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NCT Briefing: Promoting and protecting opportunities for 'normal birth'

This briefing sets out NCT policy on promoting and protecting opportunities for 'normal birth' and provides a definition of the term. It provides evidence to show that normal birth rates have declined over recent years and explains some of the main reasons for this trend. It explores why normal birth matters to many parents using the maternity services and sets out the evidence about different kinds of birth. It demonstrates the benefits of straightforward vaginal birth with a minimum of clinical procedures, where interventions are not necessary for either the mother's or the baby's wellbeing. It describes some current initiatives to increase normal birth rates and proposes that all maternity services should be taking these kinds of positive action and auditing their normal birth rates.

What is normal birth?

The term 'normal birth' is shorthand for a vaginal birth without any of the medical procedures that are carried out in hospital by a specialist hospital doctor, including induction of labour, epidural or spinal anaesthetic, and the use of forceps, ventouse or caesarean section. The idea behind the term 'normal birth' is that it is the kind of care that can be provided either at home or in a birth centre by a midwife, though it is also possible in a hospital setting. There is a precise formal definition used for monitoring purposes which is discussed later.

It is useful to have a concept of 'normal birth' so that the different ways in which labour and birth are managed can be monitored over time and compared between different maternity service providers and different settings (home, birth centre, hospital).

NCT policy

- 1. All commissioners and providers of maternity services should be aware of the trends in birth interventions, and the clinical, human and economic costs of unnecessary increases in these interventions.**
- 2. Maternity services providers should recognise the benefits of straightforward vaginal birth, with clinical interventions avoided where there is no good evidence of benefit, and should take an active interest in promoting opportunities for normal birth.**
- 3. NHS trusts and boards should take action to improve the quality of care provided to women during labour and birth by:**
 - Offering a choice of birth setting, including access to home birth and care in a birth centre**

- **Enhancing the physical environment, providing an ambience, facilities and equipment which optimise comfort, privacy and calm, together with practical preparation for active labour**
- **Offering midwife-led care and providing one-to-one midwifery support in labour from staff who are trained and encouraged to provide emotional support, and to value normal labour**
- **Employing a consultant midwife to lead on the promotion and protection of normal labour and birth**

We believe that these practices will improve the quality of care for all women, making care more personalised and responsive to the physiological, social and emotional needs of women and their families. These practices also promote opportunities for women to have a straightforward birth.

- 4. Women and their partners should be told how they can increase their chances of having a straightforward birth so that they can make informed choices in planning their birth.**
- 5. NHS trusts, boards and maternity services liaison committees across the UK should measure and audit their normal birth rates using the definition set out in the *Normal birth consensus statement*.¹ Progress in increasing normal birth rates should be reviewed annually at management board level. Rates should be published and be fully accessible to the public.**
- 6. The NCT supports the policy focus in England, Wales and Scotland to offer women more choice and better access to community-based and midwife-led services with a focus on facilitating normal birth and reducing interventions that do not show a balance of benefit for mothers or babies.**

Briefing

The following sections of this briefing provide information to explain the historical and policy context in which the policy has been developed, together with relevant evidence and background information.

- 1. All commissioners and providers of maternity services should be aware of the trends in birth interventions, and the clinical, human and economic costs of unnecessary increases in these interventions**

Historical trends

During the 20th century the usual place to have a baby changed from home to hospital, with about 1% of women having their baby in hospital in 1900² rising to about 98% by 2000.³ Although during the same period, maternal and perinatal deaths fell dramatically, epidemiologists consider that this is unlikely to be a relationship of cause and effect.² Undoubtedly some reduction in mortality rates will be due to greater access to obstetric expertise and interventions, but much of it will be due to improvements in general health, increased wealth, reduction in family size, use of aseptic techniques and access to antibiotics. Current research indicates that for women at low risk of complications, home birth is as safe as hospital birth, and that safety is not determined by place of birth.⁴

The change in setting for birth has been accompanied by an increase in the management of pregnancy and birth by medical specialists and the use of medical procedures.

Year	Births at home (England and Wales)	Births in NHS hospital (England and Wales)	Induction Rate (England)	Caesarean Rate (England)	Instrumental Rate (England)
1955	33.4%	60.2%	13.0%	2.2%	4.4%
1990	1.0%	97.9%	18.3%	11.3%	9.4%
2009 (2007)	2.9% (2007)	96.5% (2007)	20.2%	24.6%	12.2%

Although intervention rates have risen, recently there have not been any corresponding improvements in health outcomes. Caesarean rates increased from 20.6% to 23.5% between 2000 and 2006 without any change in intrapartum perinatal mortality (baby deaths caused by factors during labour and birth).⁵

In recent years, attention has begun to focus on the whole pathway of labour and birth, and the proportion of women who have an entire labour and birth without medical intervention: beginning, progressing and concluding spontaneously. This has led to the development of a formal definition of normal labour and birth which can be routinely measured.

Formal definition of normal birth

The formal definition of normal labour and birth (termed 'normal delivery' for statistical purposes by the NHS Information Centre) is birth without induction, the use of instruments, caesarean section, episiotomy and without general, spinal or epidural anaesthetic before or during delivery. From 2003-06, normal delivery rates were published annually in England by the NHS Information Centre (formerly by the Department of Health Statistics Division). The voluntary organisation BirthChoiceUK has carried out the same analysis for the years back to 1995, and made estimates for the period 1990-1994.⁶

Analyses using this definition show that:

- During the period 1990-2001 the normal birth rate in England declined from 60% to 44%.
- The decline was largely due to increases in caesarean birth, instrumental delivery and induction.⁷
- Around half of all births in the UK are now medically managed.
- There are wide variations in normal birth rates between different maternity services providers across England. For example, in 2006, normal delivery rates in obstetric units ranged between 31% and 59%,⁸ averaging at 47%. Latest available rates for individual trusts and boards are available on the BirthChoiceUK website.⁹
- There are wide variations across Europe using the same definition. Not all European countries are able to calculate normal delivery rates, but of those that are able, Finland, Latvia and Estonia have higher rates (55-60%) and Malta and Slovenia have lower rates (27-33%). The Netherlands and Scotland have similar rates to England.¹⁰

The cascade of intervention

Increases in intervention rates may be fuelled by the so-called 'cascade of intervention'. It is hypothesised that the use of routine medical interventions early in labour can lead to the need for further interventions that tend to be increasingly invasive. For example, continuous electronic fetal monitoring may restrict mobility, making labour more painful for women and increasing epidural rates, or it may slow labour down, increasing rates of augmentation with oxytocic drugs which in turn can also make labour more painful and increase the epidural rate. Use of epidurals is associated with an increase in forceps and ventouse delivery. Continuous electronic monitoring, including the intention to carry out 'just' a twenty minute trace on admission, has also been shown to lead to a higher emergency caesarean section rate with no improvement in outcomes for babies.

Consequences of interventions

There are unintended consequences of this increasing 'medicalisation' of birth for women and their babies. Although caesarean births are now safer than they have ever been, there are still risks involved.

For babies born by caesarean this can mean:

- An increased risk of breathing difficulties – according to the NICE guideline on caesarean section, 35 babies out of every 1000 born by planned caesarean suffer from breathing difficulties compared with 5 babies out of every 1000 planned to be born by vaginal birth.¹¹

- An increased need for admission to a special care baby unit, which involves separation from their mother.
- A three per cent chance that the baby will be cut during surgery.¹²
- Babies may be less likely to be breastfed as abdominal pain can make it more difficult for some mothers to establish breastfeeding after surgery.¹¹ Important opportunities for skin-to-skin contact, known to facilitate bonding and attachment and to help breastfeeding, may also be diminished if the baby is in special care.

Consequences for mothers having a caesarean include:

- Women recovering from a caesarean are more likely to suffer from pain after childbirth than women having a straightforward birth.¹¹
- For large numbers of women, the pain together with other effects of major abdominal surgery such as tiredness and lack of mobility can make looking after a newborn baby difficult.
- Many women are advised not to drive for up to six weeks after surgery, which can be both inconvenient and isolating.
- More serious consequences affecting fewer women include wound infections, damage to their bladder or bowel; and DVT (deep vein thrombosis). Routine use of drugs to prevent complications has reduced the incidence of DVT and infections. However, hospital-acquired antibiotic-resistant infections, such as MRSA, are a growing concern in all large maternity units.
- There are longer term risks as well as immediate ones, as caesarean birth is associated with a small but significant increase in future infertility, stillbirth and placental problems.¹¹
- Women's experiences of caesarean birth are important, yet there has been little qualitative research. Some women feel disfigured by their scar and a few suffer long-term pain.

Consequences of other interventions include:

- Women recovering from an assisted delivery are more likely to suffer from pain after childbirth than women who had a spontaneous vaginal birth.¹³
- Women who had labour induced or augmented, or had an episiotomy or epidural, had lower satisfaction scores than if they had a straightforward birth, according to a survey of 1,300 women.¹⁴
- Women who had an epidural reported lower emotional well-being than those that did not.¹⁴
- Some studies have suggested that operative intervention made those experiencing these procedures more vulnerable to post-traumatic stress and depression.^{15,16}

Economic costs of interventions

It is difficult to estimate the cost of medical interventions. One estimate is based on the total care cost of a woman having a caesarean birth being £1,400 more than for a woman having a normal birth.¹⁷ This would result in a total cost of over £9m per year for every 1% increase in the caesarean rate in England. This does not take account of any public health cost associated with the intervention (e.g. short and long term costs of reduced breastfeeding and the increased likelihood of future operative births).

2. Maternity services providers should recognise the benefits of straightforward vaginal birth, with clinical interventions avoided where there is no good evidence of benefit, and should take an active interest in promoting opportunities for normal birth.

Birth is a normal physiological process and most pregnant women are fit and healthy. With appropriate support, the majority of healthy women are able to have a straightforward vaginal birth with minimal assistance. With support and practical preparation, many women will feel confident and empowered to aim for an active birth without analgesic drugs. They should always have a choice and know that they can change their mind at any stage. Most women prefer to avoid interventions, provided that their baby is safe¹⁸ and they feel they can cope.¹⁴

Evidence shows that improving opportunities for women to have a normal birth has positive benefits, both physical and psychological.^{14,19,20}

- Women who have had a spontaneous vaginal birth are less likely to suffer from pain after childbirth than women recovering from a caesarean¹¹ or an assisted delivery.¹³
- Women who have a spontaneous birth are more likely to initiate breastfeeding than women who have had a caesarean birth.¹¹
- A study in 2000¹⁴ showed that women reported higher satisfaction scores if they had had a spontaneous vaginal delivery than if they had had labour induced or augmented, or had had an episiotomy or epidural.
- In the same study, women who did not have an epidural reported higher emotional well-being than those that did.¹⁴
- Women who avoid such procedures have a greater chance of starting motherhood fit and healthy which may make them more able to cope with the demands of a new baby.
- For those who are vulnerable or disadvantaged, the opportunity for having a normal birth can be empowering and reassuring.^{21,22}

Women's own stories testify to the importance of birth in their lives, to the empowering and positive nature of birth without medical intervention and to the negative effect of interventions on their birth experiences and their transition to parenthood:

"The birth was a hugely empowering experience and after the birth I felt simply wonderful – my self-esteem was restored and I have noticed a huge improvement in my general wellbeing... The way a woman gives birth can affect the whole of her life – how can that not matter?"²³

3. NHS trusts and boards should take action to improve the quality of care provided to women during labour and birth by:

- **Offering a choice of birth setting, including access to home birth and care in a birth centre**
- **Enhancing the physical environment, providing an ambiance, facilities and equipment which optimise comfort, privacy and calm, together with practical preparation for active labour**
- **Offering midwife-led care and providing one-to-one midwifery support in labour from staff who are trained and encouraged to provide emotional support, and to value normal labour**
- **Employing a consultant midwife to lead on the promotion and protection of normal labour and birth**

We believe that these practices will improve the quality of care for all women, making care more personalised and responsive to the physiological, social and emotional needs of women and their families. These practices also promote opportunities for women to have a straightforward birth.

A number of practices can improve the quality of care provided to women during labour and birth. Many of these increase opportunities for normal birth without evidence of additional risks.

Offering choice of birth setting

Having choices about important aspects of their care matters to women. Having a baby is a physical and emotional challenge as well as a major life event and it is important for women and their partners to feel they can choose a setting which feels safe, comfortable and welcoming. For many women who have a

real opportunity to consider it, planning a birth at home or in a birth centre staffed by midwives is appealing.

Women who plan birth at home are more likely to be assisted by a midwife they know and therefore to feel relaxed and secure.^{24,25} They feel an increased sense of control and empowerment which is linked to better emotional outcomes. In addition, when including all women who transfer to hospital during labour, it is known that planned home birth reduces the likelihood of interventions such as caesarean,¹¹ instrumental delivery or an epidural²⁵ compared with broadly similar women booking a hospital birth. According to one large study undertaken in the UK, the rates of caesarean and instrumental delivery are halved for women who plan to have a homebirth.²⁵

Women who give birth in a midwife-led unit or birth centre are more likely to be satisfied with their care than women giving birth in.^{26,27} Women who plan this birth setting tend to have greater continuity of care than those planning a hospital birth²⁸ and also have positive views about aspects ranging from the home-like environment, receiving personalised treatment from a midwife they know and trust, to having a sense of control over the labour and birth.²⁷ Planning a birth in a birth centre also increases the likelihood of having a straightforward labour and birth.^{27,29} Where the birth centre is alongside a hospital obstetric unit, there are lower rates of epidural use and episiotomy.²⁹ Where the birth centre is at some distance from an obstetric unit, there are also lower rates of instrumental and caesarean births and of induction.²⁷

Despite a number of studies to compare the safety of birth planned at home, in a birth centre or in hospital, there is no good quality evidence that there is any difference in safety of birth between these options.³⁰ Women at low risk of complications should therefore be offered birth settings which provide social models of care, which develop relationships of trust between women and midwives and which enhance the opportunities for giving birth safely without medical intervention.

Enhancing the birth environment

Women labour most effectively when they are in an environment which is private, calm and comfortable. This relaxed ambiance allows the hormones of labour to flow naturally and helps labour to progress without the need for intervention.

During labour, women who are given a choice tend to adopt positions which relieve the pain of their contractions. They often move about in order to be more comfortable and use a variety of positions. Where women have been given a chance to practice different positions before labour, and have a suitable environment, they usually find upright positions to be the most comfortable. This is much easier when they are in an environment in which they can easily support themselves. Having equipment such as birthing balls, pillows, beanbags, floor mattresses and furniture of varying heights lets women choose a variety of positions to help relieve pain.³¹

A review of research has shown that upright positions may not only help women feel more comfortable but also speed up labour.³² This may therefore help a greater proportion of women give birth without epidural pain relief or having labour accelerated, thus potentially increasing normal birth rates. A study carried out by the NCT showed that women who had a vaginal birth had had better access to active birth equipment than women who had had an emergency caesarean.³³

It has been shown that immersion in water provides effective pain relief, so encouraging a woman to get into a warm bath or birthing pool will help reduce the pain of the first stage of labour, and mean she is less likely to need an epidural.²⁹ It is recommended that women are discouraged from lying on their backs in second stage of labour, when the baby is ready to be born, as this can increase pain and instrumental delivery rates.²⁹

Birth environments need to be designed with these recommendations in mind. The design of birth units should ensure women's privacy and dignity, provide access to a birthing pool and a place where women can labour and give birth supported in upright positions.³⁴

NHS trusts should ensure that all staff have up-to-date skills and knowledge to support those who choose to labour in positions of their choosing or immersed in water, and that the birth environment in all settings should promote the normality of birth.³⁵

Women and their partners should be offered realistic, positive and practical preparation for labour and birth, including the opportunity to develop physical skills such as adopting a variety of upright positions. This can make a significant difference to how they experience labour and how well equipped they feel to cope (see point 4 below).

Midwife-led care and support

All women should be given individualised care and support to address their anxieties and fears. Women prefer social models of care which recognise birth as an important life event and which allow them to develop relationships of trust with their caregivers. Women also have a need for support during labour to attend to their physical and emotional needs and to act as an advocate or make suggestions and provide information where necessary. For those women who are particularly anxious or vulnerable, it is especially important that they have the opportunity to really get to know the midwife who will be with them in labour, so that they can build up a trusting relationship. Great comfort can be gained from the security of receiving care from one or two known midwives who are experienced, calm, confident and empathetic.

Patterns of care which promote this include:

- A named midwife or small team of midwives having the main responsibility for a women's care from pregnancy through to the postnatal period ('midwife-led care')
- The continuous presence of a designated midwife during labour ('one-to-one' midwifery support)

A recent review of evidence concluded that midwife-led care improved women's experiences, providing them with more personalised care. Women were more likely to be cared for in labour by a midwife they had got to know, to feel in control during labour and were more likely to start breastfeeding.³⁶ Being well supported during labour results in higher satisfaction of women giving birth and reduces feelings of trauma.^{37,38,39}

As well as providing emotional benefits, midwife-led care also results in a reduced use of regional analgesia, fewer episiotomies and fewer instrumental births and increases the chance of a spontaneous vaginal birth.³⁶ Providing continuous, one-to-one personal support during labour reduces the need for medical interventions, including caesarean, forceps/ventouse and epidurals, and fewer babies need to be separated from their mothers in special care facilities. Therefore these patterns of care which allow women to form relationships of trust and feel supported also contribute to increasing normal birth rates.

In the UK, midwives play a major role in providing emotional support during labour. However support from a birth companion or trained female supporter such as a doula is also effective.

Maternity care providers and commissioners should ensure that maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time³⁵ and the RCOG has recommended as a minimum standard that women in established labour should receive one-to-one midwifery care.⁴⁰

Consultant midwives

The grade of consultant midwife was introduced in 1998 to allow experienced midwives to progress in their careers without leaving clinical practice. The consultant midwife's role includes: providing clinical expertise and leadership based on up-to-date evidence; caring for groups of vulnerable women and those with particular needs; and support for other midwives to enhance the quality of the care they provide. One focus of the role can be to promote normality in labour, placing women and their families at the centre of care planning. This can be achieved by providing preparation for active labour and birth for parents as well as leading on educational sessions promoting normality to midwives and obstetric staff

including student midwives. Normality can be promoted in all birth settings by consultant midwives working towards increasing the home birth rate and by developing birth centres. The Department of Health encourages using the role of the consultant midwife to promote normal birth.⁴¹

Trusts providing maternity services should employ a consultant midwife to improve the quality of care provided to women, thereby increasing normal outcomes in labour, and to support midwives and medical staff in enhancing their skills in keeping labour and birth straightforward.⁴²

4. Women and their partners should be told how they can increase their chances of having a straightforward birth so that they can make informed choices in planning their birth.

Parents need up-to-date evidence-informed information about straightforward birth. They also need to be informed about the opportunities for promoting normal birth which are provided by their local maternity services.

In particular parents need to be informed about choices they may have about different birth settings, such as home birth, a local birth centre or an obstetric unit. They should be informed that birth at home or in a birth centre increases the likelihood of having a normal birth without compromising safety for women at low risk of complications. Every woman should be given the opportunity to talk through her options for place of birth and should be able to change her mind, with the possibility of a final choice being made during labour.

Parents should also be informed about the benefits conferred by midwife-led care and about the likelihood of receiving one-to-one midwifery care during labour. This may be affected by a woman's choice of place of birth.

Birth preparation classes are important for giving women and their partners, and any other birth companions, a realistic understanding of what to expect during labour. These can prepare them for coping at home during early labour as well as in established labour in their chosen birth setting. Parents need information about the benefits for women of remaining upright and mobile during labour and of assuming an upright position for the birth of their baby.²⁹ Women should be given opportunities during antenatal preparation classes to try out a variety of positions as they are less likely to assume positions that are unfamiliar to them for the first time during labour.⁴³

5. NHS trusts, boards and maternity services liaison committees across the UK should measure and audit their normal birth rates using the definition set out in the *Normal birth consensus statement*.¹ Progress in increasing normal birth rates should be reviewed annually at management board level. Rates should be published and be fully accessible to the public.

The Normal birth consensus statement has suggested that maternity services should aim to increase their normal birth rates to 60% by implementing strategies which provide women with individualised, good quality care which support women to have a positive experience of pregnancy and birth.¹

A number of factors constitute the culture in maternity units and influence normal birth rates. The 'NHS Institute Toolkit: Focus on normal birth and reducing caesarean section rates' identifies a number of behaviours and practices which are important for promoting normal birth and reducing caesarean rates to a safe minimum,⁴⁴ without compromising women's positive experiences of birth.

Characteristics include a recognition that birth is a normal life event; staff who communicate freely and learn together; providers and commissioners who work together to agree quality improvement targets; and users who actively engage with the service to help inform service development.

As first-time mothers are more likely to experience interventions,¹⁴ one aspect of the Toolkit focuses on keeping a first pregnancy and birth normal. Using the Toolkit, maternity services providers are able to identify points on a women's care pathway through pregnancy, labour and birth where additional attention to good practice would further promote opportunities for normal birth.

A multidisciplinary team, including commissioners and user representatives should address the attitudes and practices which affect levels of medical intervention during labour and birth by using the NHS Institute toolkit to identify where improvements could be made to existing practices and behaviours. The effect of these improvements on the normal birth rate should be monitored.

6. The NCT supports the policy focus in England, Wales and Scotland to offer women more choice and better access to community-based and midwife-led services with a focus on facilitating normal birth and reducing interventions that do not show a balance of benefit for mothers or babies.

In all four countries of the UK, there is a policy focus on offering women more choice and better access to community-based and midwife-led services, with an explicit focus in England, Wales and Scotland to facilitate normal birth and reduce interventions. The NCT has successfully lobbied for, and supports, these developments.

In England, the Department of Health's National Service Framework³⁵ stated that "for the majority of women, pregnancy and childbirth are normal life events requiring minimal intervention". To improve choice for women, the Department of Health has set out its 'choice guarantee' that by the end of 2009 women will be able to choose where they wish to give birth, whether at home, in a birth centre or in an obstetric unit.⁴¹

In Wales, the All Wales Clinical Pathway for Normal Labour was developed as a response to the increasing levels of intervention during labour.⁴⁵ The Welsh Assembly Government's document 'A framework for realising the potential of midwives in Wales' aimed to develop "*Policy and practice that reflects birth as a normal physiological process for the majority of women*" and recommended that "*Maternity service policies should be reviewed and developed to ensure that they minimise intervention for women with normal pregnancies*".⁴⁶ To improve choice for women, the National Service Framework for Wales stated that pregnant women should expect to be "...given information about locally available services to allow them to choose the most appropriate options" and that "...women who choose home delivery as their birth option [should be] supported in that choice."⁴⁷ Their target rate of 10% home births by 2007 was not achieved but the rate did rise from 1.9% in 2001 to 3.7% in 2007,⁴⁸ being an increase in the number of home births of 122%.

In Scotland "women should have the right to choose how and where to give birth," including community maternity units for low risk women.⁴⁹ The Scottish Government Health Directorates has established the 'Keeping Childbirth Natural and Dynamic' programme which aims to maximise opportunities for women to have as natural a birth experience as possible.⁵⁰

In Northern Ireland, standalone community midwifery units are being developed in addition to 'alongside' units.

The Consensus statement on normal birth

The NCT has worked with other organisations to produce the Maternity Care Working Party Consensus statement on normal birth which contains recommendations for action for maternity commissioners, providers and NHS boards, and for government policy, funding support and action by other national agencies.¹

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