Association for Improvements in the Maternity Services

AIMS Journal Vol:27 No:4 2015

Birthplace matters

Home births for more women

Making birth centres more accessible

Midwives supporting woman-led care

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Diary

AIMS meetings
Saturday 9 January 2016, North London
March 2016, TBC

All AIMS members are warmly invited to join us. For further details, to let us know you are attending or to send apologies please email secretary@aims.org.uk

Royal Society of Medicine Maternity and the Newborn Forum
From Barker to Bench, Beside and Beyond: The impact of epigenetics in pregnancy on mother and child
22 February 2016

and

Safe High-Quality Maternity Care: Learning from the Kirkup Report and other inquiries
17 May 2016

Royal Society of Medicine, London
maternity@rsm.ac.uk

Westminster Health Forum
Next Steps for Developing Maternity Services
23 February 2016
London
Speakers include Baroness Cumberlege, Dr Matthew Jolly and Professor Cathy Warwick.

www.westminsterforumprojects.co.uk/forums/event.php?eid=1091

Chichester Home Birth
Home Birth: Inspiring Women
12 March 2016
Chichester
Speakers include Ina May Gaskin and Sheena Byrom
Stories to inspire, inform and build confidence in health professionals and parents.

Contact Mandy 02392 462786
www.chichesterhomebirth.org.uk

Western Sydney University Australian College of Midwives University of Central Lancashire
11th International Normal Birth Conference – Normal Labour and Birth
10-13 October 2016
Sydney, Australia

Contact
normalbirth2016@midwives.org.au

Human Rights in Childbirth
India Conference
NOTE CHANGE OF DATE
January 2017
Bangalore, India
Addresses how maternity care can optimise maternal and infant health outcomes in a respectful, culturally sensitive, human rights framework.

humanrightsinchildbirth.com

Due to the overwhelming response this is now taking place in January 2017, instead of January 2016.

Association for Improvements in the Maternity Services
founded in 1960
by

Sally Willington 1931 – 2008

AIMS

campaigning for better maternity services for over 50 years

AIMS

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A group has been established to review research for the Journal. If you are interested in joining the team, please email research@aims.org.uk

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Cover Picture:
Ayeshea and her children, after birthing at home with the support of Albany midwives. See page 6.
© Becky Reed

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AGM and talk by Nicky Leap

The AIMS AGM and a workshop with Nicky Leap took place in Bristol on 12 September. The Chair of AIMS, Beverley Beech, opened the meeting with the customary lighting of the AIMS candle, signifying the AIMS motto that *'it is better to light a candle than curse the darkness'*.

Beverley provided highlights of what AIMS has been doing over the last year – successfully gaining Charity status; contributing to the Maternity Review in England; contributing knitted squares to a project in Ireland to bring to the attention of the public the tragic deaths by misadventure of women who died in childbirth between 2007 and 2013; providing hundreds of women with support through its Helpline; providing national bodies such as NICE (National Institute for Health and Care Excellence) and MBRRACE (Mothers and Babies: Reducing Risks through Audits and Confidential Enquiries) with feedback on new draft guidelines; producing four Journals; publishing two new publications (Am I Allowed and Group B Strep); holding talks to launch these; speaking at conferences; working with the European Network for Childbirth Associations; and holding an extended meeting for the Committee to further develop its vision and reaffirm its commitment to continuing as a volunteer run organisation. All AIMS volunteers were congratulated for their invaluable contributions which enabled all this and more to happen.

The finances were presented, and we are pleased to report that AIMS is in a healthy financial position, but that fundraising is needed for projects such as creating a new website, producing new publications and continuing to campaign both locally and nationally.

Following the usual business of electing the Trustees, Beverley opened the floor to discussion. This was unsurprisingly wide ranging. Our campaign for caseloading midwifery was debated, with general agreement that the Albany Midwifery Practice was unique in its provision of midwifery care from a community base for all women in its geographical catchment area, irrespective of medical, social or obstetric complications. Being part of the community and getting to know women meant that midwives could support women through pregnancy to feel confident and to develop their own support networks. It was also agreed that, like women, midwives who have not experienced caseloading are less likely to understand its benefits.

'Pain is never the sole creation of our anatomy and physiology. It emerges only at the intersection of bodies, minds, and cultures.'
David B Morris 1991

Using Maternity Services Liaison Committees to improve maternity services was discussed. We agreed that for these Committees to effectively represent women's views, 50% of members should be women. Several strategies were suggested, such as building relationships with midwives, especially consultant midwives whose remit is to support normal birth, encouraging local initiatives to gain feedback from women and raising issues that midwives might find difficult to raise themselves.

There was great enthusiasm for supporting midwives. It was recognised that midwives are constrained by lack of time and can find it challenging to provide information to women which contradicts local policies. Raising awareness among midwives of AIMS books as one potential solution to these difficulties was suggested. It was also acknowledged that a new, easy-to-use, topic-based AIMS website could be helpful to women and midwives alike.

Key messages to emerge were that resources (not enough midwives), structures (fragmented care in obstetric units) and birth culture (negative and medicalised media portrayal of birth) need to be addressed. While AIMS recognises the benefits of undisturbed birth for mothers, babies and families, wherever possible, its primary commitment is to the individual woman and providing her with information and non-judgemental support, whatever her decisions might be.

Well known and respected midwife and researcher Nicky Leap's informative, interactive, entertaining and superb afternoon session focused on women and midwives working with, rather than eliminating, pain in labour. Drawing on her work over many years and using video clips of women talking about the benefits of normal birth and midwives talking about supporting women through pain in labour, Nicky discussed the benefits and barriers to coping with the sensations of normal labour. The women in the clips, and women generally, report extremely positively on their experience of labouring and birthing without pain relief. This requires a change in the public mindset and confidence and skills on the part of midwives to journey with women through the challenging, transitional process of birthing.

Nadine Edwards

Woman-led care

Nadine Edwards and *Vicki Williams* explore the links between relationships and good care

This issue has focused on maternity services in the UK that are working well, provide excellent care and have 'good' outcomes, where 'good' extends to more than short-term physical outcomes. None of the Birthplace studies, for example, reported on in this issue were designed to look at women's emotional health as an outcome, though AIMS has campaigned for this to be included in research for many years.

We know that healthy women have fewer interventions when they birth away from obstetric unit and that this creates a healthier start for their babies. But we wanted to provide examples of services that provide more than this: examples that confer crucial other benefits to mothers', babies' and families' well-being and experiences; models that provide women with the care they want and need and that is physically, emotionally, culturally and spiritually safe; models that are genuinely inclusive rather than exclusive, models that midwives take pride in, where they can exercise their clinical and caring skills and judgement, and models in which they can increase their skills and confidence.

What is particularly striking about the examples included in this issue is their careful attention to the mother and her family – positively meeting her needs, welcoming her and her family, being unafraid to support her in her circumstances, even when she is deemed to have obstetric, medical or social complexities.

AIMS has always supported appropriate obstetric care when needed. This is vital for some women. AIMS has always supported women's decisions about place and type of birth, but what this issue shows is what can be achieved when there is flexibility, when women and midwives can feel free to make decisions and when they are well supported by maternity systems and other practitioners. As Helen Shallow describes on page 12, women are healthier and happier when they are heard, respected and supported.

The relationship of trust between a woman and midwife is crucial for both,[1] and although the midwife is with the woman for a relatively short time as she journeys through pregnancy, birth and early motherhood, this is a critical period for her well-being. We now know that positive relationships, built up over time, between mothers and midwives really do make a difference, and that mothers and midwives thrive on these. Equally important is the difference midwives can make longer-term by supporting the woman to develop social and community networks that strengthen her and therefore strengthen her community. This has been less of a focus to date.

The Albany Midwifery Practice and Serenity Birth Centre (among other examples in the UK) show that it is possible to develop maternity services that are about the individual woman, family and midwife, about their relationships, and, just as importantly, about community building. Supporting the woman within her family, within friendship circles and within her own community increases good health, strength and confidence – and also improves the care provided by midwives.

Birth centres such as Serenity that have worked hard to develop strong relationships with their colleagues and their communities tend to be more flexible and can extend the kind of supportive care they offer to more women than when boundaries around risk are too rigid.

more flexible and can extend the kind of supportive care they offer to more women

The Albany Midwifery Practice, from the start, purposefully focused on developing trusting relationships, inspiring confidence and supporting the woman in her community. It put in place several positive factors to make this happen – midwifery continuity, providing information and support to encourage women to make decisions, bringing women together to support each other and helping them to access other support networks, and crucially insisting on an 'all risk caseload'. This meant that they provided care for ALL women booking with them throughout their pregnancies, births and beyond, and thus no woman was excluded or transferred from the benefits of their midwifery care or ever denied access to medical and social care if needed.

When maternity care is woman-led, when women are supported by skilled midwives who can be their advocates, and when the evidence about the importance of relationships and place of birth is heeded, then maternity care will be transformed. In addition, midwifery needs to be well integrated into its communities and existing services and be able to provide care for all pregnant mothers in those communities irrespective of medical, obstetric or social disadvantages.

If there is a commitment to better care for all pregnant women and their babies, reducing inequalities, using the available research evidence and reducing costs of maternity care, then Serenity Birth Centre and the Albany Midwifery Practice could and should be replicated in maternity care across the UK.

Nadine Edwards and Vicki Williams

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Article

Changing a birthing culture

Becky Reed explores why so many women with the Albany Midwifery Practice had home births

In our Midwifery Practice (The Albany in Peckham, London) between the years 1997 and 2009, we achieved an overall home birth rate of 43.4%. This is especially impressive as we were working in a deprived inner-city area with what is known as an 'all-risk' caseload – this included all the women referred to us by the local GPs, regardless of their obstetric, medical or social risk. So why was it that so many of the women we looked after ended up choosing to give birth to their babies at home?

None of the midwives in the Practice would have recommended home birth in a situation where it was clear that mother or baby (or both) would be safer in hospital. There are a few situations where immediate access to medical support that is only available in hospital is definitely recommended, but these are rare. Place of birth for all women should be their decision, based on good sound information and their own feelings about what is right for them. Ideally added to this should be continuity of support with a known and trusted midwife, and importantly also the support of partners, family and friends. In our practice we discovered that when all these things came together, many more women than might be expected chose to have their babies at home.

It might be useful to unpick some of this. After all, with such a high home birth rate amongst a population not usually seen as home birthers, questions are often asked about how we achieved this.

Midwifery support with a known midwife

This has to be one of the key factors that enables women to make the right decisions for themselves. When the woman, and her family, can get to know the midwife, and the midwife can get to know them, a relationship can develop that fosters mutual trust and respect. In this environment the woman can fully explore the options available, knowing what feels safe for her, and knowing that no choice that she makes is cast in stone. Reassuring a woman that it's (almost) never too late to decide where to have her baby takes the pressure off any decision making and lets her relax and enjoy her pregnancy and grow a healthy baby. We visited every woman at home in labour, with a full set of equipment, and offered her the option of staying at home if that felt right. And of course for very many women it did, even if they had previously thought they would prefer to go to hospital – we are mammals after all, and moving away from our 'nest' in labour doesn't come naturally and is known to be unsettling for women and disruptive to the normal labour process.

Sabina (pictured opposite) had her first baby in hospital at 36 weeks. This is how she described her second birth at home:

'In my first labour I needed drugs and hospital support… so when it came to having my son Charlie I was not so sure about a home birth in case I needed to go to hospital, and I was worried about the space and the mess.

'My midwife arrived and I felt at ease. I was made to feel comfortable. I did not feel frightened or scared. She told me I was doing good and I can do it. Not only was it explained to me previously about home birth but as I was going through it I was given reassurance all the time.

'After, I was so happy to experience a home birth. I was comfortable in my own bed/home. My family came over for the birth…. they all helped me with after the birth, with baby, cleaning the house, making food. We all were much more relaxed than in a hospital environment. It's defo something I would recommend to any pregnant woman even to experience once. I am so glad it happened this way…'

I am so glad it happened this way

Sound information

With very little factually correct information in the media about the safety of home birth, and with hospital birth consistently presented as the norm, it's little wonder that women often think they have no choice. Midwives, backed up by the evidence from the Birthplace study,[1] are now hopefully correcting this, and explaining the study findings to women. But this has to be done with the back-up of a strong supportive system of care. And in my experience women benefit from the information being repeated and discussed at each antenatal visit.

In our practice every woman had continuity of carer with two named midwives, who she was able to get to know and trust, and most importantly, who would be there at her birth. We were able to discuss – and actively promote – birth at home throughout her pregnancy, supporting our discussions with good information and examples in order to make this a real option for each woman. We were careful with our language, always talking positively about the options. 'Would you like to have your baby at home?' opens up different possibilities from 'Which hospital do you prefer?' (this was London, with more than one potential maternity unit to consider). Above all we made the idea of birth at home real and normal, explaining that home birth as a default position makes sense in all births where a pregnancy has been straightforward, where the baby is well grown and in a good position, and where the woman goes into labour by herself. It is always possible to transfer to hospital, but it's virtually impossible to extricate yourself from a labour ward if you are in labour and wishing you were at home!

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Women's feelings about what is right for them

As midwives we can never know enough about each woman's individual circumstances to make decisions for her, nor indeed should we. But by booking her in her own home, getting to know her throughout her pregnancy, guaranteeing (as far as possible) to be with her when she has her baby, we can help her to explore what feels right for her when it comes to her birth. A Vietnamese woman I looked after knew instantly how continuity of carer would work for her. She had previously had two 'normal' births in hospital, and in both labours had had an epidural. When I told her at her booking visit that I would be there when she had her baby, her immediate response was *'I won't need an epidural then, will I?'* She eventually had a beautiful water birth at home, so very different from her previous experiences.

The support of partners, family and friends

When partners, and/or family, are an integral part of the woman's preparation for her birth, discussions can be had and choices can be made that feel safe and right. Women on their own can feel lonely in their decision making, and partners who are not involved, and therefore don't necessarily have sound information, may feel too ignorant or scared to support a woman's decision. Friends, neighbours, acquaintances with positive stories to share can all help. There's nothing as powerful as another woman's positive birth story – in a twist on that famous When Harry Met Sally moment: 'I want what she had'! Our well-known antenatal groups, woman-led but facilitated by a midwife, held the answer to this. Women (and their partners) learnt from other women, as nearly everyone returned to the groups to tell their story. I have observed such wonderful sharing of information, woman to woman, in these groups – I will never forget 15-year-old Linda 'teaching' 42-year-old Sheila how a baby is born!

the 'cultural norm' of birth at home

This I think is the key to the 'cultural norm' of birth at home that we were able to develop in Peckham over the twelve and a half years that we worked there. Women saw other women doing it and enjoying it. Rather than seeing it as a slightly odd and rather unsafe option, women (and their partners and families) began to see staying at home to give birth as a normal, safe, satisfying and joyful thing to do. Often we were able to point to another woman in their block or down their street who had had a baby at home and who was happy to share her story. Friendships were forged and birth became normal again, rather than something to be feared.

I remain bewildered about why the UK home birth rate remains stubbornly below three per cent. My oldest daughter had her first baby at home eleven years ago, and

© Becky Reed

Sabina and baby Charlie

she was the only one in her antenatal class to do so. My youngest daughter had her first baby at home in August of this year, and the story remains the same – when the classes started she was the only one planning a home birth. We have the information, but even apparently well-informed women are still choosing what almost feels like the path of least resistance, and we know from the evidence that this often comes at a cost.

More midwifery group practices working in a similar way to the Albany Midwifery Practice could make such a difference to women, babies, families and midwives. We changed the story in Peckham, and with the National Maternity Review well under way in England we now have the opportunity to get involved and improve women's experience nationwide.

Becky Reed

Becky Reed is an ex-Albany midwife, grandmother, doula, writer and birth activist.

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Westminster Health Forum will be holding a conference following the National Maternity Review in England; see diary on page 2 for more details.

To read about the achievements of the Albany Midwifery Practice and its unexpected and unwelcome closure see thealbanymodel.com/

What do official reports say?

Beverley Beech sets out the consistent official support for home birth over nearly 25 years

I recently examined some of the key NHS and Government documents covering England and Wales, advice provided by the Nursing and Midwifery Council (NMC) and Parliamentary debates on home birth and women's decisions about place of birth.

Below is a small selection of relevant statements pertaining to these issues from 1992 until 2015, starting with the most recent. While not exhaustive, the general message is clear.

Most recently, the NHS Choices web site[1] states that: *'If you have a straightforward pregnancy and both you and the baby are well, you might choose to give birth at home.'*

It goes on to say that, *'Giving birth is generally safe wherever you choose to have your baby…. For women having their second or subsequent baby, a planned home birth is as safe as having your baby in hospital or a midwife-led unit.'* And that *'If you give birth at home, you'll be supported by a midwife who will be with you while you're in labour.'*

The National Institute for Health and Care Excellence guidance of December 2014[2] states that for *'low-risk'* women, *'planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.'*

In 2010 the NMC advised that *'Women should be offered the choice of planning birth at home and it is a midwife's duty to make all options, benefits or risks clear and to facilitate and respect the choices a woman makes if she has the capacity to make that choice.'* And, *'Referral pathways should be in place to enable midwives to inform or seek advice from a supervisor of midwives when a woman, who may have risk factors, still wishes to have a planned home birth.'* Also, that *'The midwife must continue to give care but should seek support by discussing any concerns with her supervisor of midwives.'*[3]

It further advised that *'The available information on planning place of birth suggests that, among women who plan to give birth at home, there is a higher likelihood of a normal birth, with less intervention.'*[3]

In 2008, the Healthcare Commission's review of maternity services in England stated that: *'The choice of home birth should be offered to all women.'*[4]

In 2007, Maternity Matters, the Government's policy commitment to maternity services, made a National Choice Guarantee[5] in which it stated: *'By the end of 2009, four national choice guarantees will be available to all women and their partners.'* Among the guarantees were *'Choice of place of birth'* and which listed the options, including: *'birth supported by a midwife at home'*.

An NMC circular in 2006 stated that: *'home birth is at least as safe as hospital-based birth for healthy women with normal pregnancies.'* It went on to clarify that the woman has the right to choose her place of birth and that it is the duty of a midwife to attend. *'Whilst an employed midwife has a contractual duty to their employer, she also has a professional duty to provide midwifery care for women. A midwife would be professionally accountable for any decision to leave a woman in labour at home unattended, thus placing her at risk at a time when competent midwifery care is essential.'*[6]

the policy of encouraging all women to give birth in hospital cannot be justified on grounds of safety

In 1992, the House of Commons Maternity Care Select Committee concluded that *'the policy of encouraging all women to give birth in hospital cannot be justified on grounds of safety.'*[7]

Extracts from House of Commons and House of Lords debates

The following are selected extracts from the Commons and Lords debates about home birth and the woman's right and ability to make decisions.

In 2004, in response to a question by Helen Clark in the House of Commons, Dr Ladyman stated that *'we expect the NHS to provide a range of maternity services that includes the provision of home births.'*[8]

In 2003, Lord Hunt of Kings Heath stated *'We want to explore all the areas which we know are important to women: a safe birth which is as normal as possible; a choice of place of birth, with home birth as a realistic option.'*[9]

In the same debate, Baroness Noakes made the point *'I start with home births. They are not desired by all women, but a substantial number want home delivery … The Association for Improvements in Maternity Services has reported many instances of women being pushed into hospital delivery, usually at a very late stage in pregnancy, because they are told that no midwife will be available to support a home delivery. Those women have been denied real choice and have lost control of their birth arrangements…. We need more midwives if we are to improve the prospect of real choices being available to women – choices such as home births, but also births in other settings.'*[10]

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In 2000, Lord Hunt of Kings Heath stated *'The Government want to ensure that, where it is clinically appropriate, if a woman wishes to have a home birth she should receive the appropriate support from the health service. At the end of the day, it must be the woman's choice.'*[11]

As far back as 1998 Patrick Nicholls noted that *'Being the key player in an essentially natural operation – child birth – is not the same as being ill. Yes, medical opinion and expertise have their place, but they should start from the position that this is a normal, joyful experience, where the woman is the person who is calling the shots.'*[12]

Women have the right to decide where and how they give birth

As demonstrated above, the right to give birth at home with the support of a midwife has been and continues to be underpinned by the medical and midwifery regulatory professional bodies. The evidence suggests that home birth confers many potential benefits for healthy mothers and babies, and women who have had home births are generally extremely positive about their experiences. Midwives who support women at home also are generally enthusiastic and positive about home birth if they are well supported and have the resources they need. As the article by Becky Reed on page 6 shows, when women and midwives are able to build trusting relationships, when midwives are able to support women wherever they decide to have their babies and when women can decide where to give birth late in pregnancy or even in labour, many more women have their babies at home. The puzzle is – why are home births not more encouraged and supported?

Beverley Lawrence Beech

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9. House of Lords Debate 15 January 2003. Vol 643 col 295.
10. House of Lords Debate 15 January 2003. Vol 643 col 291 and 292.
11. House of Lords Debate 20 December 2000. Vol 620 col 733.
12. House of Commons Debate 11 February 1998. Vol 306 col 325.

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Sowing the seeds

Jessie Johnson-Cash and *Rachel Reed* explore establishing a healthy microbiome for your baby

Imagine a freshly ploughed field, with rich soil, ready for new life. The first seeds to take root, the first colonisers, determine which ecosystem will thrive there. Will they be a variety of indigenous plants, local to the area, carried in by wind, animal or other means? Or will they be a mass monoculture of foreign crops, reliant on fertilisers, herbicides and the constant tending of a dedicated farmer in order to survive?

Just as the newly ploughed field lies ready to be 'seeded', so too does a newborn baby, and the first colonisers have long-term implications for the health of the baby. The complex human ecosystem includes bacteria, viruses, fungi and protozoa and is known collectively as the human microbiota.

What is the human microbiome?

'Microbiome' and 'gut health' are buzzwords that have been making their way into mainstream vocabulary recently, spurred on by documentaries such as Microbirth (microbirth.com). The human microbiome refers to the collective microbial genes, gene products and genomes (the combined genetic material) of the microbiota.[1] The microbiota is the community of microbes that live symbiotically with the human body, priming immunity and maintaining homeostasis (balance). The Human Microbiome Project (commonfund.nih.gov/hmp/overview), undertaken by the National Institutes of Health, is mapping the genome of all microbes that live on and within the human body. In addition, it is exploring the relationship between the microbiome and human health, and answering some previously unanswered questions. For example, we have known for some time about the negative impact caesarean births and formula feeding have on long-term health; however, until recently, the 'why' was still unclear. These developments add to our understanding of the importance of the human microbiome for health, and how we can improve health outcomes.

Our own cells are outnumbered 10:1. Every surface of our bodies, external and internal (digestive tract and other orifices) is alive with rich microbial ecosystems that are essential to human health and well-being. The largest of these communities lies within the human gut. These commensal (beneficial) bacteria are responsible for a multitude of health functions from protection against pathogens (disease-causing microorganisms), to helping maintain immunity, as well as processing nutrients and regulating fat storage within the body.[2] We have reached a point in time in high-income countries where infectious (communicable) diseases are no longer our biggest threat and we have seen a rise in autoimmune and inflammatory type diseases such as obesity, asthma, diabetes, cancer, autism and mental health disorders. These diseases have been found to be associated with the human microbiome.

Many parents and maternity care providers are seeking information about how to best support a healthy microbiome for babies. The establishment of the infant gut microbiota occurs in a stepped process, commencing in the prenatal period and reaching maturity at approximately two years of age.[2] There are a multitude of external factors that influence this process. By understanding the process, parents and maternity care providers can facilitate an optimum environment for seeding and establishing a baby's microbiome.

Pre-conception and pregnancy

A common, previously held belief is that babies, when inside the uterus, are sterile and only come in contact with bacteria and other microorganisms during the birth process. However, maternal gut microbiota, which changes as the woman's pregnancy develops, can pass via the maternal blood stream/placenta to the baby in-utero.[2] Therefore, a healthy maternal microbiome during pregnancy is key to establishing healthy infant microbiome in-utero.

Diet is fundamental to helping establish a good maternal microbiome. Traditionally most cultures included fermented foods in their daily diet. In modern cultures, the shift towards processed, refined and packaged foods has made diets more sterile and reduced exposure to probiotic food sources. To promote a healthy gut microbiota you need to consume both probiotics (live microorganisms which produce a positive health benefit when consumed in adequate amounts) and prebiotics (indigestible food products which stimulate the growth of beneficial gut bacteria). The most common food that contains probiotics is live-cultured yoghurt. However, there is currently a re-emergence of home-made fermented food such as sauerkraut, kimchi, kefir and kombucha. Prebiotics are available in starchy foods such as sweet potato, pumpkin and rice. In addition to influencing the gut microbiome, a diet rich in probiotics may also assist with promoting healthy vaginal microbes.[3]

Environmental and lifestyle factors influence the microbiome. For example, smoking alters gut biota reducing microbial diversity.[4] Pharmaceutical drugs, particularly antibiotics, and anti-bacterial cleaning products (such as Dettol) eliminate both good and bad microbes damaging the microbiome.[5,6,7] In addition, maternal stress during pregnancy has been found to negatively alter the infant gut microbiota.[8] Although it is not always possible to eliminate stress, focusing on ways to relax and reduce stress should be a priority during pregnancy.

Birth

Although the maternal microbiome during pregnancy has an impact, babies are primarily colonised by the first microbe-rich environment they encounter as they are born. There are clear differences in the microbiota of infants born by caesarean when compared with infants born vaginally.[9] Babies born by caesarean are colonised by the hospital environment and maternal skin, primarily by Staphylococci and C Difficile. They also have less microbial diversity and significantly lower levels of Bifidobacterium compared with

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babies born vaginally. Babies that are born vaginally are colonised by maternal vaginal and faecal bacteria, primarily by Lactobaccillus, Prevotella and Sneathia. Babies born vaginally in their mothers' own environment (home) have the most beneficial gut microbiota.[10] The physiological process of labour may influence the microbiome of breastmilk.[11] Women who have had caesareans without any labour have different microbes in their breastmilk compared with women who experience labour. This may indicate that physiological stress or hormonal signals influence microbial transmission into breastmilk after birth.

what, and who, comes into contact with the baby

However, not all babies can be born vaginally at home and there are some simple ways of optimising early microbial colonisation. Promoting vaginal birth, limiting exposure to antibiotics during labour, and minimising physical contact between the mother-baby dyad and health care providers are all beneficial to establishing a good microbiome. Research is currently underway to trial a method of optimising seeding for caesarean born babies. Vaginal swabs are taken prior to surgery, and applied to the baby immediately after birth in an attempt to introduce vaginal microbiota onto the baby (see www.commonhealth.wbur.org/2014/06/birth-canal-bacteria-c-section). Early results are promising, with the babies born by caesarean and seeded with vaginal swabs having microbiomes that more closely resemble those of vaginally born babies.

The two other factors that women often ask about in relation to their impact on the infant microbiome are water birth and en caul birth. Although there are many theoretical ideas about their impact, there is currently no research available to provide clear answers.

Postnatal period

In the first days following birth the baby is colonised by the microbiota he or she was exposed to during birth, and the microbiota they are exposed to in the postnatal environment. This process can be assisted by careful consideration of what, and who, comes into contact with the baby. Encouraging the mother to have as much skin-to-skin as possible allows the baby to become colonised by her skin microbiota. Unnecessary touching of the baby by care providers and other non-family members should be avoided. Clothes and wraps that have been colonised with microbes from the mother's home environment can be used rather than hospital linen.

After type of birth, infant feeding method is the second most influential factor in the development of the baby's microbiome.[9] There are significant differences in the microbiota of breastfed babies compared with formula-fed babies. Beneficial bacteria are directly transported to the baby's gut by breastmilk and the oligosaccarides in breastmilk support the growth of these bacteria. Breastmilk contains the perfect package of probiotics and prebiotics to support a healthy microbiome. The difference in the gut microbiome of a formula-fed baby may underpin the long-term health risks associated with formula feeding.

Exposure to antibiotics during the birth process is common, for example during caesareans and for 'prolonged' rupture of membranes. Probiotic therapy for mother and baby may help to mitigate some of the disruption to the microbiome caused by antibiotics. Probiotic supplements may also be helpful for babies born by caesarean.

Summary

Pregnancy, birth and the early postnatal period are pivotal in influencing the establishment of the microbiome. This early seeding and colonisation has lifelong health implications. Type of birth and infant feeding method are the two most significant factors in the establishment of the infant microbiome. However, maternal diet and lifestyle during pregnancy, exposure to antibiotics and environmental factors also play a role. Current research suggests that the optimal conditions for the development of a healthy infant microbiome include: a prebiotic and probiotic diet during pregnancy; avoidance of antibiotics, antimicrobial products, smoking and stress; a vaginal birth in the mother's own environment and early exposure to maternal microbiota; avoidance of contact with non-family microbes; and exclusive breastfeeding. However, it is not always possible to provide the optimal conditions for all babies, and strategies to enhance seeding and colonisation for these babies are being developed.

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Article

VBAC in birth centres

Helen Shallow looks at women, VBAC, choice and decision-making

In 2013 I wrote about 'deviant mothers and midwives'[1] when I described my journey to support women having vaginal birth after caesarean section (VBAC).

That journey started soon after I qualified as a midwife in 1987 when I encountered women giving birth unexpectedly after being told they could not possibly give birth vaginally as their pelvises were 'too small'. Very early in my career back in the 1980s I started to question the prevailing rhetoric that 'once a section always a section' when I met women who, despite being told their previous caesarean was due to a narrow pelvis, would arrive and give birth before we had a chance to rush them to theatre.

However, we have come a long way, and I would like to share two accounts of women whose first babies were born by caesarean section who then chose not to give birth in an obstetric unit despite the hospital recommendations and NICE guidance that they should. I have been supporting such women for much of my career and latterly more formally in my role as consultant midwife and then as a head of midwifery as well. My deep-rooted belief is that women have the right to self-determination and autonomous decision-making. As simple and obvious as that may sound, nowhere is this more problematic than in maternity care in most high-income countries where birth interventions are on the rise and normal birth is in decline.

Rules, guidelines, checklists and protocols all but stifle individual decision-making and generally do not engender partnership working between women and midwives. The legacy of 20th century dogma around childbirth has led midwives to fear stepping out of line to support women when they request to use the pool, to have intermittent auscultation or to give birth in the birth centre or at home when hospital guidelines recommend otherwise. The phrase I have often heard from reluctant midwives is *'I'm protecting my registration'*. Registration with the Nursing and Midwifery Council (NMC) ensures midwives are legally entitled to practise midwifery.

In a similar way a woman's agency or sense of self is undermined when she is met with opposition, cynicism and sometimes hostility when she refuses to comply with rigid rules around how she should birth her baby. However, the climate is slowly changing and improving, and notably as the discussion about women, childbirth and human rights has come to the fore[2] many NHS midwives and doctors are picking up the mantle and making change happen towards a new dialogue of partnership working and women centred care. Nevertheless, we still have much work to do. The following are just two examples of women successfully having VBACs from my personal experience. I have changed names to protect anonymity.

> ## NICE
> The National Institute for Health and Care Excellence attempts to bring together evidence related to any given medical condition or in this case pregnancy and birth and formulates recommendations based on the interpretation of that evidence. www.nice.org.uk

Sally

Sally had a caesarean section with her first baby after prolonged rupture of membranes and failed induction. On reflection Sally believed that had she waited longer, her labour would have started by itself and the caesarean might not have been necessary. However, she was persuaded by the standard recommendation that, after 24 hours of ruptured membranes, if a woman's labour has not started, the hormone drip (syntocinon) is commenced to push the labour on. Sally did not feel she had a choice in the decision and as soon as 'risk to baby' was mentioned she knew she would follow professional advice. This time, however, she felt stronger and more sure of herself. She simply wanted the opportunity to birth her baby without interventions. She determined that the birth centre was the best place for this to happen.

A framework to support women

In 2008 the freestanding birth centre in West Yorkshire had not been open long and I led on setting it up and wrote the guidelines and criteria for the birth centre based on NICE guidance. No other recommendations at the time would have been acceptable. I anticipated that women who did not 'fit the criteria' would also want to use the birth centre, based on prior experience in another maternity unit. I therefore compiled a 'framework' to support women who make decisions outwith Trust recommendations. I involved the obstetricians and senior midwives from the outset so that we all agreed a mechanism to support this group of women. For midwives this resulted in open and honest communications without feeling threatened or guilty that in some way they were breaking the rules. Midwives found the framework particularly helpful and obstetricians accepted that some women would choose midwifery-led care despite their advice to the contrary. This included some women with a high BMI or women on medication for other conditions who would have been advised to have an obstetric unit birth.

Sally's waters broke again 'just like last time' and we, no I, had an anxious time crossing fingers and toes that her labour would start spontaneously. We kept in touch and I am convinced the relationship and rapport that we had built up over the months helped her to relax and let go so that her labour commenced spontaneously. She birthed in the pool in the birth centre and was delighted

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and triumphant as so many women are when they experience their own power, sometimes for the first time.

Milly's story – not quite a birth centre birth, but triumphant nevertheless

Milly had a previous caesarean section due to genuine concerns about her baby in early labour. The caesarean section was the right course of action and Milly was happy her baby could be supported appropriately soon after the birth. Two years on and pregnant again, she expressed the desire to go to the birth centre. She was not considered a suitable candidate for the birth centre due to her previous caesarean section but she challenged that decision and was sent to my clinic for further discussion. I think some midwives and some doctors mistakenly believed I would talk women out of their decisions!

That was not the purpose of my clinic. Nor was the purpose of the meetings just to say yes that's fine off you go. I felt the purpose of our meetings was to get to know Milly and other women like her. I wanted to explore what was behind their requests to do something that the Trust did not recommend. Consistently I found that women simply wanted a chance to give birth with support and minimal interference or intervention, be that at home or in the birth centre. They wanted the opportunity to labour in an environment that best suited their needs, calm and relaxed and not rushed and noisy.

Milly was very clear about her motives and that safety for her equated to the birth centre and not the obstetric unit. She did not want to be treated as 'high risk'. She wanted to be treated like any other mother having a baby. We talked about the travel time should transfer be necessary and we discussed how midwives would know if problems were developing in labour. Just as in a home birth Milly understood that transfer meant a potential delay if any emergency treatment was required. Milly was fully informed about what the birth centre could offer and what it could not. In support of her decision to use the birth centre I gave her a copy of the VBAC framework to keep with her notes and I wrote to the birth centre manager, and copied this to the consultant, with her details so that the team would know to expect her.

Milly went into labour around her due date. The photograph shows her working hard in the birth centre as she worked through her labour. However, at a key point the midwives became concerned that her labour was not progressing and she was still having strong contractions. After discussion with Milly, she agreed to transfer to the obstetric unit. About two hours after the transfer Milly gave birth to her baby. Like Sally she was ecstatic. She wrote to me afterwards and described how well everyone had supported her and how her care had been seamless throughout. She felt the midwives at the birth centre had done their best to support her. She had used the pool and tried all the active birth techniques to progress her labour. She agreed the need to transfer and found the labour ward team welcoming and supportive, and she felt that they helped her to achieve the normal birth she had so longed for. Milly was triumphant and

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Milly labouring at the birth centre

delighted. She agreed that I could use her photograph to share her story with other mothers who might be in a similar situation.

I chose to share Milly's story because we need to move away from blunt choices. Choosing one option such as birth at home or birth centre birth does not exclude the help and support that may be needed if and when that need arises. Surely that is a better approach? In other words as the government documents repeatedly suggest: appropriate care in the appropriate place at the appropriate time.[3,4]

In conclusion the way forward for women who don't fit standard criteria for out-of-hospital birth, be that in a birth centre or a home birth, is to seek out midwives who will engage with them and work in partnership with them to ensure that they have all the information in a non-biased way so that it is their decision. No-one can force a woman to do anything without her permission, but unfortunately the 20th century legacy of fear around childbirth still casts it shadow and we have more work to do to support women to realise their potential. However, when women know their rights and know what is possible and midwives are supported to facilitate women's decisions, the power of women is unleashed and the most extraordinary ordinary normal births result.

Helen Shallow

Helen is a freelance Consultant Midwife and 3rd year PhD student

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Serenity

Beverley Beech, Nadine Edwards and *Nicky Leap* report on their visits in 2012 and 2015

Although the definitions of alongside midwifery units (AMUs) vary,[1] healthy, well women giving birth in an AMU have fewer interventions than similarly healthy women giving birth in an obstetric unit, but more interventions than those at home or in free-standing birth centres (FMUs).

Currently, however, AMUs are more likely to be opened than new FMUs as they are deemed by many Trusts and Health Boards to be the best of both worlds, and easier and cheaper to open despite the lower intervention rates in FMUs. Perversely, as AIMS knows, FMUs are often under threat of closure.

However, there are some outstanding examples of how AMUs can be very similar to FMUs. AMUs with excellent outcomes consistently have teams which are assigned solely to the AMU, enabling them to create a welcoming, low-key environment that mothers and families love and where all staff enjoy working within a strong midwifery ethos.

An article in The Practising Midwife[2] provided some insight into what makes AMUs successful and the challenges they face due to being in such close proximity to a main labour ward. It identified several features that are needed: midwives skilled in supporting normal birth, good relationships between staff in the AMU and the main obstetric unit, guidelines that have been developed by all involved and that can be flexible in order to support women's decisions and ensure women know what to expect of an AMU and its potential benefits. It is unhelpful to present the AMU (as researchers found was the case) *'as a trade-off between a comfortable environment and access to pharmacological pain relief, without giving women information about the other ways in which a midwifery-led environment and care would help them to manage pain non-pharmacologically'*.[2] Too often this message is also given to women considering birthing in an FMU or at home.

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Serenity, which calls itself a birth centre (www.swbh.nhs.uk/services/maternity/), is technically an AMU:

'My image of the birth centre was that it was set quite separately from the hospital, but it is not. That's the Halcyon Birth Centre.' (See box)

Beverley

It is a stunning example of how an AMU can work for the benefit of its local community and midwives:

'Our visit to the Serenity Birth Centre surpassed all my expectations and I came away in awe of what I had seen and heard. The remarkable thing is that the Serenity Birth Centre is the default place for ALL women with uncomplicated pregnancies. What has been achieved in terms of improving outcomes for women and families and promoting straightforward birth is extraordinary.'[3]

Nicky

The Serenity Birth Centre was set up in West Birmingham in 2010 alongside the main maternity hospital in response to concerns about the high number of interventions (37% caesarean section rate, 48% induction rate and one woman a week admitted into intensive care), as well as 15-30 complaints a month. The hospital was under threat of losing its status as a student placement and the vacancy rate for staff was about 22%. A report published by the Campaign to End Child Poverty[4] identified that over a third of families in Birmingham experience child poverty (up to 46% in the Ladywood area near the hospital).

Midwife (and psychotherapist) Kathryn Gutteridge led a rigorous and careful process of cultural and practical change that resulted in tackling bullying, improving staff

What is Halcyon?

Halcyon Birth Centre is West Birmingham's free-standing birth centre, run by midwives (FMU). It opened in 2011. It has three birthing rooms each with a birth pool. See AIMS Journal 24(2).

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training and supervision, examining adverse incidents and outcomes, and setting up the new Serenity Birth Centre. Kathryn was given a budget and eight months to open it. She sent colleagues to look at hospices and wedding planning, and recruited midwives. In order to attract enthusiastic, passionate midwives, applicants were asked to create a collage representing their journey and passion for midwifery. Kathryn gave clear (non-negotiable) directions for the birthing rooms, the garden and family space. Objections by Health and Safety tended to be met with *'we hear what you say, but we'll take that risk anyway'*:

'Kathryn decreed that the specifications for the rooms were not negotiable. She thanked occupational health and safety experts for their advice about features such as hoists over pools and politely explained that as the birth centre would only be for low-risk women who, theoretically, could have their babies at home, such features were not necessary.'

Nicky

The guiding belief was to create a nurturing environment, let birth happen and be a safety net if needed. Kathryn started a campaign to talk to local people about the hospital, which had had a bad reputation (a bus collected young fathers for an evening session during which they could express their views and experiences and it was a young father who suggested the name Serenity for the birth centre). The birth centre and the care in it was shaped by the local community's views:

West Birmingham birth centre statistics for Serenity and Halcyon

The total number of midwifery-led unit births in West Birmingham for 2011–2013 was 4040 (of which 144 were in Halcyon, a free-standing birth centre in the same Trust, and 3896 were in Serenity). All the percentages refer to the total number of births.

3859 (95.2%) women had spontaneous vaginal births (SVD)

518 (12.7%) women transferred to the main labour ward during labour or birth

50 (1.23%) women requested epidurals for pain relief

64 (1.58%) women had assisted births

127 (3.13%) women had caesarean sections

531 (13.1%) women had a perineal repair for a second degree tear

47 (1.16%) women had a perineal repair for a third/fourth-degree tear

29 (0.7%) had an episiotomy

32 (0.79%) had a postpartum haemorrhage

24 (0.59%) of the women's babies were admitted to the Neonatal Intensive Care Unit

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'In venues such as children's centres and mosques, women were asked about their previous experiences of giving birth: "Tell me why you don't want to come back to our hospital." At these Birth Story Lunches women agreed to be videoed so that maternity care staff could hear directly from them about their experiences, how these had impacted on their lives and what they would want if they were pregnant again.'

Nicky

The birth centre is an open place which women and families can visit. There is a picture book of the centre for families and visitors to look at, a YouTube video (www.youtube.com/watch?v=74WbsblPHGc), recorded stories (www.swbh.nhs.uk/services/maternity/), active birth workshops and a 'Big Mother Chair' for women to share thoughts and experiences. The birth centre really is part of the community.

The birth centre really is part of the community

An increasingly virtuous circle has been created: relationships between the staff and public are good: as Kathryn said, *'everyone smiles more and is more relaxed.'* The staff value and support each other and roles are more flexible, so that if midwives are all with women, maternity assistants and cleaning staff will welcome anyone coming to the door at the centre:

'I was introduced to the staff and it struck me how supportive of each other they were.'

Beverley

As Kathryn said, having the unwavering support of Elaine Newell, Director of Midwifery, as well as others has

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been crucial to the success of Serenity. Elaine has negotiated persistently for funding which has resulted in more midwives and better facilities.

With a sound philosophy and guidelines, good support and adequate resources, midwives have developed their skills to support physiological birth, criteria for using the birth centre are more flexible and if women with complications request the centre, they can be accepted (any woman in need of medical care transfers to the main labour ward). Women having twins and vaginal births after previous caesarean sections have given birth at Serenity and, on one occasion, a woman was accompanied by her partner, child and dog. Although women are usually over 16 and under 45, women between the ages of 14 and 16 have birthed there, and as many local women have a low haemoglobin, women with relatively low haemoglobin levels who have not had heavy blood losses previously are accepted.

By May of this year, 91 women had had vaginal births after caesareans (VBACs) in the birth centre with a 95.6% success rate. The midwives do not use continuous electronic fetal heart monitoring and most of these women laboured, and many gave birth, in water.

All healthy women in the area give birth in the birth centre unless they wish to use the main labour ward. They leave four to six hours after birth if all is well, but with good postnatal support. Any transfer out of the centre is carefully examined and medical students on placement there receive a session on 'courtesy and dignity'.

Beverley summarised her visit thus:

'I had taken the view that alongside midwifery units take second place to the free-standing ones, but having been around this centre I have changed my view. Kathryn has ensured that the midwives are completely separate from the obstetric unit (they do not rotate) but they have the support of the obstetric unit and the staff work as a united and supported team. It was such a joy to see.'

It goes without saying that outcomes for mothers and babies are excellent.

If an AMU is being considered in your area, a visit to Serenity and Halcyon would provide valuable insight into how Kathryn and her colleagues set up the birth centre, tackled bullying or lack of enthusiasm, recruited committed and passionate staff, listened to and gained support from the community to make it the community hub that it is, and how they achieved excellent outcomes.

Nadine Edwards

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Home birth research

Gemma McKenzie looks at additional evidence on birthing at home

Recently, there have been a number of studies published that focus on home birth. This review will explore the main points raised in two of these.[1,2] Both studies stemmed from the results of the Birthplace England Research Study[3] (BPE), which was carried out in 2011.

First Study

The results of the BPE showed that there were a number of women classed as 'higher risk' whom obstetric guidance would have advised to birth in an obstetric unit (OU) but who planned to give birth at home. The first study analysed the outcome of these planned home births when compared with the 'higher risk' women who planned to give birth in an OU. This covered 8180 'higher risk' women from the BPE cohort.

Women considered 'higher risk' were those who had:

- *Pre-existing medical conditions, such as epilepsy, asthma and cardiac disease;*
- *Complications in a previous pregnancy such as a retained placenta or a caesarean section;*
- *Conditions that could affect the current pregnancy, for example, pre-eclampsia, a BMI over 35, gestational diabetes or a pregnancy that had gone beyond 42 weeks.*

The outcomes that the researchers were analysing, as in the main BPE study, were:

- *Intrapartum-related mortality and morbidity of the baby, intrapartum stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury and fractured humerus or clavicle;*
- *Admission of the baby to the neonatal unit within 48 hours of the birth, for at least 48 hours;*
- *Interventions carried out on the mother during birth and adverse maternal outcomes;*
- *Straightforward vaginal birth.*

Results

The first interesting point to come out of the study was that the 'higher risk' women choosing a planned home birth were more likely to have had more than one previous pregnancy. Further, out of all of the women in the study, the proportion of women who gave birth at 42 weeks' gestation or more was higher in the planned home birth group. The results also showed that women with a number of risk factors were more likely to give birth in the OU.

There was a very low rate of intrapartum-related mortality and morbidity in both the home birth and OU babies and the difference was so small that it was not statistically significant.

Surprisingly, the research showed that the risk of a baby being admitted to the neonatal unit was higher in the OU births. This was still the case even when the researchers restricted their analysis to women who did not have any pre-existing medical conditions.

In planned home births, the risk of neonatal admission was significantly higher for 'higher risk' women than in 'low-risk' women. It did not make much difference whether this was the woman's first baby or whether she had given birth before. However, when the researchers removed the women who had pre-existing medical conditions (see 'higher risk' criteria listed above) from the analysis, the risk of neonatal admission for babies born to women considered 'higher risk' was not statistically significant when compared to 'low-risk' women.

Compared with a planned OU birth, a planned home birth was associated with a significantly lower risk of intrapartum interventions and adverse maternal outcomes. This was regardless of whether the woman had given birth before. In addition, planned home birth was associated with a significantly higher probability of 'a straightforward vaginal birth'.

The researchers asked the question *'why would a higher risk woman choose to birth at home?'* They suggested that a possible answer to this could be that these women may want to avoid the interventions associated with an OU birth, but they are excluded from midwifery-led units. This means that to avoid an OU, their only real option is a home birth. They concluded that more research needs to be done to see whether the criteria for midwifery-led units could be safely relaxed so that some 'higher risk' women could also have the option of using that facility if this is what they want.

Glossary

Intrapartum – during labour or birth.
Perinatal – the time just before and just after birth.
Intrapartum stillbirth – stillbirth after the start of labour.
Early neonatal – new born.
Neonatal encephalopathy – neurological (nerve) problems observed in the newborn's first days of life, sometimes caused by lack of oxygen. The terminology NE is preferred to Hypoxic Ischemic Encephalopathy (HIE) as it is not always possible to document a significant hypoxic incident and there are potentially other causes.
Meconium aspiration syndrome – a condition which occurs in association with a baby inhaling meconium into their lungs.
Brachial plexus injury – damage to the baby's nerves between its spine and arm, shoulder or hand.
Humerus – the bone between the shoulder and elbow.
Clavicle – collar bone.

Second Study

The second study compared the place of birth and outcomes of all low-risk women who gave birth in New Zealand between 2006 and 2010. This was then compared with the results of the BPE. For inclusion in the study all of the women had to have had a singleton pregnancy, have a baby in the head down position, and be at least 37 weeks 0 days when they gave birth.

Results

Firstly, both the New Zealand study and the BPE found that fewer women having their first babies (nulliparous) planned to birth at home than women having subsequent babies (multiparous). Further, the rates of transfer from planned home births to hospital were lower in New Zealand than in England (16.9% and 21% respectively). Forty-five percent of the English transfers were for women having their first baby, whereas this was only 35.8% in New Zealand.

All types of adverse outcomes were rare. Neonatal unit admission and perinatal mortality were significantly higher for babies born to women who transferred from home after labour had commenced. Overall, women who gave birth in their planned place of birth had lower levels of perinatal mortality than women who were transferred to hospital from home.

The researchers concluded that for low-risk women, the risk of adverse neonatal outcomes is low and that this is not affected by whether the mother chooses to give birth at home or in another maternity setting.

AIMS Comments

These studies provide useful information, but, as is so often the case, the research also raises many questions. The researchers observed in the first study that a number of women had multiple risk factors. They also noted that a greater proportion of the 'higher risk' women who planned a home birth had had a previous pregnancy. The research was not designed to find out why, so we do not know what other factors influenced these women's decisions to plan a home birth for their next baby. Could it be that for some 'higher risk' women, previous experiences of hospital births influence their decision to birth at home, even when this goes against medical advice? Arguably, this could also be linked to a woman's growing confidence in her own body's abilities, especially as the second study highlighted that fewer women having their first babies chose to home birth than those having subsequent babies. This decision may also be influenced by the woman's midwife. Perhaps midwives are less encouraging of home births when the mother has yet to experience labour and birth.

Another question raised by the first piece of research was why the risk of neonatal admission was higher for babies whose mothers were 'higher risk' but had chosen to birth at the OU instead of at home? Could something happening in the OU birth room be affecting the initial health of the baby? Examples could be the use of syntocinon to induce labour, or forceps delivery of the baby, both of which would not be used during a home birth. Given that the results showed that home births had a higher probability of resulting in 'a straightforward vaginal birth', is it this lack of 'a straightforward vaginal birth' that is causing the problems? Could it be linked to over-monitoring of babies born in an OU, which could result in over-cautionary treatment of the newborn? Could the proximity of the neonatal unit influence decisions made, especially where there is an assumption that a baby born to a 'higher risk' woman will need extra medical care? Alternatively, perhaps some of the conditions recognised and treated within the OU are being adequately treated at home following a home birth. The authors point out that: *'The high neonatal admission rate in planned OU births at term is costly and the separation of mother and baby may have negative consequences.'*

The researchers suggested that a possible explanation for the apparent additional treatment required by babies born in the OU was due to 'under-treatment' of the planned home birthed babies. However, this argument does not sit well with their conclusion that the difference between intrapartum-related mortality and morbidity within the OU and home birth groups was not statistically significant.

In the New Zealand study, the researchers found that women who gave birth in their planned place of birth had lower rates of perinatal mortality than women who were transferred from home to hospital. Does this suggest that moving a woman during labour carries its own risks and therefore in borderline cases moving a woman from home to hospital could actually do more harm than good? Or is it indicative of correct assessments by midwives whereby women in real need of medical assistance are being appropriately transferred to the hospital? Without further research, the answer is unclear.

These two studies show that home birth is safe and has significant benefits for mothers. The authors of the first study acknowledge, however, that the number of women included in the study meant that it had *'limited power to detect a difference in risk'* but that *'Planned home birth was associated with a reduced risk of maternal intervention or adverse outcome requiring obstetric care and an increased probability of having a "straightforward birth" compared with planned OU birth.'*

All women need a range of birth place options and need to be treated as individuals. More research is needed to ensure that women are informed and well supported to have a safe and positive birth experience, whether they plan to birth at home or elsewhere.

Gemma McKenzie

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After *Birthplace*

Louisa Noël looks at the Birthplace England follow-on study

The National Institute for Health Research has published a follow-on study[1] to the 2011 Birthplace in England study.[2]

The original Birthplace study looked at the safety outcomes for healthy mothers and babies by planned place of birth. These included hospital obstetric units (OUs), midwifery-led units in a hospital (alongside midwifery units or AMUs), midwifery-led units at a distance from the hospital (free-standing midwifery units or FMUs) and home.

The Birthplace study was designed to *'support the development and delivery of safe, equitable and effective maternity services and to inform women's choice of birth setting by strengthening the evidence-base relating to planned place of birth.'* The recently published follow-on study comprised five complementary studies examining:[1]

- whether intervention rates (such as forceps or ventouse delivery, and caesarean birth) and outcomes for the mother (such as 'straightforward birth' and 'normal birth') are affected by where the woman planned to give birth;
- any effect of the characteristics of the mother (such as how many babies she has had, ethnicity, social disadvantage and her age) on interventions and outcomes;
- transfers from non-OU settings during labour;
- whether there was any difference in outcomes depending on what time of day, or day of the week, women gave birth; and
- which women at 'higher risk' of complications plan birth in AMUs, FMUs or at home, how they are treated during labour and their outcomes.

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The part of the study looking at 'higher-risk' women is reviewed in detail on page 17 of this Journal. The remaining four studies, reviewed below, included only 'low-risk' women. The same data, collected during April 2008 to April 2010, were used for both the 2011 and 2015 studies.

Place of birth

Overall, the likelihood of experiencing an intervention varies more between the different places of birth than would be expected by chance, and according to the study it isn't clear what causes these differences. In the case of births planned in an OU and AMU, these variations are seen for all types of interventions, especially for women having their first baby. Women consistently experience fewer interventions when they plan to give birth in an FMU or at home. In particular, births planned in an FMU are less likely to result in a caesarean section, and planned home births are less likely to result in either a caesarean section or in a forceps or ventouse birth.

Interestingly, the study found that where proportionately more births within a trust are planned in an AMU, FMU and at home, those 'low-risk' women who do plan to give birth on the labour ward experience more interventions (especially caesarean section). The research also indicated that, where a hospital has an AMU, 'low-risk' women planning to have their first baby in the OU were more likely to have a caesarean section, and women having second and subsequent babies in the OU were less likely to have a 'normal birth' or 'straightforward birth'. The study did not explore why this might occur and whether this might be to do with the OU itself, with the characteristics of the women who plan to birth in an OU, or some interaction between the two.

For women having their first babies in an FMU, the size of the FMU appeared to have an effect on the intervention rates and on the likelihood of the woman transferring to hospital during labour. Intervention and transfer rates for these women were lower in larger FMUs than in smaller ones. It appeared that interventions for women having their first baby and transfer rates for all women were also higher the further the FMU was from the nearest OU, but the study was unable to clarify to what extent this was due to more distant birth centres often being smaller. Could it be that transferring to an OU might be recommended sooner when transfer times are longer due to distance, or for some other reason, such as the skill and confidence of the midwives working there?

The study also indicated that in trusts where there is a high proportion of home births women birthing at home are more likely to have 'normal births', at least for a second or subsequent baby. Women are also less likely to be transferred to hospital during labour in those trusts. However, it isn't clear from this study what other factors impacted on those findings. Could it be that a well-established and well-supported home birth service accounts both for higher numbers of women choosing home birth and better outcomes for those women?

significantly higher chance of having a 'normal birth' or 'straightforward birth' in a non-OU setting

Different groups of 'low-risk' women

Regardless of where they planned to give birth, non-white 'low-risk' women are more likely to have a caesarean section than white 'low-risk' women. However, the study indicated that planning to give birth in an AMU, FMU or at home reduces the likelihood of interventions for both white and non-white women.

The study did not find significant associations between risk of interventions and levels of social disadvantage.

The risk of interventions increased with age for 'low-risk' women having their first baby in all settings but not for women having a second or subsequent baby. Women aged 35 or over having their first baby had a significantly higher chance of having a 'normal birth' or 'straightforward birth' in a non-OU setting.

Transfers during labour

This part of the study focused on whether transfers during labour to an OU are influenced by maternal characteristics (such as age, number of babies, ethnicity and social disadvantage) and 'complicating conditions'. It found that transfer rates were higher among women with 'complicating conditions' at the start of labour, such as waters breaking before labour starts or meconium in the amniotic fluid.

It did not seek to examine whether where a woman planned to give birth had any effect on whether she was likely to transfer to hospital during labour. However it noted that, although the risk of transfer during labour increases with age for 'low-risk' women planning births in AMUs and FMUs, this pattern was not observed in women planning home births.

In AMUs, the study suggested that there may be a link between staffing levels in the AMU and higher transfer rates among women having a second or subsequent baby. The research did not offer an explanation for this finding.

Time of day and day of week

Where birth was planned in an OU, 'normal birth' and 'straightforward birth' were less likely during weekday 'office hours' than at night. In other words there were more interventions carried out during 'office hours'. There appeared to be a peak in augmentation of labour (for example with syntocinon) and in epidural use for pain relief among women birthing at the end of the day and early evening.

In births planned in an AMU, there was no such clear association between outcomes and time of day/day of week, although augmentation of labour was less likely during weekday nights than at other times.

Conclusions

The follow-on study concluded that:

- 'Low-risk' women planning a birth in an AMU, FMU or at home have a lower risk of intervention; therefore caring for more women in out-of-hospital settings during labour would reduce intervention rates.
- There are benefits of midwifery-led care during labour for all 'low-risk' women.
- Intervention rates differ considerably but for reasons that are not understood.
- How maternity care is organised has an effect on intervention rates.
- The impact of other factors, including labour ward practices, staffing and skill mix and women's preferences and expectations, on the use of intervention should be investigated further.
- 'Complicating conditions' at the start of labour (such as prolonged rupture of membranes, meconium staining and breech presentation) resulted in a statistically significant increase in the chance of transfer to hospital during labour.

The Birthplace[2] study, along with other studies, clearly shows that providing midwifery care in birth centres and at home has many benefits for mothers and babies. These follow-on studies confirm this and raise important questions about how the services are organised and how midwifery skills might impact on normal birth and intervention rates.

Louisa Noël

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See also www.aims.org.uk/pressReleases/birthplaceInEngland.htm

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Alongside midwifery units

Andrea Nove looks at the evidence supporting out-of-hospital models of care

The Birthplace in England study[1] found that, for healthy women with 'low-risk' pregnancies, midwifery-led units (MLUs) had better outcomes for women and equally good outcomes for babies, at a lower cost than obstetric units (OUs). That study also found that freestanding midwifery units (FMUs) had slightly better outcomes than alongside midwifery units (AMUs). Both AMUs and FMUs provide midwifery-led care for women with 'low-risk' pregnancies as defined in national clinical guidelines,[2] but AMUs are located close to (usually within the same building as) OUs whereas FMUs are on a separate site.

Despite the evidence of better outcomes in FMUs than in AMUs, a recent study[3] found that both service providers and service users tend to assume that AMUs are safer due to their proximity to emergency care should it be needed. For this reason, and because it is easier and cheaper for the NHS to provide AMUs, the recent increase in the number of MLUs in England[4] may not translate to an increase in the number of FMUs.

To help understand why outcomes are poorer in AMUs than in FMUs, this study aimed to explore the organisation, staffing and management of AMUs and to examine the perceptions of AMUs among women and their partners, and among those working in maternity care, and then to make recommendations about how to maximise quality of care within this environment, given financial and organisational constraints. The researchers interviewed 136 women, partners, managers, commissioners and health workers at four NHS AMUs from different parts of the country and different types of location such as city centre and suburban. They also observed key aspects of the service, such as staff handover meetings.

Two of the four AMUs had an 'opt in' system (women had to request to birth in the AMU), and the other two an 'opt out' system (in other words it was assumed that all women with 'low-risk' pregnancies would birth in the AMU unless they requested otherwise). In theory, an 'opt out' system should result in equality of opportunity to experience midwifery-led care. Some of the medical professionals interviewed for this study felt that the AMU philosophy is designed by and for affluent, white women and has less relevance for those from other social and ethnic groups. However, the women in this study were from a wide range of backgrounds, and without exception they appreciated the experience. The only noticeable difference was that women from poorer backgrounds tended to feel more surprised to have access to what they perceived as luxurious surroundings.

Whether the system was 'opt in' or 'opt out', there were occasional problems with the provision of clear, unbiased information to women when they chose their preferred place of birth. The differences between the options were not always clearly explained, so many women could not be said to have made an informed decision. Some AMUs were working towards integrating the work of AMU midwives and midwives working in the community (for

Examining and explaining the placenta

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example at GP surgeries) so that all midwives were able to provide accurate information about the options available to women.

The fact that the study focused mainly on women who had opted for AMU care means that it did not provide much information about why women would opt out of AMU care. The study's authors question why such a small proportion of 'low-risk' women used the AMU rather than the OU, and more interviews with women who had chosen an OU birth with a 'low-risk' pregnancy may have helped to understand this. The study did find that lack of space in the AMU may be a factor, yet it did not find any evidence of plans to expand AMU capacity at the study sites, which does not bode well for women, who may be unable to opt for AMU care even if they want it.

Most of the health professionals interviewed felt that strict criteria should be used to determine whether or not a woman should be offered an AMU birth. They felt that any bending of the rules presented risks to both the women and the AMU midwives, and also to future choice for women. For example, if a woman with known risk factors gave birth in an AMU and experienced problems, then not only would the woman and/or baby suffer, but the attending midwives may be subject to an investigation and the whole future of midwife-led care could be jeopardised. On the other hand, some AMU midwives thought that there should be more flexibility, and that the focus should be on strict guidelines for when to transfer to the OU rather than whether or not to admit to the AMU. Interestingly, when OUs were busy, they sometimes asked AMUs to admit women who did not meet the AMU admission criteria. Likewise, sometimes women with 'high-risk' pregnancies asked for an AMU birth because they did not want an OU birth. The study authors recommend careful documentation of birth plans and advice given by health professionals, so that women's decisions can be respected without putting the NHS or health professionals at risk of being sued. These situations raise important questions about how to maximise safety whilst not denying women the option to make their own decisions, and about the extent to which fear of legal action unnecessarily limits the range of options presented to women.

Despite the history of professional tensions between midwives and obstetricians in the UK,[5] the study found that obstetricians were generally supportive of AMUs, because this model means that they can focus on caring for women with complications. There was, however, professional tension between AMU midwives and OU midwives. When women transferred from AMU to OU, sometimes the AMU midwives felt that the OU midwives judged them to have 'failed', and sometimes the labouring women noticed the resultant tension. Perhaps of more concern was that this can lead to AMU midwives being reluctant to recommend transfer to the OU even when this would be the most appropriate option. Similarly, if the OU was busy, there were examples of the OU refusing to accept a transfer from the AMU for non-emergencies, such as a request for an epidural. Such cases were not viewed as priorities, which was distressing for the labouring women and the AMU midwives. Sometimes, if there were staffing shortages in the OU, the AMU midwives would get 'pulled' to work in the OU. This caused tension because fewer midwives in the AMU could lead to it being closed due to staff shortages, thus limiting women's options.

The issue of women being sent home if they arrive at an OU in early labour, and the distress that this can cause, is well-documented.[6] This study found similar issues at AMUs, which regularly sent women home due partly to a belief that home is the best place when in early labour and partly to lack of space. This policy of not admitting women who wish to be admitted is at odds with the philosophy of woman-centred care that AMUs are designed to promote, and the study authors suggest that the policy should be reviewed at the same time as improving information and support for women to minimise the number who come to hospital in early labour. [**Editor's note:** AIMS would like to see more midwifery support for women in early labour at home regardless of where they are planning to give birth.]

The development of MLUs presents an important opportunity to provide women with a broader range of birthplace options and a model of care that reduces the number of unnecessary interventions and avoids some of the risks associated with OU birth. To make the most of this opportunity, the health service must show strong leadership, make evidence-based decisions and rise to the management challenges identified by this study. The study noted that the existence of the current set of AMUs was not due to any commitment to this model of care among health service managers; they were simply a pragmatic response to a set of circumstances such as a perceived need to centralise all services on a single site. This suggests that the expansion of access to midwife-led care will require targeted advocacy work with health service management.

Andrea Nove

Andrea is a researcher and statistician with a special interest in maternal and newborn health.

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Zara's birth

Sandar Warshal tells the story of the birth of her grandson Raphael

What could be more important than one's own birth – perhaps the birth experience of one's daughter? This came home to me as I watched my daughter, Zara, make decisions about the birth of her first child.

I had worked for AIMS for 15 years in the 1980s and had seen women undermined by their birth experience. The dream of a supportive and drug-free labour seemed almost impossible to achieve. It might have been mentioned as a possibility, but when women entered the hospital their confidence was eroded and their births became highly medicalised events.

Thus, I was keen for my daughter to have an independent midwife and had offered her the choice. She felt very comfortable going to University College Hospital (UCHL) in London and birthing in the birth centre. I was extremely dubious that a natural birth would materialise but several of her friends had achieved this there. I offered her a doula which she was happy to have and this person taught her good coping mechanisms for birth as well as general information and support.

Zara and Raphael

Her midwife care was the usual; pleasant but anonymous. She never saw the same person twice. Zara is a healthy 34 year old woman so had no problems with her pregnancy besides the usual discomfort near the end. At nine days past 40 weeks, Zara's labour began one evening.

As it happened, Zara could be our poster girl for natural birth. She went through three days of labour completely relaxed and in control. It never occurred to her to do it any other way. She used 'hypnobirthing' which gave her confidence and coping mechanisms. She went in to UCHL after 24 hours of slow labour but they found she was only two centimetres dilated and sent her home. We had another 24 hours of increasing contractions at home so we went in again. This time they found she was four centimetres dilated so 'qualified' for the birth centre.

Zara was welcomed in a pleasant, unhurried way and shown her room. It was like a bland hotel except it had a big birthing pool, a low bed, a birth ball and various places to hang from. The midwife was easy going and nobody seemed unduly flapped by the previous 48 hours of labour. The baby's heartbeat was taken frequently and was strong.

Zara used the pool beautifully; flipping, bouncing, stretching, moaning and going with her body. The midwife murmured discreet encouragement and occasionally suggested ways to keep comfortable. After a long night, Zara reached full dilation.

She then had a very long second stage, by which time I was a little uptight but the midwife kept checking the heartbeat and remained calm.

Eventually, out came Raphael and his parents were overjoyed and proud. Zara felt triumphant and I felt my 15 years of working for AIMS had been more than worth it. I have despaired as Zara's contemporaries, who were all healthy women who chose a hospital birth, wound up with caesarean sections, unwanted drugs and inductions. Our birth was a perfect antidote.

Zara had absorbed faith and respect for her body as she grew up with a mother who was discussing and campaigning for natural childbirth. When it came time for my daughter to choose her way of birthing, I am so pleased she could go to a birth centre and find what she wanted.

I thank AIMS for its foresight and give masses of credit to UCHL who had the strength to set up a midwife unit and then let the midwives do their job. Our experience was textbook AIMS and I will always be grateful to you all for continuing the campaign.

Sandar Warshal

Poppy's story

Poppy Johnson talks about her decision to birth at home and how it was supported

I knew from the moment I saw the little blue line on the pregnancy test that I wanted a home birth, but I'm not small (I'm not sure how flattering I find the term 'borderline obese' but I suspect it is clinically accurate) and my family has a history of high blood pressure and diabetes, so I worried that I would be up against some opposition to my plans.

My booking appointment was a nightmare, where I felt that I was being steered down a path of damage-limitation and that all I was facing was closed doors – I hadn't even mentioned my wish for a home birth. The assessment seemed totally focused round my weight and how that could affect the size of my baby, how that could mean my labour would be long and painful, how my baby might get stuck half-born, how I might bleed heavily.... However, after a long and tearful phone call with a local doula, I decided to hire her and get better informed.

I sought out care from an independent midwife, hoping that would widen my options, but, after talking to several, I felt that hiring a midwife who lived more than two hours away wasn't going to get me the support I wanted either, so I decided to stick with my local NHS team and make sure that I got my emotional care and antenatal preparation from my doula.

By my next appointment I was feeling much more confident, and I fairly bombarded my midwife with questions and plans for making a birth in hospital as close to what I wanted as possible. I was stunned when she said, 'it sounds like you have done your homework, have you thought about birthing your baby at home? You will have much more freedom to make your own decisions that way.' I could have hugged her. That is just what I needed to hear.

I began to make plans, lists and lists of lists. My doula lent me all the AIMS books on her shelf, a stack of magazines and some really good articles on bigger mamas, and I met little real resistance to my home birth from then on. My community midwife (not the one I'd seen at the GP booking clinic) was supportive, telling me what risks or objections I might hear, and suggesting I read up and work out what I wanted for each of them. She kept telling me what the local policy was, but then reminding me that I was free to decide if I wanted to go that route or not. I felt like it was totally my decision. I'm sure having a doula helped me to go to those appointments feeling confident and sure of my knowledge, and that meant I could ask for what I wanted knowing just what I was requesting and why. I don't think you can underestimate the power of being sure in your choices.

I had intended to decline the glucose tolerance test, based on all I had read about the risks of being over-weight, having a big baby and how our bodies process sugar, but somehow I felt that I should pick my battles. I was certain that, although I'm large, I eat a healthy diet and get plenty of exercise and fresh air, I would not be diagnosed as diabetic. The results came back totally normal. I now feel wiser though because the test was truly awful. That amount of sugar on an empty stomach made me feel sick and peculiar, and interestingly that was my only remotely high blood pressure test of my whole pregnancy. Next time I will definitely say, 'Thanks but no thanks.'

I don't think you can underestimate the power of being sure in your choices

When my waters went, in the early hours of the morning, at 40+9, I called the maternity unit, and was calmly told that I should call back when my labour had been strong for at least a couple of hours, and that I perhaps should try to sleep if nothing much was happening. Sleep? No way. I was far too excited.

I niggled all that day, and as it started to get dark the following evening my contractions really got going. After a couple of hours of having to concentrate on my breathing and not being able to talk through contractions I called my doula and then my midwives. My doula arrived quickly. The midwives took a lot longer, which was good for me – I had been warned that might happen as they could be coming from some distance and they would meet up and come together. When they arrived they were lovely and very respectful of my birth plan which my doula shared with them before they came into my space. All was calm and peaceful, everyone sat drinking tea whilst I wandered my house, stopping every now and then for a contraction to pass. I thought I was still very early as I was not even slightly yelling for drugs. I declined vaginal examinations and listening to my baby's heartbeat, and I didn't hear either mentioned again.

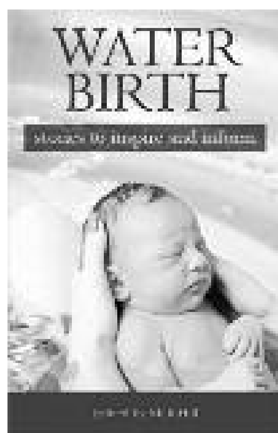
After about two hours (which feels both like two minutes and two days at the same time) of incredibly intense contractions and blissfully restful gaps my beautiful, 8lb 2oz, pink and squawking daughter emerged in one huge, triumphant, animalistic push, followed not long afterwards by her placenta. Then it was all over, and very soon we were happily tucked in bed, breastfeeding and eating toast, with no drama, just pure joy.

Poppy Johnson

Reviews

Water birth: stories to inspire and inform

By Milli Hill (Ed.)
Lonely Scribe 2015
ISBN 978 1905179138



This is a book of lovely birth stories collated and edited by founder of the Positive Birth Movement Milli Hill. All the stories are positive and uplifting, with a clear sense of the wonder and magic of birth and the calming, healing power of water. The births featured in this book are a far cry from the 'ordinary bad birth' that is currently so common in the UK and they will certainly inspire others to see labouring and birthing in water as a unique way to manage the sensations of labour and create an environment of relaxation. It had the added bonus of making me feel enormously broody, hoping that if I have another baby it is again born at home, in water.

However, I was disappointed with bits of the book. I think it was a missed opportunity as it frequently shifts the focus away from the women whose births are featured, 'passing the buck' back to the carers, which gave me the message that even though women are fighting so hard to reclaim their births, the focus is still on the carer. Nor does it have enough depth of information to be truly useful to professionals who are seeking water birth confidence or women who wish to make a case for water birth to family, friends or their care-team. I felt that the personal stories from professionals were a little out of place, because, whilst they were positive stories, I didn't feel quite comfortable that they were being told by 'experts' rather than women themselves.

The other splinter in my finger was how pervasive the image of birth attendants being somehow 'in charge' is; so much so that it has seeped, seamlessly, even into books such as this. The use of the word 'delivery' rather than reclaiming the word 'birth' felt like a huge oversight for me as an AIMS-educated campaigner. I was saddened by the realisation that virtually all the stories, with the notable exception of Melissa Thomas's planned unassisted birth in the bath, have an element of midwives being the gate-keepers. The incidences of the midwives setting store by dilation, telling women it is OK to push, being the first to touch the baby (even if it is to 'guide' or 'nudge' baby to mother) all stood out as stark reminders that even in a lovely book of extremely positive birth stories, it is hard to find examples of a truly 'hands-off' birth. I suspect that is much more a reflection on how far we still have to go in reclaiming our birthing autonomy than a criticism of the book, and if you want to immerse yourself in positive water birth stories, and don't mind the bits that irked me, this book is one of the good ones.

Katie Roberts

Do we need midwives?

By Michel Odent
Pinter and Martin 2015
ISBN 978-1-78066-220-6

A ludicrous question or a very provocative challenge?

It's hard not to be goaded by Michel Odent's insistence that we step back and ask some unlikely but vital questions about childbirth, midwives, and the future of humanity. Not all of these questions are new ones; he has been pursuing these trains of thought for some years and through his 14 previous books. Frustratingly, he does not provide many simple answers.

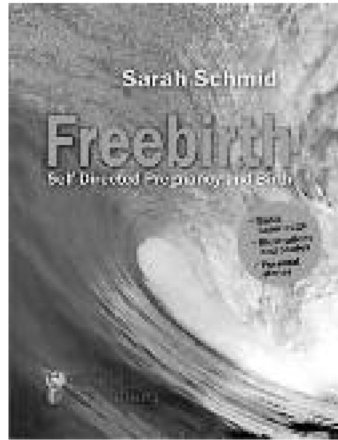
His interdisciplinary Primal Health Research Database (www.primalhealthresearch.com, www.wombecology.com) throws up fascinating links which demand to be followed up: risk factors for autism in the perinatal period, the dangers of neutralising the laws of natural selection and the effect on the evolution of Homo Sapiens in relation to the way babies are born are just a few. An example of one of the recommendations which emerges is that after the recent paradigm shift in brain science he argues that questions must be phrased differently: it should not be 'how to control labour pain' but 'how to make birth as easy as possible so that the physiological system of protection against pain is as effective as possible.'

Odent has been highlighting the importance of the microbiome for many years, well before the crowd-funded film Microbirth (2014) brought to our attention the work of scientists, as well as epidemiologists and anthropologists worldwide who are now researching variations in gut microbe populations and their impact on health. He refers to the film and speculates that microbes picked up in the passage through the vagina might not in fact be crucial as he believes that in prehistory many babies would have been born in the caul. His argument is that before the Neanderthal revolution women tended to give birth alone so that the innate 'fetus ejection reflex' was uninterrupted, and that since then the socialisation of childbirth has resulted in much increased difficulty in giving birth. His thoughts on this, as well as on every aspect of giving birth, especially, in my view, the importance not only of small, dark, quiet environments but, critically, of feeling unobserved, are incisive and exciting. *'Let us imagine a laboring woman in a small, dark and warm room. There is no one else present except for one experienced and silent midwife sitting in the corner knitting'*: this is the picture I want to take away to inform my campaigning.

Gill Boden

Freebirth – self-directed pregnancy and birth

By Sarah Schmid
Riedenburg E.U. 2015
ISBN 978 3902943866



When I became aware of this publication I was really quite excited. There were a couple of YouTube births that had inspired me. One, a birth at night outside surrounded by trees and one during the day whilst she stood, goddess-like, and birthed standing up in a doorway. These births were unassisted and no health professional was present. When picking up the title to read, I had expected personal accounts and a theme of the power of woman, intrinsic knowledge and a simplicity that only comes with undisturbed births: for the most part, I was disappointed.

The introduction and second chapter were by far the highlights of the book. The second chapter focuses on responsibility, fear and safety. There are a lot of words that encourage reflection:

'Our pregnancies are influenced in one way or another by other people's fears. But the most treacherous of all is a birth professional's fear.' (p20)

fear is how modern obstetrics has become the beast it is

There is a train of thought running through this chapter about getting women to own and face their fears which is something often ignored in antenatal education. Often, pre-birth, fears can be masked over with positivity without the time spent exploring them. The author acknowledges that fear is how modern obstetrics has become the beast it is.

The chapter on nutrition is great, but I guess women need to be at a certain place in their life journey to follow such a prescriptive diet.

The next part of the book really disappointed me. It was so complicated and quite medical in its focus, which made me feel like I was reading a do-it-yourself midwifery manual rather than a guide to a freebirth. It advocated women needing to know the position of their baby, which is simply not true, and there was lots of talk of measuring and analysing data. This felt dangerous. I am not sure I would want to have an obstetric mind whilst trying to switch off and go with what my body needed. This whole section reinforced a view of women not knowing enough intrinsically and that took away from a theme that I would have expected – that women are already the experts of their own bodies and babies. The sheer volume of information may have really over-stimulated some women and put women off having a freebirth, which is much simpler than this book suggests.

The chapters on birth stories had some pleasing elements, like hearing the views of men/partners. This would be helpful for partners unsure about taking responsibility. But the format was again overcomplicated and at first I did not know where to look on the page. It could have been simpler, instead of having a lot of repetition with bits of stories under separate paragraphs illustrating other points.

In conclusion, this may be a good book for a woman planning home birth with midwives and who is perhaps a person who needs to run through every scenario in order to feel less anxious. However, I do not think this is a great book for anyone planning a freebirth because it overcomplicates the simplest act of childbirth when alone without interference.

Hannah Robertson

Hannah is a mother, doula and antenatal advocacy worker

Hormonal physiology of childbearing: evidence and implications for women, babies, and maternity care

Executive Summary
By Sarah Buckley
Childbirth Connection, a program of the National Partnership for Women & Families. Washington, DC. January 2015.

Available with full report and related documents at:
www.ChildbirthConnection.org/HormonalPhysiology

Several generations of childbearing women in the UK have been exposed to the message that childbirth is dangerous and painful and that hospital birth with doctors available is necessary.

The evidence is now overwhelming that, for women without medical complications, birth away from hospital is not only as safe but also in many ways, and for many reasons, safer. Obstetricians are beginning to point out to women that caesarean section has negative outcomes for mother and baby as well as potentially lifesaving consequences for the few.

Sarah Buckley's report is a detailed and comprehensive review of evidence from human and animal studies of how unnecessary medical and other interventions in childbirth are causing harm to mothers and babies.

In the context of reducing health care budgets and closure of obstetric units this information is crucial in the campaign to improve out-of-hospital facilities for birth and properly to inform women of their relative benefits and risks.

Gill Boden

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News

Out-of-hospital safety

For this news page, we have provided details of a number of recent research reports (all available online) on the benefits of out-of-hospital births in several high-income countries. There is mounting evidence that for healthy women, giving birth outside an obstetric unit is safer for mothers because it reduces the rate of interventions, and that it is safe for babies. Some of us may well argue that if mothers have fewer interventions and are healthier themselves, this is safer for babies. This needs to be examined further.

Germany

A report in 2014 on 42,154 births with midwives in birth centres and at home is the largest ever carried out in Germany. It looked at health outcomes for mothers and babies, and also at the quality of the care provided and transfer rates. It concludes that:

'First, the data demonstrates the high quality of care that midwives provide to women in out-of-hospital births. For example, most of the women have spontaneous births, even if they have to be transferred to hospital during birth (transfer rate 12%). Second, the data serves as a baseline for the midwifery profession itself, one early outgrowth of which has already been the collaboration between the author and midwives' associations in establishing 17 professional goals to be met or exceeded in the coming years.

'The results of "A German Birth Study" are a challenge to conventional medical assumptions about birth. This book deserves a wide readership and much discussion.'

www.quag.de/quag/factsinenglish.htm

Netherlands

A 2014 study in the Netherlands which included 743,070 'low-risk' planned home and hospital births looked at outcomes for babies up to 28 days after birth. These outcomes included baby deaths, APGAR scores and admission to a neonatal intensive care unit. All the women included were healthy and, at the start of their labours, planned midwife only care. 466,112 women had a planned home birth and 276,958 women had planned hospital births. The authors found *'no increased risk of adverse perinatal outcomes for planned home births among low-risk women,'* and acknowledged that *'Our results may only apply to regions where home births are well integrated into the maternity care system.'*
onlinelibrary.wiley.com/doi/10.1111/1471-0528.13084/pdf

Another study is underway in the Netherlands to evaluate Dutch birth centres in order to provide good information to women, professionals, policy makers and health care financers about these centres. Its aims are:

1. *Identification of birth centres and measuring integration of organization and care.*
2. *Measuring the quality of birth centre care.*
3. *Effects of introducing a birth centre on regional quality and provision of care.*
4. *Cost-effectiveness analysis*
5. *In-depth longitudinal analysis of the organization and processes in birth centres.*

www.biomedcentral.com/1471-2393/15/148

nearly 94% of all the women had vaginal births

North America

Reported on in 2014, this North American study included 16,924 women who planned home births at the start of labour. This study was carried out by the Midwives Alliance of North America Statistics Project. It was partly initiated by a 41% increase in home births between 2004 and 2010. Nearly 90% of the women gave birth at home and nearly 94% of all the women had vaginal births. 11% of women transferred to hospital during labour and transfers after birth were rare (1.5% for mothers and just under 1% of babies). When babies with anomalies incompatible with life were excluded, the intrapartum, early neonatal, and late neonatal mortality rates were 1.30, 0.41, and 0.35 per 1000, respectively. The authors concluded that: *'Low-risk women in this cohort experienced high rates of physiologic birth and low rates of intervention without an increase in adverse outcomes.'* One weakness in the study is that not all midwives attending home births contributed to it. Further research comparing outcomes for similar women planning to birth in hospital will be a welcome addition.
onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

For a more detailed commentary see www.scienceandsensibility.org/research-review-outcomes-of-care-for-16924-planned-home-births-in-the-united-states/

Canada

Home births in Canada are now better supported for healthy women, and while in the UK researchers have looked at the costs of birth in different settings, this has not been done in Canada before. This study examined the cost of planned home birth compared with the cost of hospital birth in British Columbia, attended by registered midwives and physicians. It concluded that: '*Planned home birth in British Columbia with a registered midwife compared to planned hospital birth is less expensive for our health care system up to eight weeks postpartum and to one year of age for the infant.'*
journals.plos.org/plosone/article?id=10.1371/journal.pone.0133524

Many women tell us that they wished that they had found us earlier

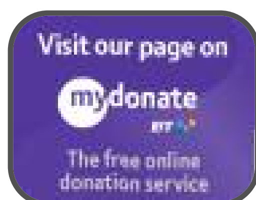
Help more women to find AIMS in time

The project	To raise £6,000 for the development of a new, professionally constructed website. Make the AIMS website **'The Website for Pregnancy and Birth Information'**.
Why	The new website will be easy to use, more appealing and accessible to a wider audience. We particularly want to reach those experiencing maternity care for the first time.
How soon	Now, but by 31st March 2016 at the latest.

Donate towards the new AIMS Website

mydonate.bt.com/charities/aims

RAISE FUNDS
We have plenty of ideas at www.aims.org.uk/?fundraising.htm. Have fun and raise awareness about birth whilst raising funds.



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Look out for an email from us about the questionnaire.
If you think we might not have your email address and are happy to be contacted by email, then email membership@aims.org.uk and we will add it to your membership details.