How Do Women Who Plan Home Birth Prepare for Childbirth?

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ABSTRACT

In this column, the findings of a secondary analysis of data from a larger qualitative study of the experience of home birth are discussed. The aim was to describe the ways in which women who plan home birth prepare for their births. The findings provide support for the idea of birth preparation and education occurring throughout pregnancy and describe the ways in which women planning to give birth at home develop confidence, plan for support, and make decisions related to the particulars of the labor and birth. Implications of these findings for childbirth education are explored.

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Before birth moved from home to hospital, preparation for birth took place within families. After birth moved to the hospital, much of the childbirth knowledge that was traditionally passed from one generation of women to the next all but disappeared. In the 1960s, formal childbirth education was born. The model, still used today, included formal classes started late in pregnancy. The classes provided knowledge of the process of labor and birth, how to avoid medication (''twilight sleep''), and how to ensure husbands would be allowed in the labor and delivery room. Classes helped women humanize what had become a lonely, medical event shrouded in mystery. Most women who attended those early formal classes wanted a natural birth.

While conducting a qualitative study of the experience of planned home birth for women and their midwives, I became intrigued with the ways in which the women prepared for their home birth. These women were a throwback to earlier times when almost all women gave birth at home. And, like the women in the 1960s and 1970s who attended the first formal childbirth classes, these women wanted to give birth as naturally as possible. The aim then of a secondary analysis of the data obtained in the larger study was to describe how women planning a home birth prepare for the birth of their babies.

METHOD

In the larger study, women and midwives were invited to participate. Study participants included five certified nurse-midwives and 14 women. The women included pregnant women who were expecting their first baby and pregnant women who already had one child. All of the women described themselves as ''usually pretty mainstream'' and ''not crunchy granola at all.'' One half of the

women made their decision to have a planned home birth before or early in pregnancy. Five women had previous negative birth experiences in hospitals with obstetricians, and four women had negative experiences with obstetricians during their current pregnancy. Almost one third of the women initially planned traditional maternity care but changed to a home birth midwifery practice between 18 and 24 weeks. The participants lived in a large urban area, were middle class, and were mostly White and Hispanic. One woman was married to an African American man. All the women wanted a natural birth.

I interviewed the women formally and informally in their homes during pregnancy and after the birth. In addition, I observed prenatal and postpartum visits and attended some births. The interviews and the observations lasted 2–3 hours. All the women were interviewed at least twice, and half of the women were interviewed three or more times.

The interviews were audio-taped and transcribed. The interview transcripts and the narratives of the observations were analyzed using standard qualitative techniques. Codes, categories, and themes were developed. Criteria to ensure trustworthiness were followed. The Institutional Review Board of Seton Hall University approved the study. The findings provide rich descriptions of how women who plan home birth prepare for the birth of their babies.

FINDINGS

The women in this study thought deeply about the birth itself well before the third trimester. All the women wanted a natural birth, and most of the women had mothers who had given birth naturally and shared positive birth stories with their daughters. The decision to have a planned home birth involved a great deal of information gathering and personal reflection. For some of the women, this happened before or early in the pregnancy; for others, a previous negative birth experience or a negative experience with an obstetrician or hospital during the current pregnancy precipitated reading, Internet searches, and discussion with other women who had given birth naturally. All the women expressed worry over their slim chance of having a natural birth in a hospital setting with an obstetrician. The decision to have a planned home birth, to step outside the standard maternity care system, changed the course of their pregnancy and birth in powerful ways and shaped their planning and preparation for the birth. The decision to have a planned home birth was a first and important step in preparing for the birth of their babies. The second step was choosing a midwife. Again, the women used the Internet, talked to other women who had had home births, and interviewed midwives.

The pattern of actively searching for information and listening to birth stories that led the women to choose a planned home birth and a midwife continued to be an important way that the women prepared for the birth of their babies. In addition, the prenatal care provided by their midwife was an important part of preparing for birth. Prenatal care helped the women develop confidence in the process of labor and birth and in their own ability to give birth. The midwives guided the women to think carefully about the details and the practicalities of the labor and birth and to plan in advance for what the women wanted. Some of the women, although not all, attended formal childbirth education or prenatal yoga classes. Each woman had a unique approach to preparing for her home birth and made personal, individualized choices for her pregnancy, labor, and birth, which were somewhat different from how the other women prepared for their home birth. One size did not fit all.

Reading and Research

All of the women read extensively about birth. One woman said, ''I read 17 books. I've never prepared for anything like I have for birth.'' Most of the women had read *Ina May's Guide to Pregnancy* (Gaskin, 2003) and found the content inspiring and useful. Several women read *The Official Lamaze Guide: Giving Birth with Confidence* (Lothian & DeVries, 2005) and *Pushed: The Painful Truth about Childbirth and Modern Maternity Care* (Block, 2008). All the women spent time on the Internet searching for information, following blogs, and viewing YouTube videos of births. Most of the

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women had seen the documentary film *The Business of Being Born* (Lake & Epstein, 2008), and many of the women had also seen the documentary film *Orgasmic Birth* (Pascali-Bonaro, 2008). Their research included interviewing obstetricians and midwives and going on hospital tours almost as soon as they knew they were pregnant. One woman said:

> *You know, I toured those places and I just didn't have a good feeling. I just didn't feel like it made sense to have a baby there. I had been reading all this about birth, and it is so important to follow what your body needs to do, and I didn't know I would feel that way in a hospital. I don't understand how things work here. I don't feel in control. People can just come in. . . .*

Three of the women already had extensive knowledge of birth because one was a midwife and two were doulas and childbirth educators (they also made their decision to have a planned home birth before becoming pregnant). All the women's research included seeking out women's birth stories, both their own mother's stories and the stories of other women who had natural births, including home births. Their reading and research continued through the pregnancy and expanded to include finding information about prenatal testing, routine infant procedures, breastfeeding, parenting, and choices related to labor support and finding comfort in labor.

Prenatal Care

The women's prenatal visits with their midwife took place in the women's home, and each visit lasted at least 1 hour and often longer. The focus of each visit was on the individual woman, her concerns, her questions, and "just what is happening in my life." The visits were casual and not rushed in any way: a cup of tea, lounging on the sofa, playing with an older child. The routine evaluations—checking blood pressure and the fetal heart rate-—took very little time. Most of the visit was spent in long discussions about things related to the woman's pregnancy and birth, for example prenatal testing or newborn procedures, or about everyday concerns such as stress and relationships. The midwives shared birth stories over the course of the pregnancy, always highlighting women's ability to give birth naturally. All the midwives asked early in the pregnancy, and at each visit, about each woman's desires for her birth: "Who will support you?" and "What about childbirth classes?" and "Have you thought about whether you might want a birthing tub?"

In getting to know each other well, each woman and her midwife prepared for the birth together. Right from the first visit, the women were happy with their midwives and described their relationship in a variety of ways:

> *She was very warm. Just calm, confident. She answered our questions. . .very straightforward in language we could understand.*

> *Visits almost felt like therapy. It was all about me and my world.*

> *We just talk. Anything I need to be thinking about? How things are going for me. Nothing is a problem. There is no need to worry.*

> *I think the major difference was how normal everything was for her. Everything is going to be fine. If not, we will deal with it.*

> *The other amazing thing is she said, "If you need me, call me," and every time we do she answers herself or calls back right away.*

> *I can be open and honest.*

> *She gets to the heart of what's going on in your life . . .what's important to you.*

Another hallmark of prenatal care was the midwives' commitment not just to informed decision making but to autonomy in decision making. Over and over again, the women asked about choices, and the midwives reassured them, "You can do what you want," as reflected in the following women's accounts:

> *About prenatal testing? She says you can do whatever you want. You can do everything. You can do nothing. It's whatever you want. I wanted to find out the sex in the end. I didn't feel like I was being judged.*

> *I refused all testing so far. No ultrasounds. Nothing.*

> *We did the 20-week ultrasound. I never wanted a vaginal exam, and she said, "Fine." It's*

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wonderful to have freedom and respect as a woman, as a parent.

Over the course of the pregnancy, the women became more confident in their ability to make decisions for themselves, never feeling pressured or judged. As one woman described, ''I feel supported, but I feel like I am making the decisions.''

Traditional Childbirth Education and Other Classes

The midwives encouraged the women to attend childbirth classes, and about half of the women did so. The midwives recommended classes outside the hospital and classes given by childbirth educators whom they knew personally. As it turned out, most of the teachers had experienced their own planned home birth. Their class participants included women who planned a home birth as well as women who were planning a hospital birth. One woman in the study attended hypnobirthing classes as well as standard childbirth classes. None of the women in the study attended classes marketed as Lamaze classes; however, three of the women (the midwife and the two doulas) were also Lamaze Certified Childbirth Educators. The women who attended formal childbirth classes were typically women having their first baby. They reported that, in the classes, they received support for their decision to give birth at home. They found value in learning comfort techniques and developing a network of relationships with other women, especially with other women planning home births. The women who had attended childbirth classes during previous pregnancies did not find the classes valuable enough to attend again.

One midwife encouraged the women to attend at least one prenatal visit at her home/office. This prenatal visit was a group visit, usually with a guest speaker, and provided an opportunity for the women in this midwife's practice to get to know each other.

Two women who had had previous negative birth experiences were encouraged by their midwife to attend sessions with a birth counselor to work through issues related to their previous birth in preparation for their current birth. Counseling made a significant difference in the women's ability to approach their current birth with confidence.

A majority of the women attended prenatal yoga classes. One of these women attended a yoga workshop with her husband, as a couple, in preparation for the birth. Doulas also helped the women prepare for their births. The women met with their doula at least twice before the birth. The visits provided an opportunity to get to know each other and to continue the work of planning the specifics of the birth. During prenatal visits, the midwives helped the women define the role that each support person at the birth would play, including the doula's role.

Comfort and Support: Working Out the Details

Because the women were giving birth in their own home, planning for comfort and support was less complex than planning to give birth in the hospital. The midwives helped the women think about what they specifically needed to feel safe and comfortable at home and then to make plans. Each woman's choices were uniquely her own.

Labor support. From the early prenatal visits, the midwives explored with each woman who she wanted to be with her in labor. The discussion usually emerged out of larger discussions regarding support in the women's lives. The midwives encouraged the women to think about what kind of support they wanted and who could best provide it. There were also discussions of whether other children would be at the birth. The midwives talked about doulas with all of the women, and each woman carefully considered whether to have a doula. Four women decided that ''I feel most comfortable with my mother,'' and four did hire a doula. Two women had friends with them during labor. One woman had her mother, her sister, a doula, and a journalist (who later published an article about home birth) at the birth. The support role that each person played was carefully thought out by each woman, with guidance from her midwife.

The women made plans for who would cook, who would watch the other children, and who would just be present with no other role. There was also discussion about who should not be at the birth because of ''bad energy.'' One woman summed up what all the women felt: ''I wanted every single person with me to be in my circle of trust. No one touching me or my baby that I didn't know and trust.''

Comfort. Being at home insured that the women could do what they wanted in labor, but the space constraints of many of the women's home required careful planning. The midwives guided the women as they figured out how to make the space work for them. Most of the women rented or bought birthing tubs. The women who chose not to use a birthing

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tub planned to use their own shower/bath in labor. Most of the women bought birthing balls and used them during pregnancy. During prenatal visits, the women discussed when to call the midwife, the doula, their partner, or their mother. The midwives offered constant reassurance that they would be available whenever the women needed them. Many of the women selected music they would play during labor. They also planned what to wear, choosing items that would be most comfortable. Some of the women bought special sheets that would be soft and beautiful for the birth. One woman shared, ''I love the idea of sitting in that pool right there in the comfort of my own living room. To put my head on my pillow, my smell, not bleached sheets under bright lights.''

Another woman shared that, when her midwife visited, ''she wants to know where I keep my robe, what pillows I like, what bath salts or tea I really love. Gearing everything, all the plans for birth, to me.''

Food and drink. The women thought about what they might want to eat and drink in labor. They filled their refrigerators with Gatorade, water, and juice. Many had champagne being chilled, waiting to celebrate the birth. One woman, whose husband is an importer of wine, shared, ''He is already planning for after the birth. Cold French wine. French cheese. Fresh fruit.''

Some home birth basics. There were very few special preparations the women needed to make because of giving birth at home. The midwives told the women to have plenty of old towels available and to buy a plastic shower curtain to protect the bed mattress. The women ordered birth kits on the Internet. The midwife came to the births with all the other necessary medical equipment, such as handheld Dopplers, oxygen, and intravenous supplies.Right before the birth, women shared these comments: ''I have the box of towels. I've been freezing food. I'm ready'' and ''It's fun to prepare. Everything is here and ready. I am in charge.''

SUMMARY

One woman said, ''I feel more prepared for birthing than I have for anything in my life,'' and this captured how all the women felt as the birth approached. The decision to have a home birth, the choice of a midwife, and then the preparation and planning that happened over the course of the pregnancy helped all the women feel completely prepared for the birth of their baby. The women took all the decisions they made during pregnancy seriously, and their preparation focused on having a safe, satisfying, natural birth. By the time their baby was born, the women were confident in their ability to give birth, confident in the process of labor and birth, and confident in their midwife's ability to support them in labor. All the components of a satisfying birth—a positive relationship with the midwife, excellent labor support, high expectations for the experience, and being part of decision making—were present by the time the women went into labor. The planning was simple, much simpler than if they had planned a hospital birth.

IMPLICATIONS FOR CHILDBIRTH EDUCATION

Unlike the women in this study, only 37% of women in the United States want to give birth naturally (Declercq, Sakala, Corry, & Applebaum, 2006). Unlike the women in this study—for whom reading, reflecting, viewing videos, hearing and seeing birth stories, and participating in early hospital tours highlighted issues with hospital birth—most women do not become aware of the problems with the current maternity care system until late-pregnancy childbirth classes. Unlike the women in this study, many women in classes have unsatisfactory relationships with their providers, and most have severely limited choices. Childbirth class is often the first time they are aware that having the birth they want requires a great deal of communication and negotiation and, even with enormous commitment, it is not likely that they will have the birth they want.

Can childbirth education better meet the needs of the women who are preparing to give birth in hospitals with obstetricians? I see three broad implications of the current study's findings for childbirth education. Most importantly, the findings suggest that the childbirth educator can play a role throughout the entire pregnancy, not just at the end of pregnancy teaching traditional classes. If childbirth education starts early in pregnancy, the educator has an opportunity to guide the woman, like the midwife does, helping her to see choices, develop confidence, and make decisions that enhance her ability to give birth naturally.

Or, for women who do not initially think they want to have a natural birth, starting childbirth education early in pregnancy allows the time required to persuade women to see the value of giving birth naturally (Lothian, 2009). Secondly, if the childbirth educator meets women early in pregnancy, there is the opportunity for the development of a personal relationship, similar to the relationship developed with the midwives in this study. A personal relationship with the childbirth educator has the potential to further strengthen women's confidence. Lastly, a goal of classes might be to help women connect to other women, allowing them to develop friendships over the course of the pregnancy that ultimately provide additional support for each other. Early formal childbirth classes provided this opportunity. It is time to reconsider its value.

Re-envisioning childbirth education in this way may be a step in the direction of reclaiming the ways in which women prepared for the birth of their babies before birth moved to the hospital and was taken over by "experts" who do not trust birth or women's ability to give birth.

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