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Why do so few women give birth at home? Interpreting place in childbirth discourse

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Abstract

The aim of this study is to understand why so few women in England give birth at home. A qualitative approach focuses on the childbirth-related experiences and attitudes of thirteen women (with twenty-six childbirth experiences between them) living in a village in North-West England. Data was collected through semi-structured interviews, which included a substantial narrative component. A key element of the interviews was a focus on new spatial imaginaries, where women were encouraged to think about their ideal spaces for giving birth, and about a 'home birth as default' scenario. The main finding of this study is that the desire to give birth in hospital is not as entrenched as might be predicted. Non-hospital settings featured strongly in women's ideal spatial imaginaries, and women reveal a positive approach when home birth is presented as the norm. The conclusion of this study is that the hegemonic discourse of childbirth acts to prevent more women choosing to give birth at home. However, the competing discourse is potentially strong. Women might benefit from the opening up of new discursive spaces (of which the current study is an example) that privilege women's knowledge and capacity for autonomy.

Contents

1: Introduction

In England, around 96% of babies are born in hospital. Around 2% of babies are born in freestanding midwife-led birth centres and around 2% at home[1]. The central research question underlying this report, prepared on the basis of research carried out in 2008 as part of a Masters in Social and Cultural Geography, is why so few women give birth at home.

This question is asked in the context of mounting research evidence that highlights the relative safety of giving birth at home. In 1993, the Government's Changing Childbirth report concluded that there was no evidence-based case for encouraging 100% hospital births on the grounds of safety (Department of Health, 1993). A woman's right to choose where she gives birth became – and continues to be - a key maternity policy objective, underpinned by the NHS-supported home birth service (Department of Health, 2007).

This report does not intend to take a stance on the relative safety of different places of birth; this is a deeply-contested issue, highly likely to remain so (Campbell and Macfarlane, 1994; Lane, 1995) despite large programmes of ongoing work[2]. I am also keenly aware of the dangers of reinforcing the hegemony of risk through research (Walsh et al, 2004; Dornan, 2008). Rather, this report seeks to explore women's experiences of making decisions about where to give birth, and their views on different places to give birth, in the context of their own lives and childbirth experiences. Based on a qualitative research project undertaken with 13 women, I consider how these women come to decide where they will give birth, on the basis of what information and under what influences and constraints (section 4). I look at what decisions they make, and how well these reflect their preferences (section 5). I explore their expectations and experiences of the hospital as a space to give birth (section 6). Finally, I explore alternative spatial imaginaries: their ideal birth places and their reactions to a 'home birth as default' scenario (section 7).

On the basis of this small study, I conclude that non-hospital spaces such as home and free-standing birth centres seem to be more popular with women, and women's apparent preference to give birth in hospital less entrenched, than the statistics suggest. Thus the key issue is not so much why home-birth is unpopular, but why a latent preference for home (and free-standing birth centres) is not achieved by women. I explore this by considering the role of the hegemonic discourse of childbirth, and suggest the creation of new discursive spaces to enable women to challenge the powerful structures of authoritative knowledge that work against the enactment of their preferences.

[1] 2006/07 statistics (Healthcare Commission, 2008).
[2] E.g. Birthplace. http://www.npeu.ox.ac.uk/birthplace

2: Background

The historical and political context of place of birth discourse

As already highlighted, the vast majority (96%) of women in England[3] give birth in hospital. This reflects a major shift from the position in the late 1920s, when 85% of births took place at home. That shift had been almost completed by the early 1970s, when 90% of births took place in hospital, with the figure reaching today's levels in the early 1990s (Campbell and Macfarlane, 1994). This twentieth-century trend towards the hospitalization of maternity care is not unique to England: it has been followed in all industrialized countries except the Netherlands, where the home birth rate remains relatively high at around 30% (Declercq et al, 2001).

To understand this shift, it is necessary to consider briefly the ambivalent meanings attached to childbirth: whilst on the one hand it represents the positive and powerful emergence of new human life, it has also been 'an area of myth, secrecy, terror and potential death' (Symonds and Hunt, 1996, p85; Murphy-Lawless, 1998). Driven by a fear of and lack of knowledge about the raw feminine energy of childbirth, men's historical desire to tame and control childbirth has been well documented (Arms, 1975; Rothman, 1982; Symonds and Hunt, 1996). This analysis underpins an important strand of radical feminist thinking, which views reproduction and childbirth as a key source of women's power and therefore, within a patriarchal society, likely to be a key site of oppression[4] (Oakley, 1986).

As childbirth is managed and controlled, women's bodies are reconceptualised – within a Cartesian framework - as machines (Arney, 1982; Martin, 1989). Technocratic rituals, underpinned by new medical technologies, are applied to the mechanical problem of birth (Rothman, 1982; Davis-Floyd, 1992), with scant regard for a woman's active participation beyond the provision of her body as vessel (Martin 1989; Young, 1984; Longhurst, 2008). This approach to childbirth, involving a shift in power from female midwives to 'medical men' (or man-midwives) (Connor Versluysen, 1981), eventually requires a shift in the place of birth. It is during this phase that large modern industrial hospital units become the normalised place for childbirth, culturally constructed as the safest place to give birth, with a pathological approach to childbirth gaining ascendency within a medicalized model (Illich, 1975; Oakley, 1979; Graham and Oakley, 1981; Cahill, 2000; Lupton, 2003). This shift to the hospital also reflects the understanding that death is an ever possible outcome of childbirth, an important driver of behaviour in a culture which dreads 'death [as] the worst possible consequence' (Gabe, 1995; Breakwell, 2007, p24). Within the medicalized model,

[3] This report focuses on England; the administrations in Wales, Scotland and Northern Ireland have devolved responsibility for health policy.

[4] This is in contrast to another key strand of feminist theory, perhaps best represented by the work of Shulamith Firestone, where the reproduction is purposefully not theorized as central to women's potential power, but represented rather as a slightly embarrassing reminder of women's embodiment, and an obstacle to be overcome as women strive for equality (Firestone,1970; Kaufmann, 2004).

the social construction of pain as intolerable, and the consequent offer of pain-relief, is central to the further promotion of the hegemonic discourse of women as incapable of giving birth without medical assistance, thus legitimising the passing of control over birth from the birthing woman to the medical experts within the hospital setting (Stewart, 2004; Symonds and Hunt, 1996; Leap and Anderson, 2004).

Scholars have been particularly interested to explore how the shift to the hospital took place despite the evidence that pointed to the poor historic safety record of the hospital compared to other settings. They argue that information about the relative safety of different birth settings has generally been (and continues to be) controlled to reinforce the hegemonic discourse (Campbell and Macfarlane, 1986 and 1990; Lane, 1995; Tew, 1998). The need for such ongoing control might be limited, however, given the strong socialization mechanism at play (Symonds and Hunt, 1996), and the fact that 'people are remarkably resistant to changing their prior risk estimates' even when presented with new information (Breakwell, 2007, p59). Thus an imaginary of the hospital as safe may persist despite the emergence of contrary evidence that raises the possibility, for example, that the iatrogenic risks associated with giving birth in hospital may be greater than any benefits provided (Heptinstall and Lee, 2004): in other words, that, for some women, home births may be 'at least as safe if not safer than hospital birth' (Mead, 2004, p73).

More recently, the post-fordist neoliberalist framework begins to shift the balance slightly (Wrede et al, 2001) with a new managerialism challenging the power of the medical profession (Beck, 1992; Lane, 1995; Bates, 2004; Gabe et al, 2006). The rhetoric of consumer choice is introduced (Lupton, 2003), reflecting a new focus on individualism and a shift in responsibility to the individual to make the 'right' choices (Ansell, 2008), underpinned by a market-based approach to healthcare services. But governing the context of such choice, the hegemonic discourse on place of birth remains intact, with the central notion of the hospital as the safest place to give birth now entrenched for forty years. The medicalized and pathological framing of childbirth remains powerful (Downe and McCourt, 2004; Crossley, 2007). This shifting management and control of childbirth fits within broader social and political developments, in particular the increasingly neoliberal medical system, as discussed extensively elsewhere (Gabe, 1995; Lupton, 2003; Kelleher et al 2006). Its current form reflects a good alignment within what has been theorized as an increasingly risk-dominated society (Beck, 1992; Breakwell, 2007; Dornan, 2008), and reflects key aspects of a Foucauldian culture of governmentality and surveillance (Petersen and Bunton, 1997; Brown and Duncan, 2002).

The context described so far perhaps best represents what we know about why more women don't give birth at home, and reflects the important contributions made to this debate by a wide range of social scientists. Some more specific answers to the question are located within an increasingly vibrant tradition of critical midwifery studies. The very notion of choice about place of birth is the subject of powerful critiques, as scholars explore the unfulfilled rhetoric of choice in maternity care (Anderson, 2004; Edwards, 2004 and 2005; Kirkham, 2004; Stapleton, 2004; Jomeen, 2007). Information failure, driven by power dynamics, is

seen as a key problematic in women's exercising of choice (Madi and Crow, 2003). The difficulty of obtaining women's input into an agenda for change is noted, given the tendency for women to report satisfaction with the type of maternity care they receive, whatever their experience (DeVries et al, 2001). The role of the midwife in encouraging home births is examined, and it is found that teams of midwives can raise home birth rates if they work to do so (Sandall et al, 2001). Whilst these are all interesting and important evidence-based perspectives, they might be criticized for a degree of professional bias (in favour of a normative view that midwife-led improvements within a midwife-led maternity service will be able to define and meet the needs of childbearing women), generally positioned within a model of 'experts caring for non-expert women', rather than one that conceptualises women as powerful, autonomous and knowing agents who might choose to access additional expert knowledge about childbirth from a variety of sources and on their own terms.

Geographical scholarship on place of birth

Whilst the issue of where a woman gives birth is a subject of much debate and discussion in various parts of the academy, the issue has received only intermittent attention from geographers. Indeed in 1991, Abel and Kearns reported that 'there has been no attempt to explore … choices for place of birth from a geographical perspective' (Abel and Kearns, 1991, 825). In 2008, there is still very little published geographical scholarship in this area, although geographical research into other health-related topics is analytically helpful (Parr and Philo, 1996; Dyck, 1999; Gesler and Kearns, 2002). For such an inherently spatial issue, it is perhaps surprising that discussion about the places and spaces in which women give birth has been of only limited and occasional interest to geographers. In that context, it is important to recognize that the issue was placed on the agenda by UK feminist geographers in the early 1980s. The Women and Geography Study Group (WGSG), for example, discuss inequalities in access to maternity services, especially from the perspective of class and race (WSGS, 1984). This socialist feminist perspective arguably led to an overly-narrow research agenda, that downplayed the significance of the issue as one that is relevant to all women: as Naomi Wolf's popular writing about the phenomenon of 'ordinary bad births' powerfully demonstrates, it is not only subaltern women who are let down by current birth practices (Wolf, 2001; Lawrence Beech and Phipps, 2004).

Noting the prevalence of the risk/safety debate in the scholarship about place of birth, the health geographer Robin Kearns worked with anthropologist and midwife Sally Abel in the late 1980s/early 1990s with the aim of shifting attention in the academy towards women's opinions and experiences of place of birth (Abel and Kearns, 1991). In the context of policy changes in New Zealand that were supposed to herald more opportunities for home birth, Abel and Kearns studied the meaning of home as a place of birth, and proposed that home represented an optimistic and vital space for childbirth (Kearns, 1993). Two further spaces of childbirth were examined by geographers Scott Sharpe and Maria Fannin in the following decade. Sharpe's research, in a new hospital-based Birth Centre in Sydney, examined narratives about childbirth, and identified the importance of dualistic thinking about spaces of childbirth (i.e. hospital versus home) - continually re-examined and re-negotiated within the

Birth Centre – as playing a crucial role 'in opening up a space for alternative practice' (Sharpe, 1999, 103). Fannin studied the emergence of a more problematic childbirth space: the 'home-like' spaces within the US maternity care system (Fannin, 2003). In her analysis, Fannin describes how mainstream hospitals have introduced such spaces not with any intention to reform their philosophical approach to childbirth, but as a chintzy appeal to customers who might thus be lured into the hospital. Analysing the politics of space in childbirth in this way, Fannin suggests that such new spaces work to 'reify and reinscribe hospital birth as natural and the domestic as ideal' (Fannin, 2003, p531), rather than to create meaningful alternative options.

Building on Sharpe and Fannin's work, Robyn Longhurst, in the context of her more general study of maternity, reconsiders discourses around different spaces of childbirth in New Zealand (Longhurst, 2008). After exploring the meanings and importance of home birth from the perspective of one Maori family, and in support of Sharpe and Fannin's arguments, she draws attention to the tendency (on the part of home birth advocates) – in opposition to the hegemonic discourse - to 'reify home as an idealized site' space for birth (ibid, p93) and to represent the hospital 'as essentially 'bad'' (ibid, p82). In that context, she introduces the newly-emerging birth centres in New Zealand, as Sharpe did in the Australian context, as 'represent[ing] one way of troubling this binary' (ibid, p99).

Most recently, Becky Mansfield has looked at the 'social nature of natural childbirth' in the US (Mansfield, 2008). In doing so, she provides a useful perspective on place of birth in the US context, where a woman's decision about where she plans to give birth is likely to be intimately connected with the type of birth she wants to have. It is important to note, however, that this reflects the specific system of maternity care in the US, where there is a sharp divide between mainstream hospital-based care and midwife-led care (where the latter tends to support 'natural childbirth' in the woman's home). This is very different from the monopolistic UK context, where there is a strong tradition of planning for 'natural' childbirth within the hospital, and where an NHS-supported home birth service can be viewed as bringing the hospital to the home, rather than as necessarily supporting the radicalism of a 'natural' childbirth experience (Edwards, 2005; Saks, 2006). Nevertheless, Mansfield's analysis is a useful reminder of the inherently socialized nature of all approaches to childbirth, and thus focuses attention on the politics behind the claims of different approaches to birth (Symonds and Hunt, 1996).

This review of specific geography scholarship on place of birth suggests the wide-ranging and thoughtful nature of geographical engagement. Although limited in extent, this work – and more general work within health geography - has been of interest to other disciplines (Carolan et al, 2006; Burges Watson et al, 2007). Noteworthy, however, is the lack of focus on the opinions and experiences of the majority of women (i.e. women who choose to give birth within mainstream hospital provision). Whilst remaining interested primarily in the alternative space of home as a place to give birth, I seek to partially address this gap, by

approaching the issue of place of birth from the perspective of women who don't typically choose such alternative spaces[5].

3: Investigating spaces of childbirth - methodological issues

This project draws on a feminist and action-oriented methodology (Harding, 1987; Letherby, 2003). I decided that the study should purposefully seek to privilege women's voices, because this would provide women with an opportunity for reflection on the issues discussed as well as an opportunity for local consciousness-raising (Marshall, 2002). A desired focus on the meaning and significance that women give to their actions (in this case choices about where to give birth) led to an in-depth interview design (Jones, 1985), combining a narrative approach with a traditional semi-structured interview format.

I considered a number of potential study areas, including rural and urban areas, areas with relatively high and relatively low home birth rates. The location for the study chosen is a small rural village in the North-West of England, on the outskirts of a metropolitan region, with a population of around 1600 people. This is currently my own area of residence, in an area with a relatively low home birth rate (1.3%[6]).

Participant criteria and recruitment

Purposeful sampling was undertaken, to ensure 'rich and willing' informants' (Wengraf, 2001, p105). The two key recruitment criteria were that participants should be (a) mothers with a youngest child of 4 or younger at the time of the study who (b) regularly access village pre-school services. In addition, given my desire to engage participants in debate rather than simply extract data from them, it was important to select participants who were likely to be forthcoming and reflective in an interview situation, and who might have thought critically about the issues under discussion.

I had been expecting most of the women to have given birth in hospital, but I was hoping that many of them would have experienced a spontaneous onset of labour and a spontaneous and unassisted vaginal delivery (i.e. a birth experience that had not necessarily required the specialist facilities of a hospital). I theorized that such experiences might be crucial to an understanding of the research question. When I started to recruit participants, however, I found that only a small number of women met these criteria. This posed a dilemma: should I exclude women who had probably had a more 'difficult' childbirth experience? What would this say about the value that the academy places on their experience (and on them)? I decided

[5] This persistent focus on 'alternative' spaces might be criticized as representing the geographer's yearning for exploration and the discovery of new territory; more positively, I would suggest that it represents a continued attempt to redraw existing maps of childbirth, welcoming in marginalized actors and identifying how to reconnect marginalized spaces, if desirable, to a wider group of - currently excluded - women.

[6] Based on the latest available local statistics for 2005/6, available at www.birthchoiceuk.com. The same statistics show the England rate for that period as 2.69%.

to include many of these women, but also to expand the number of participants to allow for a balance of experience. This 'loss of control' over the study design led to a wider than expected range of childbirth experiences which turned out to be extremely helpful to this study (Al-Hindi and Kawabata, 2002).

Women were recruited at the local parent/toddler group and at the local pre-school in three stages: each stage sought to provide women with an opportunity to refuse to participate in or to withdraw from the study, and one did so. Key participant and relevant birth characteristics are set out in appendix 1. I had met twelve of the women before the period of research, and I knew three fairly well. The average extent of relationships between the women is probably similar to my own (Wengraf, 2001).

Data collection

The thirteen women selected were interviewed during June and July 2008, with meetings lasting around two hours, and the interviews on average one and a quarter hours. All participants agreed to the interviews being recorded, resulting in over seventeen hours of tapes. In the interviews, participants were first asked to give a narrative account of their childbirth experiences; they were then asked to respond to some specific questions. Despite the relative brevity of our contact, all participants were willing to share with me 'personal and intimate details about their lives' (Letherby, 2003, p13, Oakley, 1981). Interviews were often conversational in nature, and I answered participant's questions about my own experiences and feelings as a part of that conversation, reflecting my desire to enact a non-hierarchical approach as far as possible (McKay, 2002; Oakley, 1981). I sought to reflect back to participants my understanding of what they were telling me, which provided both an opportunity to check my understanding and scope for mutual reflection on emerging themes (Al-Hindi and Kawabata, 2002). Appendix 2 presents the outline interview schedule.

All but one interview took place in a single session. Interviews took place either at my home or the home of the interviewee, depending on what was more practical. They took place at different times of day (morning, afternoon or evening), with or without babies present, reflecting the reality of interviewing mothers (Letherby, 2003). The first three interviews took place as a pilot phase of the study; a review of this phase resulted in changes to the interview schedule (see Section 7).

In addition to these interviews, I interviewed a small number of other people in connection with this project (including a midwife and a health visitor), attended two 'webinars' aimed at midwives, acquainted myself in depth with the place of birth discourse represented in 20 issues of current UK pregnancy and birth magazines, regularly followed home birth internet chat-room discussions and watched a number of films and television programmes on place of birth. I also benefited from a number of conversations with a practising midwife, to check my understanding of technical data.

Data analysis

Data was analysed on an ongoing basis. A research journal was kept from the launch of the project through to the write-up phase (a period spanning 6 months), as a tool for reflection,

analysis and sense-making; numerous memos and theoretical summaries were written (Strauss and Corbin, 1990; Nairn, 2002). Reflective and analytical notes were made after each interview. A full listen-through of each interview provided a holistic sense of the encounter. Tapes were transcribed (by a third-party) verbatim, and the transcriptions were then edited (England, 2002), read, and reread, and marked-up as key themes emerged. As well as working with the transcripts, I listened to different segments of the tapes frequently throughout the post-interview period (Strauss and Corbin, 1990; England, 2002).

An important component of the data collection process was the focus on narrative method (Pollock, 1999; Wengraf, 2001). Taken together, the narrative and 'response' data provided a text of discourse for analysis (Lupton, 2003) from which to identify 'unsayable' assumptions that participants held about childbirth (Wengraf, 2001, p7). The narrative also provided space for the 'fortuitous emergence of data' (Strauss and Corbin, 1990, p184).

In the process of data analysis, I drew on my own experience in unforeseen ways. Reflections on the emerging data were made in conjunction with an ongoing process of reflection on my own childbirth experiences. Juxtaposing my stories with very different kinds of birth gave rise to important insights and to an emotional engagement with the research (Strauss and Corbin, 1990; Letherby, 2003). For example, when listening to women's descriptions, I realized that their imaginary of home birth, and the way they might set this up in opposition to hospital births, provided a very different understanding of place than I had from my own experiences, provoking an analysis of the reasons underlying these differences (Glaser, 1992; Moss, 1999).

Ethical issues

Because of the intensely personal and potentially traumatic nature of the subject under discussion, care was taken to minimize the potential for a negative impact on participants. Pregnant women were excluded. During the recruitment phase, I sought to make clear the nature of the issues to be discussed. I gathered information on birth support organisations, so that I could offer this information at the interview if appropriate. At the beginning of each interview, I drew attention to the personal and potentially traumatic nature of the topic, and suggested that we should stop the interview at any time if we felt uncomfortable. I was aware of the potential of my questions to trouble the 'coping strategies' that women might have created to make sense of their birth experiences (Letherby, 2003) and sought to remain attentive to this. Where appropriate, I made follow-up calls to participants to check whether any further support might be offered.

Given the focus of the study, I wanted to reveal that I had given birth both in hospital (twice) and at home (once). I planned to introduce this information after I had gained an understanding of the place of home within the decision-making process but before moving on to specific questions about home birth. Given the messy nature of real human interaction, this wasn't always possible. I also wanted to be clear about my lack of expert medical knowledge, and that I was undertaking this research as a geographer. Despite this, there were points where I felt it appropriate to share some 'medical' knowledge gained from my background

reading. When I did so, I pointed out the contested nature of research in this area, and suggested that participants would need to review the research themselves to come to their own view on it.

Confidentiality and power are two key issues raised by my position as a member of the small community being researched. It is important that I am seen to be respecting the trust with which personal information was offered up within the research context, and am not seen to be taking advantage of my access to that data. This affects how I join in 'everyday gossip' and, given my residence 'in the field', this is bound to be an ongoing issue. It also affects the writing of this report, where I have avoided linking individual quotations (for example via pseudonyms) or drawing attention to certain specific demographic characteristics, to seek to preserve anonymity as far as possible.

4: Where can women give birth?

Knowledge is a key theme in the UK government's agenda for improving maternity services: women should be able to make an 'informed choice', on the basis of clear unbiased advice, about various pregnancy and childbirth options, including where they give birth (Department of Health, 1993 and 2007). Often, it is assumed that midwives are (and should be) women's main source of information and thus retain ultimate control by deciding when and how to 'offer' choices to women (Chamberlain et al, 1997, 11; Mander and Melender, 2008). Knowledge and information held and distributed by these sources is thus often experienced as authoritative (Symonds and Hunt, 1996; Jordan, 1997), within a power-charged relationship (Lupton, 2003). The current analysis challenges that stance, by treating women's own knowledge as equally important (Machin and Scamell, 1997; Jomeen, 2007).

This section considers what and how women can know about birthing spaces. In doing so, key issues are addressed, such as 'what is relevant knowledge', 'how is knowledge distributed and shared' and 'how is knowledge continually constructed and valorised'. It also constructs a map of local options from these various perspectives.

Different types of knowledge

Experiential knowledge of birth places

After women had given birth once, their own birthing experience was a key trusted source of knowledge for subsequent decisions[7]. In this study, their reliance on other types of experiential knowledge was less evident.

All study participants knew where they were born and at least some brief details about their own birth. Knowledge about one's own place of birth was only referred to spontaneously by a few participants, late in the interview. Two women were born in hospitals local to the study

[7] This is not to suggest that women make these decisions alone; some women talked about a joint decision made with their partner/husband.

location, and these women chose to give birth to their first baby in that hospital, although this information wasn't volunteered in an initial discussion about what had influenced their choice. None of the study participants born at home gave birth at home. The two study participants who planned home births were born in hospital.

Women had varying levels of first-hand knowledge about the locations of other births. None had been present during another woman's labour and childbirth, although some suggested that they would be honoured to have the opportunity to support another woman during childbirth. Reflecting its prevalence within their lifespan, hospital births were the most known-about places for childbirth. Six study participants had good knowledge of home births (of friends or close same-generation relatives): they described these births as 'amazing', 'perfect', 'very good', 'beautiful', 'idyllic', 'fabulous' and 'fantastic'. The woman who accounted for the one achieved home birth in the study, however, did so without knowing anybody personally who had given birth at home:

> "I'd never heard anybody talk about a home birth. It was only after [my second] that I thought I could have had her at home. It's a shame that [bad] situations have to occur before you work it out."

Few people seemed to be aware of this woman's own home birth. Indeed, one of her local friends found out about it just before our interview. This evokes well-rehearsed concerns about the devaluation of (women's) experiential knowledge (Belenky et al, 1986):

> "I just thought she knew, to be honest. I mean, I thought I had told people."

Personal knowledge of the local area

All thirteen study participants moved to the study village in adulthood, with no prior family links to the village, and all worked outside the village before giving birth to their first child. Five study participants were either born or had spent a considerable part of their childhood in the local area, and thus had prior knowledge about local healthcare options.

The women live and experience different local geographies, linked to where they have lived and worked, where they access local services (including retail), and their social networks (which for some is predominantly family and for others friends). The result is that each woman has an individual local world: a way of understanding, relating to and feeling comfortable within the local area. These different local worlds form another key part of a woman's relationship with knowledge about local options for giving birth, or their 'socio-spatial knowledge networks' (Gesler and Kearns, 2002). Thus women had different views on the 'localness' of different hospitals:

> "We were more familiar with the geographical area of [the nearest hospital]. And when you are rushing somewhere … I think it was closer anyway … I didn't even consider any other hospital…"

The local childbearing community as a source of knowledge

Within the village, social networks exist between those with children of similar ages, and these networks can provide access to knowledge about local childbirth options. Once a baby is born, an entrée to local social networks is provided via the weekly village parent/toddler group, which hosts the monthly health visitor-run baby clinic[8]. Within and beyond the village, some women also access social networks created through common attendance at ante-natal and post-natal groups; given their large catchment area, however, these networks tend to be amongst groups of disparately located women. Thus a local 'childbearing community' exists, within the locally-situated (although inevitably national- and internationally-influenced) culture of childrearing (Laurie et al, 1999). This community might play an important role in post-natal support and in supporting subsequent pregnancies, but its usefulness as a source of knowledge about places for birth for women during their first pregnancies was found in this study to be extremely limited

Accessing knowledge via non-NHS antenatal groups

Some women accessed antenatal classes provided by the National Childbirth Trust (the NCT). Relevant to the issue of choice over place of birth, the local NCT area is geographically centred towards a freestanding birth centre in a neighbouring NHS trust area. This option was therefore promoted to NCT-users, as was the notion that women should feel able to change their decisions about place of birth as their pregnancy progressed.

Accessing official knowledge

National NHS material exists to inform choice, including printed and, increasingly, web-based material. Decisions about what supplementary information to provide on local options have historically been made at the local level, although there is an increasing amount of comparative information about local options on national websites (for example on the NHS Choices website, and the Healthcare Commission's site). A large amount of discretion remains for individual midwives in the way they talk about different options in their one-to-one private encounters with pregnant women:

> "I was so excited when I went in … [The midwife] just looked at me and said 'what hospital do you want to have it in?' I replied that I was new to the area; 'where do you recommend?' She said 'oh, I can't make those recommendations and I can't do anything until I know where you're going'."

Study participants came into contact with a number of different midwives. There is no GP surgery in the village, so study participants tend to access local maternity services via a range of midwives working out of various GP surgeries in a small cluster of neighbouring villages. All of these midwives form part of the same community midwifery team and are managed

[8] Of course, this is not to imply that all local women with young children necessarily access this group.

out of the nearest hospital. The implication of the link between their midwife and the 'local' hospital was influential for some women[9]:

> "I think I was slightly swayed by the midwife because she said that it was easier if everything was compact, and I didn't know about anywhere else anyway."

Individual discussions with midwives seemed to be the forum for 'official' place of birth discussions; this topic was not identified as one that arose in NHS antenatal classes. Many study participants suggested that they should be able to rely on their midwife to inform them about all local options for where to give birth. Midwives seem to have their own criteria for offering information and choice, however, especially for the birth centre option:

> "You weren't pushed that way at all … I don't know if it was because it was [my first]."

> "She explained I could go wherever I wished. So I said what about [the birth centre]… She said that might not be possible because you are an older mum. So I said 'fine'."[10]

A number of women reported that the rhetoric of their midwife was very much along the 'correct' lines: that they could choose 'wherever they wanted' to give birth. Women reported a silence about the local freestanding birth centre, however, and little mention of home as a feasible option. Instead, the hospital was seemingly privileged as the default option:

> "I remember saying to [my midwife] at the beginning, when she asked me to make a choice between the two local hospitals, that I'd quite like a home birth. But she was horrified. She more or less said 'forget it, we don't do home deliveries'. That finished that idea. I said to her later on that I was quite keen to go to [the birth centre], and I don't think she'd ever heard of it actually."

> "[The midwife] said I could change my choice at any time. She said 'we'll put [the local hospital] down for now, but you can think about it'... it never occurred to me to change my mind."

Only one woman suggested that home birth had been positively promoted:

> "So the next time I went in, I saw [another midwife] who was fantastic. She started off with 'definitely a home birth for you, I think'… I was rather doubtful ..."

This study provides scant evidence that official information provision succeeds in compensating for uneven access to information amongst women, or for correcting any information that the women might have encountered that would have seemed to limit their choices. Indeed, the role of the midwives in this study – as found in other studies (Kirkham,

[9] Midwives are also told about the importance of attracting first-time mothers to a service, given women's propensity to stick with what they know for future births (Jones and Smith, 1996).

[10] This birth centre, however, has no such blanket rules on first pregnancies or age.

2004) - might have been to reinforce existing inequalities, as the persistent gap in knowledge about the birth centre demonstrates.[11]

The mass media as a source of knowledge

Another source of information is the mass media, in its many various forms including television programmes, books, magazines, websites and internet chat rooms, whether aimed at a general audience or specifically targeted towards pregnant women (Bury and Gabe, 2006). Such sources of information were encountered and consulted by study participants to varying degrees, but were not talked about by study participants as informing their choice of where to give birth. Some women noted that these sources suggested options for places to give birth that did not seem to be available in the local area (e.g. a birth centre). Rather than using knowledge gained from such sources to challenge 'the authoritative source', however, such discrepancies were more likely to be dismissed, in recognition that all options might not be available in all areas:

> "I'd read up about [birth centres]… But nobody offered me one. I was surprised … Basically all I was asked was which hospital did I prefer. Nobody said anything about home. Nobody said anything about a birthing unit. I probably just assumed there wasn't one locally."

Mapping local options

Taking into account differential knowledge about places to give birth, a range of local places are hypothetically available for all birthing women in the study area.

The 'local' hospitals

The study village is sited just within the boundary of a Metropolitan District, which has its 'own' local NHS trust and general hospital, providing a consultant-led maternity unit (CLU)[12]. This hospital provides the closest accident and emergency services to the study location (within 5 miles), and is the only hospital accessible from the village by a direct public transport service. These factors underpin the notion amongst many study participants that this hospital provides the obvious 'local' maternity unit. All women were aware of this option.

Because of the rural location of the study area, however, and the fact that travel to any hospital involves a journey to a neighbouring town, it becomes clear that a second nearby-hospital is viewed as equally 'local' by some women (dependent on their existing local worlds, as discussed above). The second-closest maternity facilities to the study village are thus provided in this hospital (less than 7 miles away) and consist of a consultant-led-unit and an alongside midwife-led birth unit (ABU). Most women knew about this option, and some were aware that it usually achieves higher ratings than the 'local' hospital.

[11] See Valerie Levy's work for a useful and complementary discussion of the midwifery perspective on such encounters (Levy, 2004).

[12] Note, however, that the NHS Patient Choice initiative seeks to challenge such perceptions of the 'local'.

Other hospitals

As well as these 'local' maternity units, there is fast (motorway) access to a range of maternity units in the wider metropolitan area. Within 15 miles, for example, there are nine further maternity units. Some of these are located within teaching hospitals, and some provide both an alongside midwife-led unit (ABU) in addition to a consultant-led unit (CLU)[13]. For some women, these represent highly accessible and desirable options. For others, they seem distant and irrelevant:

> "I think [those two] were the only options. From here, where else could you go? Apart from home. I mean, there isn't anywhere else is there?"

Freestanding midwife-led birth centres

In addition, there is one freestanding midwife-led birthing centre (FBC) considered local and easily accessible by some study participants. Located within a cottage hospital, it is a 20 mile drive away from the study location (by rural roads). It represents the only local freestanding institutional provision of a low-tech midwifery-run birth environment, firmly underpinned by a physiological –as opposed to a pathological - model of birth. The philosophy promoted by the midwifery team in that area underpins the second-highest home birth rate in the North-West, of 14%[14].

A very low level of knowledge about this option was reported by the study participants. Eight had not heard of the option at the time of making a decision about where to give birth, and five remained unaware of it at the time of the interview:

> "No, I've never heard about it. In what circumstances would you be told about it? … What a shame. Oh well, maybe I'll have another one …"

Home

The women's own homes provide another option for birth[15]. Most women seemed to think of their home as a plausible venue for giving birth, with none reporting lack of privacy issues, for example. Only one women suggested that her (rented) home might have been physically unsuitable for a home birth (due to a damp and mould problem). Another woman suggested that home might be an unimaginable place for giving birth:

> "Do you know, there's not one room in the house where I can imagine giving birth?"

[13] This study revealed some confusion about the purpose of 'alongside birth centres' (ABUs) and this type of facility rarely featured in the accounts of study participants. For example, the nearest hospital also has an ABU, but this didn't feature in any accounts.

[14] Figure for 2006/7, North West Local Supervising Authority (2008).

[15] This study revealed only incidental knowledge of private sector maternity provision (e.g. for antenatal testing unavailable on the NHS), and none of the women discussed the possibility of either giving birth in a non-NHS facility or at home under the sole care of an independent midwife.

5: Where do women give birth?

Section 4 introduced the notion of differential knowledge about spaces for giving birth. This section looks at the decisions made about the choice of location of the twenty-six childbirth experiences included in this study.

Where did the study births take place? A statistical overview

Twenty-four of the births in the study took place in hospital, one took place at home and one took place in a free-standing birth centre. These are the 'facts' on place of birth for the twenty-six births in this study, which, for example, would form the basis for national statistical 'type of birth place' reporting. For the purposes of research into place of birth, it would additionally be noted that two of the hospital births were 'transferred during labour' from non-hospital settings: one from home and one from the birth centre (both were non-emergency transfers). Thus twenty-two of the twenty-six births had been planned to be in hospital, two in a free-standing birth centre and two at home.

In terms of hospital locations, fourteen of the twenty-four hospital births took place at the 'local' hospital; five took place at the second-closest hospital and five took place in other local hospitals. Again, these are facts that might be noted as statistically relevant by, for example, an audit of how well patient choice is being delivered and taken-up.

In the previous section, the notion of the 'local hospital as default' was suggested as an expected outcome of a decision-making process in which official knowledge is seen as authoritative (Davis-Floyd and Sargent, 1997) and where the position of the midwife is influential. In that context, the fact that as many as ten births took place at hospitals other than the 'local' hospital warrants further examination – see table 1.

Births at second nearest hospital (n=5)	***Births at other hospitals (n=5)***
Mother had been born herself in that hospital, had grown up and continued to be registered with a GP in area (n=1)	Birth-place planning started before moving to the study area. Desire to remain with hospital local to previous residence (n=1)
Not planned, but ended up there because of the hospital's back-up role for a free-standing birth centre (n=2)	The family was living in two locations and chose a hospital that was equidistant from both (n=2)
Desire to avoid the local hospital, after a poor experience there with earlier births (n=2)	Desire to avoid the local hospital, due to its perceived poor reputation (n=2)

Table 1: Understanding 'non-local' hospital choices

Reasons for 'non-local' hospital choices are varied. Four decisions seem to represent choices still based on locality; four are linked to decisions to avoid the local hospital; and two are linked to birth centre back-up arrangements. This complicates an initial reading of the statistics as illustrating a positive outcome of informed choice.

How far do outcomes reflect women's wishes?

In the majority of cases, the women reported that the decision-making process was straightforward and they got what they chose. Most women suggested that they had already made their minds up before announcing their decision to the midwife:

> "I just thought 'right, I am pregnant. Where's the nearest hospital with a maternity ward?' I checked it had a good reputation, and that was it ... Then when I saw the midwife I confirmed it with her."

This questions the notion of the midwife as being in an inevitable position of influence in the decision-making process about birth place options. However, it is possible that an overt demonstration of influence is only necessary where women are in danger of making 'incorrect' choices (Anderson, 2004). As illustrated in the last section, some women reported having been put off their choice of either birth centre or home by their midwife. In some cases, a negative midwife reaction was accentuated by the views of friends and family:

> "I said … 'I actually wondered about a home birth …' and got about that much out. It was stamped on. And my friends said 'oh god, you can't possibly', and that was it. It was quelled in this tirade – this huge rush - of emotion and negativeness… "

In all cases, the negotiated nature of the choice seems to have been accepted quite readily at the time, and women revealed - through the sequencing of their accounts - a high degree of ownership of their final choice and a tendency to forget any desire for a different outcome.

For some women, a degree of Foucauldian self-governance was evident (Lupton, 2003) as they reported discounting the possibility of a home birth themselves, without any discussion with the midwife:

> "I did consider home seriously with [my third] since the other two had been straightforward … but fairly quickly decided it probably wasn't a good idea … my body was older … I wasn't sure enough about it to fight that hard for it… [My cousin] had a terrible fight. "

Although most women argued that having a choice over where to give birth was important to them, others suggested that it wasn't:

> "If there had not been a choice, though, I don't think it would have worried me too much. I mean, if everyone went to one hospital, then I would have gone there too… It wasn't that important."

Opting for a hospital birth: the 'obvious' choice

As the statistics indicate, hospital was the preferred option for where to give birth, and the local hospital was generally preferred over other options. This reconfirms studies where proximity to hospital has tended to be a key driver of choice (Jones and Smith, 1996). When asked why they had chosen their local hospital, many women had straightforward responses – especially for their first childbirth experience:

> "I had this idea that I would go into labour and need to get to hospital quickly… It was geography really rather than anything else…"
>
> "It was the closest hospital … I did not think of any other options to be honest."
>
> "Well really I just thought it best to go to the local hospital"

For subsequent births, women obviously had more personal experience – and often more information from new social contacts – on which to base decisions about where to give birth. As reported earlier, a few women actively chose to avoid the hospital where they had previously had a bad experience:

> "I just thought I may as well try somewhere else …that might be just as bad, might be worse. But at least I've given myself a chance of somewhere different."
>
> "I was determined not to [go there again] … I knew for a fact that this would be the last child I had … and I wanted to try and choose the best place…"

Other women, however, returned to the same hospital, despite being unhappy with their previous experience. In these cases, poor experiences were readily excused if 'everything turned out alright in the end', even where the level of care experienced had triggered a formal complaint:

> "The consultant apologized … We did not take it any further … [We went there again] because everything was fine with [my first baby] in the end."

Choosing a birth centre: a limited option

The freestanding birth centre was preferred by two women who had first-hand reports about it from friends or work colleagues. Both of these women also attended NCT classes, where another study participant was persuaded of its benefits. All three women were clear that this option had not been promoted by their own local midwife:

> "Somebody at work … talked to me about this lovely unit she had been to. Then we all went to [NCT] antenatal classes in the town where [the birth centre] is."
>
> "Do you know, my midwife had never heard of it? I mentioned it to her and she said it sounded like heaven."

Planning for home birth: two different pathways

In contrast to other women's attempts, two women who planned a home birth reported of their success. The first woman, exposed to positive home birth experiences through friends, had commenced her pregnancy in London, where the local midwifery team was keen to promote and support home birth:

> "So I told them [here] that I wanted to have a water birth at home … They said that they'd never done a home birth like that. I said 'well, that's what I want, so what are we going to do about it?' and they said 'well, we're not saying no'"

The second woman had learnt through experience: after one poor experience, for her second birth she delayed her journey to the hospital until very late in her labour. From that experience, she realized that she could manage perfectly well at home, which she went on to do with her third baby:

> "They were very supportive when I went for the home birth … They didn't try to put me off at all. Just asked me why, and I said I wasn't happy with my experience at the hospital, and they said 'ok, that's fine'."

Both women developed strategies to help ensure that they got the home birth they wanted. The first arranged for an independent midwife to attend the birth, as a 'home birth consultant' to support the local midwives. The second woman reported taking special iron tablets 'four or five times a day' to stop her anaemia putting a home birth into question:

> "I was very sick through my pregnancy … and I was fainting all the time. They were obviously trying to put me off a home birth, saying my iron levels were low … and they didn't advise it … But I reached the [iron] level she was happy with, so that problem went away."

This evidence, together with women's rejected requests for home birth highlighted earlier, contrasts with Madi and Crow's findings that women who know about home birth and want it are generally well supported in that choice (Madi and Crow, 2003).

As a footnote to this section, one more issue that is relevant to where women choose to give birth is the extent to which they might be constrained in their choices by medical circumstances. My analysis, based on a close examination of the women's accounts, suggests that the preference for hospital is not explained by medical circumstances. It suggests that at least seventeen of these labours could have commenced either at home or in a birth-centre, if that had been the woman's wish. There is a good case for supposing that at least twelve of these would have likely progressed to a successful birth at home or in the birth-centre, given appropriate support. On the evidence available, no emergency transfers should have been necessary. This information may be said to be silenced knowledge.

6: The ambivalent spatial imaginary of the hospital

Sections 4 and 5 looked at the different types of knowledge that women access about the places where they can give birth, and how and where the women in the study chose to give birth. This section looks more closely at what women reveal about their expectations and experiences of hospital as a place to give birth.

Women in this study attached a wide range of meanings to the hospital, which are overlapping and inter-related but which I organize into three themes: support, safety and the notion of 'being in the right place'. In examining these themes, it was apparent that there were frequent areas of discord between expectations and experience (Oakley, 1986).

Expectations of hospital

There is a recurring theme about the hospital providing necessary support in labour and childbirth. The women talked about the hospital being the place where they would access expert care during labour: this was often focused on the idea of continuous and supportive care from a single midwife, who would be on hand to validate and encourage the woman's good efforts at coping with the labour. Immediate access to desired pain relief was important, as was access to clean bathroom facilities including a bath to relieve labour pain. For the period after the birth, women talked about the support they expected, to help them with practical baby care tasks (such as bathing the baby) and to establish breastfeeding. These are all needs that can be provided in any setting, of course, but the imaginary of the hospital as the therapeutic landscape of choice is strongly suggested in these accounts (Burges Watson et al, 2007).

In terms of safety, the hospital was valued as a place where problems in pregnancy and labour could be properly diagnosed and quickly dealt with if necessary, with the use of scanning, monitoring, operative or instrumental technology. Hospital was valued as a place where constant surveillance during pregnancy for women identified as high-risk (for example showing signs of pre-eclampsia) could avert the emergence of serious life-threatening problems, and as a place where premature babies could be properly looked after. The hospital represented a place where the process of labour could be triggered or speeded up at will, which was talked about by some women as desirable when faced with a prolonged pregnancy or a slow and tiring labour. The hospital was valued as a place where an immediate threat to life during childbirth could be averted. Following difficult birth experiences, the hospital and its technology was seen by some as there to be appropriated by women to ensure better control over the progress of a subsequent birth (Davis-Floyd, 1992; Farnworth et al, 2008). Hospital was explained by one woman as a 'no regrets' choice, especially for a first baby.

Closely related to both of these themes, the idea emerged of the hospital as being 'the right place to be' when giving birth, implying that birth might be considered 'out of place' in other settings (Cresswell, 1996). Some women referred to experiencing a sense of relief, security and safety when arriving at the hospital. Being allowed access to the hospital in good time was important for some, to allow a period of settling. Others talked in terms of needing to be at the hospital just for the birth itself, comfortable to labour at home alone or with family. Some talked about the hospital as providing a useful space away from older children. Others talked in terms of the hospital – in contrast to home – as providing a space in which the messy process of birth should take place (Douglas, 1966; Sibley, 1995).

Examining the experience of hospital

These ideas, about what the hospital should offer, often contrasted with the sometimes traumatic experience of hospital birth as presented through birth narratives and in response to later questions, in which negative experiences featured strongly. This section explores negative aspects of the hospital experience highlighted in the accounts of 18 (out of 24) hospital births.

Some women were angry about the lack of access to support in early labour. In some cases, this was represented by a lack of access to the hospital itself; for example, when being told that they couldn't yet be admitted on examination, or being told over the phone that it wasn't yet time for them to come in. One woman described this lack of support as the first negative intervention in her labour, and the other talked of it in terms of disrupting her wish to settle-in before the birth event, evoking the modern silencing of the nesting instinct discussed by Walsh (Walsh, 2006). For others, it was the lack of access to their chosen birth partner that was troubling; for example, when women went into labour (following induction) on the antenatal ward, where strict visiting hours were in operation.

Once in hospital, midwifery support often fell below expectations, with frequent negative references to shift changes, new faces and long periods of being left alone. The lack of access to appetizing and nutritious food and drink was of concern, and toast featured heavily when a nil by mouth regime was relaxed (Mead, 2004). Narrow hospital beds were an annoyance: during the hours (and sometimes days) leading up to the birth, they allowed little opportunity for partners to rest; in the days following the birth, they constrained women's options to rest, feed and be with their baby.

Many women reported being strongly encouraged to undergo procedures or to take pain relief that they felt to be unnecessary and unhelpful; only some of these women were able to resist these 'encouragements'. Some women were surprised at the unpredictable outcomes of induction or augmentation of labour. Decisions about and activity around a range of interventions, especially where these involved doctors, were experienced by many as unacceptably and worryingly slow, until the medical team were assembled and had decided that there was an 'emergency'. Reflecting their differential power, doctors were seen as able to change their minds, but women felt unable to do so once they had – even if reluctantly - agreed to a course of action.

After the birth, care was experienced as uneven. Tellings-off from staff – as women were initiated into the unwritten rules of the postnatal ward - featured frequently: for staying in bed (especially with the baby), for getting out of bed, and for not getting out of bed; for changing the baby on the bed. One woman told of her struggles to establish breastfeeding until a night cleaner helped out. Many of these negative experiences are unsurprising from reading various audits of national and local maternity service provision (e.g. Healthcare Commission, 2008).

Achieving positive birth experiences in the hospital

This focus on the negative side of the hospital experience is not intended to imply that the women didn't also have good things to say about their care whilst in hospital, or that they could not potentially experience the births they want within the hospital environment. For some women, hospitals do seem to provide a space for a safe and rewarding birth experience (Declercq et al, 2001). But in this study, this seemed to be the exception, and was talked about in terms of an outcome of extraordinary strong will:

> "I felt really empowered afterwards… The thing is, if I'd been bullied [into the epidural] then I would have assumed that I couldn't have done the next two without an epidural. It was only because I had such a good midwife that I managed."

Indeed for some women, the battle to achieve a satisfactory birth experience might become the basis for the ensuing sense of empowerment as much as the birth itself.

> "They started to say I would have to go to theatre, and I said 'there is no way that is happening'… I remember going down [to theatre] and getting a contraction… The midwife said 'she's still pushing'… They didn't encourage me to push or anything … They had obviously decided that I was having a c-section… It was awful, the anxiety… I remember the last push … I did the biggest push in the world. It was incredible … I heard the anaesthetist say 'Jesus, it worked'… I had wanted to go into labour and I had wanted to experience that. I really needed to experience that …"

The important structural – or cultural - barriers to women achieving the types of labour and births they desire in a hospital setting, as they are drawn into an 'irresistible bio-medical metaphor' (Machin and Scamell, 1997) are demonstrated within the accounts of many women in this study. The hospital, for many, was experienced as overpowering, and seemed for some to almost inevitably define them as inadequate to give birth to their baby:

> "The drip was up so fast … almost like a signal… They might as well have written on my forehead 'you can intervene when you want'… So as soon as I went in, I was theirs"

Processing the misalignment of experience and expectation

Interestingly, much of this experiential knowledge seemed to be discounted when many of the women came to make decisions about subsequent births, as women retained an overwhelmingly positive spatial imaginary of the hospital. Hospital still represented safety and 'the right place to be'. If the imaginary had been sufficiently troubled, the response was not to reject the hospital; indeed negative experiences tended to increase the worry about birth, and thus provoke an expressed need for future hospital care. The typical response was to develop strategies of control to protect against future harm in the hospital: these ranged from switching hospitals, accepting an offer of a domino arrangement, or by negotiating in advance access to specific technological support (for example, an early caesarean). From a social psychology perspective, this latter response might be theorized in terms of the precautionary principle, which in the childbirth context would act to deny women the - perhaps worthwhile - risk of physiological childbirth because of the 'dictating role' of doubt and fear (Breakwell, 2007, p6).

For the purposes of this study, it is interesting to note how one of the key elements of the spatial imaginary of the hospital – that of support - is frequently challenged experientially. The theme of hospital as a safe place to give birth, however, is much less challenged within women's accounts. This seems to be linked to the potential (and often unpredictable) need for

the doctor: whether to administer particular forms of pain relief or to be on stand-by to perform a caesarean operation.

For most women in this study, the availability of a doctor (whether or not actually required) seems to be a vital part of the birth experience (Lupton, 2003), and thus only settings where the doctor is able to attend seem to be considered as correct places to give birth[16]. Yet for most of the women in this study, attitudes towards doctors were ambivalent. At some level, most women believed that the midwife was the only the medically-qualified support person required at a straightforward birth:

> "I don't really see why a doctor has to be involved at all, frankly… As soon as a doctor comes in, I'm sure that slows everything down and gets you anxious…"

Thus there emerges a tension between the desire for good support (that is generally experienced as poor in the hospital) and the desire for on-hand medical back-up (via the concern that something might go wrong and that a doctor might be needed urgently). In this tension, the pathological bias is clear, and suggests that perhaps the key issue surrounding the low level of current home births is just this: the prevalence of the assumption that childbirth is a pathological – rather than a physiological – event (Walsh et al, 2004).

7: Learning from other imaginaries

The previous section explored spatial imaginaries of the hospital and exposed an ambivalent attitude that women seem to have towards the hospital as a space for giving birth, despite their strong attachment to it as the birth place of choice. This section introduces two further spatial imaginaries, to seek to better understand this tension.

Ideal places for labour and birthing

First, I asked women to imagine their ideal spaces for labour and birthing. It was soon clear that this was not an easy question. Whilst some women provided an initial answer quite quickly, for many it was a difficult and multi-dimensional task.

	Ideal spaces: first baby	**Ideal spaces: subsequent babies**	*Memo: places of birth for first (and subs) babies in study*
Home	3	5	*0/1*
Freestanding birth centre	5	4	*0/1*

[16] Midwife support was also thought of as crucial to even the most straightforward births, despite some interest shown in free-birthing (where a woman plans to give birth at home without calling upon a midwife).

Hospital	3	1	*13/11*
Alongside birth centre	0	1	*0/0*
No strong preference	2	2	*n/a*

Table 2: Summary of women's ideal places for giving birth

As shown in table 2, the notion of an ideal space for giving birth outside the hospital (or indeed outside of any institutional setting) was revealed to be strong amongst these women, and increases with subsequent births. Women talked about having different ideals at different times, and some related a narrowing down of their options (or a reduction in their idealism) as they got older. The way in which women talked about ideal places was often highly dependent on their previous childbirth experiences. In some cases, previous experiences perceived as 'difficult' led to a 'flight to safety', defined in terms of the full medical back-up that only a hospital could provide:

> "Because they had been so slow about making medical decisions when I was in the hospital, the idea of being out of the hospital and someone trying to make a medical decision about me, I just thought 'I'm not having that'. "

On the other hand, some women suggested that the highly medicalized environment of the hospital might have contributed to – or even created – their 'difficult' experience, thus making another kind of environment more attractive in retrospect:

> "The next thing I remember was being laid down to be monitored … and I couldn't move… it was just a really unpleasant experience… I think I would have coped better [at home]."

Others noted that their particular circumstances led them to believe that they personally needed to be within a hospital environment to give birth, but that this didn't affect their belief in a home or birth centre birth as better options for women with straightforward pregnancies:

> "Certainly for young, healthy women who have no complications I think we should encourage it. I know that in Holland where they have a high rate of home births they have a much lower rate of stillbirths. [Holland] is one of the safest places to give birth."

Clearly, there are issues with interpreting expressed notions of an ideal. There are the regularly-trod concerns, for example, that people might tend to suggest what they see as a 'socially acceptable' or 'correct' in an interview scenario. There are more general difficulties with interpreting the significance of an ideal: for example, to understand whether it represents a realistic desire on the part of the woman, or whether it is already – in its telling - considered unachievable. Thus a woman who states that her ideal would be to labour and birth at home might (a) be very willing to do so, if given the opportunity; or (b) never intend to go through

with it, even with the most enthusiastic support from her midwife and social network. The first scenario raises further questions about what stops a woman from putting in place her ideal. In the context of the ideal of home in particular, there are further warnings provided by a well-developed geographical literature which seeks to interrogate the sometimes essentialist 'romanticized idealized visions of home' (Varley, 2008; Blunt and Dowling, 2006): this again suggests the need for caution.

Treading cautiously, then, I will proceed because the rift between the ideals of these women and the plans they make does seem to me to be of significance. Indeed it may constitute a useful way of responding to the question asked in an earlier section about whether women got what they wanted. With the benefit of hindsight, only three of the women suggested that they had been in their ideal place for at least one of their births. Two were 'transferred away' from their ideal place whilst in labour; one woman was relaxed about this; the other wasn't. For some women, it is clear that they developed a good understanding of their ideal spaces for labour and giving birth only after they had experienced giving birth once or twice. Thus they had perhaps thought they were choosing their ideal location for their births, but realized in retrospect that this had not been the case. This seems to represent a clear opportunity.

Some women reflected on the fact that an 'ideal scenario' had not been part of their thinking when deciding where to give birth. Despite the rhetoric of choice - that they could give birth wherever they wanted - the decision-making process had not been experienced as one that truly offered a space for them to think about what they really wanted. In that context, their 'ideals' were not construed as being relevant knowledge.

Envisioning the option of home birth as the default

Moving on from ideal spaces for labour and birth, I next used the idea of creating 'believable hypothetical choices' (DeVries et al, 2001, p261) to access more information about the home as a space for labour and birth. One of the pilot interviewees (who reflected that she 'could have easily given birth to her third child at home, and it would have been better') had suggested the need for much more encouragement from the community midwife before a home birth would be seriously contemplated. Drawing on this, I posed a new scenario for the subsequent interviews[17], that of home birth as the new default option (see appendix 2). I hoped that this would start to break through some of the dualistic thinking I had encountered, where women often talked about home with reference to the hospital, rather than on its own terms, evoking an A/ not-A dichotomy (Prokhovnik, 2002,p24).

Given the current maternity policy focus on choice, I understand that this scenario might be criticized as wholly unrealistic[18]. It is important to recall, however, that it was developed as a data collection tool. The important point for the purposes of this research is that the option certainly did seem plausible to the interviewees in the interview context.

[17] Because this scenario was introduced after the pilot phase, this section discusses data collected from just ten women.

[18] See Barber et al, however, where it is proposed as a policy option (Barber et al, 2007).

Most reactions to this new scenario were positive, including from women who hadn't previously seemed that interested in home birth, or who had expressed opposition to it. Some women noted that their experience of an unassisted vaginal delivery boosted their confidence about this new scenario (Fenwick et al, 2007):

> "I think I would fully embrace it. I have had a natural birth and know I can do it. So the psychological barrier has been taken away. I would definitely go for it."

Reactions didn't display any lack of realism, however. Some women reflected on their mixed feelings about the scenario:

> "Excitedly nervous. There would be a real thrill about that. Excited, because I would feel I could do it at home, which would be great. Nervous about the complications, if any. But if they said 'you could be in hospital within ten minutes if there was a problem', then I think that would take the pressure off. Grounded. I think I would feel quite grounded and I would really like that."

One 'committed birth centre supporter' unexpectedly switched her allegiances back to home, on the basis that proper support now existed:

> "I think I would feel really positive about it. I would feel great. Yes, if I felt there was absolute and support and enthusiasm … yes, I think I would feel great about that."

Another woman explained how she would need to get used to the idea:

> "I suppose if I had started a pregnancy knowing this, it would not be a problem at all … Because if everyone did it, then that would be fine … I would say, 'well, ok', being very low key about it, but getting more confident over time. "

Perhaps most surprisingly, a woman who had stressed the importance of access to an epidural suggested that – although still not her preference – she'd be able to cope at home:

> "I think I would probably find it quite daunting. If the necessary pain relief could be administered … gas and air and pethidine at least. If that could be given, I would feel better. I would probably warm to the possibility …"

One woman was surprised, and reflective, about the change of mind that this scenario had provoked. She suggested that it was connected to the notion of expectation; of a new social norm; of evident support and enthusiasm from the midwife[19]:

> "This is what is expected. This is good. This is deemed as something that is positive and we will get you to hospital if necessary. [We] know what we are doing; [we] are here to support you. How about it? And I would say YES!"

[19] Checking the tapes, I am certain that I did not portray any particular enthusiasm for this scenario. The matter-of-fact way in which it was presented, however, would certainly have implications for how it was understood.

A woman who had very much enjoyed a home birth with her third baby reflected on how she might have felt if presented with the scenario during her first two pregnancies:

> "As I have done it, I would be absolutely delighted. But had it been my first, I would have been petrified … horrified. But I was inexperienced."

Another reading of this data would be that the positive nature of the responses to this scenario were quite predictable, reflecting a tendency for pregnant women to go along with what they're offered, on the assumption that the medical experts know best. I would not seek to dispute this suggestion, and believe that it is an important interpretation. A number of women talked in those terms:

> "I think I would probably have gone along with that, because to be honest I do what I'm told."

Focusing on what the data in this section implies about attitudes towards home birth, however, it does seem to suggest that home birth is not as inherently alien or unacceptable to women as current statistics might indicate.

8: Conclusions

Section 2 introduced the notion of the hegemonic discourse of place of birth in England as one that strongly promotes the hospital as the right place to give birth. Sections 4-7 of this report, in setting out a selection of data gathered through primary research, provide a number of illustrations of this discourse in action, as represented in the accounts and experiences of thirteen women.

In face of this hegemonic discourse, it was perhaps unsurprising to find a group of women who make their decisions about where to give birth very much within the bounds of that discourse, and whose place of birth outcomes then work to further reproduce its normality and taken-for-granted nature. What was more interesting to discover, however, was its simultaneously contested nature. There was a consistent pattern to the findings that suggested a potential energy to trouble the hegemonic discourse. This was particularly evident in the wide-ranging concerns discussed by women about their experience of hospital birth (section 6), about their ideal places to give birth and in their reactions to a 'homebirth as default' scenario (section 7).

For the most part, however, these energies were dissipated and did not affect place of birth outcomes. It was suggested that this may be particularly influenced by a lack of access to information about options (section 4) and the constraining nature of the environment within which women make their decisions (section 5). The repeated ability of women to silence their own knowledge was also striking (sections 4, 5 and 6). Whilst this 'troubling energy' did not generally result in different outcomes, therefore (and in some cases could not have done so,

since it reflected the benefit of hindsight), it suggests that the hegemonic discourse on place of birth is more contested than might be thought.

The research also suggests how a competing discourse of home as the right place to give birth is tolerated, if kept within acceptable limits. Thus the current minority take-up of home birth is allowed - and even encouraged - by the hegemonic discourse, as a voluntary choice (representing the liberalism of the dominant position). A choice for home-birth is seen in terms of a woman's prioritisation of her own experience over that of safety (for her and her baby). It is seen as a quirky and risky choice, but one that is permitted and controlled, and in this way it poses no threat to hegemonic discourse. Indeed this framing of home birth, together with a vigilant policing of the boundaries, might be said to strengthen rather than weaken the hegemonic discourse.

Focusing on the central research question, I would suggest that this analysis provides a continuum of situations explaining why more women in this particular study didn't give birth at home:

- some women may not think about home birth, and thus not even consider it as an option. Hegemonic discourse, for these women, silences not only the potential benefits of giving birth outside the hospital, but also the option itself;

- a second group of women may consider the option of giving birth at home, but rule it out on the grounds of safety. For these women, the role of hegemonic discourse in promoting hospital as the safest place to give birth, for the overwhelming majority of women, is key;

- other women may think about home birth and seriously consider it as an option. They may subsequently decide themselves that it would not be a good idea, however; or they may seek to test out the possibility with healthcare workers and/or friends and family before coming to a firm decision. The current study suggests that these women will generally be dissuaded. For these women, hegemonic discourse acts to disrupt their desires for other possibilities;

- a fourth group of women may decide that they would definitely like to plan to give birth at home, and their approach to their midwife meets with success (though it will often require some strategic effort on their part to keep to the plan). In this final case, and if limited to a small minority, hegemonic discourse allows this course of action.

This continuum - which is necessarily likely to be partial, reflecting the small-scale qualitative nature of the research on which it is based - suggests a number of criteria that would have to be fulfilled if claims to home birth were to become more achievable: the option would have to be better publicized; the debate on the relative safety of different birth settings would have to be better understood; healthcare workers and others would have to be more supportive of women who are attracted by the option, but lack the confidence to insist on it; the healthcare system would need to focus on supporting women achieving their home birth plan.

It is not possible from the current study to provide any indication of the likely respective importance of each of these actions. Perhaps underpinning these actions, however, and recognizing the fundamentally intertwined aspects of knowledge and power, the current findings would suggest the need for new local discursive spaces, protected from the undue influence of professionals. These could allow better access to, and status for, a wider range of childbirth-related knowledge (including women's own knowledge) than is currently the case, and form a space within the 'new social movement' that privileges personal autonomy over dependency (Illich, 1975; Kelleher, 2006).

Although this report has focused on place of birth, however, in some sense the underlying issue here is not really about where birth takes place at all. Rather, one could argue that place has become a proxy within a broader debate about childbirth, knowledge and power. It becomes an issue about place of birth only because the behavior associated with the maintenance of the hegemonic discourse starts to become destructive. The hospital's dominant ideology - that women's ability to birth is suspect – leads to unnecessary intervention, loss of a woman's control over her birth experience and poor outcomes as the unsurprising result.

This debate about place of birth, then, is perhaps rather more fundamentally a debate about whether the physiological process of birth itself is trusted and valued. This report does not seek to suggest that all women either could or should plan to give birth at home. But a more present awareness of, and confidence in, their body's ability to give birth would mean that women would then enter wherever they choose to give birth in quite a different position of knowledge and power. This is well illustrated when birth takes place at home with limited intervention:

> "With a home birth, you have no choice other than to go with your own body… I just think you can prove to women [that they can do it]. I mean, I'm not anything like pro-women, but the one thing I think women can do, and do really well, is to give birth, and to give birth really well … I absolutely believe that … I just think that from the woman's point of view, [giving birth at home] is probably the best way, I honestly do… I do feel that you can do it ..."

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Appendix 1: Characteristics of study participants (n=13) and births (n=26)

Age at interview

33-34	2
35-39	8
40-46	3

Age at birth of first child

21-29	3
30-35	8
35-39	0
40-45	2

Number of births per woman

1	3
2	7
3	3

(all singleton pregnancies)

Age of youngest child

Under 1 year	3
1-2	4
3-4	6

Ages of children

Under 1 year	3
1 or 2	6
3 or 4	9
5 or 6	5
7 or older	4

(including one adopted child)

Highest educational level attained

Vocational qualification	1
A-levels or higher	5
Degree or higher	7

Occupation of main earner

(NS-SEC5 household rating)

1	5
2	4
3	3
4	1
5	0

Where participants have given birth

Home only	0
Home and hospital	1
Home and birth centre	0
Home, birth centre and hospital	0
Hospital only	11
Hospital and birth centre	1
Birth centre births only	0

Type of onsets of labour/birth

Spontaneous	19
Induced	2
C-section	5

Type of birth

Vaginal births	15
- of which assisted	(2)
Caesarean births	11
- of which elective	(5)

Experience of vaginal/ caesarean births

Vaginal births only	5
Caesarean births only	6
Vaginal and caesarean births (both VBAC)	2

Normality of births

Normal births[20]	12

[20] According to the agreed definition in Consensus Statement on Normal Birth: "without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery" (Maternity Care Working Party, 2007)

Appendix 2: Interview schedule

Preliminaries

1. Brief explanation of purpose of interview
2. Check voluntary nature of participation; clarify anonymity of data; seek consent to record interview
3. Remind interviewee that interview/ tape can be paused or stopped at any time, and that they can withdraw from study at any time
4. Explain two-part structure of interview/ check time available.
5. Turn on voice recorder.

Part One: telling birth stories (a narrative approach)

1. Request/confirm details of children
2. Encourage narrative telling of birth stories for each child
3. Conclude and move on / check need for break

Part Two: focusing on spaces of labour and birth

1. Probe interviewee experience and feelings about place. Eg:
    a. precise locations/ sequence of settings and movements during labour and birth, and thoughts about these;
    b. any changes between place plans and outcome;
    c. reasons for/ influencers of choice of setting ask whether it was important to interviewee to have had a choice over where to give birth
2. Seek knowledge, thoughts and feeling about/ personal experiences of <u>other</u> settings as places for birth
3. Ask to rehearse considerations about ideal place ***'Thinking about places, still, I would like you to imagine giving birth again. Could you tell me about the places that you would associate with your ideal labour and birth?'***
4. Seek insights into associations/ imagery of <u>home</u> birth. Reveal briefly own positionality with respect to home birth.
5. Probe personal knowledge of and attitudes towards home birth
6. Seek an understanding of the possibility of interviewee giving birth at home. ***I'd like us to imagine that you are pregnant. You are told by your midwife that the maternity care system now expected women to give birth at home. Midwives, with the necessary kit, would attend you at home when you went into labour, or to check things were ok if you were overdue. You would only be transferred to a hospital if it was agreed to be necessary. Could you tell me how you might feel about that?***
7. Elicit understandings of outcomes associated with different labour/birthing spaces
8. Elicit knowledge of 'cascade of intervention' theory.
9. Conclude.

After interview

1. Run through checklist of demographic information.
2. Ask interviewee to read and sign consent form.
3. Discuss next steps/ options for further involvement.