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**Choosing Care: Negotiating and
reconciling interference in narratives of
home births**

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Abstract

While the literature on home birth emphasises women's capacity to relate to birth in deeply meaningful terms, less attention has been paid to 'interferences' in this process. The extent to which women's birthing needs are met relates to their capacity to make meaningful birth choices. By drawing on four case studies of South African home birthers, this paper examines the kinds of care which generate a sense of containment and continual relationship for birthing women, despite interference. Where home births validate and affirm the psycho-social nature of relational birthing subjects; being supported, being seen and being heard, translates into a social environment of care. Subjective interpretations of what matters most, narrated by home birthers in relationship with partners and caregivers, describe social environments which uphold safety, intimacy, connection, and agency. Homes are not controlled environments, so the inconsistency between narrated birth and actual birth experiences offers an interesting vantage point on the social contexts that generate empowered birthing selves. The care afforded home birthers allows them to create and maintain safe birth spaces, even as homes - bridges of public/private divides - intrude on relational selves. This research adds to an understanding of the consequences of women's birth choices. By foregrounding interference, this paper highlights that choices (contested as they are) remain fundamental to women's experiences of birth.

Introduction

The rhetoric of 'choice' as a well-established concept in the childbirth literature has proved controversial in feminist debates championing women's rights (see Annandale and Clarke, 1996; Beckett, 2005; Chadwick, 2007). Not only has the justification of 'choice' proven itself confined to the benefits of privileged women, but its adoption by *both* the alternative birth movement and the pro-caesarean movement exhibits defunct grounds from which to argue for women's birthing liberation (Beckett, 2005: 263). Women choosing to birth at home, known to be middle to well-off, with higher education qualifications (Edwards,

2005: 1), are afforded privileges by virtue of their higher socio economic status, unavailable to other social classes. Expectations of birth on the other hand, are said to derive *from* social class, shaping women's choices, expectations and perspectives (Martin, 1987: 197). Research has confirmed that middle class women adopt an active approach to birth, while working class women adopt a more passive approach (Zadoroznyj, 1999). Lazarus (1997) accounts for distinctly different priorities between working and middle class women, whilst Nelson's (1983) research attributes different values and purposes to middle and working class experiences of birth. The present study is located within the spectrum of middle class women's birthing needs, preferences and opportunities. This study offers a way of understanding the consequences arising from home birthing women's child birth choices, in terms of maintaining a coherent sense of self, through a disruptive, life-changing event.

This paper was drawn from a wider qualitative study that explored the personal narratives of six women from the greater Cape Town area in addition to five on-line South African birth stories. The four case studies presented here seek to reconcile the discrepancy between narrated birth experiences and actual birth experiences, by analysing 'interference' in home birth narratives. Interference as it is here refers, relates to disruptions or discrepancy in either 'planned' or 'lived' home birth experiences. Lacking overall coherence in the birth narrative, interference as a phenomenon produces changes that alter or modify imagined, as well as actual home birth outcomes. Such interference, unlikely to be subjectively identified as an 'intervention' in the birth process is nonetheless a disturbing or obstructing occurrence in home birth narratives and as such, is worthy of analytical interest. The additional focus on choice, and its function within the marginalised practice of home birth, serves to highlight consideration of the factors that allow women to relate to birth in deeply meaningful ways, in spite of interference.

Research into the relationship between care and identity construction has pinpointed specific aspects of the social environment that generates subjective experiences of healing and of wholeness (see Edvardsson *et al.*, 2003). The implications of middle class home birthing choices are thus considered in relation to, not only home birthing women's subjectivity, but the wider "political purposes, bodily effects and material consequences" that accompany this often overlooked birth practice (Beckett, 2005: 264). Consequently, these choices draw attention to the atmosphere, attitudes and prevailing conditions which afford "relational inclusion and co-presence" in the experience of care during home birth. (Mason, 2004: 167). Home births validate and affirm the psycho-social nature of relational birthing subjects in so far as being supported, being seen and being heard generates a sense of containment and continual relationship for birthing women. Thus suggesting that feeling and being at home

- both literally and figuratively - enables social environments of care that transform local, everyday experiences of birth.

Context (Home birthing in South Africa)

In South Africa, socio-economic factors largely determines not only access to health care (Mooney, 2012), but impacts on the quality of those services too (Chadwick *et al.*, 2014). Whilst total health care expenditure amounts to 8.7% of GDP, (Engelbrecht and Crisp, 2010: 196) a remarkable 60% of that goes directly towards the private sector (Parkhurst *et al.*, 2005: 132) which only services 16% of the population (McIntyre, 2010: 148). Such skewed access to resources, whilst exacerbating existing social inequality, has significantly different implications for middle and working classes, which briefly need sketching when it comes to women's child birth choices.

The delivery of obstetric care, located as it is, within a bifurcated maternal health system, is highly unequal. Women delivering in private hospitals in South Africa have been declared the world's most likely to have a caesarean section (Burns, 2001 cited in Chadwick, 2007: 11). Within the current maternal health system 93.5% of women give birth in a medical facility, yet of these, only 6% do so in *private* hospitals (Chadwick and Foster, 2013a: 321). As a resource that services mainly middle to high income groups, the private sector has an astonishing caesarean section rate of 65% nationally (Naidoo and Moodley, 2009: 257). Therefore, middle class women's highly medicalised experience of birth far surpasses the World Health Organisations maximum suggested caesarean section rate of 10-15% (WHO, 1985).

Blatant misuse of obstetric technologies as a consequence of the privatisation of healthcare has been acknowledged to over-treat those with medical insurance and to under-treat or disregard those without (Beckett, 2005: 256). Echoed in findings with low-risk South African women expecting 'natural' deliveries in private hospitals, Humphrey's (1998) middle class participants all experienced intrusive medical interventions during labour and birth. Highly medicalised birth has long been an undisputed outcome of hospitalisation (Oakley, 1980; Miller, 2005) that in the South African context has even more damaging repercussions given both the overwhelming tendency towards caesarean section in private hospitals and the inadequate health practices in public hospitals.

Avoidable health system failures (Chopra, *et al.*, 2009: 369) plague publically provided health care facilities, contributing to unacceptably high and increasing maternal mortality (see Blaauw and Penn-Kekana, 2010; Chadwick *et al.*, 2014). Maternal and child mortality, rated as the fourth burden of disease, features as

a prominent health issue generating far more research interest on underprivileged women's experiences of childbirth (Jewkes *et al.*, 1998; Chalmers, 1998; Abrahams *et al.*, 2001; Nzama and Hofmeyr, 2005; Chadwick, 2013; Sengane, 2013; Chadwick *et al.*, 2014). Privileged women's experiences of childbirth are less likely to be explored. Experiences of home births are least likely to be explored, with one key author publishing all known research on middle class women's home birthing experiences (see Chadwick, 2007; 2009; 2012; Chadwick and Foster, 2013a; Chadwick and Foster, 2013b). Yet the detrimental consequences of polarized experiences of hospital based childbirth strongly suggest the need for alternative, out-of-hospital settings that meet women's childbirth needs. This paper, in analysing middle class women's experiences of birth, argues that for these women, home birth is one such alternative, which directly and indirectly supported women's interests, and the interests of both their immediate and wider communities.

Independent Midwifery: An alternative, largely unexplored context for childbirth?

Understandably, home birth, accounting for an absolute minority of all births is under researched. However, the affordability of independent midwifery costs in middle income terms means that (in addition to those already drawn to midwifery) those without medical aid are more likely to consider it (Sheldon, 2008: 84). Specific, localised socio-cultural nuances (Viisainen, 2001: 1109) contribute to problematizing a deeply unequal health care system's ability to meet women's birthing needs adequately. Particularly in light of a highly medicalised birthing culture and lack of support for midwifery and home birth (Chadwick, 2007: 14) considerable obstacles prevent middle class women from seriously considering home births. The profession of independent midwifery which sustains home birth is dwindling in numbers and constantly under threat (Chadwick, 2007: 13). Subsumed under The South African Nursing Council (SANC), with no independent, direct-entry qualification and inadequate training of nurse-midwives (see Daniels, 2012), has intensified the marginalisation of home births. Additionally, recent legislation requiring gynaecological back-up for all VBAC's (vaginal birth after caesarean section), now makes VBAC's, at home, virtually impossible. This drastically reduces middle class women's chances for a 'normal' delivery following a caesarean (Rothman, 2012: 50), perpetuating exorbitant caesarean section rates. Because the choices women make are shaped by social, cultural and political structures (Chadwick and Foster, 2013: 332), these choices, in turn, shape birth outcomes and the resultant birth culture.

As recourse against skewed delivery of obstetric care, independent midwifery has largely been ignored in maternal health policies. Yet the possibilities for social and health reform are extensive (see Kitzinger, 2005). Home births dismantle the dominant concepts of birth that create fear, disempowerment and consider high-tech obstetric practices as normative (Cheyney, 2008). Research into home births and the practice of midwifery that supports it, promotes and generates an entirely different ‘body of knowledge’ from that produced in institutions (Rothman and Simonds, 2005; Beckett, 2005). The difference is greater equity in terms of scarce health resources, lowered dependence on technology and the ability to subject obstetric knowledge to enquiry and critique (Beckett, 2005). The model of care practiced in independent midwifery’s approach to birth is relevant to the greater context of meeting women’s wider reproductive health needs, with soft benefits contributing towards gender equality and the realisation of women’s rights (UNFPA, 2011), much needed in the South African setting. In prioritising continuous care, the midwifery model advocates for trusting, open relationships that develop through one-on-one concern, from a dedicated caregiver, for the duration of the childbearing cycle (Edwards, 2005: 23). As a result, there is greater investment in birth outcomes by pregnant women and caregivers alike.

Theoretical Framework

MacDonald (2006; 2007) found midwifery itself utilised to challenge normative constructions of gender. In particular, being offered choices – a central tenant of midwifery care – validated women’s feelings by employing fluid, contingent definitions of what can be considered ‘natural’ during birth (MacDonald, 2006: 248-251). ‘Natural’ birth became synonymous with the midwifery model of care in recognising women and their bodies as intrinsically capable (MacDonald, 2007: 70). The ‘natural-ness’ of birth however, is a vastly contested, and complex form of empowerment for women (Viisainen, 2001; MacDonald, 2006 and 2007; Mansfield, 2008). Chadwick and Foster (2013a: 317) found that natural childbirth was seen to ‘regulate’ home birthers behaviour to such an extent, that ‘natural’ became non-negotiable, acting as a “gendered technology of power” overseeing middle-class women’s childbirth preferences. Whilst reproducing essentialist *and* alternative scripts of birth (Chadwick and Foster, 2013a: 329), discourses of the natural, are nonetheless understood to be one of few ways of articulating a ‘woman-centred’ language of birth (Chadwick, 2007: 229). Positioning women as capable and sure, in natural birth (MacDonald, 2006: 245), the birthing woman is pivotal, their bodies authoritative and their experiences are seen as authentic and real.

In contrasting home with institutional birth, home birthers positively associated increased authority over their birthing experience with the following words: “freedom, control, autonomy, and lack of hospital-imposed restrictions” (Boucher *et al.*, 2009: 124). This contrast, Boucher *et al.* (2009) argue, stands out as a conflict of interest relating to issues of power and control. Owning the space, either literally or figuratively allows women control over the birth place practices that shape understandings of birth (Rothman and Simonds, 2005: 88). Home births, based on a fundamentally different value system, with contrasting meanings to medicalised birth, afford women different choices. Several authors have noted with irony that accompanying the institutional trend towards homely fixtures and features for delivery has been an increase in caesarean section rates (Rothman and Simonds, 2005; Cheyney, 2008). Rothman and Simonds (2005: 91-93) thus convincingly argue that the hierarchies of power associated with place cannot be shifted, even if appearances can. Home births give a birthing woman “the choice to control her own body and space” and *this* they conclude is exactly why medical institutions oppose it and why it’s worth fighting for (Rothman and Simonds, 2005: 103).

Writing in the genre of the sociology of birth, Rothman (2012: 51) calls attention to the contentious issue of safety in home births as the difference between feeling safe and *being* safe. The literature unanimously concludes that women who choose to birth at home do so for the freedom, safety and comfort it offers (Klassen, 2001; Rothman and Simonds, 2005; Edwards, 2005; Boucher *et al.*, 2009). Safety, as defined by home birth expert, Edwards’ (2005: 96) is the capacity for deep sharing, patience, respect and admiration, where “trusting relationships, autonomy and safety become utterly inseparable to this way of thinking”. Despite this, in both mainstream and academic circles, the safety of home births is constantly contested. Given the number of publications by the Cochrane Collaboration and British Medical Journal which *testify* to the safety of home birth outcomes (Anderson and Murphy, 1995; Wieggers *et al.*, 1996; Johnson and Daviss, 2005; Fullerton *et al.*, 2007; de Jonge *et al.*, 2009; Birthplace collaborative group, 2011; Olsen and Clausen, 2012), what is understood as ‘safe’, in home births, is reconsidered and re-evaluated according to fundamentally different principles. The resulting capacity of women in a home birth to act, look, do and be with whatever feels right, creates and maintains *being* safe; being supported; being heard; being understood (Edwards, 2005: 150-155).

Chadwick and Foster (2013a: 332) maintain that such childbirth choices are not merely products of rational agential decisions, but in pointing to the importance of social contexts in shaping choices, compels us to ask about the specific contexts in which home birth ‘care’, which facilitates such choices, is provided. Correspondingly, the social conditions, present on ward floors, which facilitated

a coherent sense of self throughout a disruptive and life transforming event, were surprisingly similar to home. The insightful work of Edvardsson *et al.*, (2003) has direct bearing on the adaptation of a theoretical framework that privileges the psycho-social nature of relational home birth subjects. These authors identify four dimensions of care that impact on the construction of identities. ‘Experiencing calmness’; ‘being seen’; ‘being who you want to be’; and ‘recognising the self’, were critical elements of a social environment of care that communicated a welcoming sense of “being at home” in the experience (2003: 381-385). Their conclusion is that the psycho-social dimension of human interactions within a setting, account for experiences of care that either aid or impede the realisation of the self (2003: 390-392).

Cheyney (2008: 265) derives three theoretical categories which, in home births, translate into practices that sustain and integrate the concepts of knowledge, power and connectivity to produce a “systems challenging praxis”. The embodiment of these concepts and adaptation of birth place models, which foster relatedness, mean that home births not only correct the skewed power structures of medical systems, but also challenge the basis of medical hegemony (Cheyney, 2008: 255). Correlating the view that South African birth expert Rachelle Chadwick (2007: 225) has determined about home birth choices - they are located within an alternative epistemological position on birth - gleaned through “knowing-in-relation”. The birthing woman, articulated at the centre of the experience is poised “between the birthing body, cultural stories of childbirth and the midwife” (Chadwick, 2007: 227). Through ‘knowing in relation’, birth comes to be known experientially; knowledge comes through the body, and what is known, is gleaned through a series of interactions and connections with significant others, the body and culturally derived sources of meaning (Chadwick, 2007: 225-226). These findings suggest that in South African as well as internationally, ‘lived’ experiences of home birth alter perceptions of the nature of childbirth itself (Rothman and Simonds, 2005; MacDonald, 2006 and 2007; Cheyney, 2008).

Although Chadwick (2007: 227) insists that “knowing in relation” is not a ‘pure’ position home birthers maintain, such an alternative epistemology has direct bearing on the social aspects of care that impact on the capacity to make meaningful birth choices. The birthing woman’s experience of care is contingent upon an environment where “people, selves and values are conceptualised as relational, connected and embedded” (Mason, 2004: 163). When individuals become interwoven as relational selves, during home births, the care that substantiates meaningfulness is felt, received and lived in mutually inclusive ways (Mason, 2004: 162-164). A relational epistemology of birth, as premised on ‘experiential’ knowledge, has been identified in narrative constructions of

home birth as told using a narrative of ‘lived birth’ to script an empowered, embodied agency (Chadwick, 2007: 267).

As Chadwick (2007; 2009) makes clear, research which prioritises the subjective experience of childbirth is seldom articulated. Yet, how women make sense of and interpret their specific experience is essential for creating the conditions necessary to meet women’s maternal health needs. An extensive review of Chadwick’s work indicates that the experience of (home) birth on women’s subjectivity is often contradictory and unstable. While more is known about home birth as an alternative way of coming to know birth, less attention has focussed on the ambiguous nature of birthing subjectivities. Taking as my starting point, home birthing subjectivities as subjects in flux, the analysis which is to follow traces the tensions and interruptions in birthing narratives that offer ways of conceptualising birthing subjectivities as situated, dynamic and connected. The inter-connectedness of people and place in an environment that reflects ownership and agency, allows for embedded relationships to sustain the idea of an uninterrupted self.

Such an approach necessitates broadening the focus of enquiry in home births to explore the kinds of care women experience in home birth that impact on their subjectivity. How do women who undertake home births experience safeness, naturalness and wellness? All of the women in my sample interrogated their caregivers in some way or another. They recognised that their care givers would irrevocably impact on their experience, and thus, carefully considered the implications of place, space and person. Their experiences and the meanings they attach to them, highlights an aspect of the literature that is under-developed. Why and how do women who choose home birth negotiate the social environment of care?

Methodology

This paper will analyse four case studies, according to their themes, sequence, affect, structure and linguistic choices (Riessman, 2001: 6-8) to understand the ways social environments of care uphold safety, intimacy, connection and agency. The analysis maintains that what is said about birth is as important as *how* it is said. Narrative methodologies, in allowing the process of interaction between teller and listener to be intrinsic to the formation of meaning, re-establish the primacy of intimate inter-personal connections to the production of knowledge (Riessman, 2001; Mauthner and Doucet, 2003). As such, it reflects the theoretical stance of home birthers who prioritise close, caring relationships, and female centred, intuitive knowing (Cheyney, 2008). Insights into the relational nature of the networks surrounding home birth make this

methodological choice critical to understanding how women's experiences shape their birth choices and how choices, in turn, shape birth experiences.

As a home birther myself, I wanted my interpretations to be led by the teller, to ascertain the significance they themselves attach to their experience. Precisely because of the subjective nature of women's experience during childbirth, narratives align the teller with their own best intentions; providing creative justification and impetus for what they think, say, do and feel, even if in reality, these are not clear (Riessman, 1990b: 1199). Narrative studies represent reality by focusing on storied ways of knowing, and communicating through language as it is derived from social, cultural and historical resources (Riessman, 2005: 1). By interpreting the social world, the narrator links the personal with the political in ways that are situated, imaginal and fluid; yet these shifting dynamics are integral to the construction of identities (Riessman, 2001: 20). Birthing practices are central to women's narratives, ways of knowing and the means through which identities can be claimed, undone or re-made (Klassen, 2001: xiii). Narratives are therefore valued, because in crediting subjectivity, they create texts that allow what is most influential to the teller to become known, drawing together social, cultural and personal worlds (Mason, 2004: 165). Birth narratives, embedded in the life story of the narrator offer reflections on changes to self and society that reveal factors, which both motivate and constrain, choices.

Qualitative research designs need to be flexible, to allow for decision making to take place as the research is unfolding (Mason, 2002; Ritchie and Lewis, 2003; Punch, 2005). This flexibility was applied using three sampling and recruitment strategies. My first gate keeper forwarded my introductory email to a home birth mailing list. Another gate keeper sent me names of previous clients to contact via facebook. This led me to my second strategy which was to post on my facebook page: *Know of anyone in Cape Town who has given birth at home within the last year and had a midwife present? Please could you pass me their contact details - or mine to them? Thanks!* This strategy proved particularly successful. Through snowballing, it brought forward an important negative case in which a home birth was transferred to hospital.

The interviews were arranged to take place in participant's homes, at their convenience. The interview was structured in an organic way, sensitive to the dynamics taking place in the homes of participants. More often than not, children were being attended to as the interview took place, requiring the prioritising of their needs, rather than my own. I always accepted tea and engaged in small talk before the interview in an attempt to 'be on their ground'. Once settled, I proceeded to ask about the home birth: "As you know I'm interested in the stories of women who've had a home birth with a midwife.

Would you please take as much time as you need and tell me in as much detail as possible the story of your child's birth?"

The ethical concerns of social science research require that the researcher protect the identity and integrity of the individuals upon whose contributions this study is based. The potential for harm in such research is often in the form of emotional distress resulting from a breach in trust that comes with exposing others' intimate stories (Gabb, 2010: 471). Presentation of these findings and the narrative sequences upon which the analysis is based have thus had to ensure that key identifying markers were either erased or altered. In particular, related individuals and the communities of which they are a part should be unable to identify the actual individuals and situations discussed. The relational dimension of these stories makes this a challenging but vital aspect of disclosing personal narratives. Pseudonyms have been used for throughout to disguise the names of husbands, family members, geographical areas, midwives or doula's mentioned by the narrator (except in the case of known birth experts). Ethical clearance was gained from the Sociology department at the University of Cape Town, and all standard protocols regarding informed consent, confidentiality and anonymity were followed.

Methods of Analysis

Formal methodological models of narrative analysis abound, however I found the work of Catherine Kohler Riessman, provided the most useful application of various analytical forms. I felt it appropriate to be flexible in my approach, to gain coherence through a multiplicity of techniques and thorough engagement with the data. Attentiveness to metaphors, key words, verb tense and other linguistic choices focused my analytical interest on the structural interpretation of why something was said in the way it was (Riessman, 1993: 52). Engaging in an iterative way with the narratives allowed my interpretive understanding to deepen. By identifying segments of the text and examining how they support particular interpretations, I was making methodological choices regarding different approaches. For example, although I trace affect in the narratives of both Gayle and Joy, Joy's narrative was represented according to its poetic structure. This representation privileged Joy's situated, emotional response within a small narrative segment. Whereas with Gayle, only after parsing her complete narrative, in which 6 different stories are told in 3 parts, could affect come to represent the heart of her narrative when traced throughout. Methodological choices such as these reflect the different narrative styles chosen by the participants. A variety of methods were thus used to interpret the narratives, while different representations of the texts allowed me to analyse meaning at different levels, ensuring the rigour and reliability of the process.

Riessman (1993) suggests that analysis of narratives should begin using the outline provided by Labov. This approach is suggested because Labov identified a common set of elements around which narratives are organised, which is judged to be a useful starting point, given that it prioritises the structure and organisation of the narrative response (Riessman, 1990b; 1993). The abstract (AB) tells us what the story is about; the orientation (OR) tells us who, where and when; the complicating action (CA) tells us how: it is the central plot of what happened; the resolution (RE) explains why it matters; the coda (CODA) returns to the present and ends the story (Frost, 2007: 4). However, it is the evaluation (EV) that is said to be the soul of the narrative (Riessman, 1990b: 1198). Evaluative clauses convey the quality of mind and attitude of the teller. These are important because they provide a way for the analyst to reflect on the impression the narrator composes of themselves, by which the listener is convinced (Riessman, 1990b). Nonetheless, not all stories can be read by applying Labov's framework. Labov argued for chronological order, in topic specific narratives where "what happened" is causally sequenced (Riessman, 1993: 17, 59). Riessman (2001: 6-7) makes us aware that subsequent authors, including herself have extended the approach for application in multiple forms of narrative discourse. In this way the strict order of the Labovian framework can be rearranged, although the set of elements for interpretation remain the same.

Analysis

Care that affirms and supports trust in oneself: Annie

The job of identifying narrative segments comes through close textual analysis of the speaker's organisation of their narrative (Riessman, 1993: 58-60). Such segments tell the core story that supports particular interpretations of the lived experience being narrated. Annie's narrative of the home birth of her third daughter has many of the structural elements that allow it to be parsed according to the outline provided by Labov (Riessman, 1990b; 2001). The characters, plot, setting and time frame are all clearly articulated and referenced in relation to what happened. Annie's narrative tells the story of a disagreement with her care provider that causes her to feel 'I'd rather do it on my own'. Such a drastic turn of events was hardly arbitrary, thus, she has a hard job convincing the listener of her point of view. As the start of her birth narrative proper, this segment sketches an outline of the right way and the wrong way to give birth according

to the narrator's interpretation. This dichotomy is maintained throughout the entire narrative for a very distinct purpose.

“I mean it, it was quite scary”

I was actually going to have a gynae, AB
um Bianca and um we ended up having a really big argument
about how she was going to handle the birth.
With Magda's birth I haemorrhaged quite a bit and um, OR
she wanted to have quite an active management of the afterbirth.
And I wasn't happy with that at all.
You know, cord clamping and all that kind of thing. CA
I really didn't want that and,
we had a big fight about it and
she eventually agreed to do what I wanted, but
I just felt she was going into the birth expecting things to go wrong. EV
Yah, you know I read a book called birth and breastfeeding OR
by Michel Odent Um well
that book really talks about the importance of privacy in birth and I think
after I read that book I almost felt like I'd rather do it on my own EV
than have someone I didn't want there.....
And, yah and then at the last minute..... CA
Fiona said well why don't you try Acacia, you might you know, get lucky.
It was really, kind of a luck. EV
I think I was about 36 weeks and I phoned Acacia OR
and she managed to wrangle things, so she could do the birth....
I mean it, it was quite scary EV
and um anyway her dates kind of just coincided. CA
But I needed to be on time with the birth to have her
so that was a little scary (laughs). EV
But, it did work out.
I took, when I was 40, 40 weeks exactly I took castor oil OR
and that brought labour on.
I mean I actually really needed someone like Acacia EV
because I think um Bianca felt that, considering my history,
she reckoned I shouldn't have considered a home birth....
Whereas, I think Acacia was very, very open minded RE
and much more trusting.
And I think I needed someone to trust that process. CODA

Annie's narrative of different approaches to maternity care highlights the importance of choosing caregivers whose views align with one's own. In

orientating the listener, Annie explains that due to severe haemorrhaging in her second birth, the suggested approach to managing her risk caused a serious altercation between herself and Bianca. For Annie, approaching the birth with a 'medical' outlook imposes negative expectations on the natural process of birth. Although this is the story of her third daughter Samantha's home birth, the outcomes of her second home birth create significant interference in this narrative. The problem Annie faces is how to translate her confidence that things would work out into a story that doesn't sound careless. Annie's certainty and clarity that things are as she sees it is sustained in the narrative through a habitual rendering of events. In this narrative form, few stories are told and the general course of things is spoken about, often without dramatization (Riessman, 1990a: 76-78). The listener is not drawn into the story or called to re-live the moment with the teller, with the content of the experience never being fully elaborated on. In Annie's narrative, it is her belief in what is natural that is actively argued for and central to her interpretation of events.

'Considering my history, she reckoned I shouldn't have considered a home birth', highlights the fact that Annie is high risk. As a consequence, her decision to have a home birth, insistence on a 'hands off' approach, and dependence on a caregiver who is possibly unavailable creates a massive tension in the narrative. This tension is off-set by the strength of her conviction and steadfast belief in the natural physiology of birth. 'Someone like Acacia' who is open to and completely trusting of home birth is aligned to internationally renowned, leader in the field of natural birth, Michel Odent. By utilising known natural birth experts to advocate for Annie's idea of how to 'handle the birth', this narrator lends credibility and legitimacy to her opinion that Bianca's approach to the birth was flawed.

Her credence in the birthing women's authority and expertise is tantamount to viewing herself as 'the specialist' in birth. Given this perception, as much as Acacia may come to represent natural birth, having her at the birth is presented as nothing more than 'a luck'. She later explains that even though 'Acacia was amazing....she just helped the process. You see I did it, she didn't do it.' While this is hardly an exaggeration, it ignores the fact that Acacia had to untwist multiple times, a tightly wound umbilical cord from Samantha's neck. Clearly, we need to be attentive to the impression that Annie is creating for herself. Michel Odent is a French endocrinologist and midwife well-known for his vociferous support of natural, uninterrupted childbirth (Sheldon, 2008: 60-61). Advocating for trust in a women's body, Odent, having studied the "behavioural effects of maternal hormones" insists that women have primal, intuitive knowledge of birth (Odent, 2012: 86-87). For Annie to align her views so closely to his, by choosing to birth in a manner cognisant of his key teachings, she constructs a particular self for whom a puritan view of childbirth is deemed

morally correct and superior to the medical approach. The strategic presentation of a birthing self that draws on a repertoire of known social, biological and scientific evidence supporting natural child birth serves to validate Annie's moral character. By evoking such a distinguished writer, she is providing evidence to support her claims that 'natural' child birth is the right way to birth.

Individuals "engage in the creation of reality in their tellings and re-tellings, constructing their world and themselves through interpretation" (Riessman, 1990a: 13). Many of the key interpretive qualities used by the narrator to substantiate the meaning she claims for herself and her approach to her home birth are present in her narration of her second daughter's birth.

And urgh yah, with Magda's birth, I was just knocked for a six and not really able to cope with it.....

N: It seems like Magda's birth is a really important story for you?

Yah so Magda's birth was, t'was ok,

it was fine I mean I - you know, she was fine,

in the end I was fine but you know,

it wasn't like I had to use any drugs,

but it was really traumatic..... And um,

whereas shoo with Magda's birth I couldn't walk up the stairs for two weeks,

it was, it was really (pause) hectic, I think.

And, you know, I was really badly torn and it was,

yeah there was the haemorrhaging,

it was just, it was very, very traumatic.

I mean the haemorrhaging was quite bad and it was quite serious

but it was handled really well and I'm fine

– because women can die from it,

um but it was much more medical kind of thing.

The way she chooses to tell the story of haemorrhaging at Magda's births shows a divided subjectivity. When Annie says 'it was handled really well because women can die from it' she clearly understands that those very same medical procedures which disempowered her, also saved her life. Such a connection however, could not be made by the narrator, because she is determinedly 'natural' in her outlook. Due to the birth having become a 'medical' event, it is perceived by Annie to be the wrong type of birth. In the segment above, what seems to take precedent in her re-telling of being 'unable to walk' and 'really badly torn' is the fact that she didn't need any medication. Not having to resort to drugs, means having retained the principles of natural birth, which in the face of its medicalization, seems to have been the primary point the teller wishes to make. Annie's struggle for the right type of birth, with the right influences,

augments her drastic decision to seek alternative care in the final stage of her pregnancy.

Annie's narrative is not purely sequential, as habitual rendering of stories often are and this attunes us to the role of Magda's birth in her story. It is a disturbing interference in the narration of Samantha's birth, but plays a vital role in recapitulating Annie's choices for a home birth, the third time. Her insistence on undisturbed mother – child bonding after delivery; delayed cord clamping; the separation of men from the labour and birth process; her fervent belief in birth as a natural process; and in her own capacity to birth, all support her view that 'birth is not a medical process'. This position is sustained through referral to known birth experts; both Acacia and Michel Odent are used in support of her choices. In this respect, her argument with Bianca is not only a matter of opinion, it's about who controls the power to determine what happens in birth.

Although Annie makes it clear through numerous repetitions that her second birth experience was hectic and traumatic, what is specifically experienced as disempowering is the fact that it became a medical event. Through the medicalization of her birth, she *lost control* of her own experience. Specifically stating later on that 'I think part of the problem with Magda's birth was that there were too many people, it was too medical, even though it was at home it was um, it wasn't really my process, it was taken over.' Suggests that place of birth is not necessarily enough to circumvent the hierarchies of power which disempower women's birthing selves. The conditions which support women's empowered birthing selves are based on choices made the entire way through pregnancy and labour. Carefully attending to the optimal conditions that create trust, safety, relationship, intimacy and agency, engenders a social environment where the highest outcomes for birth can be achieved.

In her third birth, Annie is left with an undisputed sense of her own achievement. The psychological impact of a positive birth experience, seen as both a personal and physiological victory, is as meaningful as it is healing. While clearly still suffering from the trauma of her second birth, her third birth is unquestioningly narrated as 'lovely', 'easy and nice', 'a wonderful experience'. Thus, her narrative upholds generalisations that take for granted a particular view of the world. For Annie, as a vegan and spiritualist, her conviction that the natural way is the best way must be represented by outward actions that match her inner commitment. In upholding her version of the truth, this narrative creates an 'emotional and spiritual' context of birth that nonetheless is embedded with social and political purpose. Annie creates a narrative in which she claims authorship over her birth rights by privileging subjectivity. In subverting the status quo and reasserting the right and authority of women to make choices about their own bodies in childbirth, this narrative

tackles topical social and political issues. Through this subjective account of a home birth, the controversy over who controls the power in birth is shown to be intimately tied to the possibilities for healing birthing selves and empowering women.

Care that acknowledges who you are: Hannah

Hannah's narrative is lengthy and not framed in any clearly discernable manner. Although temporally sequenced, this long re-telling of the attempted home birth of her daughter was based on a complex arrangement of linked ideas that was dense, wordy and difficult to make sense of. Openings into vivid recollections and deep feelings would render long stories. Sentences would be repeated but as they were, more of the story attached to them would be unravelled, connecting seemingly disparate aspects of an inter-related pattern into a deeply intimate, multi-faceted narrative. Hannah convinces her listeners of her interpretation of events due to the way in which she structures her story which supports her own particular lived experience (Edvardsson *et al.*, 2003: 379). Interpretation occurs through representation, and finding the most suitable technique to begin unpacking key elements was a vital analytical prerequisite. My structural analysis was thus drawn from the work of James Gee as explained by Riessman (1993: 44-52). This form of representation is not always useful because it can cut away too many of the narrative clues which signify meaning (Riessman, 1993). In this case, a more simplistic representation of an already complex narrative structure was a useful way to begin.

Detailed interpretation highlighted a narrative arranged episodically with a total of 23 scenes, each ending in a coda or summary. Parsed sentences were grouped into stanza's on a single topic and labelled according to the theme or prominent idea (using the narrators own words). At the end of a group of stanza's the narrator would naturally end that set of ideas and present the listener with an outcome which would then return to the main plot of the narrative (Riessman, 2005: 3). Naturally organised into scenes which included between 3 and 7 stanzas plus a coda, with 3 - 4 scenes making up a part, coherently structured into 6 themes: labouring at home, evaluations and expectations, being in hospital, 'I remember snippets', post-traumatic stress and owning the full experience. Only by parsing the narrative in its entirety could the inherent logic and connection to the life story of the participant become clear.

Hannah's narrative tells of a planned home birth that ended up as a caesarean birth in hospital. In a particularly salient comparison of the experience of home birth versus hospital birth, Part 3 ('being in hospital') uses pain as a descriptive

word for the very first time, to describe the physiological sensations of labour¹. We know that her contractions have been ‘strong enough and regular enough’ at home. Yet when Hannah reaches the hospital, a sudden awakening of the experience of pain dramatically focuses attention on the discomfort that constraining physical and structural factors provoked in her.

Stanza 41: (Not pleasant)

290. So there, there I was,
291. I was out of it,
292. I was tired,
293. I was uncomfortable,
294. I was in pain
295. it was, it was really not pleasant.

The first three scenes of Part 3, ‘being in hospital’, (scenes 7, 8 and 9) showcase the documented potential of “ward atmosphere (to) create alienation from self, others and the surrounding world” (Edvardsson *et al.*, 2003: 385). The imposition of standard, non-negotiable protocols that such an institutional context requires, curtails the experience of freedom she had at home. It restricts her ability to respond to the physical experience of labour ‘so there I was really battling figuring out how to cope with it’. Restrained as she is within her birthing body, the cumulative effect of the ‘hard baths’, ‘the CTG’, the ‘hospital regulations’ requiring her to be ‘strapped down’ become a debilitating force, infringing on her ability to find respite. A strong sense of disempowerment permeates this narrative segment, as the role Hannah plays in her own labour becomes a subservient one. Seriously lacking the choices to manage her labour, the heightening sensation of pain creates an aggravation which reduces her capacity to impact positively on her own experience. Showing distinct signs of fatigue and anguish, it quickly becomes clear that Hannah faces only ‘one choice..... caesarean’.

Scene 8: How long do we still have to go?

Stanza 43 (Worst for me)

308. Oh and the worst for me, that’s a funny one.
309. One of the worst things for me was the CTG.
310. It was, it was *horrible!* [my emphasis, demonstrating tone]

¹ It is worth noting that none of the narrators of home birth in this sample utilise the word ‘pain’ in describing their physiological experience of labour and birth.

311. Um cause you limited. You have to lie on a bed, be in a certain position,
312. you have this thing strapped on
313. and you're having contractions.
314. And it's so painful.

Stanza 44 (She hated it)

315. And she hated it,

Stanza 45 (I hated it)

320. and I hated it, it was like, ooohhh
321. and my poor midwife was just like, we have to do this and I,
322. I kept on complaining "how long do I still have to have this thing on me?"
(laughs)
323. But it was so painful!

Stanza 46 (Hospital regulations)

324. That, that aggravated, it really aggravated the whole situation for me
325. being stuck there with that thing on me and,
326. and I mean at home she kept on checking with the doppler
327. and I'm like, you checked me with the doppler, why don't you
328. - hospital regulations - you know you have to do it.
330. It's so stupid I think you have to do it for 20 minutes, its, its long.

Summary

334. and that was really horrible, I hated that.

CODA (Counting the minutes)

337. There I was counting the minutes, I was like –
338. how long do we still have to go,
339. how long do we still have to go?

Earlier, in scene 6 of part 2, Hannah made it clear that she abdicates herself of responsibility for the birth outcomes. Hannah prioritised wanting to be a first time mother, without her professional judgement clouding her experience. *'I didn't really wanna make decisions while giving birth. So what I did was I made sure that in advance I have a midwife / gynae team that I can trust, that I feel comfortable with'*. Having constructed her caregivers as the experts, positioned them as responsible for the well-being of herself and her baby, she allows them

to make a choice that is not in line with what she believes, one which she would not normally *choose* for herself. Through detailing the open, trusting and reassuring relationships she has with her caregivers, the caesarean is affirmed as necessary; as a life-saving measure. Stanzas 53-55 of scene 10 (below) shows the narrator coming to terms with the outcome of her labour and attempting to make sense of it. In three consecutive stanzas there are three summaries before the coda, 'decision made', which concludes the scene and part 3 of her narrative. The significance of this change in structure relates to the state of mind of the narrator who, still in the process of reflecting on and understanding her feelings, needs to continually summarise the facts to get to grips with them. In this scenario, it becomes evident that it was the duty of her caregivers to impose their will upon hers, and hers to concede to their decision. Through the structuring of this scene, the listener is convinced of the way Hannah, as a natural medicine advocate, comes to terms with her caesarean.

Scene 10: Thank God for Caesareans

Stanza 53 (In good hands)

380. But with her, I was like, "I'm in good hands, I'm fine."
381. It was nice that feeling
384. of ok, it's not my choice,
385. I can't believe I'm having a caesarean,
386. I'm so, fanatically natural-medicine minded
387. but thank god for caesarean's. (laughs)

Summary

388. Otherwise we both would've been dead by now most probably,
389. so I was very thankful for her.

Stanza 54 (Don't feel let down)

390. And what was really nice was she came in and she sat next to me
391. and she said, "do you feel we're pushing you into this"?
392. And I said "no, I don't feel like you're pushing me into anything.
393. I realise it's the right thing to do."
394. And what was also awesome was she said,
395. "don't feel like your body let you down."

Summary

396. Cause that's what you feel, you feel like an idiot.
397. You feel like I was made to give birth you know

Stanza 55 (Being a woman)

398. I'm a woman and
399. I can't even do that.
400. You know it's a silly thing but you think,
401. I'm supposed to be able to do this.
402. It's the most natural thing
403. and I can't even do this right.

Summary

404. And if it wasn't for an operation I would've been dead.
405. You know it's weird

CODA (Decision made)

406. but she was really, really especially nice
407. and from then on I don't remember much.
408. I think it was, decision made. Okay.

A second, interrelated issue that the interaction with her gynaecologist highlighted is the idea that women are 'made to give birth'. Hannah, who is fit and strong and healthy, could not 'walk for the last month of pregnancy and then having a not so wonderful birth', her perception of who she is and what she is capable of was altered. The concept herein, that because women's bodies are physiologically constructed to give birth, meaning that all women giving birth *should* know how to, is significant. It makes clear the subjective cost involved in striving for a 'natural' birth. Without a sense of having birthed her baby herself (naturally), the effect of a caesarean on Hannah's subjectivity is deeply wounding when 'to give birth' is conceived as something supposedly fundamental to her identity as a woman. It creates the impetus, not only to justify the caesarean, but find peace in the outcome of her body's birthing process, which this gynaecologist acknowledges.

The nature of the care she receives from her support team, which recognises not only her medical risk, but the risk to her person through acquiescing to a caesarean shows up "the crucial significance of the social environment of care"

(Edvardsson *et al.*, 2003: 392). Scene 10 makes it clear that a social environment of care can circumvent institutional disempowerment and constellate a reality in which an integrated sense of self can be sustained. The personalised nature of the care she receives during a disappointing and traumatic adjustment to her projected reality brings to the fore the human qualities of relating and respect that engender a sense of trust and safety, in spite of the outer circumstances.

Through a long development of stanzas across consecutive scenes, Hannah is able to narrate the two worst aspects of her birth experience. Beginning with the frustrations resulting from the physical, post-operative wound, to having missed out on the deep, intimate, parent-child bonding that takes place during the first few hours post birth. In part 6, owning the full experience means exactly that; witnessing her pain and anguish, whilst simultaneously striving to claim what is personally meaningful. Hannah is aware that if she lets what went wrong in her birth affect her completely then, ‘it doesn’t feel very natural to me’. And the laughter that accompanies this statement *both* times emphasises that this is no light matter.

She has spoken of herself as a ‘fanatically natural-medicine minded’ person. Natural medicine is not just what she does, it’s what she is. The energy she gets from clean living, from being physically active, from knowing she can, disintegrates if she focuses too much on the details of the birth and not the bigger picture. Narrating both the depth of her sadness and disappointment with a deep gratitude for what she does have, indicates that although the emotional scars linger, she has resolved them for herself. In scene 23, she repeats 3 times that she is ‘very thankful’ and in so doing concludes her narrative holding both the hurt and the healing in conscious alignment. After all, her caesarean ‘saved’ her child’s life, but her experience of birthing at home, gave her something precious too.

CODA (This is it)

773. So I’m consciously going back to that picture that I had
774. of lying in that birth pool and looking at the ocean thinking wow
775. this is awesome, this is beautiful.
776. That is what I want to keep.

Care through being in community with self and others: Gayle

To tell her story, Gayle does several things simultaneously. In her opening line, she sets up a mega-frame which, similarly to a rationale, justifies why this story is worth telling and makes clear her prerequisites for choosing a place of birth. *‘What was important for me was also to find a very safe place to have birth. And I wasn’t sure where it was going to be’*. Within this mega frame, Gayle tells 10 stories (titled using the authors own words): focussing on myself; private hospital; public hospital; Ruan is born; my mother’s house; my father’s panic; ‘the families just way too intense’; the birth itself; the signs; the thread throughout. These stories make sense of the subjective meanings this narrator attaches to a place of safety, and its purpose within her particular life phase. Gayle’s search for safety is conducted both internally and externally, as an exploration of the ‘emotional resonance’ of safety. What makes Gayle safe is being in connection with that which holds true. The mega-frame naturally binds the narrative together, offering both a beginning and an ending to the birth narrative.

As the opening frame suggests, home birth was not the primary birth option for this narrator. Gayle’s first three stories critically shape her decision to birth at home. All three mini-stories are told in a manner that allows them to be analysed according to a Labovian framework. They are “brief, topically-centred and temporally ordered stories” (Riessman, 2005: 3). The first, ‘focussing on myself’ discusses her collapse at work that serves to warn her of the possibility of pre-mature labour. When Gayle’s weakness surfaces it affects the foetus, making Gayle realise the need to prioritise *her* safety, in order to protect her offspring. Her mother’s home becomes her place of refuge and of shelter. Immediately inside of her organising framework, the story of her need to ‘internalise’, allows Gayle to articulate a need to stop and retreat to a place where she was able to be fragile and vulnerable. Seen in terms of the broader narrative in which birth catalysed a disruption in Gayle’s sense of self, this story can be interpreted as the point at which Gayle begins ‘letting go’ of the idea of herself as strong, as a necessary part of her own transformation.

The second story is an experience of being in a private hospital where she feels isolated and ‘alone’. Her relationship to the cold, ‘sterile place’ bringing forth feelings of alienation and disconnect, that does not engender a sense of safety. In contrast, her experience of the public hospital in the third story, which she expects will be horrible, is not. Here she feels warmth, and a welcoming that encourages a sense of ‘ease’. The feeling of being in community stands out as cementing her sense of safety in this space. These two stories side by side

suggest that Gayle's subjective experience of safety was turned upside down on these two occasions. The high-tech, high-end hospital, assumed to be safest, was not. While, on the other hand, the hospital she 'was very, um nervous about going' to, had the strongest "emotional resonance" of safety, for her personally (Rothman, 2012: 51). Really being safe, as narrated by Gayle comes from an environment of care where the qualities of relating and of interaction, bring forth lasting relationships. Such a relational space, where birth has meaning on social, cultural and personal levels, was her childhood home.

Being fully attentive to the narrator's subjective meanings insists that we recognise the central tension in the narrative according to the teller. Gayle's narrative of transformation into Ruan's mother is told in 6 parts: the collapse; before the birth; the birth; affect; the birth re-visited; the archetype of transformation. What stands out, if we privilege Gayle's feelings and emotions, by tracing affect as it recurs throughout the narrative is the disruption in Gayle's identity due to the birth of her son. It is a massive reduction of the text but is valuable because it describes the impetus behind Gayle's individuation; the interruption to her sense of self, catalysed by the birth of her son. Gayle points to her physical and psychological break down in lines 26-31. Her weakness is not only unusual and irregular; it also marks a turning point. For at least a month before the birth up until a month afterwards, she felt physically and emotionally constrained. Gayle's chosen place of birth creates a tension that challenges her to move beyond her constricted identity as a good daughter, into a good mother.

Affect in the Narrative

26. I was most of the time also just lying in bed
27. after being (really) a very active person.
28. Um and it really helped me to (pause)
29. prepare myself for Ruan coming.
30. I mean I felt very weak (p)
31. and um, it took time, um (p).
73. And, I think a lot of this process was (in breath) about (p)
74. letting go. Just allowing things to happen
75. as – whatever way they come....
77. but it was a very good process (p)
78. of letting go.
172. yah a lot of its been also feeling - not only are you caring for the little one
173. but having to care so much for your parents
174. and all their anxieties which they check down on you.
184. It was very wobbly, at least also for about a month afterwards,
185. it was very very (pause) yah, um took a long time to (p)

186. recover that I was strong enough to also just not lie in bed.
 187. It was very odd for me because I'm quite a healthy person
 188. and I'm (pause) quite strong physically
 189. but I think it was valuable to (p)
 190. yah, to know your, your ritual of becoming a mother (p)
 191. of becoming something else.
 192. Um, taking time to (pause) think and be and breathe.
 193. Um and not be busy, yeah so (p).
 194. Yeah, it was very - Im very, very thankful
 195. that I had a good birth.
 196. because I feel everything around me was so, *is* so unstable
 197. (pause) um and vulnerable (p).
 198. And my birth really gave me the foundation
 199. to know that I could pull through.
 200. And I mean Ruan is just so, so good,
 201. he's such a kind baby you know –
 202. it's like he's taking care of us.
 203. So (pause) I'm very, very grateful that I had a home birth as well.
 220. Um I always felt that um, I'm maybe not so in touch
 221. with the animal in me (p)
 222. you know um (pause) and also quite shy (p).
 223. Also not very sexual, you know all those kind of things,
 224. it's all so new to me. So (p)
 225. it's quite amazing that it all worked well - you know.
 229. And then in the end (p)
 230. he actually, I caught him myself!
 236. and that was really lovely.
 243. So that was lucky, and it was interesting,
 250. and just, yeah it was very sweet.
 275. and it was all something that means something to me already before.
 283. But it's nice that it's not particular only to that moment that it's-
 284. I feel like this thread throughout,
 285. you know the course of my life, that's nice.
 286. Yah (giggle), very, very lucky (pause).
 293. I'm also pleased I'm older
 294. cause it's, you lose self-confidence
 295. but you also know that you capable of things.

In Gayle's narrative, her mother, her father and her sister at different parts in the story are described as 'freaking out' (at her). Her sister when she found out she was pregnant, her father during the course of the birth and her mother immediately afterwards. In line 196 she locates herself within her family dynamic, which as a result of her parents separation, is 'unstable, um and

vulnerable'. Her role as the good or 'easiest daughter' is threatened by her parents separation, which is spoken of twice in the narrative, indicating that it is not a trivial detail for her. Being the good daughter meant looking after everyone, shouldering their burdens. We see in this narrative, what begins to take shape, is the realisation that the role of good mother requires that Gayle begins drawing boundaries around her family's psychological issues. As a mother, her resources for everyone else's 'anxieties', diminishes when she attends to the wellbeing of her son. Thus, the safety Gayle strives for shapes not only her subjective experience of the birth, but ultimately the environment she aims to provide for her son. Her transformation into a mother requires her to trust herself, and her experience of Ruan's birth provides the basis for her to do so.

Symbolically uniting both the purpose and meaning of her life, to her son's, Gayle's narrative suggests that the potential for a different ending lies in new beginnings. '*Something that means something to me already before..... (that's) not particular only to that moment that it's.....this thread throughout*'. Time, narrative and memory are interlaced in narratives whose structure offers an account of truth that draws shifting connections between past, present and future (Riessman, 2001: 20). Throughout her narrative, Gayle emphasises the connections between her life story, Ruan's conception, the pregnancy and his birth. Through the interpretive work of telling stories, new mothers claim linkages between that which they were and that which they are becoming, re-fashioning an integrated self to account for both the loss and the gain. Frost (2007: 5) says that instances of incoherence in events, resulting from disruptions to an individual's identity are useful for making sense of changes to the self and its relationships. Birth as a particularly powerful moment in time, brings to light the way social identities are made and remade, over time, and in an instant.

Care that connects to what's most meaningful: Joy

Close textual analysis of the organisation of Joy's narrative allows me to utilise a narrative segment to tell the core story (Riessman, 1993: 58-60). Although there is a distinct plot line, representation of this narrative's coherence seemed better suited to stanzas, as its poetic structure lends itself to a discussion of Joy's emotional response. I therefore prioritised 'affect' in the narrative, whilst being lenient in my methodological application. The technique I found most useful for representing this narrative segment is based on the adaptation of Gee given by Riessman (1993). In relation to the transcription, it is an "ideal realisation" of the text, whereby pauses and interactions and false starts are excluded (Riessman, 1993: 44). Insights from Labov's method have been retained, particularly in regards to the evaluation of the narrative and the resolution which

determined the end of the segment (Riessman, 2005: 3). Looking through Joy's narrative and paying specific attention to the patterning of her speech highlighted the teller's own emphasis. Lexical markers guided me as to the conventions the teller was using to mark her discourse. Very often a sentence beginning with 'so' was the teller's summary, whilst parsing within stanza's accorded to her use of 'and'. These clues suggested how meaning was sustained by Joy throughout the narrative and in inter-linking different narrative segments.

Intricate investigation of Joy's narrative shows her framing the story well, by orientating the listener to the time, date and place of her planned home birth. Included in that frame are the factors that militate against being adequately prepared and in the right frame of mind for the commencement of labour. According to Joy's calculations, she gives birth 11 days sooner than she expects. Evaluating her expected reality with her actual reality helps Joy re-frame her story towards the end of this segment, to re-align her determination for a home birth with her lived experience, more fully.

“How it happened”

Frame

Um, so, how it happened,
it was all here, in my home.
Um it was midwinter, so it was like the 14th of July.
And um, my daughter
I thought first baby always comes a week late
and I'm quite the sort of last minute kind of person,
so I was still sort of preparing everything and getting everything ready,
you know the week before she was born.
And then she came four days early!

Stanza 1: Central tension

So on the day when I started going into labour, um,
we had a delivery of furniture
that I inherited from my grandmother
that arrived by truck,
that came
that day.

Stanza 2: Labour

So, in the middle of the night
at around 3 o'clock I um
started having these sort of cramps,
which obviously if you're giving birth the first time,
you don't know that they're contractions.

Summary

So I had these experiences
and I thought, oh well
and nothings really bad
and I could still keep sleeping,
so I thought it was fine.

Stanza 3: Central Tension

And then I woke up
at around 7 or 8 o'clock in the morning
the movers called me
and said "we're here, there's this big truck and we've got all this furniture"
and that's also when I started experiencing more of the contractions
and realised they really WERE contractions.

Summary

So we had this truck and these people wanting to deliver stuff.

Stanza 4: Trying to fit it all in

And so, my husband had to go to work
and so, I said well that's fine, go.
And at first these guys arrived
and brought in all this furniture, which in our house
there's not really a lot of space.

Summary

So we had to try and fit it in our ceiling.
So I was having, by then I was having sort of contractions.

Stanza 5: Affect

And people were coming in
and I'd say "excuse me, I just need to focus a bit
and have a little contraction."
So it was quite an intense start,
not what I imagined.

Stanza 6: Dream sequence

I really imagined having um having a birth where the day would start
and I would bake something
and I'd have my sister who was going to be my doula with me from the start
and we'd be just going through it.
I'd be reading and we'd be practicing sort of meditation

Re-Frame

but um, it didn't start like that.
She came four days early so first of all I was a bit unprepared,
emotionally, or I think more mentally
and like "urgh, she's coming"
and I haven't like bought all the things I need to buy you know,
all these concerns.

Stanza 7: Central tension, expanded

But we had the movers come
and then our domestic worker came
and she started cleaning the house, so there was
she was in my space vacuuming
and that was also quite disconcerting,

Stanza 8: Affect

so I just remember thinking, this is not how I imagined it!
I was like, "NO!"

Stanza 9: (Her concerns)

And my sister couldn't come until the afternoon
So I.....I'd be sitting in the bedroom
trying to just sort of focus on the pain

and I'd call my midwife and ask her, ok this is how far they are apart
and she says, its fine, just keep going

Summary

So I was managing it ok
and I wasn't really worried,
the sort of contractions weren't too painful,
I wasn't getting stressed or worried it was just,

Stanza 10: Resolve

Um, but I eventually told um our domestic worker to go home,
because I sort of felt like I needed the space back
and my sister arrived
and that was great!
Having her, having some more sort of feminine energy
or someone that I could trust
and who was there with me.

Stanza 1 is a description of the central tension: the simultaneous recognition of labour coupled with the arrival of the movers. Accentuating the delivery of furniture with her child's birth-day, this home birth narrative immediately captivates the listener's attention. Stanza 2 goes back in time, to the initial sensations felt earlier that morning which she had dismissed. The disjuncture created by the uncertainty that marks the beginning of labour with the dismay of what was happening on *this* day creates a sort of comedy of errors. Dramatization builds tension in stanza 3, which not only returns to the underlying tension, but through the use of present time, brings the plot twist into real time (Riessman, 1990a). Speaking as the movers, "we're here" is effective in heightening the tension, while the rhythm of the story creates intrigue. Re-living and telling the events, in present tense, with a summary of events, in past tense, makes for a compelling story. A sense of anticipation and suspense is woven into the narrative through repetition and the use of various vantage points on the action. The consequences of the dawning realisation on the part of the narrator as to what exactly is going on in her body are thus accentuated.

Stanza 4 is symbolic of the way in which the movers' intrusion into her birth-space constrained her freedom to respond to her labour: 'there's not really a lot of space'. The effect imposes a disorder and a cluttering of her physical and psychological space which is quite 'intense'. Her capacity to relate to her birth in a meaningful way is compromised. In stanza 5, in light of the restraint imposed upon her and the uncanny circumstances of her labour, she is reduced

to apologising to the work men. In many ways excusing herself (and her body) is a reaction that relates to the idea of a rogue body in labour: it is uncontrollable, unpredictable, shocking and even rude. Without a way to comprehend the surprising start to her home birth, Joy reverts to her cultural conditioning in apologising for the inconvenience of her labour's disruption to the normal course of events.

In stanza 6, Joy inserts a "hypothetical narrative" where she presents to the listener an imagined reality in which she is supported by her sister, has complete creative freedom and a sense of ease (Riessman, 1990a: 77). What stands out in this idealised example is the exclusive attention paid to the birthing process by the labouring woman *and* her partner. Inserting the dream narrative into the middle of this segment, alerts the listener to the strived-for reality, that stands in stark contrast in the lived reality presently unfolding in Joy's home birth. What Joy wanted to have happen, didn't and this was clearly frustrating. She did not have the time to mentally prepare herself in the way she hoped because of the 'kind of person' she is, her husband had to go to work, her sister 'couldn't come until the afternoon' and this leaves her feeling uneasy, unsettled, with 'all these concerns'; quite the opposite of the meditative state she'd hoped for. Evaluating her hoped for experience against her actual experience helps her re-frame the story because 'it didn't start like that.'

Stanza 7 expands the central tension with the additional interruption of her domestic helper, and the intrusion into her sonic space of the vacuum cleaner. When she thus repeats in stanza 8 the emotional affect on her subjective state, 'that this is not how I imagined it', the immediacy of her exacerbated 'No' reflects the inner turmoil of being constrained within her own home. Her environment has been physically, psychologically, conceptually, and sonically absorbed into the mundane. Her retreat into her bedroom to lessen the detrimental effect of these interruptions is too far removed from an environment of care, to be comforting. The need to shut off from external intrusions is a situated response that coincidentally highlights the absence of the type of care necessary to sustain an empowered birthing self. In stanza 9 there is nothing essentially wrong, but there is nothing right either. The fact that Joy is now alone, locked out of interaction with that which brings meaning, energy and life, explains why the summary is flat, lacking in emotion.

The resolve in stanza 10 brings with it palpable relief. Not only is Joy able to assert authority over the space, but she is able to claim her own experience. In an attempt to have ownership over the physiological, emotional, mental and psychological space of birth, women choose to birth their babies at home where the possibility of this type of ownership is more feasible. Why does it matter? It matters because birth is something that can be enjoyed, can be cherished, and in

the words of Joy, can be 'great!' The narrative segment following this one is peppered with references to things being great. Her sister's support is 'really great', her husband coming home and lighting the fire is 'great', Kirsten the assistant midwife was 'really great', and being in the birth pool also 'felt great'. In this segment in particular, the fact that there is relationship when her sister arrives, 'someone that I could trust, that was there with me', makes all the difference. It is not the negation of interference in a home birth that is affirming. Rather, it is the continuous connection that witnesses, acknowledges and responds appropriately to the birthing process which makes Joy feel as if she has finally, come home.

Findings

Through long descriptive tales, these narratives speak of the ways in which birth as an act and strived for reality transforms perceptions of the self. Birth at home gave these participants an opportunity to circumvent traditional hierarchies of power. However, in so doing it creates situations where women must confront their individual reality and address pre-held assumptions. Through interrogation of caregivers; specifically chosen birth attendants; careful consideration of place; conscious crafting of meaningful birth spaces; attentiveness to emotional, psychological and spiritual aspects of their physical undertaking, these home birthers refused to take for granted the nature of their own relational involvement in birth. The midwife as the main care provider for women in home births mediates between the physical, psychological and social aspects of birth. But while this role is no doubt central, it occurs *in relation* to the social environment that the birth (or birthing mother) occupies. Care in a home birth surrounds the birthing mother, allowing her to impact on her environment and her environment to impact on her.

Doing, being and acting at home during birth, in a characteristically meaningful environment, allows women to know what they know, in a relational matrix that positions the birthing woman as essential and central. Mutuality however, is also a key aspect of such care that creates the necessary conditions for birth to become meaningful on social and cultural and personal levels. The resultant enablement or constraint of birth choices reflects the commitment to women's and societies health. Mutually acknowledging and including others leads to healthcare practices that negotiate caring for both the providers and receivers of that care, symbiotically. Edvardsson *et al.* (2003: 390) draw on research which identifies the "psychosocial climate of a setting". It is this climate in a home birth that lies at the heart of the creative capacity of home birth mothers to circumvent interference and re-inscribe uninterrupted into their birthing narratives. Where the psycho-social aspects of birth figure as

importantly as the physical, women are seen and responded to in ways that allows for integration of the self to reconcile divergent subjectivities.

The kinds of care and support women receive during home birth determine their capacity to relate to birth in deeply meaningful terms. Annie receives care that allows her to claim authorship over her own experience. Hannah receives care that allows her to maintain a memory of giving birth in an atmosphere of calm presence. Gayle receives care that validates and affirms her connection to a sense of space and of continuous meaning. Finally, Joy receives care that is actualised in relation to significant others who, in seeing her, being with her and witnessing the birth, transform her experience. Through bodily and intuitive knowledge of how to give birth, women are instinctively drawn to ways of being with birth that affirm their feelings and give voice to their emotions. Social environments of care, experienced in home births, generate psycho-social containment for birth that upholds continuous relationship and supportive engagement in the process of birth, to refute interruption. By reducing anxiety and apprehension, generating feelings of safety and security, the correct balance of maternal hormones stimulates an altered state of consciousness (Odent, 2012: 36) that transforms ordinary experience into extraordinary experience.

The interrupting story of Annie's second birth exposes a lingering scar of self-doubt into the narrative of her third daughter's birth. Her persistent belief in the right, most natural way to give birth serves a vital and necessary role in helping Annie claim back an empowered birthing self. Annie's decision to trust her instincts, seen as a dismantling of the medical hierarchy surrounding not only births, but home births as well, validates her sense of self. Standing behind her convictions, Annie re-establishes a hierarchy of the natural; drawing upon well-known principles that argue for the primal and instinctual capacity of women to give birth. Championing carefully chosen birth heroes whose ideals reflect hers, Annie re-claims an embodied wisdom. Making choices to induce her own labour, to ensure only those essential to birth are present and insistence upon delayed cord clamping, she firmly anchors herself in the role of birth expert. By establishing an active role in controlling the outcomes of her birth, Annie's narrative shows how affecting greater trust in her body, herself and her belief system, allows her to claim her own knowledge, claim her own self.

In providing a rich, detailed account of being listened to, seen as person and treated as capable, Hannah's narrative highlights the central importance of a 'social environment of care' for retaining a coherent sense of self, throughout the birth experience. As a medical practitioner, Hannah knew how to be discerning in her choice of health care professionals and experienced continuous, uninterrupted care even though care providers changed. Able to sustain being an active participant in issues relating to her subjective experience,

acknowledgement and agency afford her a sense of containment. “Feeling confirmed, seen as a person, embraced in hospitality and having the chance to talk openly and freely about emotions and worries are essential for well-being and recovery of patients” (Edvardsson *et al.*, 2003: 390). Hannah’s narrative is littered with references to care providers who validate her feelings by taking into account the personal nature of both her need and her distress.

Gayle’s search for safety is internalised and we see her identifying a place of safety as residing inside herself as well as outside. This dynamic interaction of what it means to be safe physically and emotionally, psychologically and socially, is what gives this narrative and its particular interplay of stories, integration into the life-story of the teller. Gayle’s narrative makes it obvious that stories of birth are not singular moments in time. Birth narratives draw together aspects of a person’s life to become a meaningful way in which individuals make sense of their new identities in relation to previous ones (Frost, 2007: 5). Inside her narrative are several other stories relating directly to the birth, but also relating to her childhood, her family’s history, her characterisation, and her belief systems. Home births, framed around birth as an intrinsically healthy physiological process with concurrent emotional import, significantly shifts the way birth is approached, framed and performed (MacDonald, 2006; Carter, 2009).

Part of the complexity in Joy’s narrative comes from the difficulty of aligning the present moment with a projection of that moment. Home is a socially and culturally interactive space, which although it is private, is intruded upon in many different ways. Joy’s narrative draws our attention to what in a home birth is actually more important than a lack of disturbance. Home is powerfully binding because of the ways in which we interact with those things that are personally, culturally and socially meaningful. In the in-depth interview following the narrative Joy says ‘home for me is a very warm and personal space.....there needs to be stuff that I can touch and look at and be inspired by’. In her dream sequence, she begins a recalibration process that helps resolve both the inner and outer disconnect, highlighting the elements of a socially caring environment that feed back to the safety, security and self-worth of the labouring woman. As her imagined reality of birth becomes aligned with the reality of life unfolding around her, there is a sense of deep satisfaction in the personalisation of her space and the attentiveness to her wellbeing by those around her.

Less than a year after birthing their children the women in this study had had time to process and merge disparate identities into an integrated self, embedded into a wider network of significance. The personalised nature of the care these participants received and their successful reconciliation of disparate identities

and realities is a powerful indication of their ability to maintain an intact subjectivity during and immediately after birth. The nature of how birthing women know what they know clearly centres on a relational matrix of meaning. Relationality as contingent and context specific either enables or constrains the factors that afford women choices during labour, birth and narrations of home birth. Presenting a narrated subjectivity that deftly negotiated and reconciled interference, these women claim a social and emotional currency that is both abundant and adept. In choosing a social environment where care is relationally maintained, subjective representations of purpose, strength and inspiration are gained through symbiotic interaction. Seeing the self in relation during a home birth affords reflection, recovery and discovery of that which is most meaningful, including ‘ways of knowing’, all of which mutually encompass what matters most.

These home birth narratives showcase how reconciling and negotiating the actual birth experience with narrative constructions of birth generates greater connectivity and an embodied wisdom. Really being safe featured in social environments where qualities of relating sustained an ‘emotional resonance’ with self-assuredness and steadfastness. As the kernel of the home birth experience, being safe is the container in which continuously unfolding, fluctuating birthing subjectivities reconciled incoherence and interference. Negotiated relationally, a level of authenticity can be realised at home that encompasses both disconnect and connection in the process of birth. The middle class women in this study were coaxed, through social environments of care, to listen within, to voice their concerns, to trust themselves and their bodies and to let themselves be supported. By being confirmed as a person with faults and all, caring environments render meaningful those choices which affirm women’s capacity for full responsiveness. As such, home births make possible a holistic response to the encounter with birth, which validates choosing care, to claim different ways of being with birth and new social structures where knowing, caring and responsibility are shared horizontally.

The nature of the way in which these interviews were held meant that although the narrators seldom speak directly of their identities as mothers, it was being performed and lived as the narrative construction took place. Coming into being at the time of birth is not only the new born, but a mother too. Social environments of care encourages us to recognise the way necessary skills are imparted to new mothers that empower them through a significant life transition. Many women feel their competence as mothers is strengthened when they are allowed to trust their intuitions and trust their bodies innate knowing. The importance of which is stated by Barbara Rothman in Edwards (2005: 225) when she notes that birth is not only about making babies it “is also about

making mothers – strong, competent, capable mothers who trust themselves and know their inner strength”.

Limitations

This project was limited in several ways, most concerning of which was the self-selective nature of sampling through facebook. The willingness of this study’s participants drew attention to the eagerness with which most of these women told their stories. Perhaps they likened their own agenda – to get more women to choose home births - to mine. Or, more likely, they were women already comfortable with the outcomes of their births, who were proud of themselves and thus willing to reveal deeply personal narratives. In addition, having utilised social networking, there is the chance that they may have felt compelled or pressurised into sharing their stories. For these and any number of other reasons, my chosen participants’ narratives impact substantially on the findings of this study. In fact, the inclusion of women only, limited this project. The relational nature of the care that was so important to these women’s choices suggests that further research into home births should include men, midwives and doula’s contributions to and perspectives on social environments of care. Finally, this research is limited by its focus on middle class women. Women with varied racial, class and other social backgrounds would make the findings more applicable in multi-cultural contexts.

Conclusion

Home births account for a relational dimension of birth, in which social environments of care, established as a feature of labour and delivery, influence how women exercise control and negotiate choice. The birth narratives here presented draw our attention to the way in which social environments of care are enduring; creating and sustaining the conditions necessary for integration of the self and healing of disjuncture. The inter-connectedness of people and place in an environment that reflects belonging and meaning, validates the self. Subjective perceptions of self are maintained through continuous relating, continuous support and continuous care where embedded relationships sustain the idea of an uninterrupted self. The uninterrupted birth is thus an idea that works in synchrony with narrative constructions of the self, whereupon narrators can claim wholeness and wellness, significant to their subjectivity. In effect, expanding an understanding of home births that needn’t refute interference but proposes ways of ‘caring’ that circumvents interference.

Uncaring, conversely understood, is not only detrimental to women's birthing subjectivity, but more importantly, is exposed as an ethical issue of critical importance for maternal health. Particularly in a system which is over-medicalised for the rich and under-resourced for the poor, women's birthing preferences and needs often fail to be prioritised. Yet this paper suggests that the interests which promote and support social environments of care are the basis for ensuring universally dignifying and honouring experiences of birth. The controversy over who controls the power in birth, shown to be intimately tied to the possibilities for healing birthing selves and empowering women, has far reaching ethical implications. The distribution of health 'care' resources in a highly unequal medical context is a form of professional misconduct which subordinates certain women's interests at the expense of others. Expectations of and desirability for social environments of care on the other hand are accountable to every woman's birthing needs, not solely the middle classes. Environments of care draw attention to the reciprocal nature of humane acts of care that impact on the collective through local, everyday social relations.

Homes, which are already a source of validation, comfort and security for middle class women, reflect the qualities of care that generate containment and continuous relating during the shattering and unstable subjective experience of birth. Home births are not only affordable, their resources are more accessible, and their service portable, but they afford autonomy for birthing women, their families and midwives alike. Women in this study were shown to take command of their own birth processes. They made choices reflecting the need for intimacy, safety, connectivity and agency to be intrinsic to empowered birthing subjectivities. By choosing care, home birthers provides a lens through which to scrutinise and critique birthing practices and to demand socially caring environments as an integral aspect of the health of themselves, their babies and their communities. Where neither the public nor the private sector are presently fulfilling such needs, user demand for alternative, out of hospital settings for birth must precipitate such change.

Relational experiences of care, which are felt and maintained, in connection to people, place and space are not restricted to home births. Social environments of care are easily transferable and they impact profoundly on the ability to empower birthing subjects. Environments of care that sustain meaningful interpersonal interactions, uphold spatial climates conducive to psycho-social engagement with issues of health and wellbeing. Thereby prioritising a form of holistic care to transcend interference and imposed limitations. Where caring facilitates healing, it provides an experiential basis from which to come to know what it means to be human. By adjusting both physically and psychologically to interference in home births, women author stories of childbirth in ways that

highlight how social environments of care act as the foundation for sustaining humane, meaningful, life-affirming experiences of birth.

The participants in this research project have shown that stitching together an integrated identity, to account for the disruptive nature of birthing subjectivities is a meaningful way women make sense of themselves. Birth, as a particularly powerful moment in time, brings to light the way social identities are made and remade, over time, and in an instant. This paper has shown how the narrative undertaking allows women to gain subjective knowledge and insight into their own shifting identities. The value of these narratives are therefore embedded in the creative endeavour, where to reflect and present a reality is not necessarily to assume its truth, but to claim a position that may ordinarily be out of reach. Their resultant narratives joined together selves which construct their identities as mothers, lovers, daughters, sisters, and wives into a continuously connected, coherent sense of self. Where the psychosocial aspects of the birth setting validates and affirms the psychosocial nature of birth - principally narrated in this research project relationally and contextually - then there's no place like home in which to give birth.

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