AIMS

JOURNAL

Where will the baby come out? Birthplace dreams, instincts and lived experience

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By Alex Smith

Welcome to the June issue of the AIMS journal. The theme for this quarter is birthplace.

Just for a moment I invite you to imagine this - imagine it even if, for a zillion reasons, it is just not possible - imagine that you are about to give birth to a baby. Everything feels just right. You feel warm, safe, and calm. You feel strong, grounded and capable. Everything is as you would wish. You could close your eyes now, just for that moment, and notice where you are. Where is this good place? What can you see, hear, touch, smell or taste? What are you doing? Is anyone with you? If so, what are they doing?

The images and feelings that emerge in that moment are important. They tell us something about the natural conditions for human birth. They speak of our primal mammalian instincts, and, despite all of our cultural conditioning and the deeply entrenched medical paradigm of birth, those instincts creep into our hopes and dreams regardless. As the birth approaches many women, even (and perhaps especially) those who have not consciously questioned the appropriateness of giving birth in a hospital, begin to feel an undefined sense of disquiet and may express this by saying that they just wish they could hide away somewhere until after the birth. Sometimes women have very clear images of nature that come to mind when they have this feeling. One mother who spoke to me described with real poignancy her longing to give birth surrounded by the safety and tranquillity of her childhood garden.

> "I am gently wading through long grass which discreetly peaks at eye level. I am surrounded by the sounds of buzzing bees, flitting cabbage whites and red admirals and the occasional chirrup from the robin. I envisage myself in this serene and secure existence and I would naturally be at one with the land and bring forth life."

Another mother, Deborah Maw, writing in this issue, felt this pull so strongly that she bought a car and, with only a month to go, drove to friends in West Cork, where, on one warm summer afternoon (the

garden was 'lush'), she gave birth to her first baby.

> "...using tree trunks to pull against as I pushed… just after midday, my daughter was born, beneath a tree."

Other women have an instinct to move more closely to their mother at this time; they experience a strong 'homing instinct'. My own daughter had no sense of 'rightness' when she considered the birthplace options for her first baby, not until she was in labour, and then she packed a bag and came to my house. After her baby was born she said that she knew that everything was all right because she could hear her father watering the tomatoes on the coal bunker - a sound of her childhood. Another woman I met told me that, quite early in her pregnancy, she had relocated from England to Wales to be near her mother as this was the only arrangement that gave her a sense of safety.

Sometimes the homing instinct is more related to the geographical place of the woman's own birth or childhood. In the Welsh language the word 'hiraeth' describes the sense of longing and yearning a Welsh person may have for their homeland[1] - a longing to be where your spirit lives - but nuanced with a sense of irretrievable loss and grief. Cornwall (hireth), Brittany (hiraezh) and Ireland (síreacht)have similar words - all roughly conveying a deep and sad longing for home. I feel certain that the deep instinctive pull towards a place of familiarity and safety that women approaching birth describe, is related to hiraeth, especially when it is accompanied by a feeling that, for whatever reason, this possibility has been lost to them. It puts me in mind of the way that salmon travel thousands of miles using their acute sense of smell to return to their own birth-river when they are ready to spawn. Perhaps the smell of home in human birth is more important than we realise, and that if her 'river' is blocked, it can stir deep, unfathomable emotions in a woman approaching her time. This is certainly true for many women who approach the AIMS helpline. In this issue of the journal, Katherine Revell explains that when a Trust suspends their home birth service it leaves women feeling angry, let down and scared, but doulaSue Boughton describes how she proved to be an alternative place of safety for a massage client who couldn't 'swim home'.

While some women who have spoken with me describe a longed-for birthplace in rich detail, others only experience fleeting moments of wanting to hide away - so fleeting that they are gone before clear mental images of the 'hideout' can be formed. Commonly, a sense of being alone and private and undisturbed is expressed, but this 'confession' is often followed by a dismissive explanation that they are being daft or suffering from 'anxiety' or 'hormones'. These feelings should not be dismissed too quickly as unsafe fantasies. In her two-part article Kathryn Kelly (part 1, part 2) revisits the research showing that birth outside of the hospital can be safe for most mothers and babies, and that planning for such reduces the rate of medical intervention. Indeed, bringing birthplace dreams out into the light and paying respectful attention to them may help shape the birth experience in positive ways. The results of a recent study[2] found that:

> "The birth-related mindset assessed during pregnancy predicted labour and birth: Women with a more natural mindset had a higher probability of having a low-intervention birth.

> This in turn had a positive effect on the birth experience, which led to greater general emotional and physical well-being in the first 6 weeks after birth. Breastfeeding and the well-being and (perceived) behaviour of the infant were also positively affected. These short-term positive effects in turn predicted longer-term psychological well-being up to 6 months after the birth, operationalized as [reduction in] postpartum depression, post-traumatic stress symptoms, and [better]bonding with the infant."

In another recent study[3] aiming to explore both mothers' and fathers' lived experiences of the birth environment, three main themes emerged from the data: 'the home–hospital gap', 'midwifery care' and 'movement in labour'. While both partners shared many views and regarded the midwife as being more important than the physical environment, the researchers found that:

> "Mothers and fathers felt differently about personalizing the birth space. This was more important and achievable for mothers, while fathers felt that the space was more about functionality."

> "Mothers and fathers differed in that fathers observed closely how the midwives worked, which put them at ease. On the other hand, for mothers it was more about how the midwife made them feel, in what was considered to be a sacred time for the mother as she focused on her labor and trusted her midwife."

This shows that it may only be the person who is actually giving birth that experiences the need for a birth 'den' or 'nest' that aligns with their instinctive sense of comfort and safety. For anyone else, the away-from-home setting is seen as a place where midwives are carrying out *their* work. However, some midwives also describe a strong calling that is only fully satisfied through practice in the home setting. In our June issue, James Bourton remembers that as a child he would dream about being in the birthing space of women even before he knew how babies were born. He is now a Midwifery Team lead and clinical midwife who specialises in home birth.

Even though some fantastic work is going into the design of hospital birth environments with results confirming the importance of a calm atmosphere, greater intimacy, a spacious and adaptable birth room, clarity of service points, clarity in finding midwives, sufficient space for labour, noise and privacy [,5] birth outcomes in modified hospital birth rooms compared with the standard hospital rooms are often little different. One study from Sweden[6] compared an 'Institutional' room, where birth was approached as a critical event, designating birthing women as passive with a 'Personal' room, where birth was approached as a physiological event in which women's agency was facilitated. They found that behaviours were similar in both rooms[7], concluding that:

> "Institutional authority permeated the atmosphere within the birth environment, irrespective of the design of the room. A power imbalance between institutional demands and birthing women's needs was identified, emphasising the vital role the birth philosophy

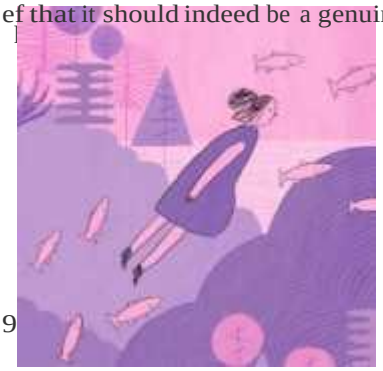
plays in creating safe birth environments that increase women's sense of agency."

This very much echoes the research findings of Florence Darling, writing in this issue. In her PhD study, in which midwives were primed to offer a physiological approach to care in an obstetric unit, Florence observed that:

> "Most midwives did not regard themselves as autonomous decision-makers and sought permission to implement a physiological approach. They were predominantly observed not to challenge routine clinical intervention use."

When institutional authority 'permeates the atmosphere' and when midwives are unable or unwilling to challenge it, it can be traumatising; traumatising for the mothers and their supporters*and* also for the midwives themselves. Doulas Grace Hall and Shellie Poulter each address the effects of stress and trauma in the birthplace in this issue of the journal.

There are many complex reasons why a woman's own home may not be where she wants to give birth, and why she may not be able to 'swim home' to her mother instead. Away-from-home birth settings should provide a safe alternative. One mother I met told me of her dream since childhood that one beautiful day she would give birth to a baby in a hospital. In her dream she was surrounded by radiant angel-like midwives all attending her with gentleness and kindness. Sadly, her lived experience was bitterly disappointing. Every woman in today's world should be able to expect to feel safe and private and respected throughout their labour in hospital - to be attended with gentleness and kindness. They should certainly not feel that the likelihood of experiencing a smooth and safe physiological birth is sabotaged the moment that they walk through the doors. This is why AIMS is campaigning for physiology-Informed maternity services.[8] In the meantime, Anne Glover, opens this issue by setting out AIMS position on c
ef that it should indeed be a genuine choice.



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Also in this issue:

Mary Nolan reviews 'Squaring the Circle: Normal birth research, theory and practice in a technological age'. Edited by Soo Downe and Sheena Byrom, this book is all about how to support safe, personalised and equitable care. Mary concludes by saying that if every person walking beside childbearing women and people read and acted on this book, the experience of bringing a baby into the world would unquestionably be transformed for the better.

On the same note of quality improvement (because surely that is the underlying principle on which every NICE guideline is based) Nadia Higson and Debbie Chippington Derrick outline the important role of the stakeholder in helping to shape and update the NICE guidance related to maternity care, ensuring that it always remembers and upholds the rights of service users.

Laura Scarlett's article is one I have been very eager to read. Laura Scarlett introduces the latest Lancet series on breastfeeding - three articles that explain how formula milk companies exploit parents' emotions and manipulate scientific information to generate sales at the expense of the health and rights of families, women, and children.

Holding a very important place in this issue - and forever in our hearts - we remember Beverley Beech. Debbie Chippington Derrick reflects on Beverley's legacy, and goes on to share the memories of some of those who knew her through her AIMS work.

And last but not least, the AIMS Campaigns Team share what they have been up to since March.

We are very grateful to all the volunteers who help in the production of our Journal: our authors, peer reviewers, proofreaders, website uploaders and, of course, our readers and supporters. This edition especially benefited from the help of Anne Glover, Carolyn Warrington, Caroline Mayers, Joanne Maylin, Jo Dagustun, Danielle Gilmour, Joanna Rana, Salli Ward, Katherine Revell and Josey Smith.

The theme for the September issue of the AIMS journal is *Being a Birth Companion.* If you have been with a family member as they gave birth, if you have made it your business to support people at this time as a doula, or if you are with birthing people 'in spirit' because they have 'taken your voice with them' as their childbirth educator or advocate - I would love to hear from you. Please email: alex.smith@aims.org.uk

1 Editor's note: Homeland, in relation to hiraeth, can be a real, an imagined or a 'felt' place.

2 Hoffmann, L., Hilger, N., & Banse, R. (2023). The mindset of birth predicts birth outcomes: Evidence from a prospective longitudinal study. *European Journal of Social Psychology,* 00, 1– 15.

3 Mizzi, R., and Pace Parascandalo, R. (2022). First-time couples' shared experiences of the birth environment. *European Journal of Midwifery,* 6(October), pp.1-9.

4Setola N, Iannuzzi L, Santini M, Cocina GG, Naldi E, Branchini L, Morano S, Escuriet Peiró R, Downe S.

Optimal settings for childbirth. Minerva Ginecol. 2018 Dec;70(6):687-699. doi: 10.23736/S0026-4784.18.04327-7. Epub 2018 Oct 5. PMID: 30299042. http://clok.uclan.ac.uk/24584/1/Minerva%20Ginecol-4327_Bozza%20in%20PDF_V1_2018-10-11%20nicoletta%20optimal%20settings.pdf

5Nicoletta S, Eletta N, Cardinali P, Migliorini L. A Broad Study to Develop Maternity Units Design Knowledge Combining Spatial Analysis and Mothers' and Midwives' Perception of the Birth Environment. *HERD: Health Environments Research & Design Journal.* 2022;15(4):204-232.

6Goldkuhl L, Dellenborg L, Berg M, Wijk H, Nilsson C. The influence and meaning of the birth environment for nulliparous women at a hospital-based labour ward in Sweden: An ethnographic study. Women Birth. 2022 Jul;35(4):e337-e347. doi: 10.1016/j.wombi.2021.07.005. Epub 2021 Jul 26. PMID: 34321183.

7"It [behaviour] was dependent on the care providers' permissive approach that enabled the women's agency as well as the women's readiness to take ownership over the room…the care providers shaped the environment regardless of the room's spatial design."

8AIMS (2023) Physiology-informed Maternity Services https://www.aims.org.uk/assets/media/730/aims-position-paper-physiology-informed-maternity-care.pdf

9Image by Brian Rea from an article by Rachel Stevens (2021) Swimming Upstream in Heels and Skinny Pants. New York Times https://www.nytimes.com/2021/11/26/style/modern-love-salmon-miscarriage- heels-skinny-pants.html

A Mother's Instinct

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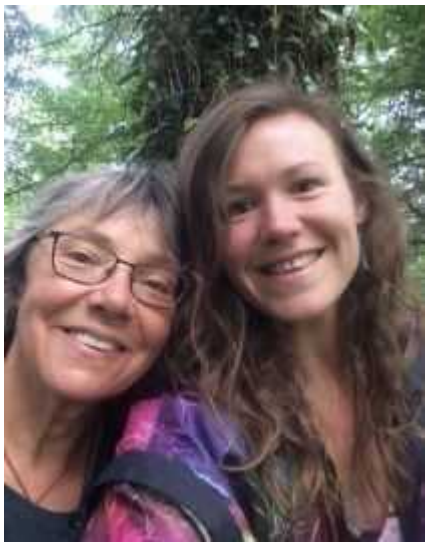


By Deborah Maw

My first baby was born in Eire, although we were living in Dumfries and Galloway at the time, 20 miles from Dumfries - the nearest hospital.

I had my heart set on a homebirth; it was one of those 'knowings' that mothers get. I knew I must not be in hospital but, at about 7 months into my pregnancy, I was living alone in an isolated caravan, with no car or phone (way before the mobile-phone era), and the midwives who came to visit said, 'No'.

They persuaded me to visit the hospital where I was taken to meet a consultant in what looked to me like a boardroom. He completely ridiculed my birth plan - because I wanted to be outside - and then barricaded the door when I tried to leave in floods of tears. I went straight to a phone box and called my friend in Eire who told me to come to her.

Everything then happened at once. I was given a council house but this was still 20 miles away from the hospital and I still had no phone. I moved in, bought a car and an old flat bed pram, persuaded a friend to accompany me and at 8 months pregnant I drove down to West Cork.

It was so beautiful. Late June, the weather was hot, the garden lush, and I settled into the last weeks of pregnancy with friends and babies all around.

The weeks passed. I was about two weeks overdue when I started with medium but regular

contractions - for two days. They really kicked in on the third evening, but other than being exhausted nothing had changed by the following morning. I was hanging - literally from anything that would support me - in the garden as it was a beautiful day again. I went into the second stage mid morning. Our midwife friend came over. The hospital was over two hours away in Cork and we didn't have a phone.

My waters broke - full of meconium - however it was obviously old and my baby's heartbeat was good. The midwife was using a cardboard tube pinard (stethoscope) that worked perfectly well. But nothing was happening except that I was getting more and more 'out of it', being walked around the garden and using tree trunks to pull against as I pushed.

Three hours of second stage later, just after midday, my daughter was born, beneath a tree. After a bit of suctioning she was absolutely fine despite a very temporarily misshapen skull. 7lb. I already had her name since the caravan days - Geminy, with Bridget as a second name to honour my friend and the country of her birth.

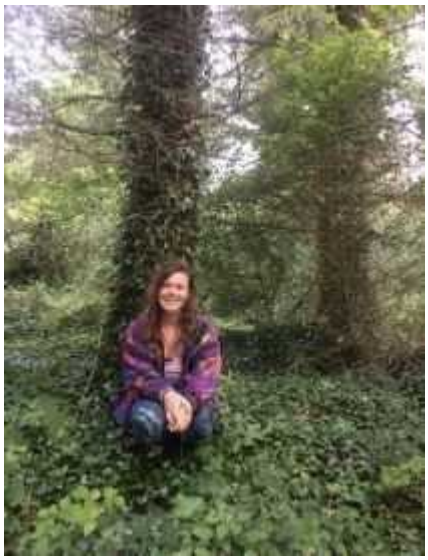
We had to go to Skibbereen to register her birth. The registrant was completely discombobulated - and when we saw the register we realised why. My daughter was the first baby born in West Cork for over 20 years as everyone now went to hospital in Cork City. We returned to the UK a month later.

Geminy, now 34, is so grateful to have dual citizenship with a British and an EU passport. Because of the latter, she has just been accepted for a Canadian working visa. For Brits without an EU passport, it's a random lottery.

I may have been running a risk, however, had I remained in 'the system' it is highly unlikely I would have been allowed to go two weeks overdue, or to be in first stage for three days, or second stage for three hours, especially after my baby had obviously been in distress at some point. As a primigravida mother (old at 31) I would have had medical intervention at some point - possibly resulting in a C-section. As it was, I hadn't even torn. This meant I was able to go on and have two more home births - both with three hour second stages - and both with much bigger babies.

I highly recommend Ina May Gaskin's book 'Spiritual Midwifery' for all mothers who want to trust their instinct and need to be fully informed.

For Geminy's 30th birthday we returned to West Cork for a cycling tour holiday of the Beara Peninsula, visiting Bridget, Ballydehob (the village of Geminy's birth), the house and the tree under which she was born.



Author Bio: Deborah believes that everyone is free to make their own decisions, to follow their inner guidance. She began her education in science; however, after gaining a PGCE and PhD in Biochemistry, she changed track, travelling for 4 years before starting a family and re-training as a complementary therapist and artist. Deborah now works with people who want more freedom in their lives, freedom to follow their dreams.

Choice of Birthplace

AIMS Journal, 2023, Vol 35, No 2

By Anne Glover

AIMS has a position paper on Choice of Birthplace which states that choice of place of birth is a fundamental human right protected under Article 8 of the European Convention on Human Rights Act, 'the principle of autonomy'.

AIMS believes that every pregnant woman and person should be made aware of all their choices and respectfully supported by their care providers when making an informed decision on where to birth their baby. Choice is the key word here, and to be able to make choices, you need to know all your options.

AIMS does not promote any particular birthplace as being better than another, recognising that different birthplaces will be appropriate for different people depending on their circumstances, preferences and clinical needs. However, AIMS believes that everyone has the right to access any of the four birthplace options, no matter where they live, what Trust or Board they come under and whatever the current staff situation. This means that all Trusts/Boards should be making all the options available:

- Home setting
- Freestanding birth centre/midwife-led unit
- Alongside birth centre/midwife-led unit
- Obstetric unit/delivery suite

However, as the recent pandemic has demonstrated, even where options exist, restrictions can be placed at short notice leaving people with very limited choices. Even now, our Helpline continues to hear from people planning a home birth who have been told that the local home birth team has been suspended, due, for example, to staff sickness.

So we will continue to campaign and lobby for everyone to have the right to all four options throughout the UK. We ask you to share our position paper with maternity service users and MVP/MSLC[1] user representatives, to check your Trust/Boards' policy on access to birth centres and support for homebirths, and to lobby for improvements. This way, everyone is made aware of their options and can confidently choose where to birth their baby.

If you are interested in joining our campaigning work, please drop us a line at campaigns@aims.org.uk

Author Bio: Anne is a well-known doula in Northern Ireland and is forever going on about maternity choices to anyone who will listen! She has recently been lobbying for all four birthing options to be available to all families in Northern Ireland.

[1] Maternity Voices Partnership (MVP) and Maternity Services Liaison Committees (MSLCs)

Homebirths suspended and under review

AIMS Journal, 2023, Vol 35, No 2

By Katherine Revell

During the covid pandemic home birth services were suspended in many Trusts and Boards throughout the UK. Some areas were more badly affected than others. As a consequence, the AIMS Helpline saw a big increase in enquiries from people who had just been told they couldn't have a home birth. This was devastating news. It's hard to gauge how many women were affected. We know that most people don't contact AIMS - we only hear from a small fraction of the population.

For the people who did contact us our strategy was to support them to argue their case in advance for a homebirth, citing their particular needs and experiences, and to stick to their guns when the time came. Often Trusts went out of their way to provide a service, so for many this was a successful strategy. However, there were incidents when only an ambulance crew showed up, leaving birthing women in a difficult situation – should they go into hospital in the ambulance or stay home and give birth without a midwife?

Since the pandemic the situation has eased a little in terms of the number of enquiries, but now instead of homebirths being suspended, they're "under review", due to serious midwife shortages. This is even more unsettling for women planning a homebirth, as they cannot plan. It's pot luck whether there's a midwife available on the day. Over the past few months, the emphasis seems to have changed from "we'll try our utmost to support you in your home birth" to "we can't guarantee anything."

This leaves women feeling angry, let down and scared. Most people will probably just give in and accept that they have to go to hospital. Other people will get their homebirth if they persevere and are lucky. Some will stay home, hoping for a midwife to show up and then give birth with just the ambulance crew in attendance, or not even that. A few will hire an Independent Midwife (if they can find one and if they can afford it) or a Doula. Some will actively choose to stay home and freebirth.

Here is a typical letter from the Helpline Inbox:

> Dear AIMS Helpline Volunteers,
>
> I am nearly 34 weeks pregnant and due on (_____). I have been planning to have a home birth but have just been told by my midwife that the home birth service is currently being reviewed daily due to staffing levels. Therefore, they can't say for sure that they will be able to offer me a homebirth at the time I'm due. This has left me feeling distressed and anxious.
>
> I know that legally I have a right to birth at home and cannot be compelled to go to hospital to give birth, yet these rights are being ignored.
>
> Due to the impact of my previous traumatic hospital birth, I have found making plans for my home birth very reassuring. I have discussed the choice with my consultant and my midwife and I am optimistic that a calm approach at home will minimise the chances of a similar traumatic outcome.
>
> I feel that I am being denied what should be a basic right to birth in the place where I will feel most safe. I cannot afford to pay for an Independent Midwife and I am now having to consider birthing at home without medical support. This is not an option I would normally choose but feel that if midwifery care continues to be declined, I will have no alternative.
>
> Please can you help me to negotiate with the Trust. Are there any resources that you can recommend about birthing without medical support? I want to be as informed as possible so that I can make the best decisions and hopefully make my homebirth happen.
>
> With kind regards

And here would be a typical AIMS reply:

> Dear _____
>
> Thank you for contacting AIMS and many congratulations on your pregnancy.

The homebirth situation is very much like this around the country, and the legal side of things is complex. While you have a legal and human right to decide where you give birth, a hospital Trust has no legal duty to provide a homebirth service. At the same time, midwives are still bound by their Code of Practice to attend you at home if you call them while in labour. However, they could be in trouble with their employers (the Trust) if they did so at a point when the Trust had suspended the service.

These fact sheets may be helpful: https://www.birthrights.org.uk/factsheets/choice-of-place-of-birth/,[1] and https://www.birthrights.org.uk/2018/03/07/home-birth-what-are-a- trusts-responsibilities-towards-midwives-and-women/[2] - and this article may feel relevant too: https://www.birthrights.org.uk/2022/11/03/home-birth-series-the-realities-of- planning-a-home-birth-in-autumn-2022/[3]

The suggestion we have made in the past and still offer is two-fold:

Firstly you can consider writing to the Head of Midwifery stating that you intend to give birth at home and that you expect a midwife to attend. This gives them fair warning and therefore enough time to make suitable staffing arrangements. We have a sample letter on this AIMS information page: https://www.aims.org.uk/information/item/booking-a-home-birth.[4] Please feel free to copy AIMS into any written communications.

You could also call the hospital to make an appointment to speak to the consultant midwife. A consultant midwife has more authority to tailor care to the individual and to advocate for you. It may be a good idea to keep a record of every written communication and to ask for any verbal guidance or information you are given to be confirmed in writing. This request often helps people to focus on their legal duties more clearly.

Secondly, we used to suggest that the mother (if she wishes) holds tight to her homebirth plan and, when she is in labour, has someone else call for a midwife. If they are told that no one is available, this other person can simply repeat that the mother does not intend to leave the house and that she is expecting a midwife to attend. There is no need for them to be drawn into a debate; it is a matter of just calmly repeating the request.

We used to find that those two things almost always resulted in a midwife attending. ***This is still worth trying.*** Unfortunately, though, Trusts are getting wise to this tactic and sometimes women are told that they have a right to give birth at home without a midwife (free birth), and to call an ambulance if they are worried. They are correct in saying that free birth is your legal right, but it should not be something you feel forced to do.

In terms of resources about freebirthing, these fact sheets may be of interest: AIMS: https://www.aims.org.uk/information/item/freebirth,[5] and Birthrights: https://www.birthrights.org.uk/factsheets/unassisted-birth/[6]

Some women are handling this uncertainty by having a contingency plan. They may hire an experienced doula to be with them at home so that if a midwife does not arrive promptly, they feel supported (https://doula.org.uk/).[7] They may also read up about free birth and talk with others who have chosen this option (https://caerphillydoula.co.uk/exploring-freebirth/).[8] And there is also Anita Evensen's book, "The Unassisted Baby",[9] which is useful for anyone planning a homebirth - midwife attended or not.

With any birth there is the possibility of the baby arriving before the midwife, or even before there is time to get in the car to travel to the hospital. Therefore, it is always useful to feel ready and relaxed to welcome your baby without the help of a midwife or doctor - whatever the plan.

We hope this is useful to you. Please let us know how you get on and if we can be of any further help.

With kind regards,

So where does all this leave us and where are we heading? The situation of midwife shortages looks set to continue, if not to deteriorate. For us on the AIMS Helpline it's no longer possible to reassure people that they will probably get their homebirth if they stick to their plans. It feels expedient to suggest they explore all of their options, including having plans to either go to hospital on their own terms, or to freebirth in a fully informed and prepared way. Then, if a midwife does not appear, the woman is still at the helm and her personal contingency plans can fall into place. However, this could be experienced by the mother as capitulation[10] and, in the bigger picture of things, not serve well in reinforcing women's rights to decide on the place of birth.

As staffing levels are always the reason given for not being able to guarantee that a midwife will attend a homebirth, how do we retain our current midwives and recruit new ones? Is this a question of money, investment, or job satisfaction? The RCM (Royal College of Midwives) is looking closely at this situation.[11] If money is the issue, homebirth is much cheaper than birth in hospital and could pay for itself in terms of increasing the number of midwives.[12] If job satisfaction is an issue in midwife retention, then changing models of practice, greater autonomy, more midwives and smaller caseloads seem to be the answer,[13] and worked well for midwives and mothers in New Zealand.[14]

How do we transform the system and how do we change the accepted view that a hospital is the normal place in which to give birth? In my mind these two things fit together: if homebirths were the norm, there would be more midwives; if there were more midwives, homebirths would be the norm.

Author Bio: Katherine Revell became passionate about childbirth when pregnant for the first time, back in 1994. Her first homebirth was a deeply empowering experience, and led her to train and work as an active birth teacher and doula, which she did for over twenty years. She no longer works in the birthing world, but keeps her passion alive by working as a Helpline Volunteer for AIMS. Please visit ninjagranny.org to find out more about Katherine's work as a Tai chi, Qigong and Somatics teacher.

1 Birthrights: Choice of Place of Birth

https://www.birthrights.org.uk/factsheets/choice-of-place-of-birth/

2 Birthrights: Home birth – what are a Trust's responsibilities towards midwives and women?

https://www.birthrights.org.uk/2018/03/07/home-birth-what-are-a-trusts-responsibilities-towards-midwives-and-women/

3 Birthrights: Home Birth Series: The reality of planning a home birth in autumn 2022

https://www.birthrights.org.uk/2022/11/03/home-birth-series-the-realities-of-planning-a-home-birth-in-autumn-2022/

4 AIMS: Booking a Homebirth

https://www.aims.org.uk/information/item/booking-a-home-birth

5 AIMS: Freebirth, Unassisted Childbirth and Unassisted Pregnancy

https://www.aims.org.uk/information/item/freebirth

6 Birthrights: Unassisted Birth

https://www.birthrights.org.uk/factsheets/unassisted-birth/

7 Doula UK. Find a doula near me. https://doula.org.uk/

8 Gadsden S, Exploring Freebirth And Birthing Without A Midwife

https://caerphillydoula.co.uk/exploring-freebirth/

9 Evenson A. (2021) Snow Drop Press, LLC; 3rd edition

10 Editor's note: Capitulation means the action of ceasing to resist an opponent or demand.

11 RCM (2022) RCM calls for investment in maternity services as midwife numbers fall in every English region

https://www.rcm.org.uk/media-releases/2022/august/rcm-calls-for-investment-in-maternity-services-as-midwife-numbers-fall-in-every-english-region/

12 NPEU (update 2022) Birthplace cost-effectiveness study: key findings

https://www.npeu.ox.ac.uk/birthplace/cost-effectiveness-results

13 Common L. (2015) Homebirth in England: Factors that impact on job satisfaction for community midwives. British Journal of Midwifery. 23(10):716-722

https://www.researchgate.net/publication/282425404_Homebirth_in_England_Factors_that_impact_on_job_satisfaction_for_community_midwives

14 Clemons, J. H., Gilkison, A., Mharapara, T. L., Dixon, L., and McAra-Couper, J. (2020). Midwifery job autonomy in New Zealand: I do it all the time. *Women and Birth* 34, 30–37.
https://www.sciencedirect.com/science/article/pii/S1871519220303218

Safety and place of birth: part one

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By Kathryn Kelly

Introduction

Until relatively recently, women[1] gave birth at home as the norm and only used a 'maternity home' or hospital if they had social or medical needs or could afford the private fee. In 1946, 46% of births in England and Wales were at home, with the balance in a maternity home or hospital.[2] By 1970 birth at home was down to 13%, and in GP units 12%. By 1990 home birth was at 1%, and GP Units 1.6%[2] In her seminal statistical analysis of birth data, Tew describes the "almost universal misunderstanding" of what the evidence showed, that "birth is the safer, the less its process is interfered with".[2]

Data for 2021 shows that 97% of parents in England and Wales gave birth in an NHS establishment[3] with a home birth rate of 2.5%,[3] but despite this wholesale move to a perceived place of safety, anecdotally anxiety about birth appears to be rising alongside the intervention rate.

The National Institute of Health and Care Excellence (NICE) states that women should have access to four planned places of birth: Home, Freestanding Midwife-Led Unit (FMLU), Alongside Midwife-Led Unit (AMLU), and Obstetric Unit (OU). While NICE considers that women at low risk of complications are free to decide on place of birth, it suggests that those with certain risk factors should be given information about those risks before being supported in their decision. It states that personal views or judgements of the healthcare provider should not be shared.[4]

When we talk about safety in childbirth, most people think of a 'healthy baby', with 'healthy' as a

euphemism for 'live', and perhaps as an afterthought a 'healthy mother'. Parents I speak with who have already given birth are more likely to prioritise factors such as psychological safety, cultural safety, and a sense of control.

In this article I intend to explore what research tells us about place of birth and safety for babies and mothers. I will also consider the wider factors involved, as well as what makes birth unsafe and who are we keeping safe.

Definitions and statistics – for the baby

Let's start with some definitions and, because all definitions are situated within time and place, context.

Table 1. Definitions and statistics of stillbirth and infant mortality in the UK in 2023.[3]'[5]'[6]'[7]'[8]

Term	Term	Definition	Rate	More information	
Stillbirth		Born after 24 weeks, never takes a breath	3.8/1,000	Of all live and stillbirths	Also known as 'Extended perinatal death'
Of which...	Late stillbirth	Born after 28 weeks, never takes a breath	2.9/1,000	Vs 1.3-8.8/1,000 in high-income countries	
Neonatal mortality		Born breathing, dies up to 28 days	2.8/1,000	Of all live births	
Of which...	Early neonatal death	Born breathing, dies up to 7 days		Accounts for over half of all neonatal mortality	
Infant mortality		Born breathing, dies up to one year	3.8/1,000	Of all live births	

9]

MBRRACE-UK shows the causes of stillbirth to be relatively consistent over the period 2016-2020![7]

- Unknown causes are reducing, but still over 30% of all stillbirths
- Related to the placenta (over 30%)
-

Congenital anomalies (under 10%)

- Other conditions: fetal, cord, infection, maternal (each around 5%)
- Intrapartum (around 2% of all stillbirths)

Intrapartum death is a tiny component of the 'safety' dimension

An intrapartum death describes the rare situations when the baby was assessed as alive at the onset of labour, but dead at birth. Even if we add intrapartum stillbirths and neonatal deaths due to intrapartum causes, we still arrive at a rate of less than 0.1 per 1,000 live and still births.[7] While acknowledging that every death is a huge and painful loss, we can also see that there is a very rare chance of it happening.

For the mother

As Winnicott identified, maternal wellbeing is critical to the baby as they adjust to life outside the womb. [10]

Table 2: Maternal mortality in the UK, 2018-2020.[11]

When mothers died		Number	Rate	Of all women who died
During or up to six weeks after the end of pregnancy		229	10.9 per 100,000	14% during pregnancy; 32% up to six weeks
	Died from Covid	9		
	Covid deaths removed	220	10.5 per 100,000	
	Black women		34 per 100,000	
	Asian women		16 per 100,000	
Between six weeks and a year		289	13.8 per 100,000	54% six weeks to 12 months

The MBRRACE review of maternal mortality in 2018-2020 includes a table of place of birth.[11] This shows that 5 (4%) of the women who died had given birth at home, and only one of those had died of 'direct causes' (a wide definition which includes thrombosis, suicide, sepsis, and haemorrhage).[12] The remainder gave birth either in hospital, the emergency department, or an ambulance. This data is not shown by 'intended' place of birth, so we should acknowledge that more of the deaths could be associated with place of birth, though the variety of 'direct causes' might suggest that a good quality and well supported out-of-hospital birth service would not be a contributing factor.

What about the safety of the health professional?

Protecting midwives is sometimes given as the reason for withdrawing the home birth service when the maternity or ambulance services are compromised. Understandably, a Director of Midwifery doesn't want to put their staff in a situation without good backup. There is also enormous pressure for documented adherence to guidelines, to protect both individual healthcare workers and the service provider from the fear of withdrawal of employment or litigation.

With the harm of long-term exposure to Entonox in the news this year, 'safety' takes on another perspective. Midwives may be working in older hospitals without adequate scavenging systems that remove harmful gases.[13] For them, a home or midwife-led unit with windows providing fresh air could be protective.

What reduces or mediates safety?

Most stillbirths occur in pregnancies without established risk factors.[8] So what reduces that safety, and what protects it?

Routine antenatal care looks for the key factors associated with poor outcomes for the mother or baby. Early scans and blood tests look for congenital abnormality, and monitoring of the baby's growth checks whether that slows or stops. Monitoring of the mother's blood pressure and urine check for pre-eclampsia. In the event of any concern, or when labour starts before 37 weeks, it's recommended that care is provided on the obstetric unit, and parents can accept or decline that increased level of medical care.

We know that previous birth experiences have a significant impact, both on risk status and the perception of safety.[14] A first-time mother or pregnant person is known as nulliparous (nullip), and someone who has given birth before is multiparous (multip). Even with a more complicated pregnancy, a multip (except by caesarean) is less likely to have a complicated birth in a subsequent pregnancy, while a woman who has had a previous caesarean is considered to have the same risk status as a nullip.

For the unexpected outcomes we can ask why place of birth would have an impact? The resources at home and midwife-led units are identical. An analysis of intrapartum deaths at home and in MLUs found that risk assessment in pregnancy or early labour could be improved, along with a better standard of monitoring, resuscitation, and timely transfer.[15] So, while staff at different locations should have the same skills - and they routinely conduct 'skills drills' to practise for emergency situations - there is scope for improvement. But the most significant factor is time and distance from speedy intervention if it's needed, which I will explore later.

While the planned place of birth is captured in the raw data, it is not currently shown as a risk factor for infants. What we do know is that stillbirth has been rising since 2010 for the poorest families, while it falls for the more advantaged. "The stillbirth rate in the 10% most deprived areas in England was 5.6 stillbirths per 1,000 births in 2021; in contrast, the stillbirth rate was lower in the 10% least deprived areas in England at 2.7 stillbirths per 1,000 births".[3] The UK has a high level of inequality (when

compared with economically similar countries) and lower socioeconomic groups are less likely to access antenatal care promptly, more likely to smoke and to be obese.[6] There is also an association between deprivation, stress, domestic abuse, and small or premature babies and late stillbirth[16]'[17]

Ethnicity is a significant factor: "Babies from the Black ethnic group continued to have the highest stillbirth rate at 6.9 stillbirths per 1,000 births in 2021".[3] Since the MBRRACE-UK report published in 2020 there has been a spotlight on the need to address ethnic disparities (which were already present but not highlighted). While this is partly laid down to socioeconomic deprivation, that doesn't fully explain it. For example, research with migrant women illustrated the need for clear and consistent protective messages.[18]

Just as with babies, mothers with severe disadvantages are over-represented in the data, and 20% of women who died were "known to social services".[3] These were known vulnerabilities, which makes this even more unacceptable. Black, Asian, and mixed-ethnicity women are over-represented in the numbers, and while there is intersection with other vulnerabilities, this doesn't explain it all. Ina May Gaskin points out that women's bodies are not "inadequate" to birth, and this remains true of Black and Asian women and babies, so we need to understand how weathering[19] and gendered racism are leading to these worse outcomes.[20]

Social disparities are not only more difficult to resolve, they are also public health issues outside the remit of maternity services. So, while Continuity of Care (CoC) teams may be established to focus on providing holistic support to groups with identified medical or social needs, healthcare providers tend to focus on more easily measured factors, such as smoking, obesity, and high blood pressure. However, "target driven care can be actively harmful".[21]

What's the best source of information about place and safety?

'Birthplace in England' was a large and robust study that looked at where women had planned to give birth and what the outcomes were.[22] While it may feel to parents that a report published in 2011 is 'old', there has been no update and it remains the 'go-to' source for this specific information. By analysing outcomes by 'planned' place of birth it showed all outcomes, wherever birth finally took place, which makes it an interesting resource. When we compare newer research, we have to bear that point in mind.

There were several analyses of the data collected. In the report, 'perinatal and maternal outcomes by planned place of birth for healthy women with low-risk pregnancies', four planned places of birth were included: Home, FMLU, AMLU (in the same building as the OU, though sometimes not on the same floor), and OU (commonly known as 'Labour Ward'). The OU is the only place doctors will be found, though most of the care is still undertaken by midwives.

Table 3: Summary of Birthplace findings for women with 'low risk pregnancies'[23]' [24]

Report and link	Focus	Findings
Birthplace in England Collaborative Group, 2011[22]	Women at low risk, home, freestanding MLU, alongside MLU, Obstetric Unit (OU)	Very safe in all locations. Small increase in perinatal adverse outcomes in first time mothers at home (from 5.3/1,000 to 9.3/1,000). Likelihood of birth without intervention decreased with proximity to OU (92.8% home, 76.4% OU) High rates of transfer to OU for first time mothers from all settings (36%-45%), vs 9.4%-12.5% for multips.
Rowe et al, 2012[23]	Transfers from freestanding MLU, alongside MLU	Transfer in labour or immediately after birth is common; "only a minority of transfers take place as a response to an unequivocal emergency". Both proximity to OU and parity have an effect.
Hollowell et al, 2017[24]	Secondary analysis comparing outcomes in freestanding and alongside MLUs	No difference for babies, or in chance of caesarean birth. Instrumental birth lower in freestanding MLU.

The top line from the first published study was that "giving birth is generally very safe"[25] This explored the experience of women with 'low risk' pregnancies, and a primary outcome of "perinatal mortality and specific neonatal morbidities: stillbirth after the start of care in labour, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus, and fractured clavicle".[22] This composite was designed to capture outcomes that might be related to quality of intrapartum care, and includes those factors which could potentially have a long-lasting impact on the baby and family.

The study found that for multips there was no difference in adverse outcomes across all four places of planned birth. For nullips there was a small but significant increase in adverse outcomes for the baby if birth was planned at home (4 in 1,000 babies).[22]

For the secondary outcome of "neonatal and maternal morbidities, maternal interventions, and mode of birth" the finding was that women who planned births off the obstetric unit were much less likely to experience "an instrumental or operative delivery or to receive medical interventions such as

augmentation, epidural or spinal analgesia, general anaesthesia, or episiotomy".[22] I find it's often necessary to remind parents at this point that all the women started with the same 'low risk' factors, so those on the obstetric unit were not having these procedures because they 'needed' them at the start of labour.

A useful decision aid for birth workers and parents is Dr Kirstie Coxon's graphic, which illustrates both primary and secondary outcomes.[26]

I mentioned earlier that time and distance from emergency care could be considered the only point when place of birth might have a safety dimension. For context, the top three reasons for transfer from either FMLU or AMLU are not for emergencies but a cautious response to a slower than expected labour or meconium staining, or for access to epidural pain relief (especially in AMLU)[23] Much less common were reasons such as fetal distress in the first stage (4or 6 in the list), or postpartum haemorrhage (9 or 10 in the list). First time mothers (especially older nullips) were more likely to transfer, and the authors theorise that this may have been down to care-provider caution.

For women considering the difference between freestanding MLU and alongside MLU, a secondary analysis showed no significant difference in adverse outcomes for babies, or chance of caesarean birth.[24] Instrumental birth (forceps or ventouse) was lower in freestanding settings.

Let's talk about 'low risk'

Much like the fact that most medical research is conducted on men because they don't have pesky hormonal cycles that might muddy the waters, most place of birth research looks at women with 'low risk' pregnancies. The Birthplace study used the NICE definition to identify women with conditions that may lead to higher risk status.[4]

A 2014 study found that 45% of women would have been considered low risk using these definitions, so even then, any guidance aimed at 'low risk' women already applied to less than half the birthing population.[27] Since then, we've had a pandemic which resulted in a dramatic reconfiguration of maternity services, and an increase in poverty and social disparities. Research has not yet been published that would address how these changes might affect risk. Nor has there been a recent exploration of whether these definitions of higher risk remain valid.

In the next article I discuss the majority who are regarded as not having a low-risk pregnancy, and look at other factors we need to consider.

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[1] This article is based on research and other sources that refer only to 'women'.

[2] Tew M (1998) Safer Childbirth?: a critical history of maternity care. (2nd Edition). London. Free Association Books Ltd.

[3] Office for National Statistics (ONS), released 19 January 2023, ONS website, statistical bulletin, Birth characteristics in England and Wales: 2021. Worksheets 1 and 17. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthcharacteristicsinenglandandwales

[4] NICE (2014) Intrapartum care for healthy women and babies [CG190]. www.nice.org.uk/guidance/cg190

[5] Morris J (2018) Understanding the health of babies and expectant mothers. Nuffield Trust. www.nuffieldtrust.org.uk/resource/understanding-the-health-of-babies-and-expectant-mothers#how-do-stillbirth-and-infant-mortality-rates-compare-internationally

[6] Draper ES, Gallimore ID, Smith LK, Matthews RJ, Fenton AC, Kurinczuk JJ, Smith PW, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2020. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2022 www.npeu.ox.ac.uk/mbrrace-uk/reports

[7] Nuffield Trust (2023) Stillbirths and neonatal and infant mortality. www.nuffieldtrust.org.uk/resource/infant-and-neonatal-mortality#background

[8] O'Brien, L, Warland J, Stacey T, Heazell AEP, Mitchell EA. (2019) Maternal sleep practices and stillbirth: Findings from an international case-control study. Birth. 46 (2) pp344-354. doi.org/10.1111/birt.12416

[9] Editor's note: The full definition of "stillborn child" in England and Wales is contained in the Births and Deaths Registration Act 1953 section 4 as amended by the Stillbirth (Definition) Act 1992 section 1(1) and is as follows: "a child which has issued forth from its mother after the 24th week of pregnancy and which did not at any time breathe or show any other signs of life". Similar definitions apply in Scotland

and Northern Ireland. www.parliament.uk/globalassets/documents/commons-library/Registration-of-stillbirth-SN05595.pdf

[10] Jan Abram (2008) Donald Woods Winnicott (1896–1971): A brief introduction, The International Journal of Psychoanalysis, 89:6, 1189-1217. doi.org/10.1111/j.1745-8315.2008.00088.x

[11] Knight M, Bunch K, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2022. www.npeu.ox.ac.uk/mbrrace-uk/reports

[12] Indirect causes included cardiac, covid, neurological, and other.

[13] RCM (No date) Entonox safety in the workplace, administration equipment, scavenging and ventilation systems, occupational exposure levels. www.rcm.org.uk/workplace-reps-hub/health-and-safety-representatives/entonox-safety-in-workplace-1/

[14] Jardine et al (2020) Risk of complicated birth at term in nulliparous and multiparous women using routinely collected maternity data in England: cohort study. BMJ. 371.doi.org/10.1136/bmj.m3377

[15] Rowe, R. et al. (2020) ' Intrapartum related perinatal deaths in births planned in midwifery led settings in Great Britain: findings and recommendations from the ESMiE confidential enquiry.', BJOG: An International Journal of Obstetrics & Gynaecology, 127(13), pp 1665- 1675. Available at: obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.16327

[16] Heazell, AEP, Budd, J, Smith, L, Li, M, Cronin, R, Bradford, B, McCowan, L, Mitchell, E, Stacey, T, Roberts, D & Thompson, J 2021, 'Associations Between Social and Behavioural Factors and the Risk of Late Stillbirth – Findings from the Midland and North of England Stillbirth Case-Control Study', BJOG: An International Journal of Obstetrics and Gynaecology, vol. 128, no. 4, pp. 704-713. doi.org/10.1111/1471-0528.16543

[17] Stacey, T., Prady, S., Haith-Cooper, M. et al. Ethno-Specific Risk Factors for Adverse Pregnancy Outcomes: Findings from the Born in Bradford Cohort Study. Matern Child Health J 20, 1394–1404 (2016). doi.org/10.1007/s10995-016-1936-x

[18] Stacey, T, Haith-Cooper, M, Almas, N & Kenyon, C 2021, 'An exploration of migrant women's perceptions of public health messages to reduce stillbirth in the UK: a qualitative study', BMC Pregnancy

and Childbirth, vol. 21, no. 1, 394. doi.org/10.1186/s12884-021-03879-2

[19] Editor's note: For an explanation of weathering (being worn down by) in this context, read: www.ncbi.nlm.nih.gov/pmc/articles/PMC1470581/

[20] Patterson, E.J., Becker, A. & Baluran, D.A. Gendered Racism on the Body: An Intersectional Approach to Maternal Mortality in the United States. Popul Res Policy Rev 41, 1261–1294 (2022). link.springer.com/article/10.1007/s11113-021-09691-2

[21] Downe S, Byrom S (2019) Normal Birth; what's going on? 4 Jul. Maternity and Midwifery Forum. youtu.be/Qy5RTDuHdvs

[22] Birthplace in England Collaborative Group, Brocklehurst P, Hardy P, Hollowell J, Linsell L, Macfarlane A, Mccourt C, Marlow N, Miller A, Newburn M, Petrou S, Puddicombe D, Redshaw M, Rowe R, Sandall J, Silverton L, Stewart M. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study
BMJ 2011; 343 :d7400 doi.org/10.1136/bmj.d7400

[23] Rowe R, Fitzpatrick R, Hollowell J, Kurinczuk J. Transfers of women planning birth in midwifery units: data from the Birthplace prospective cohort study. BJOG 2012;119:1081–1090. doi.org/10.1111/j.1471-0528.2012.03414.x

[24] Hollowell, J., Li, Y., Bunch, K. *et al.* A comparison of intrapartum interventions and adverse outcomes by parity in planned freestanding midwifery unit and alongside midwifery unit births: secondary analysis of 'low risk' births in the birthplace in England cohort. *BMC Pregnancy Childbirth* **17**, 95 (2017). doi.org/10.1186/s12884-017-1271-2

[25] NPEU (No date) Birthplace in England research programme: key findings. www.npeu.ox.ac.uk/birthplace#the-cohort-study-key-findings

[26] Coxon, Kirstie. (2015). Birth place decisions: Information for women and partners on planning where to give birth A resource for women and clinicians. doi.org/10.13140/2.1.3522.5929

[27] Sandall J, Murrells T, Dodwell M, Gibson R, Bewley S, Coxon K, Bick D, Cookson G, Warwick C, Hamilton-Fairley D. The efficient use of the maternity workforce and the implications for safety and quality in maternity care: a population-based, cross-sectional study. Southampton (UK): NIHR Journals Library; 2014 Oct. PMID: 25642571. doi.org/10.3310/hsdr02380

Safety and place of birth: part two

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By Kathryn Kelly

In the first article I explored evidence around mother and infant mortality for low-risk pregnancies and place of birth. Now I move on to consider the majority of women and pregnant people[1], and the other factors we might encompass with the term 'safety'.

What about the 55% who are not 'low risk'?

We know that most women are now directed to give birth in an Obstetric Unit (OU), despite Tew's finding that "obstetric intervention only rarely improves the natural processes".[2] The Birthplace study[3] conducted various secondary analyses to explore different risk factors for women with 'higher risk' pregnancies (See Table 2).

Table 1: Summary of Birthplace on women with 'higher risk pregnancies[4,5,6,7]

Report and link	Focus	Findings
Hollowell et al, 2014 [3]	Effect of obesity (otherwise low risk)	"Modest" increase of chance of intervention and some adverse outcomes for mother. Lower for multips.
Li et al, 2014 [4]	Effect of maternal age in women (otherwise low risk)	Absolute chance of interventions lower in all non-OU settings, at all ages, for both primips and multips. Adverse outcomes for both mothers and babies increase with maternal age. Older first-time mothers birthing outside OU more likely to experience interventions (augmentation). For babies, no difference in adverse outcomes until woman over 40 and giving birth on OU.
Li et al, 2015 [5]	Women at higher risk, home or obstetric unit.	Lower incidence of mortality, morbidity, and neonatal admission in planned home births. Maternal interventions are also lower.
Rowe et al, 2015 [6]	Women planning VBAC, home or obstetric unit	Similar adverse outcomes for both mother and baby in both locations. Chance of vaginal birth higher at home. Transfer rates high, particularly in women with only one previous birth (56.7% vs 24.6%)

Analysis of the effect of obesity[3] showed a modest increase of risk of intervention and some adverse maternal outcomes. However, otherwise healthy women who have already given birth (multips) were at lower risk of intervention than first-time mothers (nullips). The conclusion was that birth in non-obstetric settings could be a positive option for healthy women who already had a baby.

Secondary analysis of the effect of maternal age (otherwise low risk)[4] showed that adverse outcomes for both mothers and babies increased with maternal age, but without a specific age (i.e. 40) when risk increased. The absolute chance of interventions was lower in all non-OU settings, at all ages, for both multips and nullips. However, older nullips planning birth off the OU were more likely to experience interventions, particularly of augmentation with syntocinon (which could only take place after transfer to the OU). For the baby, the risks showed no difference unless the woman was having her first baby over 40 and giving birth on the OU, when the chance of neonatal unit admission or perinatal death increased. There is an interesting discussion of possible reasons for the disparities in the 'comparison with the existing literature', which includes the potential impact of labelling women.

A comparison of outcomes for women at 'higher risk' of complications planning birth at home or in the OU found the home birth group had a lower incidence of mortality, morbidity, and longer neonatal admission.[5] This echoes Tew's work in the 1980s which found that only those at the very highest risk had lower infant mortality in hospital compared with home or GP unit.[1] Maternal interventions were also

lower in this group. The team qualified their findings around neonatal care by saying that while more babies born in the OU were admitted to neonatal care, it was "unclear if this reflects a real difference in morbidity".[5] Which is to say that, if the neonatal unit is next door, you may be more likely to send the baby there than if it required an ambulance transfer. Potentially this mirrors the 'next door' effect of a higher rate of women transferring from AMLU to OU for an epidural, though we also need to recognise that women with additional risk factors may have negotiated to labour on the AMLU, knowing transfer would be easy if necessary.

Another higher risk group is women planning vaginal birth after caesarean (VBAC), and a further study looked at planned birth at home or in the OU.[6] While mother and baby experienced similar risks of adverse outcomes in both locations, the chance of having a vaginal birth was significantly better at home. However, transfer rates were high, particularly for women who had only one previous birth (56.7% vs 24.6%).

While we're thinking about safety, a fascinating insight came from the one piece of qualitative research that formed part of Birthplace.[8] This small study of 58 'low risk' postnatal women found that 30 women reported 'speaking up', defined as "insistent and vehement communication when faced with failure by staff to listen and respond".[7] This highlighted that women may be trying to self-advocate for their safety in the face of the failure of staff to listen. The presence of a lay supporter (i.e. partner, relative or doula) helped the women speak up. With such a small study, even though researchers looked at birth planned in different locations, place cannot be identified as a factor.

Follow-on study

Further analysis of the Birthplace data addressed five areas in more depth.[9] Their conclusions state that further centralisation of services in larger units should be done thoughtfully, monitored and evaluated, because intervention rates are lower in out-of-hospital birth. For example, more support for home birth for multips is recommended. It also highlights that "non-clinical factors may be leading to an 'excess' use of epidurals and augmentation in women labouring during 'office hours'" and suggests a review of these practices.[8] And it highlights the "marked age-related increases" in interventions, and "prolonged" neonatal unit admission as meriting further investigation.[8] Better data recording, and information for women to support decision-making were also suggested.

'Risk' is conditional and flexible

Any of us who work with pregnant women know that risk isn't a fixed concept, and that "very few women are absolutely always either low- or high risk and neither definition may hold true at all times during the childbirth experience".[10] Health conditions (which may or may not be pregnancy-related) emerge, and "complicating conditions",[2] such as prolonged rupture of membranes or meconium in the waters, may appear at the start of labour.

Parents are usually aware that, as in life, the assessment of risk might change, with consequent impacts on their plans. This is not a reason not to plan a birth in a specific location, but a reminder that decisions

are always contextual and have implications.

The identification of risk factors is intended to ensure a woman and baby get appropriate care. However, they are only predictive tools, and not guarantees. More recent thinking highlights a need for research to better understand any specific risk factors associated with place of birth so that parents can be given evidence-based information on which to base a decision.[11]

Other pressures on choosing place of birth

The pandemic brought about rapid service reconfigurations such as remote consultations and telephone triage, to protect women and their carers from infection. Many of these services have remained in place as the time saved can be attractive to both parents and staff. However, the HSIB (Healthcare Safety Investigation Branch) report of intrapartum stillbirth during that period recommends that those services should be reviewed for safety and effectiveness, as in-person contact can improve diagnosis.[12] The report also suggested the definition of a minimum standard for use of interpretation services, along with other structural improvements such as data recording that can be more easily shared between stakeholders and across geographical boundaries, improving speedy and effective transfer.

We know that a woman or pregnant person might be interested in exploring different places of birth, but experiencing pressure to labour on an obstetric unit, either from healthcare professionals or their partner. Some women say they can't make what might be viewed as a 'riskier' decision because 'it's his baby too'; alternatively, they may feel they would be safer away from an abusive partner. Being cared for by health professionals, away from home, could also be attractive to a woman overwhelmed by the demands of her family.

Even if she's healthy and not under pressure, the uncertainties of low staffing and an overstretched ambulance service, with some MLUs having restricted opening hours, or the potential for home birth support to be withdrawn at short notice, can feel too risky an emotional load to cope with. As a nation we are moving from more, smaller units to fewer, larger units, which is likely to have a negative impact on extended outcomes – a lose-lose scenario where first time mothers either take the slightly increased risk and stay at home, or move to the OU with the strong likelihood of more intervention. As a result, many women now seem to be making 'least-worst' decisions and choosing what feels to them a predictable intervention over the unpredictable unfolding of labour and birth. My local Trust are alarmed at the rate of maternal-request elective caesareans, but who can blame the women for wanting the only form of control they seem able to grasp, especially when told how 'safe' it is.

As birth workers we can help parents explore their feelings around minute but potentially catastrophic risks, versus a higher chance of interventions that may feel less immediately daunting but can have potentially life changing repercussions. Because, despite the good intentions of healthcare staff, there is not good evidence for many interventions.[13]

Research since Birthplace

In the Netherlands, where the home birth rate is around 20% versus 2.5% in England and Wales, research

found no difference in adverse outcomes for babies of nullips birthing at home or in hospital. The authors concluded that midwives' greater experience of home birth was at the root of this difference.[14]

Systematic review and meta-analysis bring together multiple studies. Two recent reviews have found that for 'low-risk' pregnancies place of birth had no statistically significant impact on infant mortality, and a lower chance of morbidity and interventions for mothers.[15,16] For both reviews the studies included may not have been large enough to detect rare outcomes, and even in well-resourced countries maternity systems differ, so we must be cautious about interpretation.

During the 2020 Coronavirus pandemic it was highlighted that for women who didn't require obstetric care it would have made more sense to birth outside hospital.[17] This would have protected women from hospital acquired infection and reduced the stress on maternity units. However, the increased anxiety from hospital Trusts in England saw a dramatic and military entrenchment, and, in many areas, a withdrawal of out-of-hospital care in any form. This did lead to more women considering freebirth,[18] and a hasty briefing sheet from an anxious Royal College of Midwives.[19]

What else do we need to consider?

Research is conducted on populations and is generalisable only to the extent that we are represented by that population. So, increased risks for women and pregnant people over 40 will include those with multiple health, social and economic issues, as well as the fit, healthy, and well supported. Population data will also be more representative of the majority ethnic groups, and, "In all reviews that aim to draw conclusions about population health needs, it is vital that explicit consideration is given to ethnic minority communities", yet coding data about ethnicity is often inconsistent or missing, muddying our understanding of the issues.[20] So, while population data is necessary for the configuration of services, it may not apply well to an individual.

In research looking at what people value when selecting care there was an almost universal desire for a local service with a known midwife, and a sense of control in decision-making.[21] However, while some prefer easy access to doctors and a range of pain relief, others had different priorities.[19] Safety and psychological wellbeing were equally valued by birthing women as part of a positive experience.[22]

Despite NICE guidance, planning a place of birth is often a process of negotiation and compromise. Middle settings such as Freestanding MLUs may be perceived by midwives as less suitable for women with higher risk status, while there can be more flexibility around use of the Alongside MLU (especially if it is literally through a set of doors rather than on another floor). Some women will request home birth as an initial step to negotiate MLU care, or will accept 'lesser' interventions such as a managed third stage to calm midwife anxieties about home birth.

Sometimes women and birthing people choose not to give birth in hospital because they have experienced trauma and find the systems and attitudes insufficiently flexible to meet their needs.[23,24] When women have experienced both hospital and home birth, their experience of birthing at home was more positive than hospital.[25] These researchers concluded a need for genuine choice, and the

"importance of care which is respectful and responsive to divergent ideologies about birth".[23] This echoes work showing that ethnic and social inequalities are reflected in the options offered to women.[26]

In evidence to the Health and Social Care Committee, Birthrights stated that they were "concerned by the ongoing risk that focusing on too narrow a definition of "safety" – one governed solely by policies, procedures, checklists, monitoring and equipment leads to the sort of inhuman, conveyor belt maternity care described by women in the Better Births report".[27]

When adverse events occur, we must be thoughtful about assuming that the later identified risk factors should have excluded a woman from a particular care setting. Perhaps the initial risk assessment was inaccurate, and the woman was not given correct information on which to base her decision. Perhaps the risk factors were not shared with other members of the care team, or acted upon, to provide the best care. Was the care continuously monitored and reviewed as labour progressed, with adaptations made to the care plan as risk status changed, and were communications between teams and locations effective?

Women used to experience a lying-in period, with traditions of sister or neighbour care, often the same people who supported them during labour. Now, most will experience care within the NHS establishment, and will be encouraged to return home promptly to a family who can theoretically provide better support than they will get on the postnatal ward. But 'well enough to go home' is often understood as 'well' which, given that maternal mortality is greater after birth than before or during, puts women at greater risk.

For the infant, we know that breastfeeding is positively affected by birth at home,[28] and potentially protective against longer-term health conditions.[29] Where partners are actively involved, which may be more likely in an out-of-hospital setting, their experience of birth is also more positive.[30]

What about the cost?

Some people feel that the individualised care at a home birth, for example, would be more expensive than in hospital, and that it is 'selfish' of women to ask for such personalised care. It is useful to know that around the world birth in hospital is known to be more expensive for the service, as well as physically and psychologically costly for the women.[31,32] Maternity services should "re-orientate themselves to provide choice of place of birth", because "while the cost savings would be attractive to planners, the central driver of service redesign should be to safely meet the woman's physical, social, and emotional needs".[33]

Perspectives on risk

Our values and attitudes to risk matter too. People who choose an out of hospital setting, with either low or high-risk factors, and with or without midwifery care, may be making a more active and informed decision than those who opt for hospital and may have a mindset that leads them to be better prepared physically and emotionally for the challenges of labour and birth. Fear based choices do not protect, and for these people, choosing a place of birth can be a composite of balancing physical and emotional risks, and encompassing cultural safety in addition to what works best logistically for the family.[34] Excessive

talk about 'risk' can be considered coercive, and lead to women disengaging from maternity services, bringing its own set of new risks.[35]

What next?

An exciting development is this year's Cochrane review comparing low risk home and hospital birth.[36] The authors identify that there is not enough evidence from Randomised Controlled Trials (RCTs) to draw conclusions - most women are not willing to be randomised to a place of birth, and studies would need to be very large to address the rare adverse events. They further conclude that as, "there is strong evidence that out-of-hospital birth supported by a registered midwife is safe, equipoise may no longer exist".[34]

Equipoise means that nobody can state with certainty which option is better, and is the necessary starting point for an RCT, because it would be unethical to randomise someone to a pathway known to be inferior in any way. They suggest that Cochrane will move to using well conducted observational studies in future updates of this regular review of place of birth.

For practice, their recommendations refer to "a planned home birth attended by a midwife backed up by a modern hospital system (in case a transfer should turn out to be necessary)".[34] Our problem in 2023 is that with NHS services under significant strain, the well-organised integration of out-of-hospital birth suffers, sometimes because of pressure on ambulance services. It feels bizarre that a service could not only cause more iatrogenic harm, but also cost more, because it does not act on a well-founded evidence-base.

Conclusion

The public understanding of childbirth is poor, and it is understandable that expectant parents focus on the negatives. Yet the absolute risks are very small, and "perinatal mortality rates are now so low that they are a crude measure of safety".[37] Therefore, differences between birth place locations remain very small, though this may not be how they're framed to parents.[38] Moving to the more technological obstetric environment may 'feel' safer for some parents and healthcare professionals, but it doesn't remove risk.

Even in her 1989 preface to the first edition, Tew identified that "action to reduce losses in childbirth still further would have to concentrate on improving the health of the neediest mothers",[2] and poorer outcomes in the UK remain more likely to be a result of social inequalities than either ill health or inadequate care. When women choose to birth outside the system it is often the result of trauma experienced (around 4-5% of women who have given birth)[39] or anticipated in hospital, and their need to feel a safety that goes beyond 'a healthy baby'. Integral to safety is listening to women, birthing people and their families, meeting their psycho-social and cultural needs as well as their health needs.

While risk can change during labour, quality care will accommodate that. Well integrated services - where out-of-hospital birth is supported by skilled and experienced midwives and excellent ambulance services - are known to be safer. However, UK services were sub-optimal before Covid, and have been

hard hit by staffing and organisational issues since. We don't yet know what impact this is having on safety, nor the effect of the Integrated Care Boards established in England during 2022 to replace Clinical Commissioning Groups.[40]

Dahlen states that rather than asking if home birth is safe, we should be asking if birth in hospital is safe.[10] Safety not just as an element of birth but part of a woman's reproductive life and human rights, and she states, "we need to change the embedded narrative, to embrace a definition of safety that women instinctively understand and strive for, including physical, psychological, social, cultural and spiritual safety".[10]

Yes, future research needs to explore what increases risks out-of-hospital, but it should also address the financial and environmental aspects of place of birth. We can campaign for what we know is protective: well-integrated care; skilled, supported and culturally competent health professionals providing respectful relational continuity of care;[41] and adequate resources including places of birth that meet the parents' needs.

Ultimately, I'd argue that place of birth is less relevant to safety than care, and good and poor care can arise in any location. So, let's be brave, and challenge the choice architecture, which ignores individual needs and restricts access. Let's assure mothers that their care will be excellent in any location, and then make that a reality. After all, if more women were encouraged to birth out-of-hospital, what difference would that make to the stories we hear and share?

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1 Where research is in 'women' or 'mothers' or refers to 'maternal' I use that term

2 Tew M (1998) Safer Childbirth (2nd Edition). London. Free Association Books Ltd.

3 Birthplace in England Collaborative Group, Brocklehurst P, Hardy P, Hollowell J, Linsell L, Macfarlane A, Mccourt C, Marlow N, Miller A, Newburn M, Petrou S, Puddicombe D, Redshaw M, Rowe R, Sandall J, Silverton L, Stewart M. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study BMJ 2011; 343 :d7400 https://doi.org/10.1136/bmj.d7400

4 Hollowell J, Pillas D, Rowe R, Linsell L, Knight M, Brocklehurst P. The impact of maternal obesity on intrapartum outcomes in otherwise low risk women: secondary analysis of the Birthplace national prospective cohort study. Br Journal Obstet Gynaecol. 2014;121:343-55.https://doi.org/10.1111/1471-

0528.12437

5 Li Y, Townend J, Rowe R, *et al* The effect of maternal age and planned place of birth on intrapartum outcomes in healthy women with straightforward pregnancies: secondary analysis of the Birthplace national prospective cohort study *BMJ Open* 2014;**4:**e004026. https://doi.org/10.1136/bmjopen-2013-
004026

6 Li Y, Townend J, Rowe R, Brocklehurst P, Knight M, Linsell L, Macfarlane A, McCourt C, Newburn M, Marlow N, Pasupathy D, Redshaw M, Sandall J, Silverton L, Hollowell J. Perinatal and maternal outcomes in planned home and obstetric unit births in women at 'higher risk' of complications: secondary analysis of the Birthplace national prospective cohort study. BJOG. 2015; Epub:1-13. https://doi.org/10.1111/1471-0528.13283

7 Rowe R, Li Y, Knight M, Brocklehurst P, Hollowell J. Maternal and perinatal outcomes in women planning vaginal birth after caesarean (VBAC) at home in England: secondary analysis of the Birthplace national prospective cohort study. BJOG. 2015;123(7):1123-32https://doi.org/10.1111/1471-0528.13546

8 Rance S, Mccourt C, Rayment J, Mackintosh N, Carter W, Watson K, Sandall J. Women's safety alerts in maternity care: is speaking up enough? BMJ Quality & Safety. 2013, 2013;22(4):348-55. http://dx.doi.org/10.1136/bmjqs-2012-001295

9 Hollowell et al (2015) The Birthplace in England Research Programme: further analyses to enhance policy and service delivery decision-making for planned place of birth. https://www.npeu.ox.ac.uk/birthplace/birthplace-follow-on-study

10 Dahlen H (2016) Dancing in the grey zone between normality and risk. The Practising Midwife. 19 (6) https://www.all4maternity.com/dancing-in-the-grey-zone-between-normality-and-risk

11 Dahlen H (2019) Is it Time to Ask Whether Facility Based Birth is Safe for Low Risk Women and Their Babies? eClinicalMedicine, 14. Pp9-10. https://doi.org/10.1016/j.eclinm.2019.08.003

12 Healthcare Safety Investigation Branch (2021) National Learning Report Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID pandemic, 1 April to 30 June 2020. UK: Healthcare Safety Investigation Branch. https://www.hsib.org.uk/investigations-and- reports/intrapartum-stillbirth-during-covid-19/

13 Howick J et al. Most healthcare interventions tested in Cochrane Reviews are not effective according to high quality evidence: a systematic review and meta-analysis, Journal of Clinical Epidemiology,

Volume 148, 2022, https://doi.org/10.1016/j.jclinepi.2022.04.017.

14 de Jonge, A. et al. (2015) 'Perinatal mortality and morbidity up to 28 days after birth among 743 070 low-risk planned home and hospital births: a cohort study based on three merged national perinatal databases.', BJOG : an international journal of obstetrics and gynaecology, 122(5), pp. 720–728. Available at: https://doi.org/10.1111/1471-0528.13084.

15 Scarf VL, Rossiter C, Vedam S, Dahlen HG, Ellwood D, Forster D, Foureur MJ, McLachlan H, Oats J, Sibbritt D, Thornton C, Homer CSE. (2018) Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis. Midwifery. 62: 240-255. https://doi.org/10.1016/j.midw.2018.03.024.

16 Hutton E, Reitsma A, Simioni J, Brunton G, Kuafman K. (2019) Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. The Lancet. https://doi.org/10.1016/j.eclinm.2019.07.005

17 Rocca-Ihenacho L, Alonso C. Where do women birth during a pandemic? Changing perspectives on Safe Motherhood during the COVID-19 pandemic. J Glob Health Sci. 2020 Jun;2(1):e4. https://doi.org/10.35500/jghs.2020.2.e4

18 Greenfield M (2021) 'Women felt they have no option but to give birth alone': the rise of freebirth during Covid-19. Kings College London News Centre. https://www.kcl.ac.uk/news/the-rise-of-freebirthing-during-covid

19 RCM (2020) Clinical briefing sheet: 'freebirth' or 'unassisted childbirth' during the COVID-19 pandemic. https://www.pslhub.org/learn/coronavirus-covid19/guidance/rcm-clinical-briefing-sheet-'freebirth'-or-'unassisted-childbirth'-during-the-covid-19-pandemic-r2128/

20 NHS Race and Health Observatory (2022) Policy briefing: The Ockenden Review. https://www.nhsrho.org/publications/policy-briefing-the-ockenden-review/

21 Hollowell, J., Li, Y., Malouf, R. et al. Women's birth place preferences in the United Kingdom: a systematic review and narrative synthesis of the quantitative literature. BMC Pregnancy Childbirth 16, 213 (2016). https://doi.org/10.1186/s12884-016-0998-5

22 Downe S, Finlayson K, Oladapo O, Bonet M, Gülmezoglu AM (2018) What matters to women during childbirth: A systematic qualitative review. PLOS ONE 13(5): e0197791.

https://doi.org/10.1371/journal.pone.0194906

23 Keedle, H., Schmied, V., Burns, E. *et al.* Women's reasons for, and experiences of, choosing a homebirth following a caesarean section. *BMC Pregnancy Childbirth* **15**, 206 (2015). https://doi.org/10.1186/s12884-015-0639-4

24 Hannah G. Dahlen, Soo Downe, Melanie Jackson, Holly Priddis, Ank de Jonge, Virginia Schmied. (2021) An ethnographic study of the interaction between philosophy of childbirth and place of birth, Women and Birth, 34 (6) e557-e566. https://doi.org/10.1016/j.wombi.2020.10.008.

25 Gregory S, Caffrey L, Daly D (2023) "It could not have been more different." Comparing experiences of hospital-based birth and homebirth in Ireland: A mixed-methods survey. Women and Birth. https://doi.org/10.1016/j.wombi.2023.02.003

26 Raleigh VS, Hussey D, Seccombe I, Hallt K. Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey. J R Soc Med. 2010 May;103(5):188-98. https://doi.org/10.1258/jrsm.2010.090460

27 Birthrights (2020) Birthrights submission to the Health and Social Care Committee on maternity safety. https://www.birthrights.org.uk/wp-content/uploads/2020/09/HSC-call-for-evidence-maternity-safety-Sept-2020-final.docx

28 Quigley C, Taut C, Zigman T, et al. Association between home birth and breast feeding outcomes: a cross-sectional study in 28 125 mother–infant pairs from Ireland and the UK. BMJ Open 2016;6:e010551. https://doi.org/10.1136/bmjopen-2015-010551

29 Ovaskainen K, Ojala R, Gissler M, Luukkaala T, Tammela O. Is birth out-of-hospital associated with mortality and morbidity by seven years of age? PLoS One. 2021 Apr 21;16(4):e0250163. https://doi.org/10.1371/journal.pone.0250163. PMID: 33882082; PMCID: PMC8059817.

30 Sweeney S, O'Connell R (2015) Puts the magic back into life: Fathers' experience of planned home birth. Women and Birth. 28 (2) P148-153 https://doi.org/10.1016/j.wombi.2014.12.001

31 Anderson, D.A.; Gilkison, G.M. The Cost of Home Birth in the United States. Int. J. Environ. Res. Public Health 2021, 18, 10361. https://doi.org/10.3390/ijerph181910361

32 Callander, E. J., Bull, C., McInnes, R., & Toohill, J. (2021). The opportunity costs of birth in Australia: Hospital resource savings for a post-COVID-19 era. Birth (Berkeley, Calif.), 48(2), 274–282.

https://doi.org/10.1111/birt.12538

33 Transforming maternity care collaborative (2021) What if all low risk women planned to birth in a birth centre or at home? https://www.transformingmaternity.org.au/2021/09/what-if-all-low-risk-women-planned-to-birth-in-a-birth-centre-or-at-home/

34 Jackson M, Dahlen H, Schmied V. Birthing outside the system: perceptions of risk amongst Australian women who have freebirths and high risk homebirths. Midwifery. 2012 Oct;28(5):561-7. doi: 10.1016/j.midw.2011.11.002. Epub 2012 Feb 1. PMID: 22300611.

35 Plested M, Kirkham M. (2016) Risk and fear in the lived experience of birth without a midwife. Midwifery. Jul;38:29-34. https://doi.org/10.1016/j.midw.2016.02.009

36 Olsen O, Clausen JA. Planned hospital birth compared with planned home birth for pregnant women at low risk of complications. Cochrane Database of Systematic Reviews 2023, Issue 3. Art. No.: CD000352. https://doi.org/10.1002/14651858.CD000352.pub3

37 Kitzinger, S. Forward, in Tew M (1998) Safer Childbirth (2nd Edition). London. Free Association Books Ltd.

38 Editor's note: For a very simple explanation of how statistics can give a distorted sense of the actual level of risk read: The label of 'high risk': the promise of gentle and attentive care, or a first violence in pregnancy? https://www.aims.org.uk/journal/item/editorial-june-22

39 Birth Trauma Association (No date) What is birth trauma? https://www.birthtraumaassociation.org.uk/

40 NHS England (No date) What are Integrated Care Systems? https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

41 Sandall et al (2016) Midwife-led continuity models versus other models of care for childbearing women.

https://doi.org/10.1002/14651858.CD004667.pub5

Two birth stories I love

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By Sue Boughton

A massage client gave birth in my home

This is one of my favourite birth stories. It is written with the permission of the mother who I will call N.

When N came to see me for a pregnancy massage at the Active Birth Centre therapy clinic a few years ago, she was 40 weeks pregnant with her 2nd baby. She knew exactly what she needed and that was to relax so that she could give birth. N told me that she wanted a homebirth but as they were having major building work done in their home it wasn't going to be possible. She was upset about this as she had given birth to her first baby at home, and she also mentioned that she wasn't getting on very well with her partner. This was hardly surprising given the stresses of being heavily pregnant whilst living in a building site!

At the end of her massage N asked me if she could come for another massage in a couple of days time if she hadn't gone into labour. I said, yes of course, and then I added something that I've never said to anyone before, I said, "I don t think you'll need to, your body is so ready for labour, i'm sure you'll have given birth by the end of the weekend". This was Friday evening.

N called me the next day and asked if she could book another massage. She had started to have surges[1] after the first massage, but had gone to her mother-in-law's that evening, was stressed by the visit and her surges had stopped, so we arranged for her to come to my home for a massage on Sunday evening.

N drove herself to my house but didn't tell me until afterwards that she'd had a few surges as she was

driving over. She had a few more surges during her massage and half way through she went to the bathroom and had a big surge on the way downstairs. I suggested that she call her partner to come and pick her up as I wasn't going to let her drive herself home or even to the birth centre, which was in Islington, so not far from my home. I simply thought, well, this is good, she's in early labour now so she can go straight to the birth centre after her massage.

N asked me to continue her massage and said that she would call her partner afterwards. I asked my husband to go and get her phone as she had left it in her car. N's waters broke while she was still on the massage couch after calling her partner! She shouted, "take my pants off, take my pants off!", as of course they were wet. So I helped her take them off and at that point it dawned on me that she was about to give birth and there would be no time to get her to the birth centre after all. She called her partner back to ask him to hurry up and then I called 999 just in case we needed help. I am totally confident in a woman's ability to give birth and I know that if a baby is coming quickly, at term, that it's not a problem, but I do feel nervous after the baby is born in case the baby has any trouble breathing. I am not trained in resuscitating newborn babies, so calling the paramedics is for this reason. The woman I was speaking to asked me all sorts of strange and sometimes hilarious questions: "How old is the mother? "Is the mother breathing?" How she couldn't hear the N groaning and yelling, "catch my baby, catch my baby" I will never know!

So I tried to get N back on the couch and into the knee/chest position to slow things down but she wasn't going to move anywhere; she was standing and leaning over the couch so I pulled some of the towels off the couch onto the floor in between her feet. I knew how hot and slippery a baby is from a previous BBA[2] and I think I was worried about dropping her baby. Crazy thoughts go through your head in these moments. N literally gave two grunting pushes and you could see some of her baby's head, so I suggested that she breathed slowly and her baby's head was born a few minutes later. Then she shouted, "catch my baby" and her baby boy was born, amazingly hot and very wet. I managed not to drop him and I passed him to her through her legs as she sat down. I wrapped a big towel around her shoulders and covered her baby with other towels to keep them both warm. Luckily, as she'd been having a massage, the room was warm and dark and there were plenty of towels to hand! N looked at her baby and then looked up at me and apologised for giving birth in my house. I certainly didn't need an apology; I thought it was amazing, a complete blessing and the most exciting thing to have happened in our home for years!

The paramedics arrived and I managed to get the second paramedic and their student to wait in the kitchen while one of them came in to check that the mother and baby were ok. I wanted the least disturbance possible as her placenta hadn't come yet.[3] The paramedic wanted to cut the cord but N asked him not to as she wanted to wait for her placenta to come first. He was surprised by this and not very comfortable, so I gave him a brief explanation as to why optimum cord clamping is a good idea[4] and then he was happy to wait. Amazingly, N didn't bleed at all. It was the 'cleanest' birth I'd ever seen. About ten minutes later her partner turned up. He was a bit in shock that he had missed the birth, but he was happy to meet his son.

It was interesting to find out how the emergency services work in this situation. They stayed on the

phone until the ambulance arrived, then the paramedics stayed until the midwife arrived. So N was actually booked for a homebirth after all and luckily we live in the same borough so one of the Islington community midwives came to see her and helped her birth her placenta - into my salad bowl, which I let them keep...

The reason I love this birth story is that it shows perfectly how the environment and the atmosphere are so important. N was very relaxed as she was having a massage; the room was warm and cosy; candles and fairy lights were on; calm, relaxing music was playing; and, even though we didn't know each other well, N knew I was a birth doula and must have felt safe enough to let go. She also reminded me very much of a good friend, so I felt like I already knew her, and this may have helped too. N was like a cat looking for a warm, dark, safe place in which to give birth. A few days later she said that my massage room felt 'womb like'. It does have one soft, dark red wall and red fairy lights in it, but I'd never thought of it that way before.

Mum, Dad and baby left our house a few hours later, healthy and happy (with the placenta in the salad bowl), and we sat down and had a glass of wine!

Holding out for the birth centre

I love this next birth story too, as it shows how lovely and relaxed a first birth can be and not what anyone expects. It is shared with the parent's permission

This was H and A's first baby and they were planning to use a local hospital birth centre. H noticed some of her 'show' one evening and later that night she felt her surges beginning. Her husband calls me around 2 am; the surges are irregular but already between three and six mins apart and H is feeling nervous. I suggest she has a bath or sees if moving around helps. Everyone expects a first time mum to have hours and hours of pre-labour while the body gets prepared and for the hormones to build up before labour really gets going, but it doesn't always take a long time.

A calls me again at 3.30 am. H's surges are three mins apart and very regular now so they ask me to come over. H is coping really well, breathing calmly whilst leaning over the birth ball in their candle-lit front room. She's listening to a Hypnobirthing App that handily doubles as a contraction/surge timer. Very soon the surges are building and getting stronger, I give H some Aconite (a homoeopathic remedy for fear/worry)[5] and I run her another bath. H is quiet and focused in the bathroom with her partner for about half an hour. Her surges are now much longer and stronger, so A calls the birth centre around 5.30 am. He is told that the birth centre is dealing with an emergency and that they should either go to the labour ward or stay at home for longer. They decide to stay at home when I reassure them that we have plenty of time.

Around 7am they say that they want to go in and I agree that it's probably a good idea as her labour is now looking pretty strong and appears to be moving quickly. I don't want to end up with a stressful rush to the hospital in rush hour traffic. We arrive at the birth centre (which is in the hospital) to find it

deserted, no staff and no labouring women! I make various phone calls to try and find out what's going on. Clearly it's a busy night for births in North London. H is calm and focused with her headphones (listening to the hypnobirthing app) and with her eye mask on.

I find them a comfortable place to wait with H sitting on a birth ball while I go upstairs to the labour ward to find out what's going on as no-one is answering the phone. After speaking to the midwife in charge of the labour ward and finding that the labour ward is full (though I don't tell H and A that as I don't want them to worry), we go to the antenatal ward to wait for the birth centre to open. We're hoping that the day midwives will come in at 8 am.

A midwife listens to their baby's heart rate and we get settled into a cubicle on the antenatal ward. It's quiet at least and there are midwives there if we need them. Apparently, today there are staff shortages and no midwives are available for the birth centre, so we wait, with fingers, toes and legs crossed, hoping that more midwives will be found and the birth centre will open soon.

H is coping really well considering this quite major hiccup in the proceedings. She accepts the offer of a VE and the result is that she's in active labour - well we knew that! - and the baby is in a good position, his/her heart rate is perfect and so all is well. H repeatedly changes from standing and leaning on a table to kneeling on the bed, walking to the toilet and back to standing - the typical restlessness of a woman in labour. No-one suggests this, but she very wisely and instinctively keeps her headphones and eye mask on. It's daytime now, we can't make the cubicle dark, and it's not quiet anymore on the ward. At 10.40 am H is feeling a little pressure and is beginning to make little grunting noises. I keep checking with the midwives for updates on the birth centre. We have been told that it should be open again in an hour but that was a while ago. Now they say that a midwife is taking a mum and her baby from the labour ward to the postnatal ward and then she's coming to take us to the birth centre.

A is concerned that we are running out of time and the midwives suggest that we go to the labour ward if they can't or don't want to wait. We discuss it and I say that I think they have some time to go yet as H isn't really pushing or groaning yet and that the birth centre will be lovely and quiet, so they decide to wait. Finally at 11.35 am our lovely midwife comes and quickly takes us down to the birth centre. She listens to the baby's heart rate and does a visual check (not a VE) as H is clearly getting close to giving birth. The birth centre midwives start to run the pool as soon as we got there so H gets up and takes off her T-shirt and pants before getting in the pool.

As she starts walking towards the pool she says, “Sue, it’s stinging down there”, so I bend down to check what’s happening and part of the baby’s head is visible! The midwives and myself remind her to try not to push but the baby’s head comes as we guide H back onto the bed on all fours. There wasn’t time for her to get into the pool before the baby’s head was born. The shoulders come slowly and their baby is born at midday. The midwife passes the baby in between her legs and we help her to lie down and hold her baby skin to skin. H is in shock and cries with wonder and surprise, as does her partner, A. I look at the midwives, we are surprised that their baby came so smoothly and quickly. We all thought that there was time for her to get into the pool. Well, you just never know do you!

Their baby’s birth was a really lovely surprise for everyone and she was perfect - a good sized, gorgeous baby girl.

Author Bio: Sue Boughton is a longstanding AIMS member and is a massage practitioner and doula from the North-East of England now living in London.

1 Surges is another term for contractions.

2 BBA stands for Born Before Arrival (of the midwife)

3 Editor’s note: The safe and timely separation and birth of the placenta is achieved by further uterine contractions, and these depend on continued high levels of oxytocin. Therefore it is important to maintain the warm, calm and quiet environment that increases oxytocin, so that this process is not disturbed.

4 Guideline: Delayed Umbilical Cord Clamping for Improved Maternal and Infant Health and Nutrition Outcomes. Geneva: World Health Organization; 2014. Background. Available from: https://www.ncbi.nlm.nih.gov/books/NBK310514/

5 College of Natural Health and Homoeopathy (2021) Homeopathy for Pregnancy, Birth and Beyond https://cnhh.ac.nz/homeopathy-for-pregnancy-birth-and-beyond/