What do we mean by being evidence-based?

NCT’s definitions and rationale.

Mary Newburn, Head of Research and Quality
Acknowledgements

This document was developed in consultation with a range of NCT volunteers, practitioners (antenatal teachers, breastfeeding counsellors and postnatal leaders and students from each group), maternity services activists and NCT paid staff (including policy, research, information and communications staff and practitioner tutors). Thank you to everyone who came along and participated.

Workshops were held at a series of six regional events as part of the 2010-2020 Strategy Tour in England, Scotland and Wales. A further all-day stakeholder meeting was held at NCT’s UK office. NCT postnatal leaders’ management group, the NCT Academic Board and NCT research advisors were also consulted and several individuals provided very useful references. Thanks you to everyone who fed in ideas and comments.

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1. Introduction

NCT is committed to being parent-centred and evidence-based. This document provides an introduction to what NCT means by being evidence-based. It describes NCT’s approach to using evidence in producing information for parents, practitioners and professionals. It sets out our commitment to user involvement in research. There are short descriptions of some of the different kinds of research studies that evidence comes from. Another paper, ‘What does it mean to be parent-centred?’ is also available.

NCT uses high-quality scientific evidence from natural and medical sciences and from social science to inform our:

- information for parents,
- planning and delivery of parents’ services,
- internal guidance and public policies, and
- lobbying and influencing work, which is intended to achieve change at a population or political level.

As active representatives of pregnant women and new parents, NCT contributes to the design and analysis of new studies. NCT feeds into the scope and focus of research reviews and debates on research ethics. Sometimes NCT is invited onto research funding panels. NCT is an active advocate of service users being involved in research at all stages. This includes helping to set the research agenda, in-put into the methodology, assisting with dissemination and interpretation of the significance of research findings.

NCT draws on and disseminates published evidence about maternity care, maternity and child health services, and the transition to parenthood from a wide range of reputable external sources.

NCT carries out research, independently and in collaboration with others, to create new evidence on parents’ experiences, attitudes and views.

These studies are used to inform NCT’s service developments and advocacy work. The combination of evidence from medical and social science, and our own research on parents’ experiences enables us to speak with authority on the first 1,000 days of a child’s life and on women’s and men’s journeys into parenthood.
2. Introduction to terms and concepts

Evidence-based

An evidence-based approach means supporting claims (about experiences, associations or cause and effect) with appropriate data from rigorous research studies and referencing, using reliable, up-to-date sources. A range of different methodologies are used to produce evidence. These include different beliefs about the nature of knowledge and are informed by different theoretical approaches including, for example, positivism, critical theories, such as feminism, and learning theories such as social learning and adult learning theories. Evidence can relate to – or inform - the context, the process, the content/inputs, and the outcomes, impact or effects of an activity. For example, it can inform:

- what may be most needed by different people in different places (context);
- which kinds of approach or format (process) may be most likely to bring about a desired effect (outcome) or be considered acceptable (context/outcome); and
- what informational messages or clinical care (content/inputs) may fulfil a desired purpose or have harmful effects, or unintended as well as intended consequences (outcomes).

There is now a large literature addressing what different researchers, advocate and patient groups and professional groups regard as reliable healthcare evidence. However, this has existed for less than a generation. In 1989, publication of Effective care in pregnancy and childbirth, a huge two-volume book, brought together in one place for the first time the evidence on the effectiveness of care during pregnancy and childbirth. This was a breakthrough for knowledge; a real watershed moment. Iain Chalmers, who was awarded a knighthood for his services to healthcare, worked with NCT, speaking at NCT conferences and inviting representatives to give advice the Oxford National Perinatal Epidemiology Unit. Almost a quarter of a century later, there are many books and articles that provide a useful framework and introduction to key concepts (e.g. Rees, Bailey et al, Smith et al). Ideas about what it is to be ‘evidence-based’ continue to evolve and develop.

Evidence-based medicine (EBM)

Healthcare in general, and maternity care in particular, have been influenced by the ‘evidence-based medicine movement’. This movement, supported by epidemiologists, patients and healthy service users, policy-makers and healthcare providers, has been a coordinated and deliberate strategy to ensure that health services and treatments improve health and wellbeing and avoid causing harm. This aim can be summed up in one overarching concept, ‘clinical effectiveness’. Studies may compare two or three alternative treatments, or compare a treatment with no treatment (or watchful waiting). Treatments can include drugs, surgery and talking therapies. EBM also includes evidence on different approaches to delivering healthcare (e.g. bed-rest versus mobility, care at home compared with care in hospital, doctor-led care compared with midwife-led care, or planning for birth at home or in a birth centre, compared with planning for care in an obstetric unit).

NCT, along with professional bodies and other advocacy groups, supports the use of evidence to inform the development of services and enable informed decision making about treatment options. EBM involves combining:
• evidence from scientific research studies,
• the particular social and clinical circumstances of the individual (patient/woman/baby),
• their values and preferences, possibly with other contextual factors such as,
• features of the local healthcare services (the skills, experience and beliefs of the staff),
• local geography and factors affecting access to services.

Evidence-based information

Evidence-based information is information that is based on recently published, high quality, systematic reviews of evidence. This applies whether the information is intended for professionals, managers, policy-makers, or parents. Authors of evidence-based information need support from information professionals to search for and appraise the evidence form a wide range of sources. When NCT produces information, authors draw on existing named and dated reviews from reputable sources or carry out a thorough reviewing process themselves. Thorough database searches are essential to ensure latest reviews and primary studies are taken into account. A ‘systematic review’ involves:

• defining the research question explicitly (What is population of interest? What intervention or experience is the focus of enquiry? What is that intervention or experience being compared with? What are the outcomes of interest? (PICO))
• identifying all relevant studies
• appraising the studies and identifying those of good quality
• extracting the relevant information from the studies
• producing a written report of the data and
• reaching conclusions about the nature of the current evidence (an evidence statement).

Systematic reviews are often limited to particular kinds of study, such as randomised controlled trials (RCTs), because this evidence is less subject to particular kinds of bias than other kinds of study. Well-designed RCTs can answer some specific questions more reliably than other methods of research, such as ‘Does treatment A work better than treatment B, or better than no treatment?’ Like all research methods, RCTs have limitations and are not suitable for answering all questions. Research overviews, which draw on evidence from different kinds of qualitative and quantitative studies, can also be very useful. These can be either systematic or non-systematic, and their quality can be variable. The more complex the range of questions being considered the more challenging it is to maintain a consistent quality, of completeness and impartiality. Questions might include: What are the effects of a treatment? How does it feel? How is it viewed by different parents? How is it viewed by different professionals? ‘Realist reviews’, which take more of a practical, problem-solving approach, are a recent important addition to the review library.

Evidence-based information is expensive to produce as it involves many stages of work. First, primary research studies need to have been carried out on the question of interest. As described above, systematic reviews are needed to consider, and take account of, all of the relevant studies. The target audience always needs to be considered. What questions are important to them? After a phase of systematic searching, assessment and synthesis of evidence from different studies the information needs to be written and communicated in ways that different groups of parents find helpful. Some providers of evidence-based information, such as NICE, Cochrane and MIDIRS produce two or three different outputs: long, fully referenced, reviews, with data tables (useful for the most committed readers), shorter summary statements or documents (useful for busy professionals and health advocates) and/or a leaflet-length version (useful for parents or patients).
NCT lobbies for the high-quality, parent-centred, evidence-based information to be produced for parents, that is free from commercial interests. For example, NCT has lobbied the Department of Health for information for parents on different formula milks. From an NCT perspective, evidence-based information enables pregnant women and parents:

- to know about the effects of different kinds of behavior and lifestyle, such as diet, smoking, consumption of alcohol, exposure to sunlight, to stress/relaxation, exercise, breastfeeding and so on;
- to take an active and informed role in their own and their children’s health.
- to make informed healthcare decisions during pregnancy, birth, the postnatal period and the following months.

Most people feel more in control if they are better informed about a possible treatment. This information might include the known benefits, risks and alternatives, including what they involve and how they might feel. People need the opportunity to think about their instincts and to consider doing nothing for now (watchful waiting). However, different people have different preferences and ways of coping and complex information can be experienced as emotionally overwhelming or confusing. Being asked to make decisions about different healthcare options can be anxiety provoking. Professional/parent relationships are very important in maternity care and other healthcare services, as people experiencing change and stressful life events appreciate being listened to, having their feelings and concerns acknowledged, being treated with dignity and respect, receiving explanations and encouragement, and - if they ask for it – being given advice. **NCT does not give advice, in the sense of telling parents what they should do, as the charity supports the principle of informed decision-making. We are committed to respecting parents’ autonomy and their right to make decisions that feel right for them and their family, in the circumstances of their day-to-day lives.** NCT provides education, information, and one-to-one support from trained practitioners, as well as facilitating parent-to-parent support. The charity’s services encourage parents to:

- discuss and consider options,
- reflect on their beliefs and preferences,
- have access to relevant evidence, and
- take an active role in making their own decisions.

**User involvement in research**

Parents who are using maternity services or child health and family services, and their representatives and advocates, need to be involved in the production of research and information. This makes it more likely that studies and information designed for parents will be relevant, useful and acceptable to parents. It is important to be able to participate in setting the research agenda, designing research studies, and in analysing and reporting research findings. Recommendations and guidelines play an important role in the development of public policy and services, so the way these are framed can have a major impact on the lives of parents and their children. The interests, and the particular experiences and concerns, of parents and families should be addressed. Over recent decades there has been real progress in getting health service users’ perspectives (and parents’ perspectives) included in policies, service developments and clinical guidance. This positive trend is now well established. However, there are lapses where a top-down, highly medicalised approach may be adopted. Also, sometimes a public health approach can dominate the need to respect the needs and preferences of individuals and their rights to autonomy. So there remains a good deal more important work for NCT and others to do.
NCT contributes to clinical guidelines and quality standards for the NHS developed by NICE (the National Institute for Health and Care Excellence) relating to the transition to parenthood period. NCT also works with other groups and organisations that develop evidence-based information, such as The National Literacy Trust, the Tavistock Institute, One Plus One, Bliss, Fatherhood Institute, and Maternity Action.

Evidence-based guidelines

Evidence-based guidance is provided for the NHS in England, Wales and Northern Ireland by NICE to enable commissioners and clinicians to know how different treatments and approaches to care compare with one another. As with evidence-based information (see above), in order to provide evidence-based guidance the authors need access to up-to-date, high-quality, systematic reviews of evidence. Although guidance from NICE does not apply directly in Scotland, the reviews of evidence commissioned or carried out by NICE collaborating centres is often used to inform policies and protocols in Scotland. Depending on the extent and strength of the available evidence, NICE makes clear recommendations for the NHS to follow. When evidence is lacking, ‘good practice’ recommendations are sometimes made in place of evidence-based guidance.

NCT consults and uses reviews of evidence developed by NICE collaborating centres, and sometimes critically appraises the evidence independently.9-11 We often include extracts of NICE guidance to the NHS in our information for parents, and in policy briefings for NCT maternity activists.
3. What kinds of research studies does evidence come from?

Evidence that can inform parents, and those who work with parents, during the transition to parenthood comes from epidemiology and social science research. These disciplines examine different aspects of knowledge, in different ways, sometimes making different assumptions about what matters. Different disciplines tend to use different methods for carrying out research, but there can also be overlaps.

Epidemiology is the study of the patterns, causes and effects of health and disease in specified populations. Epidemiological evidence can be used for the following:

- to understand the health of populations (such as particular groups of pregnant women and babies)
- to understand the causes of health problems,
- to quantify the association between health status (outcomes) and determinants of health or disease (risks or protective factors),
- to test the effectiveness of interventions and
- to monitor changes in health-related behaviour over time.

The remainder of this section provides a short introduction to some of the kinds of study that produce evidence, all of which are used by NCT according to what kind of research is most appropriate to answer a particular question.

- **Randomised controlled trials (RCTs)** – These experimental studies are often described as the ‘gold standard’ method of research for comparing two alternative treatments. They involve ‘randomising’ people who have been informed about the study and freely consent, to different ‘treatments’, so that the effect of the treatment can be assessed. RCTs are designed to avoid particular kinds of bias that can affect other kinds of study. It is very important that a random method of allocation is used (over which the practitioners and the researchers have no control). It is usually preferable for the ‘patient’, the practitioner and the researcher to be ‘blind’ to who is in a particular treatment group and who is in a control group (receiving a ‘placebo’ or inert treatment, or usual care), so that the potential for bias is minimised. If different drug treatments are being tested this process of blinding is usually possible, but sometimes the ‘patient’ and the ‘practitioner’ cannot be blinded, e.g. in the case of immersion in water versus epidural for coping with pain during labour.

The main strength of the RCT as a research method is that random allocation limits the risk of both known and unknown bias. Unknown bias is caused by underlying differences between different groups of people which may influence outcomes. So, in summary, large, well-conducted RCTs provide high-quality evidence about different treatments. Where an intervention is complex, such as ‘providing peer support for breastfeeding’, the design of different RCTs can vary in many ways. Use of RCTs to evaluate complex interventions like this, involving many elements, is open to criticism. Results of an RCT may fail to identify – or even conceal - important aspects of what are the (potentially) efficacious aspects of the intervention (e.g. timing, dose, context, training, etc). Any treatment or intervention that involves the practice of a specialist skill, considerable commitment by the user, or complex interpersonal interaction is a complex intervention. Examples, respectively, might include management of the third stage of labour, self-hypnosis for labour, and counselling or educational services.
RCTs are usually not suitable for studying rare outcomes where huge studies would be required in order to show differences in outcomes. RCTs are costly to run and their accuracy depends on the data being as complete as possible, and reliably collected without the introduction of bias. From time to time, very large and costly RCTs are carried out when the results might have a major impact on health service practice and costs. The INFANT study is a very large RCT currently being run in the UK to find out whether using computer-assisted software to interpret the wellbeing of babies being monitored electronically during labour results in better outcomes for babies than midwives and obstetricians interpreting the monitoring print-outs without computer assistance. The outcomes of interest are fewer deaths and less impairment, such as cerebral palsy, in babies and rates of caesarean births.

- **Meta-analysis (reviews of evidence)** - To increase the strength of evidence (degree of confidence in the results), RCTs addressing the same or similar research questions can be combined in a statistical process called meta-analysis. Greater strength of evidence means it is possible to predict with greater accuracy what the results (outcomes) of a particular treatment will be, compared with another. The Cochrane Collaboration is the leading international body producing meta-analyses based on high quality systematic ‘reviews of evidence’. In summary, meta-analyses of several RCTs have more power than single RCTs and so are, generally, a very good source of treatment-related evidence. However, carrying out a meta-analysis involves many complex processes: agreeing inclusion and exclusion criteria, searching for studies, appraisal of study quality, and synthesis of data. There is a high potential for error. Reviewers usually work in teams where appraisal and data extraction is carried out or checked by a second independent person for quality assurance purposes. Discrepancies are then addressed and resolved. Cochrane reviews are generally of high quality as they follow detailed methodological steps and structures, and a process of peer review. NCT regularly uses Cochrane reviews.

- **Systematic reviews of evidence** - A review of evidence is only of the highest quality if it is based on a systematic search for all the relevant studies and the data from the high-quality studies are all brought together. It is important to include all relevant studies in order to minimise bias. Clearly, if some studies, particularly any large studies, are overlooked, this might affect the overall balance of the results. A systematic search for studies has the following qualities: it is thorough and fully documented, uses explicit search criteria, searches using all relevant synonyms (e.g. ‘premature’ as well as ‘preterm’). Ideally, any unpublished studies are identified for inclusion (to avoid publication bias) and sometimes additional unpublished data or further explanations are requested from the study authors. All located studies are assessed for quality. Many, but not all, systematic reviews include a meta-analysis, in which the data from several RCTs are combined and analysed together. In summary, systematic reviews of evidence have the potential to provide some of the most comprehensive and strong evidence, but must be carried out using best methodological practice in order to minimise errors and bias. It is useful to go to well established sources of reviews.
• **Cohort studies** – These are *observational studies* that follow a group of people or patients over time. The group is selected according to the ‘independent variable’ or focus of research interest. This might be:
  
  • a disease or condition (e.g. diabetes, clinical depression)
  • a behaviour (e.g. smoking, breastfeeding),
  • a medical procedure (e.g. vaccination),
  • one package of care rather than another, or
  • a sociodemographic factor (e.g. social class, educational level, poverty).

As well as the cohort of interest, there needs to be a suitable comparison group. There are various options: subgroups within a cohort may be compared, a comparison group may be drawn from the general population from which the cohort is taken, or a comparison group may be drawn from a group of people who are similar apart from having little or no exposure to the independent variable under investigation. In the latter case, participants are sometimes carefully matched by individual characteristics. Statistical analysis of correlations is carried out to estimate the effects of the independent variable on ‘outcomes’. These outcomes may be positive effects such as health and wellbeing or negative effects such as risk of death, disability or other aspects of poor health. ‘Dependent variables’ which might influence the way the independent variable affects the outcome of interest, are carefully controlled for in order to show as accurately as possible how the identified independent variable (e.g. smoking, breastfeeding, depression) affects health. For example, a study designed to assess whether breastfeeding is associated with an increase in IQ needs to control for social class and educational level, as these dependent variables (confounders) might account for any observed association.

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**A cohort study used by NCT – an example**

**Birthplace in England**

Recently a cohort study was carried out in England to compare the effects for a low-risk population of mothers and babies of planning to give birth in four different places: an obstetric unit (labour ward), a midwifery unit in a hospital alongside a hospital obstetric unit, a ‘freestanding’ midwifery unit, one without an obstetric unit next to it, and home. Around 65,000 women, identified as low-risk at the start of labour care, and their babies, were followed up through labour and birth and for the first four weeks afterwards to estimate the effects for the babies and for the women of planning care in different settings (see [www.bmj.com/content/343/bmj.d7400](http://www.bmj.com/content/343/bmj.d7400)) The ‘primary outcome’ of interest was a composite measure made up of adverse outcome of the babies (including death and potentially serious conditions which might lead to disability). Dependent variables which had to be carefully controlled for to try to ensure that only planned place of birth (the independent variable) was different, included parity (whether the mother had had a baby before), maternal age, gestational age, body mass index, marital/partner status, deprivation index, ethnicity and understanding of English. In this case, a cohort study was a good option as an RCT would be considered unethical, impractical or both. (It is considered unethical to remove women’s choice and randomly allocate them to different settings for care if they have a preference, and most do have an explicit preference. It would undoubtedly be very expensive to mount a large RCT, and it is arguably more policy-relevant to compare outcomes for those who actively choose a particular healthcare package.)
• **Social science studies** – Evidence from the social science studies, is a vital part of the evidence base used by NCT. Studies informed by Anthropology, Sociology, Psychology, History, Economics and Political Science have all contributed to the literature used to underpin NCT education, public policy, lobbying and information for parents. The transition to parenthood, is marked by major physical, social and emotional changes (growth, separation, new roles and relationships, loss, etc.) Becoming a parent is subject to a range of social sanctions and approvals, and is imbued with cultural and individual meaning. As well as having individual experiences, each person forms a part of different populations and groups about whom differences can often be identified and trends demonstrated. Social science disciplines provide evidence on many aspects of the social world including:

  - social norms, roles and values,
  - perceptions and experiences,
  - attitudes, beliefs and motivations,
  - inequality, diversity, life chances and access to services,
  - trends in behaviour and service provision across space and time,
  - how adults learn,
  - what influences group and individual lifestyle and behaviour,
  - models of care.

Social science research can be **quantitative** (reporting findings using numbers and descriptive statistics or more complex analytical statistics) or **qualitative** (reporting mainly in words, using ideas grounded in people’s narratives and abstract concepts as analytical tools). Social researchers use a wide range of methods including **desk research** using published materials and records, **surveys**, **observation**, **focus groups** and **interviews**. There are quality criteria for all of these different research methods. Social science research, and research and valuation that is informed by academic disciplines, is underpinned by theoretical perspectives and conceptual models.

**NCT has been influenced by many theoretical influences, including childbirth education theories**,¹³ **Rogerian counselling theory, feminism**,¹⁴⁻¹⁸ **adult education theory**,¹⁹ **social ecology theory and social learning theory.**

Some of these approaches have been explored and tested in empirical studies and some are used more as conceptual tools.

<table>
<thead>
<tr>
<th>Theoretical constructs used by NCT – an example</th>
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<tbody>
<tr>
<td><strong>Social and medical models of care</strong></td>
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<tr>
<td>A number of ‘models of care’ have been put forward in comparative theoretical frameworks for explaining the ways that different people may think about pregnancy and maternity care. These are based on different underpinning beliefs about women’s bodies, the nature of pregnancy, the appropriate relationship between women and their carers, and the role of professionals and the maternity services.²⁰ Walsh and Newburn have compared medical and social models of childbirth juxtaposing, for example, a focus of identifying and avoiding risk and disease with a more holistic focus on prevention of illness and protection of wellbeing,²¹ ²² and Newburn applied this to care in a birth centre setting (see Appendix).²³ Some writers use the term midwifery model rather than social model.</td>
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</tbody>
</table>
4. User involvement in research

NCT research activity includes influencing the research agenda and facilitating the involvement of parents and maternity services user representatives in research. The importance of user involvement in research has now become widely accepted. NCT supports a network for members who are interested in research. There is no need to have any particular qualifications or expertise to become a NCT research networker (sometimes called ‘RENs’ for short) as the philosophy behind the initiative is to make research as widely accessible and understandable as possible. As knowledge is empowering, it is vital that parents and services users feel that they have the means to find out for themselves about clinical, social science and health services evidence. They should be able to find out about the strength of evidence behind policies and protocols, to know where there are gaps in evidence and where the quality of available evidence is poor. This will enable them to be more actively involved in shaping maternity and child health policies, and the choices made available to pregnant women, partners and new parents.

As a parents’ charity, NCT is often invited to contribute to reviews of evidence and to assist in the development of evidence-based guidance. We try to respond positively to these requests and encourage organisations planning research-based projects to include funding in the budget to support user involvement. Individual research networkers and policy research staff are also asked to peer-review research papers and research funding applications.
5. What is evidence-based policy?

In a lecture to the Annual Campbell Collaboration Colloquium in 2004, Philip Davies argued that the development of evidence-based policy is a strategic as well as an operational activity, of immediate importance and useful for future generations of policy makers and practitioners.25 He said ‘the first line of response to unanticipated events or events requiring direction or decision-making should be ‘what is already known about the problem and what is not’.25 However, as well as drawing on evidence, policy-making must also be based on the ‘experience, expertise and judgement of decision makers’ as there are often gaps in the available evidence, where research has not been carried out, the quality of studies is poor or findings are equivocal.

As well as drawing on social and epidemiological evidence, NCT policy-making draws on the knowledge and experience of professional staff with social and health sciences backgrounds, who have a longstanding and deeply grounded knowledge of the charity’s developing perspectives on birth, infant feeding, parenthood, user advocacy and service developments, together with awareness of the wider policy and political context.

This knowledge, and judgements based on it, constitutes ‘valuable human and intellectual capital’.26 Davies sums this up succinctly, ‘a major goal of evidence-based policy is to ensure that policy making integrates the experience, expertise and judgement of decision makers with the best available external evidence from systematic research’.25
6. Summary

- NCT draws on and disseminates published evidence about maternity care, maternity and child health services, and the transition to parenthood from a wide range of reputable external sources.

- NCT carries out research, independently and in collaboration with others, to create new evidence on parents’ experiences, attitudes and views. The combination of evidence from medical and social science, and our own research on parents’ experiences enables us to speak with authority on the first 1,000 days of a child’s life and on women’s and men’s journeys into parenthood.

- NCT carries out research, independently and in collaboration with others, to create new evidence on parents’ experiences, attitudes and views. This is used to inform NCT’s service developments and advocacy work.

- This enables us to speak with authority on the first 1,000 days of a child’s life and women’s and men’s journeys into parenthood.

- NCT lobbies for the high-quality, parent-centred, evidence-based information to be produced for parents, that is free from commercial interests.

- When NCT produces information, authors draw on existing named and dated reviews from reputable sources or carry out a thorough reviewing process themselves.

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- NCT contributes to clinical guidelines and quality standards for the NHS developed by NICE (National Institute for Health and Care Excellence) relating to the transition to parenthood period. We also work with other groups and organisations who develop evidence-based information, such as The National Literacy Trust, the Tavistock Institute, One Plus One, Bliss, Fatherhood Institute, and Maternity Action.

- NCT consults and uses reviews of evidence developed by NICE collaborating centres, and sometimes critically appraises the evidence independently.\(^9\)\(^{-11}\) We often include extracts of NICE guidance to the NHS in our information for parents, and in policy briefings for NCT maternity activists.

- NCT regularly uses Cochrane reviews.

- NCT has been influenced by many theoretical influences, including childbirth education theories,\(^13\) Rogerian counselling theory, feminism,\(^14\)\(^{-18}\) adult education theory,\(^19\) social ecology theory and social learning theory.

- As well as drawing on social and epidemiological evidence, NCT policy-making draws on the knowledge and experience of professional staff with social and health sciences backgrounds, who have a longstanding and deeply grounded knowledge of the charity’s developing perspectives on birth, infant feeding, parenthood, user advocacy and service developments, together with awareness of the wider policy and political context.


9. Gyte G, Newburn M, Macfarlane A. *Critique of a meta-analysis by Wax and colleagues which has claimed that there is a three-times greater risk of neonatal death among babies without congenital anomalies planned to be born at home.* London: NCT; 2010.


Appendix – The focus and priorities of the medical and social models of perinatal care.

<table>
<thead>
<tr>
<th>Medical model of care</th>
<th>Social model of care</th>
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<tbody>
<tr>
<td>Women’s bodies are seen as poorly designed to give birth and breastfeeding is seen as</td>
<td>Women are seen as having a valuable opportunity, and the resourcefulness needed,</td>
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<tr>
<td>mysterious and unreliable. Labour is seen as potentially dangerous; a mechanical process</td>
<td>to give birth and feed their baby. Labour and lactation are seen as a highly evolved</td>
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<td>involving ‘passage’, ‘passenger’ and ‘powers’; simply a means to an end.</td>
<td>processes requiring understanding of the mind, body and environment; a life-enhancing,</td>
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<td></td>
<td>potentially spiritual experience.</td>
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<td>Identification and avoidance of risk and disease.</td>
<td>Prevention of illness and protection of wellbeing.</td>
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<tr>
<td>Treatment of disease.</td>
<td>Promotion of health.</td>
</tr>
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<td>Separation and dualism – separation of mind and body; perception of the mother and</td>
<td>Integration and holism - interrelationship between mind, body and social interactions;</td>
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<tr>
<td>baby as two patients, separation of carers and cared for.</td>
<td>the mother-baby seen as connected dyad closely connected with their carers (integration</td>
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<td></td>
<td>of biopsychosocial factors).</td>
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<tr>
<td>Liberal use of high-tech and pharmacological interventions with the aim of minimising</td>
<td>Sparing use of high-tech and pharmacological interventions with aim of working with</td>
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<td>pain and improving outcomes.</td>
<td>pain improving outcomes.</td>
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<td>‘Doing’ – with central regard for actions of the professionals which have been</td>
<td>‘Being’ – with central regard for self-awareness, observing and reflecting on the</td>
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<td>developed through modern science and technology.</td>
<td>impact of one’s influence, and safeguarding biopsychosocial processes which have</td>
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<td></td>
<td>evolved over millennia</td>
</tr>
<tr>
<td>A professional-focused maternity service – the status of staff (professional,</td>
<td>Mother-baby dyad and family-focused maternity service – where status is constantly</td>
</tr>
<tr>
<td>paraprofessional, non-professional) and parents is clearly differentiated, with</td>
<td>negotiated according to function and contribution; the contribution of each individual</td>
</tr>
<tr>
<td>highest to status and power accorded to those with professional scientific knowledge.</td>
<td>to biopsychosocial processes is recognised.</td>
</tr>
</tbody>
</table>

Source: Newburn,\textsuperscript{23} developed from Walsh D, Newburn M.\textsuperscript{21,22}