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Calls to a home birth helpline: Empowerment in childbirth

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Abstract

In the UK a woman has the right to decide to give birth at home, irrespective of whether she is expecting her first or a subsequent child and of any perceived 'risk' factors. However, the rate of home births in the UK is very low (around 2%), varies widely across the country and many women do not know how to arrange midwifery cover. The Home Birth helpline is a UK-based voluntary organisation offering support and information for women planning a home birth. In order to gain direct access to the issues that are of concern to women when planning a home birth, 80 calls to the helpline were recorded. The aims of this paper are to document the problems that callers to this helpline report having when trying to arrange home births and to explore the strategies the call-taker uses in helping women to exercise their right to birth at home. The paper concludes that women are not easily able to exercise their right to choose the place of birth and suggests a number of recommendations for action.

Introduction

In the UK, as in North America and countries such as Finland and the Netherlands, a woman has the right to decide to give birth at home, regardless of whether she is expecting her first or a subsequent child and irrespective of any perceived 'risk' factors. This is a case study of the problems faced by some women in the UK when attempting to exercise this right.

In the UK, local Health Authorities (or Health Boards in Scotland and Northern Ireland) have a legal obligation to ensure women are attended by a qualified practitioner (usually a midwife) during childbirth. Although provision for a home birth is not explicitly stated, there is no doubt it is Government policy to provide a home birth service (RCM, 2002, p. 2). It is a "marker of good practice" that "all women are involved

in planning their own care with information, advice and support from professionals, including choosing the place they would like to give birth and supported by appropriately qualified professionals who will attend them throughout their pregnancy and after birth" (DH, 2004, p. 5). Following a Market and Opinion Research Institute (MORI) poll in 1993 (commissioned by the Expert Maternity Group), which found that 72% of respondents were not given a choice about the place of delivery, the House of Commons Health Committee concluded that choices are "often more illusory than real" (HC, 1992, par 51). The Committee's recent report *Choice in Maternity Services* (2003) shows that there is still a substantial amount of unmet need amongst women who want to have a home birth but "feel they do not have the opportunity to do so", or who are wrongly advised against home birth "on spurious grounds" (2003, p. 15).

A study by the National Childbirth Trust (NCT, 2001), which surveyed maternity units in the UK, showed that some healthcare providers failed to present

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home birth as a real option, and others actively discouraged it, so that there is substantial variability in the rate of home birth between Trusts—from over 10% of births in some areas, to less than 1% in others (a situation described as a “postcode lottery” by Newburn, 2003).

The wide variation suggests that the number of women choosing home birth is highly dependant on the nature of the information they receive and the attitudes of their caregivers. In particular, if a women has a primary care doctor who supports her wish to have a home birth she is significantly more likely to give birth at home (Davies, Hey, Reid, & Young, 1996). The NCT report concluded that interest is likely to be higher where home birth is seen as a realistic option and where women know others who have given birth at home. That home birth might be more widely chosen if it were more readily available, is further indicated by the Netherlands, where the home birth rate has never dropped below 30% (see Davis-Floyd, 2003, p. 1929). This is also demonstrated in Wales, where rates have risen from 2.15% in 2002 to 2.7% in 2003, as a consequence of a Welsh assembly target of 10% and in the English area of South Devon covered by Torbay General Hospital, which has the highest home birth rate in the UK (11%) as a consequence of changes in practice (Kitzinger, 2005).

Recent research suggests that women lack information about options for childbirth, including the place of delivery (Dodds & Newburn, 1995; Dowswell, Renfrew, Gregson, & Hewison, 2001; Emslie et al., 1999; Floyd, 1995; Garcia, 1999; Gready, Newburn, Dodds, & Gauge, 1995; Hosein, 1998; Hundley et al., 2000; O’Cathain, Thomas, Walters, Nicholl, & Kirkham, 2002; Singh & Newburn, 2000). For example, according to Hundley et al. (2000) fewer than half (41%) of the 1137 surveyed in Scotland (representing all women giving birth in the country during a 10-day period) reported having had a choice about whether to give birth at home—and 99% of all these births were hospital based. Similarly, fewer than half (45%) of women at 12 maternity units in Wales reported having exercised informed choice about whether or not to give birth at home (O’Cathain et al., 2002). A national (UK) survey of 1188 women found that only 36% had been given information about home birth in their first visit to the GP or midwife and that more than a quarter (27%) would have liked more information about their choices in relation to the place of birth (Singh & Newburn, 2000). Of 44 community midwives (across three health authorities in West London) only two (5%) said they routinely offered home birth at booking (Floyd, 1995). At least one National Health Service Trust (Peterborough and Stamford Hospitals NHS Trust) has recently banned home births as a consequence of staff shortages and has sacked a midwife who disobeyed their instruc-

tions and attended a home birth (<http://news.bbc.co.uk, 22/08/04>).

The most significant change in 20th century maternity care has been the movement of the place of birth from the home to large hospitals. At the beginning of the 20th century virtually all births occurred at home; by the end of the century virtually all occurred in hospitals. Around 2% of babies in England and Wales are currently born at home and well under 1% in Scotland and Northern Ireland (ONS, 2001; NCT, 2001). The move away from home birth towards hospital birth was initially motivated by a concern to provide facilities for women whose homes were overcrowded and who needed rest after the birth. Subsequently, as hospital birth became the norm (especially after the formation of the National Health Service in the 1950s), it was motivated by a perception that hospital birth was more ‘advanced’ or ‘modern’ (NCT, 2001, p. 15). In 1970, the Peel Committee proposed that the maternity service should no longer offer home delivery, advising a move to 100% hospital delivery and asserting that “the greater safety of hospital confinement for mother and child justifies this objective” (Peel, 1970, p. 60). During the 1970s and 1980s, research on the relative safety of home and hospital birth repeatedly failed to support this assumption—showing that improved rates of maternal and perinatal mortality were associated with improvements in housing, nutrition, overall maternal health, reduction in numbers of pregnancies and an increase in the time between births, rather than solely with the move from home to hospital births (Kitzinger & Davis, 1978; Tew, 1978, 1979) and that for normal, low-risk women, home birth was as safe as hospital birth resulting in fewer interventions, and less morbidity for mothers and babies (Campbell & Macfarlane, 1987).

In 1992 the Winterton Committee informed the government that Peel had been mistaken and that “the policy of encouraging all women to give birth in hospitals cannot be justified on the grounds of safety” (HC, 1992). This led to new health service policy and a government-commissioned report (*Changing Childbirth*) that stated: “the woman must be at the focus of maternity care, in control of what is happening to her” and that women can “choose where their babies are born and their right to make this choice should be respected” (DH, 1993). More recent research on the safety of home birth reinforces this message (Springer & Weel, 1996; Chamberlain, Wraight, & Crowley, 1997; Olsen, 1997; Olsen & Jewell, 2003). By the end of the 1990s the rate of home births in the UK had risen to around 2.2% nationally (NCT, 2001).

In early second wave feminist research, relatively little attention was given to women’s choices in childbirth (but see Kitzinger, 1962): instead “(a) great deal of energy went into exposing the ‘motherhood mystique’ and challenging the social conditions that sometimes

made childcare isolating and exhausting, rather than enriching” (Stanworth, 1987, p. 33). By the second half of the 1970s, a number of feminist and woman-centred studies began to draw attention to women’s experience of birth (Simonds, 2002; Bergstrom, Seidal, Skillman-Hull, & Roberts, 1997) and to critique the medical management of pregnancy and birth (e.g. Coslett, 1994; Davis-Floyd, 1992; Katz-Rothman 1991 [1982]; Martin, 1987; Oakley, 1977, 1980) and to champion the alternative tradition of midwifery (e.g. Arms, 1975; Katz-Rothman, 1991 [1982]; Oakley, 1984; Wertz & Wertz, 1989).

Researchers have explored women’s reasons for wanting a home birth (Davis-Floyd, 1992, 1994; Fordham, 1997; Hodnett, 1989; Klassen, 2001; Klieverda, Steen, Anderson, Treffers, & Everaerd, 1990; Morrison, Hauck, Percival, & McMurray, 1998; Morrison, Percival, Hauck, & McMurray, 1999; Ng & Sinclair, 2002; Viisainen, 2001)—and find that these include desire for autonomy and control over decision-making (Davis-Floyd, 1994; Hodnett, 1989; Viisainen, 2001), desire to avoid medical technology and interference (Chamberlain et al., 1997; Viisainen, 2001), being in a peaceful, relaxed and familiar environment (Klieverda et al., 1990; Morrison et al., 1998; Viisainen, 2001), privacy (Klieverda et al., 1990; Viisainen, 2001), a ‘natural’ birth (Davis-Floyd, 1994; Klassen, 2001; Ng & Sinclair, 2002; Viisainen, 2001), enjoying a relationship of equality with healthcare providers (Hodnett, 1989; Morrison et al., 1998), the ability to choose birth companions (Fordham, 1997; Klieverda et al., 1990; Morrison et al., 1998) and because a previous hospital birth was traumatic (Chamberlain et al., 1997; Viisainen, 2001). Researchers also highlight the effects that previous sexual abuse may have on women during pregnancy and childbirth (Kitzinger, 1997). A recent British survey of 3000 women (Mother and Baby magazine.com, 2005), found that 62% were confined to bed and not allowed to move around during labour, 43% were “strapped to electronic monitors continuously”, 25% were not told what was happening during their labour and birth and only 43% had the same midwife throughout (for only 4% was this the same midwife they had also seen during their antenatal visits).

The aim of the study presented here is to document the obstacles women encounter in trying to exercise their right to choose to give birth at home—irrespective of their reasons for wanting to do so. There has been virtually no previous research looking at the problems women encounter in trying to arrange a home birth as these happen during their pregnancies (as opposed to retrospective interviews after the birth).

The research is based on recordings of calls made to a telephone helpline for women planning a home birth, most of whom call the help line because they have run into difficulties. This naturalistic data set offers direct

access to women’s concerns in the course of trying to arrange a home birth at a point in their pregnancies where arranging one appears problematic.

As part of the growth in the last decade in the use of telephone helplines in the UK offering support for diverse social issues (including for example health, parenting, bullying, mental disorders and substance abuse, Telephone Helplines Association, 1999), the Home Birth helpline is a (UK-based) telephone service offering support for women seeking to arrange a home birth. It is a voluntary organisation, established in the 1980s and advertised (for example in the directories of magazines such as *Baby and You*, *Pregnancy and Mother*). The call-takers are feminist birth activists with an explicit commitment to empowering women. Thus, the aims of the helpline are both to provide support to individual callers and to work towards social transformation through empowering women (by informing them of their rights, sharing research findings and encouraging direct action).

As well as documenting the problems that women report having, this paper explores the strategies that the call-taker uses in helping women to exercise their right to birth at home, and the extent to which these strategies are or are not successful.

Method

The data set comprises audio-recorded telephone conversations between call-taker and callers to the Home Birth helpline. A total of 80 telephone conversations between one call-taker and 56 callers were audio-recorded.¹ In conformity with the ethical codes of practice produced by the British Sociological Association (2002) and the British Psychological Society (2000), ethics approval for this study and its procedures was sought and obtained from the Home Birth helpline. The call-taker sought informed consent from all callers within the first few minutes of the call (the informed refusal rate was around 5%) and guaranteed their confidentiality. In addition to calling the helpline, a number of callers sent the call-taker emails, letters and cards, some of which (together with the call-taker’s responses to them) were passed on for inclusion in the data set. Although, given the remit of the helpline, this is an ideal data set for exploring the problems and barriers women confront in trying to arrange a home birth, it should be noted that the total number of calls recorded is relatively small ($n = 80$), is self-selected, and that the problems confronted by these callers cannot be considered representative of all those confronted by women

¹Fifty-four women were calling on their own behalf, one is calling on behalf of her niece (who has herself previously used the service) and one man is calling on behalf of his partner.

planning home births in the UK. No demographic data is available, other than that gleaned from the call.

All calls were transcribed verbatim using a simplified orthography² and all names, including names of general practitioners, consultants, midwives, hospitals and towns, were pseudonymised. The data were analysed using content and thematic analysis. This involved coding participants' open-ended talk into categories that summarise and systematise the content of the data (Campbell & Schram, 1995). This method of analysis provides a useful summary of the kinds of calls the helpline receives and offers an over-view of the range and diversity of issues for which women are seeking help.

Results

Choosing a home birth

Of the 80 calls in the data set (mean duration 13 min³), 60% ($n = 48$) of the calls are first contacts with the helpline and 41% ($n = 32$) are repeat calls.⁴ The high percentage of repeat calls reflects the stated willingness of the call-taker to be involved in callers' ongoing struggles to achieve home births (e.g. by giving feedback on letters of complaint, advising on suitable courses of action following scans and tests, etc.) and her stated interest in hearing about women's experience of their labours and deliveries after the event.

A common feature of the calls was that the desire to have a home birth was treated as understandable and ordinary by both call-taker and callers. In contrast with previous research on women's experience of home birth (e.g. Davis-Floyd, 1992, 1994; Fordham, 1997; Hodnett, 1989; Klassen, 2001; Klieverda et al., 1990; Morrison et al., 1998, 1999; Ng & Sinclair, 2002; Viisainen, 2001), we do not, therefore, have much by way of information about *why* these women wanted to give birth to their babies at home—nor is this the focus of our research. There is not one instance in which the call-taker asks the caller why she wants to have a home birth—although callers do sometimes volunteer this information, and give accounts for wanting home births that clearly map

²The transcription notation includes three dots in round brackets to indicate that words have been omitted for presentational purposes, underlining to indicate emphasis and emotional expression noted immediately after the passage of speech: for example (upset), (sarcastic), (smiling).

³This figure is approximate as the very beginning of calls are often missing and occasionally so too are the ends. The median duration is 11 min, minimum is 37 s and maximum is 40 min.

⁴It should be noted that the dataset does *not* comprise all calls from all 56 callers, as 8 first calls were inadvertently not recorded by the call-taker.

on to the reasons that have been collected in interviews and questionnaires in other studies. For instance, callers to the helpline talk about their desire for autonomy and control over decision-making, contrasting hospital birth in which “you're suddenly at the mercy of what they want you to do and strapped to beds and legs up in stirrups” with home birth where “you are very much in control [...] because it's your home—it's your territory.” (Andrea 56).

Callers reported wanting to avoid medical interventions such as a hospital “one in four caesarean rate”, (Tanya 31) or foetal electronic monitoring (“they put you on the monitor—and that's the way you stay, and you're in no position to argue because you're seriously in pain and unless you've got someone speaking on your behalf I think you're trapped” (Alena 15)). Previous experience of sexual violence also impacted upon the decision to give birth at home (e.g. “as a survivor of childhood abuse, it was very important for me to have my physical integrity respected during this birth” (Zoë 63)). Like respondents in other studies, many of the callers did not trust getting any support from prenatal care and reported feeling that decision-making during a hospital labour could be a “battle” (Harriet 01) against people who are trying to “intimidate” (Bridget 16), in a situation in which “you don't want to have to come across as you know, all bolshy.” (Louise 25) (meaning deliberately combative or uncooperative).

Calls fall into four broad categories related to the reason for the call: (1) calls for general information (19% $n = 15$ calls); (2) calls for help with arranging a home birth (45% $n = 36$ calls); (3) follow-up calls (usually related to the on going planning of a home birth) (21% $n = 17$ calls); (4) birth reports (15% $n = 12$ calls).

Calls for general information

Nineteen percent ($n = 15$) of calls were requests for general information, e.g. “where can I get a birth pool from?” (Maeve 70), “is it safe to birth at home if you're carrying twins?” (Linda 38) and “what should I do with my two year old during the birth?” (Julia 47). Some women were already booked in for a home birth and wanted to meet other “like-minded” people (Georgina 18). Others wanted support and information because they had not received strong support from healthcare providers (e.g. “I don't think my GP is terribly keen on it [home birth]” Nicole 20), or because they did not anticipate doing so:

Tomorrow I've got my first appointment with my GP. The very first one. And at the moment, certainly, my husband and I are both very very keen on a home birth. And I was just- I was just ringing to see if you can give me a bit of advice, just to make sure. You know, forewarned is forearmed. (Deidre 05)

A number had already read relevant books and magazines. Some had searched for information on the Internet and contacted other relevant organisations (i.e. Association for Improvements in the Maternity Services and the National Childbirth Trust). A few had already written to the director of midwifery at their local hospital, requesting support for a homebirth. However, many callers were calling for information and as yet had only a limited understanding of their rights, or had been made to doubt their knowledge after speaking with their healthcare providers. They wanted, like Vicky (22) to “confirm that I actually do have a choice, I have a right to whatever I want”; and, like Marion (19) to confirm that if they decided to go ahead with a homebirth, a midwife is legally obliged to attend: “So if I say to my midwife I want a homebirth they will have to provide a midwife then?”

In analysing these calls we focus on what they reveal about the difficulties and obstacles that confront women planning a home birth. First, it is common throughout the data set for callers to report feelings of isolation and many said they didn’t know anybody else who was having a home birth. One woman, reflecting on her antenatal classes, commented, “in all the groups that I’ve been to, I think I’ve been the only one having a home birth”. (Penny 41). In one of the repeat calls, Beverley (36) told the call-taker: “until I’d spoken to you [...] I had never spoken to anybody, any live person, who could say ‘this is a normal thing; this is okay to do’. Just even to speak to you made me feel better”.

Second, many callers reported that friends and family had expressed reservations (ranging from “concern” to “complete horror”) about their proposed birth plans:

To be honest with you the main reason I’m calling is because [...] my friends and my mum and just about everybody else I meet apart from my husband look at me in complete horror when I tell them I want a home birth. I was in tears last night because I had a talk with one of my friends yesterday who basically said to me ‘look you know I appreciate you’re doing it but I couldn’t put my child’s health at risk like that’. (Ursula 13)

Although most partners were supportive, some women reported that their husbands were anxious about or opposed to home birth: Emily’s (17) husband “hasn’t been keen on the idea. His first reservation was safety issues, which I suppose is quite common. Then it was the mess [...] He thinks like a sort of abattoir, you know”. Despite the negative attitudes encountered, these women were resisting the medicalised culture of childbirth and persisting in their request for a home birth. This supports the findings from a previous study in which Chamberlain (in Chamberlain et al., 1997, p. 132)

concludes: “women planning home birth did so in the face of a certain amount of perceived discouragement”.

Calls for help with arranging a home birth

The single most common reason for calling (45% of the data set) was when women were having practical difficulties in arranging a home birth. Several callers reported that they had asked for midwifery cover for a home birth and been denied it because of staff shortages, or simply because, as one doctor is reported to have said, “we don’t do home births here” (Renate 48). Sometimes a health care provider “hadn’t exactly said ‘no’ to me having a home birth—she just wasn’t very positive about it” (Louise 25). Sometimes a health care provider had been more explicitly opposed: “I’ve just been for my first midwife’s appointment and we said we’d like to be at home and she said she didn’t allow home births” (Joy 57); “apparently I’m not allowed to do a home birth from this hospital” (Stacey 58); “she’s basically told me that if I ring up on the day they may be able to do it, but the likelihood is they *won’t* be able to. She was ever so nice about it, but she basically told me ‘no’” (Sarah 72). Callers described being “manoeuvred” (Petra 10) into agreeing to give birth in hospital: “It’s the way they put things to you—it’s as if they’re in control and it’s as if they’re giving you permission [...] And they’re making me feel so selfish.” (Rachel 11).

Many women were given medical reasons why they should not give birth at home. Some contraindications, such as diabetes, a heart condition, or the occurrence in late pregnancy of pre-eclampsia (high blood pressure, oedema and protein in the urine) or placenta praevia (when the placenta is in front of the baby’s head), constitute very good reasons for a woman being advised against birthing at home (Kitzinger, 2002). However, callers to the helpline were cited a wide range of other conditions—for example, because it was their first baby (“He was very just *clear* and said that you know that it’s very dangerous for a first birth.” (Harriet 01)); they were too old (“The doctor [...] said that she wouldn’t support me because I’m forty” (Vicky 22)); or overweight (“When I approached them about a home birth they were umming and ahing about it because I’m overweight.” (Alana 15)). There is no evidence that a home birth is any more problematic with a first baby (Thomas, 1998), or for women over 35 (Thomas, 1998), and while being overweight does mean more likelihood of raised blood pressure and pregnancy diabetes (Calandra, Abell, & Beisher, 1981), Alana (15) reported that her blood pressure was normal and that she had no indications of diabetes—and at five foot six and weighing 12 stone three (171 lbs), her body mass index was in fact within a normal range (taking into account her stage of pregnancy). Being ‘overdue’ was another common reason:

I'm booked for a home birth—but there's a problem because I'm ten days overdue. The midwife came out and did a stretch and sweep and immediately said 'Oh well, don't worry; I've got you booked in for an induction next Saturday'. I said, 'Well, I won't be there!' (laughs). (Andrea 53)

Problems in previous pregnancies or labours were reported as reasons for having been denied a home birth. Lottie (30) had what she described as a "slight bleed" in her last labour:

So I went in, consultant said 'You want a home birth' and I said 'That's right' an' he sort of peered over the top of his specs as he said it and you think 'he's not going to be happy here, is he'. And then he looked at my notes and sort of 'oh you had a bit of a bleed last time but it wasn't that heavy was it?' and then he looked and saw that my haemoglobin went down to six and he went into sort of full scale consultant panic [...] Sort of complete overdrive, as it were.

Problems that arose in a previous pregnancy or labour are unlikely to repeat themselves and may even have been the result of routine obstetric management (Thomas, 1998). A number of women commented that once some reason had been put forward, it seemed impossible to avoid intervention and monitoring: "It seemed once a trigger had been set, it was almost impossible to break away again, even though there was no real evidence of any problem." (Beverley 36). As one alleged contraindication is dealt with, another arises: May (23) was first told, in early pregnancy, that she couldn't have a home birth because she had placenta praevia. After this problem resolved itself, she was told she couldn't have a home birth because the baby was too big and when an ultrasound showed this not to be the case she was told she couldn't have a home birth because of her height (too short) and then finally because it was her first baby. Similarly, Zoë's (63) difficulties began when the midwife suspected intrauterine growth retardation and booked a scan. The result of the scan was that the obstetrician claimed the baby was too *big* to birth at home. When Zoë persisted with trying to get a home birth she was told she was putting her "emotions" before her baby's well being.

In their initial calls, callers reported a number of strategies used to obtain a home birth. Many callers did not trust getting any support from prenatal care staff and had avoided discussing it in order to avoid confrontations:

I don't want all that—I don't need the aggravation, you know. At this stage I just want things to go along smoothly. Rather than having to keep fighting everybody. [...] You know it's a fine line that you

cross because I didn't want to get into an argument with my midwife, so I just said nothing. (Rachel 11).

Some of the callers described their interactions with GPs, midwives and consultants in terms of a "battle", a "negotiation" or "being persistent". Others (like the women whose experiences are reported in Viisainen, 2001) adopted a strategy of compliance with prenatal care in order (they thought) to increase the likelihood of health care providers agreeing to their demand for home birth:

I didn't want to go along with them but then I thought, well if I am entering into sort of confrontation anyway, that I might go along with the scans, just to help them feel that everything's all right. (Harriet 01)

Follow-up calls

Twenty-one per cent ($n = 17$) of the calls were subsequent calls from women, usually describing the on going planning of their homebirth and reporting the ways in which they had responded to the call-taker's advice and were successfully overcoming the barriers to having their babies at home. Deidre (06) and Beverley (37) called back to tell the call-taker that they had made notes in advance of meeting their healthcare providers, about what they wanted to talk about, as she had suggested, and that the consultations were successful: both were now booked in for a homebirth. Anne (52) called back to read aloud her letter (to the director of midwifery) and get it checked by the call-taker before posting it. Louise (25) and Matilda (21) had acted on advice to change midwives and both had found ones supportive of homebirth. Davina (61) had acted on the advice to speak to midwives about her sexual abuse and consequent desire to avoid interventions, and felt "so much better". Tanya (31) had made contact with a homebirth support group in her local area. Other callers had also done this and now wanted to help other women. For instance, Andrea (56) and Ursula (32) had offered their contact details to their midwives, so that they could act as support for other women in the area wanting a homebirth.

Repeat calls: post-birth

Fifteen per cent ($n = 12$) of calls were from women calling to tell the call-taker about the birth of their child and all but four of these planned home births had taken place at home (four were hospital deliveries). Their reports were typically exultant in tone, as in this letter from Beverley (36), who in her first call to the helpline had described the healthcare providers as "really negative" and "unwilling" to agree to a homebirth:

It was everything I'd wanted for us and more. It was great for me as it helped me feel so confident in

myself as a woman and mother. It meant Kenneth could hug me and love the baby without being sent away. My teenager Karen was in the room with us seconds after Lucy surfaced from the pool. My family visited that afternoon and the whole neighbourhood sent cards, presents and cakes—we were overwhelmed.

Janet (65) had also experienced “negative” attitudes on behalf of her carers and had been told she could not have a home birth because of “staff shortages”. Her aunt called on her behalf to say:

They had a baby girl about an hour and a half ago. And she had a complete home birth. Everything went swimmingly well, and the two little girls that she had were there and they saw the baby be born. (Marjorie 67 (Janet’s aunt))

Ursula (32) had been warned against a home birth on the grounds of suspected gestational diabetes:

And it was a really wonderful positive experience. The whole thing was so different to having my little boy who I had in hospital. I just felt so relaxed. And she popped out like a little poppet! (smiling).

Andrea (56) had been over-due at the time of her first call and concerned to avoid induction. She describes her “perfect” home birth:

And I was belly dancing with them [the midwives] and they were supporting me. We were going up and down the room having a laugh, eating jaffa cakes and it was just really lovely. [...] [After the birth] my bedroom was full of candlelight and a freshly made bed and all three of us got into bed and just cuddled up and sat and drank champagne. I feel so blessed that I’ve been able to have a perfect birth. I never thought that would be possible. And it’s wonderful to be able to say I’ve done it.

Kate (73) was told she could not have a home birth after a previous caesarean with a posterior position. She described having “written all over my notes, big disclaimers saying “danger of death to mother and foetus”. Despite this, and despite the baby again being posterior, Kate had a “fabulous midwife and a fabulous birth”. Wendy (14) told a dramatic story of how she had had food poisoning, how the baby’s jaw got stuck, how there was shoulder dystocia and how the baby was “huge”. However, despite all this, the home birth was viewed as a success. Wendy was “pretty proud” of herself for coping with this and said “it couldn’t have been more perfect”.

Four of the callers had booked a home birth, but were transferred to hospital—two of these for stillbirths. Despite the tragic circumstance, one caller described the hospital birth of her stillborn baby in positive terms:

Unfortunately my baby had problems. He stopped moving. We ended up having him in hospital. I was induced and he was stillborn. He’d died beforehand; about seventy-two hours before he was born. It was acute intrauterine hypoxia; basically he suffocated. But there was nothing wrong with the placenta or the cord. It was just one of those things that happens. [...] And although I was in hospital they left my husband and I alone. They only came in when I asked them to. They gave me my own space. It was almost as good as being at home in that respect. And the plan is to have another baby as soon as we can. (Belinda 43)

Other women however were unhappy with what they saw as an unnecessary transfer to hospital due to anxious or panicking midwifery care:

I had a very young midwife, who panicked. I was having a slow labour; but I was in the pool and happy to continue dilating very slowly. But the midwife sat by the pool with a clipboard and a clock. She said ‘the trouble is your uterus could collapse and rip off the wall’ and I thought ‘Oh my god!’. Before I knew it there were two ambulance people by the pool saying ‘okay let’s go’ and I was just crying and saying ‘please, I don’t want to go. (Marina 75)

The midwife examined me and she said ‘I’m not happy to support you in your home birth. If you’re refusing to follow my advice and you’re absolutely refusing to go to hospital then I will stay with you while you’re in labour but I will call for back-up because I’m not happy to be on my own with you in your home’. She said ‘I’m really not happy with the situation’. So I just caved in then. I just said ‘right okay’. (Pam 80)

Even with a stillbirth, a woman may want to give birth at home:

I feel strongly that having planned and booked a homebirth with an independent midwife I should have been given the option to birth my son at home. Our reasons for deciding on a homebirth became even more significant when our baby died. To give birth to my dead child with strangers and then have to grieve in public was a distressing thing to be forced to do. (Jane 77)

Discussion

Unlike most previous research on home birth, which documents women’s reasons for choosing home birth and their positive experiences of it, this paper focuses specifically on women’s difficulties in obtaining home

births (whatever their reasons for wanting them) in a society which guarantees to all women the right to choose the place of birth. In the UK, the government has made a commitment to enable women to choose home birth (DH, 1993, 2004; HC, 2003) and the Royal College of Midwives (RCM) states that “[h]ome birth can no longer be regarded as a special privilege for a fringe minority—it should be understood as integral and mainstream to any modern maternity service (RCM, 2002, p. 2). In practice, as the calls to this home birth helpline reveal, women do not find it easy to exercise their right to home birth. In addition to a lack of knowledge about their rights, callers to the helpline reported other problems including: feelings of isolation (few knew anyone else who was planning a home birth), a lack of understanding from friends and family and negativity from health care providers.

Recommendations for the solution of these problems are necessarily specific to the society and service structure involved. The following suggestions relate to the UK setting of this study. We suggest that it is important that information is provided as early in pregnancy as possible. Research on information available to the newly pregnant woman demonstrates that the majority of women have their pregnancy confirmed with a home birth kit and/or a visit to their general practitioner (Nottingham Health Authority, cited in DH, 1993, p. 10). The inclusion of information about choice about place of delivery in pregnancy kits may be an effective way to increase awareness. The Health Education Authority’s *New Pregnancy Book* does contain information on place of birth. However, HEA research has shown that only 53% of women who receive the book do so in the first trimester of pregnancy (DH, 1993, p. 10).

Many GPs and midwives qualify without ever having attended a home birth and many feel under-skilled in this area (Davies et al., 1996; Hosein, 1998; Floyd, 1995). In the study by Chamberlain et al. (1997, p. 220) many midwives stated that the only way to learn about home births was to witness and undertake them and yet fewer than half of midwives had practical training relating to homebirths and 64% had attended five or fewer home births ever. Maternity services’ policy should specify the skills and experiences necessary for professionals attending home births and provide the appropriate training or suggest alternative arrangements.

Staff shortages are an organisational feature that may detract from the possibility of the provision of home birth (Hosein, 1998). The Department of Health and the Royal College of Midwives (RCM) both agree that an additional 10,000 midwives are needed throughout the UK over the next 5 years. Over-stretched and under-trained, it is perhaps not surprising that as Hosein (1998) observes, midwives and their supervisors are submissive to GPs’ unwillingness to undertake home births—home

birth is an unpopular option among health care professionals (Oakley, 1997) and in the UK more than 50% of doctors oppose home births (Newburn, 2003). However, it is UK Government policy that GPs and midwives should routinely raise the possibility of home birth and not automatically assume that women want a hospital delivery unless they specify otherwise. Our findings show that (according to callers’ reports) not only do GPs and midwives not raise home birth as a possibility, but that when a home birth is requested, they often deny or discourage the request. Guidelines should not be “inappropriately negative” (RCM, 2002, p. 5)—the emphasis should be on “assisting women to reach their own decision, rather than defining who may or may not be ‘allowed’ the option of home birth” (RCM, 2002, p. 5). More generally, the implementation of good communication practice is important, as the way in which information is presented may impact upon how it is understood. When asked by healthcare providers where they wanted to have their baby, the women surveyed by Madi and Crow (2003) interpreted this as a question about which of the available hospitals they preferred.

There is no evidence on how many women in the UK would choose a home birth if this was offered and supported. There is also limited recent research on the relevant costs of home and hospital births. An analysis of the costs of home and hospital deliveries using data from the National Birthday Trust Fund survey (Henderson & Mugford, 1997) suggests a lower average cost of home birth based on current practice. However, in order to claim that home birth is a cost-effective method of delivery, a formal analysis is required incorporating both the costs and the outcomes.

This research documents the difficulties that callers to a UK-based Home Birth helpline report having when trying to exercise their right to birth at home. The extent to which the findings are generalisable to other countries across a range of different government policies and legal frameworks relating to home birth is an empirical question and further research addressing the issues in other contexts would be welcome.

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