I. 'It's Your Body, Your Baby, Your Birth': Planning and Achieving a Home Birth

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An article in this issue, 'Childbirth, Complications and the Illusion of "Choice": A Case Study', by Michele Crossley, presents the author's personal experiences of childbirth, highlighting the disjunction between her initial antipathy to hospitalized, medicalized childbirth and her eventual caesarean section. The author concludes that her ability to exercise 'choice' in 'the actual birthing encounter was minimal'. There are a number of similarities between Crossley's experience of childbirth and the experiences of those women with whom I conducted my doctoral research.

My doctoral research analysed 80 calls to the Home Birth helpline, which is a (British) telephone service offering support for women seeking to arrange a home birth. The research looked at the problems women encountered in trying to arrange a home birth, as these happened 'on line' during callers' pregnancies (as opposed to retrospective interviews after the birth), and at the ways in which call-takers addressed the issues raised by callers. My research, like Michele Crossley's, adds to the evidence that many women don't know how to go about arranging midwifery cover for a home birth, that their attempts to do so may be blocked by health professionals and that their decision to birth at home may be regarded as risky or bizarre by those close to them.

Initially, I approached the subject of home birth with some trepidation. I have no children myself, no friends with children and at the outset knew very little about pregnancy and childbirth. On my first listening to calls to the Home Birth helpline, I was very aware of this lack of tacit knowledge. I also held a number of preconceived ideas about 'natural' birth. I had in mind a dichotomy between medicalized births, which were 'unnatural' and home births, water births and active births, which were 'natural'. Additionally, I had in mind a clear division between a majority of women who (like myself) are anxious (to a greater or lesser degree) about childbirth and think birth would be more comfortable and

pleasant with a bit of pain relief, and a minority (of 'earth mother' types) who prepare for a drug-free labour by blowing up paddling pools and are somewhat self-righteous: 'i would not hurt like all those women who screamed and took drugs' (Derricote, 1983: 108).

However, listening to the conversations between callers and call-takers on the Home Birth helpline, and reading around the issue of childbirth, has had a profound impact on my own attitudes and beliefs. The idea that there are two competing models of childbirth (the 'natural' and the 'medicalized') has been critiqued by a number of writers (e.g. Stanworth, 1987), with empirical studies showing some women actively embracing technological intervention (Davis-Floyd, 1994) and other women talking about pregnancy and birth as a 'natural' process while also making 'judicious choices' to incorporate some technologies (Viisainen, 2001: 1120). A range of empirical research, specifically on women's experiences of home birth, shows that there are a number of reasons why women choose to birth at home, including having had a previous traumatic hospital birth, wanting to avoid medical interventions (that can actually make the experience more painful and difficult), as well as desiring privacy, control over decision making, wanting to be in a familiar, relaxed environment and being able to choose who is present at the birth (e.g. Davis-Floyd, 1994; Hodnett, 1989; Viisainen, 2001). Over the course of my research, I became a convert to the idea of home birth, but also felt, like the childbirth activist Sheila Kitzinger (2002), that what really matters for women is access to the information that will enable them to participate fully in the birth experience, whether it occurs at home, in hospital or in a birth centre (Kitzinger, 2002: 8; also see Kitzinger, 2005).

In her article, Crossley highlights current debates about whether women, even if they are able to access information, are able to make explicit choices about childbirth, given the normative status of medicalized birth in many contexts. What struck me during *my* research was how difficult I personally would find it (with my limited understanding of many medical interventions related to childbirth) to exercise choice about birth if it meant being assertive with health care professionals who were not encouraging and who might set my choice against the 'needs', 'safety' and 'well-being' of the unborn child.

In the UK, the government has made a commitment to enable women to choose home birth (Department of Health, 1993, 2004; House of Commons Health Committee, 2002–03). For instance, the national service framework for maternity services states that it is a 'marker of good practice' that:

> all women are involved in planning their own care with information, advice and support from professionals, including choosing the place they would like to give birth and supported by appropriately qualified professionals who will attend them throughout their pregnancy and after birth. (Department of Health, 2004: 5)

However, in practice, women do not find it easy to exercise their right to home birth. The rate of home births is very low – approaching 2 percent (Olsen and Jewell, 2003) – and, as a report by the National Childbirth Trust (NCT) shows,

there is substantial variability in the rate of home birth between National Health Service Trusts, from over 10 percent of births in some areas to less than 1 percent in others (National Childbirth Trust, 2001). This wide variation suggests that the number of women choosing home birth is highly dependent on the nature of the information they receive and the attitudes of their caregivers. The NCT report (2001) concludes that interest is likely to be higher where home birth is seen as a realistic option and where women know others who have given birth at home. That this is the case is evidenced by Torbay General Hospital (in South Devon), which has a home birth rate of over 10 percent as a consequence of changes in practice (Kitzinger, 2005). In May 2006, it was reported that the UK Health Secretary Patricia Hewitt was commissioning work into how to make home birth more available (BBC 2006) and, currently, the National Institute for Health and Clinical Excellence (NICE) is in the process of preparing guidelines about choice in childbirth, including place of birth (main report, 2007, second consultation due September 2007; National Institute for Health and Clinical Excellence, 2007a, 2007b).

The Home Birth helpline was established in the 1980s by the birth activist and author Sheila Kitzinger to facilitate women taking an active role in their birth care. It emphasizes autonomy, access to information and informed choice about alternatives (http://sheilakitzinger.com). The primary reason for calling the Home Birth helpline in my corpus was most commonly – 44 percent of the calls – for help with arranging a home birth when callers had been told they could not have one. Reasons for denying a home birth included staff shortages, the fact it was their first baby and so on. Other reasons for calling included requests for general information about preparing for a home birth (18%) and repeat calls from callers updating the call-takers on their progress, in particular reporting on their births at home (39%) (See Shaw and Kitzinger, 2005, 2007a).

The callers to this helpline are perhaps more able than some women to exert autonomy. But even so, nearly half the recorded calls were from women who had encountered difficulties when trying to book a home birth. Callers to the helpline reported feelings of isolation (few knew anyone else who was planning a home birth), a lack of understanding from friends and family and negativity from health care providers. Callers reported that primary care general practitioners acted as gatekeepers to maternity care and attempted to dissuade them from booking home births, that consultants refused them a home birth on the grounds of staff shortages, because home births 'weren't available' in their area or for a range of medical reasons (including women being too old, overweight, too short, the baby being too big or too small, or a perceived risk from a range of things including fibroids, placenta praevia, pre-eclampsia or shoulder dystocia). Some of these (i.e. placenta praevia and pre-eclampsia) constitute very good reasons for a woman being advised against birthing at home, but others (i.e. first baby) do not (Kitzinger, 2002). In response, the call-takers on the Home Birth helpline offered advice and guidance to callers, so that they could make a more informed evaluation of the risks. Call-takers also tried to ensure that callers were informed of their

rights, because these women were not always fully informed, or had been made to doubt their knowledge after speaking with their health care providers. Arguably most importantly, the call-takers provided validation of the choice to birth at home. These helpline conversations were a (rare) place where women were not expected to justify their desire to have a home birth. Hence the title of this piece – one of the call-takers regularly tells women: 'Remember, it's your body, your baby and your birth.'

However, even when callers were informed of their rights, some were reluctant to appeal to them. The notion of it being their 'right' to birth at home was felt by some as potentially fostering an adversarial tone and callers were reluctant to assert themselves if this meant jeopardizing their relationships with the midwives they would be dependent on during labour, or 'coercing' reluctant midwives into agreeing to a home birth. This was not an unfounded concern. For instance, two callers were transferred to hospital against their wishes when their attending midwife 'panicked'. And when Zoë (a pseudonym) persisted in trying to get a home birth booked, a midwife reported her 'stubbornness' to the consultant, who interpreted her persistence as evidence of emotional instability, which then constituted another reason for not facilitating the birth of her baby at home.

The calls to the Home Birth helpline demonstrate that the concept of choice depends not only on access to reliable information, but also on there being genuine alternatives (a finding in line with recent research from within maternity services, e.g. Wiggins and Newburn, 2004: 162). A number of callers had read relevant books and magazine articles, and had searched the internet for up-to-date information about their options. However, they then found that this information contradicted local norms of practice (for example, they were told that home birth wasn't 'available' in their area). The calls suggest that, in practice, women are faced with the 'choice' of succumbing to the medical approach, having an independent midwife (*if* there are any available in their area and *if* they can afford it), birthing at home without assistance (something which is becoming more common [Robinson, 2002]) or being very assertive and persistent with their health care providers.

Collectively, the Home Birth helpline calls convey a strong sense of the power of the medical model of birth as the 'backcloth' to the conversations. This research demonstrates how the helpline is a context in which the call-taker and caller collaborate to produce choosing home birth as reasonable and understandable in a cultural milieu where it is neither of these things. However, even in these calls, callers orient to the fact that hospital birth is the default option within wider society. Shaw and Kitzinger (2007b) show that, in a majority of the calls, the caller's reason for calling is presented in a form that sets up a dilemma – (a) I want (or plan) to have a home birth, but (b) there are now impediments to my doing so. By virtue of producing the '(a) component', callers are displaying an orientation to the potentially troublesome nature of this request. For instance, it would be difficult to imagine the following callers' problem presentations, were 'hospital' substituted for 'home'.

> Basically I *really* would like a [hospital] birth. (Meg)
>
> I don't know anything about what it is that you do but I'm interested in having a [hospital] birth. (Marion)
>
> At the moment certainly uhm my husband and I are both very very keen on a [hospital] birth. (Deidre)

The underlying premise of my research (Shaw, 2006) was that whatever women's reasons for wanting to birth at home, the right to give birth in the place of one's choice is a fundamental feminist issue. What the recorded Home Birth calls show, along with Crossley's reflections on her own experiences of childbirth (this issue), as well as recent maternity services research (i.e. Kirkham, 2004), is that although in theory women are free to choose where they give birth, in practice, the realm of choice is highly circumscribed. As Katz Rothman (1989) has co-gently pointed out, although the range of choices around childbirth appear to have expanded, for those who want to make other 'alternative' choices, 'the ideology of choice disappears in the twinkling of an eye' (Anderson, 2004: 259).

ACKNOWLEDGEMENTS

This research was supervised by Celia Kitzinger, who also facilitated access to the Home Birth helpline. I would also like to say thank you to the call-taker (who wishes to be named as Sheila Kitzinger) and to the callers who gave permission for their calls to be recorded for the purposes of research and training. This research would not have been possible without their input.

REFERENCES

Anderson, T. (2004) 'The Misleading Myth of Choice: The Continuing Oppression of Women in Childbirth', in M. Kirkham (ed.) *Informed Choice in Maternity Care*, pp. 257–64), accessed 30 April 2007. Hampshire: Palgrave Mcmillan.

BBC (2006) 'Government to Promote Home Births', accessed 30 April 2007. Available: http://news.bbc.co.uk/1/hi/health/4771661.stm.

Davis-Floyd, R.E. (1994) 'The Technocratic Body: American Childbirth as Cultural Expression', *Social Science and Medicine*, 38: 1125–40.

Department of Health (1993) *Changing Childbirth. Part 1: Report of the Expert Maternity Group*. London: HMSO.

Department of Health (2004) *Maternity Standards: National Service Framework for Children, Young People and Maternity Services*. London: HMSO.

Derricote, T. (1983) *Natural Birth*. London: The Crossing Press.

Hodnett, E.D. (1989) 'Personal Control and the Birth Environment: Comparisons between Home and Hospital Settings', *Journal of Environmental Psychology* 9: 207–16.

House of Commons Health Committee (2002–03) *Choice in Maternity Services: Ninth Report*. London: HMSO.

Kirkham, M. (ed.) (2004) *Informed Choice in Maternity Care*. Hampshire: Palgrave Mcmillan.

Kitzinger, S. (2002) *Birth Your Way: Choosing Birth at Home or in a Birth Centre*. London: Dorling Kindersly.

Kitzinger, S. (2005) *The Politics of Birth*. London: Elsevier.

National Childbirth Trust. (2001) *Home Birth in the United Kingdom*. London: National Childbirth Trust.

National Institute for Health and Clinical Excellence (2007a) 'Intrapartum Care: Management and Delivery of Care to Women in Labour', guideline in development (due September 2007), accessed 30 April 2007. Available: http://guidance.nice.org.uk/page.aspx?o=guidelines.inprogress.intrapartumcare (accessed 30/04/07).

National Institute for Health and Clinical Excellence (2007b) 'Intrapartum Care: Second Consultation on Chapter 3, Planning Place of Birth, Intrapartum Care', guideline in development (due September 2007), accessed 30 April 2007. Available: http://guidance.nice.org.uk/page.aspx?o=PlaceOfBirthConsultation.

Olsen, O. and Jewell, M.D. (2003) *Home versus Hospital Birth*, The Cochrane Library, Issue 1. Oxford: Update Software.

Robinson, J. (2002) 'High-risk Clients', *British Journal of Midwifery* 10(2):109.

Rothman, B.K. (1989) *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*. New York: Norton.

Shaw, R. (2006) '"It's Your Body, Your Baby, Your Birth": A Study of Helpline Talk-in-interaction on the Home Birth Helpline', unpublished PhD thesis, University of York.

Shaw, R. and Kitzinger, C. (2005) 'Calls to a Home Birth Helpline: Empowerment in Childbirth', *Social Science and Medicine* 61(11): 2374–83.

Shaw, R. and Kitzinger, C. (2007a) 'Memory in Interaction: An Analysis of Repeat Calls to a Home Birth Helpline', *Research on Language and Social Interaction* 40(1): 117–44.

Shaw, R. and Kitzinger, C. (2007b) 'Problem Presentation and Advice-giving on a Home Birth Helpline: A Feminist Conversation Analytic Study', *Feminism and Psychology* 17(2): 203–13.

Stanworth, M. (1987) 'Technologies and the Deconstruction of Motherhood', in M. Stanworth (ed.) *Reproductive Technologies: Gender, Motherhood and Medicine*, pp.10–35. Cambridge: Polity Press.

Viisainen, K. (2001) 'Negotiating Control and Meaning: Home Birth as a Self-constructed Choice in Finland', *Social Science and Medicine* 52(7): 1109–121.

Wiggins, M. and Newburn, M. (2004) 'Information used by pregnant women, and their understanding and use of evidence-based *Informed Choice* leaflets', in M. Kirkham (ed.), *Informed Choice in Maternity Care*, pp. 147–67. Hampshire: Palgrave Mcmillan.

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