-heartedly. Even though she has heard many horror stories about the birthing process. But wanted to see if she could do it has it in her to have a natural birth. So it was an exciting time for her when her water broke – she was not nervous but rather happy.

She gave registered to give birth at the Portland and really liked her doctor there her name was Clare and a fan on Gowri's method – she felt she was both supportive and realistic about the birth process and was willing to work with the participant in the way she wanted. Claire was happy not to discuss drugs other than gas or air and never discussed a caesarean section.

She started to have practice contractions two and half months before birth did not know what they were but happened to have a session with GBM therapist Kasia who said you are having a Braxton Hicks. She was already 2 CM dilated before the end of her term. She wanted her water to break before starting the contractions started – almost a romantic notion of how the birth should go. So when the water broke she called Claire who asked them to go to the Portland to establish a baseline but not to rush there this was about 2am. When she and her husband went to the hospital they went with the idea that they were not going to come back.

First midwife she met had not received her notes – which she had specifically called into give the week before – detailing how she wanted a natural birth and no mention of drugs. However this nurse had not read these notes, kept asking her about drugs and also being negative about how long the contractions would last – participant stopped listening to her put on her headphone with Gowri's CD letting the midwife do what she wanted to do. Midwife wanted them to go back home and return when both husband and wife had a fit and told her she had to come up with an alternative solution. Finally they agreed to go downstairs to recovery section and stay there until further time had passed.

When they went downstairs a lovely Caribbean midwife met them and participant mentioned how she had had this bad experience upstairs with Irish midwife – Caribbean midwife was very supportive told her own tale of having three deliveries without drugs and drew her a graph of the contractions – explaining that they were only a minute long and the worst part was approximately 20 seconds which participant already knew but was reassuring and she retained her confidence. She continued to listen to Gowri's CD and when the contraction where especially severe she asked her husband to distract her attention by recalling a happy memory of them together which he did giving her a picture to visualise. Two hours passed which seemed like two minutes and she noticed that the contractions were returning every two minutes and she was feeling much more uncomfortable and even feeling like she needed to push. She went to the Caribbean midwife who took it seriously and sent her upstairs for an examination.

The same Irish midwife was on duty who said 'its probably nothing' however did the exam and found that she was seven centimetres dilated – the midwives tone changed completely like day and night and was suddenly supportive started rushing around preparing a bath for participant to labour in. When participant asked if midwife if could call the Dr and she said she had already done it.

Participant continued to labour in the water and when asked if she would like some gas and air did take some but after about 10 time she felt that it was interfering with her being in the zone and decided not to have it as she found it distracting. While in the water she had stopped listening to Gowri's CD but was in the zone so it was OK. Then the Dr arrived and she felt she could completely let go and relax as she had tremendous comfort and confidence in Claire especially that she would be truthful. Once Claire arrived she felt she was ready to push. Participant was getting hot in the water and also Claire felt she could help her mauve better outside and help her not to tear, so she did and pushed outside. Participant loved this stage felt the pushing was fabulous – really enjoyed that part and felt it was wonderful and euphoric.

Baby arrived at 8am and the contractions started at 2am – six hours in total – participant felt this was relatively short. Comments that her baby is a good eater and that she has been eating better as well as a result of what she learn from therapist at the GBM. However she did not official have an appointment of GBM Ayurvedic Dr for a diet consultation – even though she had some indigestion problems which in retrospect she thinks may have been practice contractions. She says her baby was amazing did not cry much after birth but just hung out with her parents looking around after birth and then they all took a family nap together. They were all very excited about the birth, calling parents at 3am in the morning and generally excited.

Back to the question on why she did not consult with the Ayurvedic Dr at GBM: participant felt that she was following the program and had already eliminated so much that she felt she could not eliminate more to follow a pitta pacifying diet as well. When she saw Gowri for her vaginal stretch Seema (Ayurvedic Dr) was present and she took her pulse and diagnosis was that her Pitta was high – which she followed some of the advice for the last week or so.

Participant's maternal grandfather and uncle were all Ayurvedic Dr, but as she grew up in America much of the Ayurvedic traditions were not followed. Participant did not feel that the GBM was really an Ayurvedic program rather a good diet and exercise regime. But she never thought she needed an Ayurvedic diet as she felt she ate pretty healthy however, now after going through the GBM she has changed her attitude and has come to the understanding that when you eat in an Ayurvedic manner one's digestion is improved and you have a different feeling – especially eliminating the spices. During her pregnancy she ate something very spicy and suffered for it.

She feels after going through the GBM she is more likely now to consider complimentary therapies and not run to allopathic doctors immediately. Before her pregnancy she has lots of headaches, which seems to have subsided since. She also tried to medicate and feels that with her daughter she will try to be more natural and try alternative remedies. Especially as her German husband is much more amicable to using natural things and defers going to see allopathic doctor as much as possible.

She is absolutely sure that she will use the GBM for her next pregnancy even if they move from London she will re-read the book and try to find the constituents of the program where ever she is. She has already recommended the program to a few of her colleagues and they are already attending the GBM clinic because of her recommendation. Also others she knows are considering birth without any medication because of her experience. She felt amazing after the birth – almost like she had run a marathon – and it was the most proud she has been of herself.

She does not know why the NHS does would not offer a program like the GBM as if more women are birthing naturally it is bound to be less expensive for the public health. As she thinks everyone will benefit from the massage but the positive thinking aspect maybe harder to broach. When she was pregnant especially in the last stages she was surprised at how negative other people were about trying to birth without medication she received many sarcastic comments so much so that she decided not to tell other that about 'her method' keeping it all very vague. She rationalise this negatively given all media and TV representation of birth being difficult and painful ordeals. But she would definitely do it again.

Participant number 5

Known case of medium to mild case of endometriosis and Adenomyosis, family friend of Yehudi Gordon so he sent her to see Gowri even before she started trying. Did four to time treatment with Gowri over the year and then started trying at which time saw Gowri about every second week – took seven months to fall pregnant. Yehudi had thought it would take her an year to fall pregnant and felt that the work she did with Gowri – treatments and visualisation helped speed the process on. Once pregnant saw Gowri on week five and Yehudi was monitoring her for progesterone levels to ensure she did not miscarry. From week seven to twelve too progesterone suppositories and saw Gowri weekly as she felt it made her go “completely loopy”. Yehudi and Gowri worked together on her during this time and she felt safe and taken cared of even though Gowri is non-interventionist at cellular level as a doctor understand what is required. Once she stopped the progesterone, she felt it was an unbelievably easy pregnancy. Even at the beginning it as easy and she did not have much morning sickness, which is the factor that alerted Yehudi to start monitoring her progesterone levels more closely. Those six weeks that she was on progesterone was real downer but otherwise pregnancy was great. Saw Gowri every second week or so, followed diet very, very closely, did pregnancy yoga, ran until twenty six weeks, did some bouncing squats as baby was not breach but not facing the right way. Did all the enemas, perineum stretching and picchu. Tried to take the baladi choornam but took it three times and broke out in a rash and Gowri asked her not to take it. Did the visualisation course with Debbie saw Sara for reflexology and Seema for diet but usually when she was seeing Gowri as well. Listened to the CD from second trimester had it on her phone so put it on every few days and spend lots of time cultivating safe place.

At the end of her second trimester went on holiday to Majorca and had a huge seafood dinner. Ended up getting seriously ill with both projectile vomiting and diarrhoea simultaneously. He husband and gone to play tennis and she was on her own – she panicked but realised that she had this tool of the ‘safe place’ and used it calm her down and pacify the anxiety; giving her space to release the tension. Gowri loves the story as it gave her a foreshadowing of how it can be useful at labour as well as the fact that it had already become instinct to her to use it so naturally when under distress. She says she used the visualisation of the safe place in a big major way during the birth as it was very difficult and very long labour and it was one of the things that allowed her not to have a c-section.

She gained 22-23 pounds during her pregnancy, as she was a bit underweight when she fell pregnant. Baby was 3.2 K. They both put on the right amount of weight as this was the impetuous for Gowri starting the GBM. Contrast in Gowri is interesting as she comes from a background of western medical doctors and grounded in scientific rigour yet is one of the most lateral thinkers she has ever met and plugged in at an energetic level.

She felt she needed to keep moving which Gowri did not always like – afraid that she would do too much and tighten but rather than keep soft and lose for birth. Toward the end also did some evening classes with Janet Balaskas – much of the similar school as GBM. Some figures of 8 and pelvic movement but also releasing at a low sound level which she liked because she was a singer.

Had herd of Ayurveda and seen a Dr before but had never stuck with it as a healing system. Planned to have her baby at St John and Lizzy but it closed three weeks before her due date so was transferred to Portland, which she felt “allergic to”. She is from the states and hates the fact that unless you pay exorbitant amounts of money you can’t have the same doctor that takes you from A-Z – rather a mix of six people. It felt really impersonal to her which was one of the factor Gowri was so important to her and she asked her early in her pregnancy if she would be at the birth. Also Yehudi had retired so he passed on to one of his colleagues Yinka Akinfenwa and obstetrician partial to the natural birth – as she said he had a difficult birth and any other

doctor would have been hammering her to have a c-section but he let her ride it out for thirty eight hours. She did end up going to the Portland as she felt ultimately it was a “hotel room” she was renting as far as she was concerned she has her team with her – Yinka and Gowri.

Baby was 38 week she had a trickle of water when in to get it checked and was told her hind waters had broken and fore waters have not broken. So she was just about to leave to labour at home when they stopped her and said she could not go as they had received a culture from 3 days ago, which showed she had Strep B and they wanted to put her on an antibiotic drip. She did not want to do this but basically Portland said that if she id not she could not have the baby there. She debated having a home birth with Gowri and her Dr but decided that it was too risky as if something went wrong they would have had to go to a random labour ward. She was not happy it was not the way she wanted it.

She was in labour for twenty-two hours and dilated 2 CM as the baby was occipital posterior and her waters now had fully broken. Because she had Strep B the Yinka gave her 24 hours to let “Gowri work her magic”. Gowri was amazing she did not leave her side for 38 hours she was incredible she was all on her own she did: cranial, massage, reflexology, more massage in the shower she was on her hands and knees unbelievable. Some of the Portland midwives were starting to say: you have done really well but you need to accept that it is not going to happen for you - you need to start considering a c-section. She was not listening to them and Gowri was trying to throw it out of the window says “its already happening what makes you think it is not going to happen”. After 24 hours Yinka came in and said you have two choices: Syntocinon or C-section. She was had been having contractions every three minutes for hours and was exhausted but decided to go the induction route.

When the Syntocinon started going it was brutal (about hour 26) and she wanted an epidural. They tried 8 times to give her the epidural but it was not go in and her spine is still not right at the spot. Epidural did not take at all on the left side, her right side was numbed by about 20-30% for about two hours so a bit of help but not much. She sees the labour in three stages: before syntocinon, dark period of epidural and syntocinon and pushing period. The first period was difficult but it was amazing as they were dancing, they baby seemed to move more to the Michael Jackson and the Jackson 5 so they were dancing to it. This included Gowri, the participant, her mother and her husband. The midwives would come in and say turn the music down and Gowri would turn it up again after they had left it was really classic! The dark part of the epidural and syntocinon was about three hours but felt like “unbelievable long and horrid”.

As she knew the epidural was not going to work she went really deep inside her safe place and used every shred of energy she had and it worked it was amazing and she loved having her team there. The baby’s head dropped. Dr flew in, he had been at an NHS meeting in a really fancy suite, rolled his shirt sleeves up and went down on his stomach and put his hand into her vagina. She was squatting and Gowri was supporting her from the back.

He said, “do you trust me?” and I was like “I better damn trust you dude” and he was like “do not push until I tell you to and we are going to be fine”. Between Gowri and him it was amazing, beautiful the last bit felt really right – but she did ask for an epidural but he said its too late the baby is here. It was all over 38 hours and a real test of perseverance on every level. She loved it other than the one little period that was not that fun – that night when she was in bed with her husband she turned to him and said can we do it all over again! It was on of the most magical experiences of her life and it did not matter that it was so long. She felt very present all of the time unlike some of her friend who said they were in a far away place during the labour. Also she feel that if Gowri or someone like her had not been there it may have not happened, also she felt very supported with her mother and husband there as well as it is very scary especially when medical authorities keep coming in every forty minutes and say you need a c-section. That was what the whole machine was pushing her toward as a few days later she called in to the Portland and when she said her name the midwife said you had a c-section and

she said now. And midwife said that was strange as when I was on duty last they were prepping the theatre for you. So having Gowri there really gave her confidence in her decisions especially as she had built a relationship with her during her birth preparation. When her Dr came in giving her the option between induction and c-section Gowri said 'I support you in what every decision you make...you have not failed if you decided to have a c-section...don't do it for anyone else but yourself'.

They had the baby monitor on all the time to ensure that baby was not in distress. So she felt totally safe. But really respects Gowri for not pushing 'her way' rather does not have a way other than what is best for the participant.

Feel the tools she used during pregnancy allowed her to have the birth she wanted. So much of the visualisation and breathing was intrinsic to her and is what got her through the induction part without an epidural. Can't quantify it but felt that the diet made her feel much lighter not in a weight sense but rather energetically and helped her feel great through her pregnancy. She reflects back on her labour and realises that she never used the word difficult just long but when she started to tell other about it they kept saying oh I am so sorry etc that she started to add the word difficult to it. Even though really for her it was amazing and euphoric. She felt that the GBM was one and the same as her labour as her labour was just a combination of the knowledge she had gained through her pregnancy preparation with the GBM.

**APPENDIX 9:
Sample Keyword Search Strategy**

# 1	childbirth
#2	Labour
#3	Pregnan*
#4	Gravid
#5	#4 OR #3 OR #2 OR #1
#6	Stress
#7	Wellness
#8	Anxiety
#9	Tension
#10	#9 OR #8 OR #7 OR # 6
#11	CAM
#12	complementary and alternative medicine
#13	complementary and alternative therapy
#14	alternative medicine
#15	alternative therapy
#16	#15 OR #14 OR #13 OR #12 OR #11
#17	#5 AND #10 AND #16
#18	limits to English