17 July 2009

Ms Claire Moore
Chair
Senate Community Affairs Legislation Committee
By E-mail: community.affairs.sen@aph.gov.au

Dear Senator Moore,

I am writing to you first and foremost as a mother and secondly as an Australian citizen to her elected representatives. I understand you are considering three bills before your Committee, which if passed, will not provide indemnity insurance to midwives and make home birth illegal. Although I did not have a home birth with my son, I feel appalled, very unhappy and honestly, a sense of panic that the Government wants to legislate to take away my individual choice on how I want to give birth. I would like to share with you my story and show you why I care so much about this issue.

My background

I am 35 years old and gave birth to my son, Aden, 7 months ago at Royal Prince Alfred Hospital in Sydney. Prior to becoming pregnant, I held a corporate position as the 'Director of Global Mobility, Asia' for Thomson Reuters, a large multinational financial services and media corporation of 50,000 staff world-wide. I was in charge of the expatriate program in Asia, managing all aspects of global relocation for staff and their families into and out of the Asia Pacific region. I was working overseas in Singapore as an expat myself for a number of years, before returning to Australia to have my child.

How I first heard about homebirth

During my overseas assignment in Singapore 2 years ago, I met a Dutch couple whom I was to become great friends with. The husband was the Asia Managing Director of a renowned international investment bank and had been posted by his European company to Singapore with his wife and three young children. He was well known within the financial markets and expatriate community in Singapore. His wife and I became good friends and she told me about the joy and dramas of the birth of her children, who were all birthed in water baths at their home in Amsterdam.

I listened to her stories about labouring at home….about her husband boiling kettles of water to keep the water warm in their hired birthing pool…about her older kids gathered around to 'help' mum give birth…about how one child was born in a record 30 mins- so quickly her husband didn't have time to fill up the pool…and about ordering her husband to make love with her right there and then to progress her labour along! They were such beautiful stories and so very different from what I had heard from family and friends about their birthing experiences of rushing to hospital, of lots of pain and lots of drugs and medical interventions like epidurals and caesareans. I had never heard anyone talk about giving birth without drugs before – heavens forbid –I didn't know it was even possible!
I was also really surprised to hear her tell me that the majority of women in The Netherlands birthed at home naturally and would never consider going to a hospital unless

something was seriously wrong. At the time, I remember thinking this was so unusual as I had never heard of it in Australia.

My pregnancy journey

I discovered I was pregnant at 3 weeks. What happened in the next 8-9 months was truly an enormous discovery journey for my husband and I, with so many twists and turns.

My GP confirmed the pregnancy straightaway and gave us a few numbers for obstetricians and I was told to "book one as fast as you can as they are all very busy and there is a baby boom in Sydney". I had no idea then that there were any other options besides the private obstetrician model of care that was told to me. I dutifully researched which obstetricians were the best and got my medical health fund ready.

It was only through talking to other people, that I found out other models of care available such as GP shared-care and midwife-led births in hospital. It was then much, much later via my own extensive research, that I found out about the option of engaging a professional independent midwife as an advocate.

My husband and I started researching different birth choices and we were astounded to find out about the high rates of medical intervention and caesareans. We found out that our best chance of getting a natural birth would be to go with a midwife-led model within a birth-centre. We discussed at length the benefits of hiring our own independent midwife to provide antenatal care from 6 weeks onwards, to birth and postnatal care. It sounded great to me- especially the fact that she would come to our house for all the antenatal checks, provide 24-hour on call advice throughout the pregnancy and during the birth, plus help with breastfeeding afterwards. The downside was that her fees would not be reimbursed by any health fund or Medicare, which seemed really unbalanced compared to the private obstetrician path. We also found out that there was no indemnity insurance. We weighed this all up, and felt the benefits outweighed the costs…we were lucky we could afford this.

Choosing to homebirth

The more I researched, the more I uncovered about my options. I remembered my friend in Singapore and her experience with positive, healthy births at home. I watched documentaries and read many books about it and found there was such a big climate of fear and ignorance in the community about home births. It seemed that many women had so much fear about birth from media stories and other women that they felt the only way they could get through it was to be completely drugged up so they couldn't feel it, or worse, under anesthetic in a caesarean surgery. I wondered how my mother and grandmother and other women in my family were able to 'get through' birth in the olden days without all this medical 'help'.

In my research, I found an article published in an international Midwifery magazine, that had a fantastic parable about cats and how they gave birth, and its parallels to human births. I've attached it here with my submission (***Andersen, T, 2002, "Out of the Laboratory: Back to the Darkened room"****.)*

I really hope you can read this article in conjunction with my submission. When I read it, it was a 'lightbulb' moment for me. Along with our other research, my husband and I then made a very conscious decision to try for a home birth with our first child.

The birth of my son Aden

We made extensive preparations for the home birth and learned about natural pain relief methods. Our midwife advised us about hiring an oxygen tank and having other medication available in case of problems. We also discussed different scenarios for when a homebirth would no longer be viable or safe and a hospital transfer would be necessary.

As it happened, our midwife detected elevated blood pressure and other complications in my pregnancy at the 36 week checkup and advised me to get tests done at hospital. She advised us that a home birth was now no longer an option, but that she would be our advocate and support in hospital. I had to go to hospital for an induction and was extremely grateful to have our private midwife with us the whole way helping me to negotiate the hospital system. It is through her professionalism, compassion, knowledge and respect for our choices, that I was able to give birth to my son naturally and drug free, even though we were classified as 'high risk' by the hospital.

I was given many doses of induction gel over 2 days to help my labour start naturally. I would not have known this was possible if my private midwife had not told us (I was led to believe you are only entitled to one dosage). I was also routinely offered and declined many other drugs such as syntocin for pain relief- even though I was not in a great deal of pain since I was employing natural pain relief methods such as active birth positions, acupressure and breathing techniques. At one stage during my labour, the attending registrar was going to give me an episiotomy (cut me) without my consent, and only stopped because our midwife told her that it was against my wishes and to give me one more push to get the baby out myself. Sure enough, I gave birth in the next push without tearing.

Even though I did not get the home birth I wanted, I am happy with the birth outcome I had given the circumstances. It really showed me that our private midwife had the health and safety of myself and my baby as her top priority.

Later, when I spoke with my family and friends about the birth, many were shocked to hear that I didn't succumb to an epidural or caesarean after being induced. One friend, who had similar complications in her pregnancy to mine, was filled with regret when she learned that she could have asked for more dosages of induction gel to try and get a natural vaginal birth. After 1 dosage of gel, she was offered the drug syntocin, which I've learned, escalates contractions and makes the labour quicker but more painful and the foetus prone to respiratory distress. After syntocin, her contractions were so painful, she was offered an epidural and then a caesarean. I was so very glad that I was able to avoid this escalation of interventions for my own birth.

Looking to the future

Although I did not achieve my goal of a home birth for my first child, I strongly want to give birth naturally and at home for my next child, provided the next pregnancy is healthy and low-risk.
I also want to hire the services of a private midwife once again as I think their services are invaluable. A birth conducted at home, in the hands of an experienced, professional midwife, has been shown to be safe for healthy women, having normal pregnancies.
As you may be aware there were media reports of a Netherlands study just released recently, which was the largest study into birth safety in the world. It studied 529,000 women who had birthed in hospitals and at home and concluded that:

> ***"planning a homebirth does not increase the risk of perinatal mortality and severe perniatal mortality among low-risk women, provided the maternity care system facilitates this choice through the availability of well-trained midwives '***
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> Source: De Jonge, A. et al (2009), Perinatal Mortality and Morbidity in a Nationwide Cohort of 529,688 Low-risk Planned Home and Hospital Births", International Journal of Obstetrics and Gynaecology.

The issue we face is that after July 2010, it will become unlawful for a midwife to attend a homebirth. They could face fines of $30,000 and/or 6 years jail if they attend a birth at home. How can this be when these women are professionals who care about helping women give birth safely, naturally and according to their personal choice? Independent midwives in private practice are highly skilled and have so much to offer our community.
Making private midwifery illegal will endanger the health and lives of women and babies as many will still choose to birth at home but without professional assistance.

Regardless of what personal views people may have on the topic of homebirth, the facts are that it is safe if done with an attendant medical professional (independent midwife) and the pregnancy is normal and healthy. It is a very individual birth choice made family by family. My husband and I did copious amounts of research and made our own informed decision about our birth preferences. To take this choice away by legislating against it, and driving it underground, is abhorrent to me and goes against everything that I know and believe in, within a free democratic society.

I strongly object to the changes the Bills represent and ask you, as our elected representatives, to defend my choice to birth the way I want – a choice that is open to women in other developed nations such as the United States, Canada, New Zealand, United Kingdom and The Netherlands.

I want to make my own choices that are in the best interests of my family and my health – not be dictated by others who disapprove based on their own ideology and personal interests. Please do not allow birth to be politicized. Thank you.

Yours sincerely,

Ms Beryl Truong

Out of the laboratory: Back to the darkened room

Tricia Anderson **was recently asked to speak at a MIDIRS Hot Topic study day on homebirth. Ironically she was needed to attend a woman giving birth at home and was not able to give her talk! So we are reproducing the text of her presentation below.**

Everyone knows that cats need to give birth undisturbed in a dark, secluded place - perhaps preparing a softly lined box in the darkest corner of the furthest room underneath the bed. And everyone who knows about cats understands that you must never disturb a cat in labour or a newly delivered cat and her litter of kittens. Otherwise the cat's labour will stop or she may reject her kittens. Everyone knows this.

But just imagine that one day, quite a long time ago, a group of well-meaning scientists decided that they wanted to study how cats give birth. So they asked anyone who had a cat, that when she went into labour to bring them to their laboratory – a brightly-lit, noisy, modern scientific laboratory where scientists could study them, by attaching lots of monitors and probes, surrounding them by strange technicians constantly coming in and out with clipboards... In the laboratory, the labouring cats could hear the sound of other cats in distress, and there were no private dark corners for them to retreat to, but only rows of brightly-lit cages under constant scrutiny of the scientists.

And the scientists studied the labouring cats in their brightly-lit cages for many years, and saw that their labours were erratic, how they slowed down and even stopped, and how heartbreakingly distressed the cats were. Their mews and their cries were terrible. They saw how many of the kittens were deprived of oxygen and were born shocked and needing resuscitation. And, after many years the scientists concluded *'well, it seems that cats do not labour very well'*.

Then, because the scientists were caring people and wanted to help the poor cats, they invented lots of clever machines to improve the cats' labours, to monitor the oxygen levels in the kittens; they invented pain-killing drugs and tranquillisers to ease the poor cats' distress, and drugs to make labour become regular and stop it slowing down. They even developed clever emergency operations to save the distressed kittens' lives.

The scientists wrote scientific papers which told everyone about the difficulties they had observed and how cats do not give birth very well, and all about the clever feline birth technology they had invented. The newspapers and television spread the word, and soon everyone started bringing their cats to the laboratory in labour, because of all their clever feline technology and of how many kittens' lives they had saved. Looking round at all the complicated technology, people were heard to say: *'This must be the safest place in the world for cats to give birth in'*.

Years passed, and the workload at the scientists' laboratories grew busier and busier. They had to take on new staff and train them in their feline labour techniques, and slowly the original scientists grew old and retired. But sadly the new up-and-coming technicians didn't know about the original experiment; they didn't even know it was an experiment. They had never seen cats giving birth in softly-lined boxes in the furthest, darkest corner of the furthest room - why, what a dangerous idea! They were absolutely convinced that cats do not give birth very well without a lot of technical assistance - why, think of all the years of scientific evidence they had collected - and would go

MIDIRS Midwifery Digest (March 2002) 12:1 pp. 65-69

home at night feeling very pleased with themselves for all their clever and good work in saving cats' and kittens' lives.

Sadly most midwives and doctors working today have trained and worked for most of their lives in that laboratory: and in that laboratory - which is of course, a modern consultant maternity unit - childbirth is in a mess. In this day and age of evidence-based practice, we talk so much of the importance of evaluating every intervention, and yet no-one is saying that we desperately need to evaluate the biggest intervention of them all - asking women in labour to get into their cars and drive to a large hospital where they are cared for by strangers.

The effects of now being well into the second generation of this en masse intervention are becoming increasingly apparent. In recent years a nationwide audit of maternity services in England has been undertaken by the English National Board. Their report for 1999-20001 makes depressing reading. Even though there are many small-scale initiatives to extend midwives' skills, expertise and scope of responsibility, the overwhelming finding is that the number of births attended solely by midwives is failing. In some services it is as low as 52%. There is a steeply rising amount of obstetric intervention, and fewer midwives. Caesarean section rates have risen dramatically, with rates above 20% now commonplace, and reaching nearly 30% in some hospitals. Inductions and instrumental deliveries are also on the increase, with many hospitals in England having rates of 1 5% and more. At the same time, the homebirth rate stays stubbornly more or less the same, nationally around 2%.

Most midwives and doctors have very little experience of birth outside the 'laboratory', and the older generation of midwives and doctors who remember when homebirth was commonplace have nearly all retired. The women we are caring for are the second generation of women to give birth in the laboratory - their mothers gave birth in hospital in the '70s, and now their daughters expect to fill our labour wards. It may be too late to turn back.

Why birth goes wrong in hospital

If we revisit the basic physiology of birth and accept that it is hormone-driven, it becomes obvious why childbirth does not work well in ‘laboratory’ conditions.

Very simply, we know that slow pulses of oxytocin are needed to make the muscles of the uterus contract. We know that powerful pain-relieving morphine-like endorphins are then released when the body enters periods of high stress that help a woman cope with the intensity of those contractions, taking her off into a withdrawn, dreamlike state. We know that there will be a lull between the first and second stages as oxytocin production decreases with the loss of pressure on the now fully dilated cervix. We know that as the fetus descends in the second stage there is another huge surge of oxytocin created by the distension of the vaginal vault that causes expulsive contractions, and that again in the third stage another surge in oxytocin causes the empty uterus to contract and the placenta to sheer off. We know that at the moment of birth, mother and baby have extraordinarily high levels of oxytocin and endorphins. These are never repeated at any other time in their lives, making them alert, open and receptive to each other - as Michel Odent might say, they are ripe to fall in love with each other.

We also know what can hinder or even stop this extraordinary process of labour and birth, and it boils down to two simple things. When a woman is anxious or frightened, embarrassed or angry her labour will not be effective because her stress hormones such as catecholamines and cortisol levels, will be too high, inhibiting the flow of oxytocin. Secondly, oxytocin – the hormone of release, vital in birth, in lactation and in love-making – can also be halted by the stimulation of our highly

developed rational brain. If a woman is being required to answer complicated rational questions, exposed to bright lights or if she feels she is being watched, feels vulnerable or must stay on her guard, her neocortex will be highly active to the detriment of the endocrine glands which produce the vitally needed oxytocin and endorphins. In both cases she will 'fail to progress' and muscular tension and ischaemia will cause labour to be more painful that it need be. Few women give birth in hospital without some pharmacological intervention and analgesia; the use of epidurals is now commonplace. Many women need them if they are to give birth in the 'laboratory'; nature would not organise labour to be unbearable, but mankind in its ineptitude has done so by insisting that women give birth on hard beds in cold, frightening places surrounded by strangers. We also know that stress hormones can pass across the placenta to the fetus – if the mother is highly stressed, so will the fetus be. New research has linked maternal cortisol levels to fetal cortisol levels' and, unsurprisingly, fetal distress is a daily occurrence on our labour wards. As the natural oxytocin is inhibited, haemorrhage is also a regular visitor.

To use Michel Odent's words, we see the 'pathological side-effects' of our inept disturbance of the natural process of giving birth on labour wards every day. We stress women by bringing them into modem 'laboratories' to have their children and then use syntocinon to 'fix' the slowing contractions and instrumental deliveries to rescue the distressed babies that are a result of what we have done. Higher mammals such as the chimpanzee, our closest relative in the animal kingdom, move away from their social group to give birth in private. We all have experience of how different we feel when we know we are being observed, and how differently we act when we are sure we are alone and nobody is watching. And yet we ask women to come into our labour wards where not only do we watch them, but we monitor and measure and document everything they do.

It is often the women who arrive at the labour ward door in advanced labour who are able to give birth without intervention – for no other reason than because there isn't time for the 'laboratory' routine to inhibit the natural labour process. Think about Dutch women giving birth at home who commonly only call the midwife when their cervix is seven or eight centimeters dilated, have no monitoring or interference throughout much of the first stage of labour' and yet have one of the best perinatal mortality rates in the world.' What does that tell us?

We know a lot about the type of managed childbirth that takes place daily in maternity units across the developed world - in our human laboratory – where women sit semi-recumbent on delivery beds while attached to monitors in brightly lit rooms, subject to regular internal examinations whilst being cared for by strangers, being told to hold their breath and push as midwives' hands fiddle at the perineum under a spotlight and proudly 'deliver' the babies. That's the kind of birth that has been studied in virtually all the randomised controlled trials and major research ever published. Indeed, we know so much about that kind of birth that many of us – midwives, doctors and sadly even women – have started to think of it as 'normal' birth. That's how most of us were trained; extraordinarily, that's how most student midwives are *still* being trained. Some of us who have spent our whole careers inside busy modem labour wards may wonder if there is, indeed, any other kind?

Birth of home

Helping women to give birth at home made me realise that there is – most definitely – another kind of birth. Working in the community and attending homebirths is often a significant turning point in a midwife's professional development. (The subsequent clash of philosophy is the cause of so much tension, horizontal bullying and personal pain on the labour ward.) At home, most of the techniques which seemed an intrinsic part of midwifery on the labour ward (and which were so stressful to learn!) are not needed. Multigravida and primigravida women give birth like Amazons to babies

that seldom need resuscitating – on all fours over the sofa, standing up holding on to the mantelpiece, squatting in the bath, often with children and other family members watching and encouraging. Take birth away from the laboratory and back to the darkened room, and the whole picture changes.

The research on homebirth confirms this impression, showing that homebirth is as safe, if not safer, than hospital birth for women at low risk of medical and obstetric complications. The latest Cochrane Review concludes that 'all low-risk pregnant women should be offered the possibility of considering a planned homebirth'.

But, if we truly believe in informed choice, the research evidence implies we should go much further. The new Royal College of Midwives (RCM) position paper on homebirth re-states the results of the National Birthday Trust Fund enquiry which found that women who gave birth at home, when matched with a similar control group, had roughly *'half the risk of experiencing caesarean section, ventouse or forceps delivery, and were less likely to suffer postpartum haemorrhage. Babies born at home were significantly less likely to have low Apgar scores or need resuscitation, and they also suffered fewer birth injuries'*. Women who give birth at home are more likely to feel relaxed and in control, need less analgesia and require less intervention, and have better emotional. outcomes. Women who have given birth both at home and in hospital overwhelmingly prefer home. Physiology explains clearly why all this is so. Midwives need to be honest with women about the risks of going into hospital, which may include: a one in four chance of having a caesarean section; a one in three chance of having some kind of instrumental delivery; a one in ten chance of acquiring a hospital-born infection – and no improved outcome for mother or baby.

Going back to the darkened room

Recent surveys of women's views demonstrate that, even in this age where giving birth at home is considered a minority activity, 22% of women would like a homebirth and yet only 2% achieve it. In our role as guardians of normal birth, one major strategy open to midwives that would increase our autonomy, broaden the choices available to women, raise the number of women who give birth normally – and be based on the best available evidence – would be a national, concerted effort to systematically increase the homebirth rate. With the current emphasis on evidence-based practice and woman- centred care, this strategy should form part of any Trust's clinical governance standards. Yet it has never been seriously explored as an option, and the question must be asked: why not?

In some areas where midwives are pro-active in supporting homebirth, the homebirth rate is around 20%. The Albany Midwifery Practice, working in a deprived area of South East London, has a homebirth rate of over 40%, which quickly scotches any myth that homebirth is the province of middle-class women only. They ascribe this to the fact that women in early labour are visited at home by a midwife, and then the woman can decide whether she wishes to stay at home or transfer to hospital. Why is there such a discrepancy around the country?

Midwife as gatekeeper

There has been a little research exploring the answers to these questions. The negative attitudes of many general practitioners are well-documented, but Hosein found that it was the personal attitudes and views of midwives that acted as a barrier to women being offered true choice about place of birth. Floyd found that only two midwives out of a sample of 44 routinely offered homebirth at booking. In reality, most midwives 'self-select' women who they think might be 'suitable' for a homebirth rather than offering it as a genuine option for all women. Midwives need to be honest

with themselves and consider how they are offering homebirth: I have heard some say they offer homebirth but the women on their patch do not want it.

Positive attitudes towards homebirth derive from midwives' previous positive experiences, education and knowledge and an autonomous view of women and midwives. Negativity arises from lack of confidence, specifically in clinical skills such as resuscitation, suturing and cannulation, inadequate support from fellow professionals and confusion over accountability and emergency services.

Midwives who were trained and have worked in the setting of a busy maternity ward, who have spent years surrounded by fetal distress, emergency deliveries and haemorrhages may have developed a fundamental disbelief in the normality and safety of birth. Like the laboratory technicians, they only know birth to be full of hazards. Unless they take the time to 'unpack' the physiology and understand the reasons why this is the case, they are unlikely to feel confident to care for women in labour outside a hospital setting, perhaps particularly for primigravidas. This disbelief can apply to midwifery managers too, who are then unlikely to support an enhanced homebirth service. This 'unpacking' is likely to be an uncomfortable process, as it involves taking an honest, critical look at the care that is given within the hospital setting.

Most midwives are not experienced or specifically trained for homebirth. The rather glib assertion that all midwives are qualified to practice in any setting on the point of qualification does not take into account the very different nature of working at home. There are very great dangers in taking the model of childbirth learnt in the 'laboratory' (where emergency facilities are at hand) into a woman's home. If a midwife uses the medicalised model of care at a homebirth, such as restricted maternal nutritional intake, regular vaginal examinations, restricted maternal position, enforced pushing, amniotomy and so on, she will re-create the maternal and fetal distress of the hospital in the home where there is no back-up nearby.

Midwives need to relearn safe homebirth skills, including understanding the natural labour hormones, the practicalities of active birth, supporting women through painful crises without recourse to pharmaceuticals, decision-making where there are no doctors, no monitors, no partograms, no active management of labour and no syntocinon, knowing when transfer is appropriate, and learning and practising emergency skills specifically for the unpredictable home situation. That there are very different skills involved is evident by how transfer rates drop significantly as midwives become more experienced and Bournemouth University has recently created a module for qualified midwives which addresses these issues. The recently published RCM position paper stresses that all students should endeavor to gain some intrapartum homebirth experience; this needs to be speedily endorsed by the new Nursing and Midwifery Council (NMC).

Midwives talk much about regaining their lost autonomy. In 1960, 33.2% of babies were born at home.' As birth moved wholesale into hospital in the 1970s and '80s, midwives lost their professional autonomy, a fact much bemoaned. One obvious way for midwives to regain their autonomy is to actively encourage birth at home, as homebirth is the province of midwives. But do all midwives really want genuine autonomy back, with all the responsibility it brings? A deeper-lying concern is that many midwives, having trained and worked in the protected environment of the 'laboratory', may not want the responsibility attached to homebirths. Being the only professional in a potentially isolated setting, responsible for the lives of both mother and baby, is an immense and sometimes overwhelming undertaking, yet one that is seldom mentioned in the literature or in the classroom.

Providing a busy homebirth service also incorporates the necessity of being 'on-call' and working long unsocial hours. Many midwives used to working clear-cut shifts that do not impinge on their home life are reluctant to change this arrangement. Other midwives who work where homebirths are rare and are used to being called only very occasionally may be reluctant to increase their homebirth workload. Being woken up at night soon loses its novelty and getting up at three am for someone you have never met is not much fun! It only starts to be tolerable if you are able to develop meaningful relationships with the women and families you are being woken up for. Working in a woman's home environment is also far more personal and the need to know the family more imperative. One of the issues restricting the development of homebirth services is the existence of large teams of midwives or integrated services in which midwives do not 'know' the clients they are having to get up in the night for. Woking in a woman's home environment is also far more personal and the need to know the family more imperative. One of this issues restricting the development of homebirth services is the existence of large teams of midwives or integrated services in which midwives do not 'know' the clients they are having to get up in the night for.

Midwives do not always get support the next day if they have been up all night, and may be called in to staff overstretched units. A thriving homebirth service is one argument for having separate employment of community midwifery staff by a Community or Primary Care Trust; the current trend towards integrating services means that the needs of a busy maternity unit will always take precedence.

The reasons that women are given for not being 'eligible' to have a homebirth range from 'your baby's too big or too small, it's your first baby or your fifth baby, you're too young or too old, your haemoglobin is too low, your blood pressure is too high', and so forth.' The entry gates for homebirth are very narrow, and midwives are not supported to take on even slightly complex cases. Widening the 'traditional' low-risk category and making it genuinely based on evidence rather than myth is another step in the strategy 'of broadening the entrance to homebirth.

Reducing the fear

There is another reason why we need to get birth out of the laboratory and back to the darkened room. Young women today are scared of birth; it has become a hidden ordeal in the medical world of the hospital. At homebirths, other women and girls can see birth as something not to be feared. I was struck when caring for a midwife in labour recently at home who said to me afterwards *"I closed my eyes and saw all the women who I had watched give birth, saw their strength, and I became one of them"*. By encouraging women to give birth at home we are also helping the next generation learn how to give birth.

Increasing homebirth

The challenge then is for each Trust to set a target of raising the homebirth rate and for them to audit their progress. The RCM has clearly stated that homebirth provision is part of mainstream maternity services and not an optional 'add-on'. Each midwife's homebirth rate should be audited and the level of information that women are getting about place of birth needs to be evaluated. The homebirth rate should be on the agenda of every Maternity Services Liaison Committee, and local and regional variations should be investigated until the birth lottery by postal code is eliminated. The new NMC should set a target that all student midwives should witness, perhaps, five homebirths. Why should not women in Belfast and Birmingham have the same opportunity of homebirth as those in Brighton?

MIDIRS Midwifery Digest (March 2002) 12:1 pp. 65-69

Raising the homebirth rate is clearly in the hands of midwives. It meets many women's wishes, increases the number of normal births, increases midwives' area of autonomy – in fact achieves all our goals. If we do not do it soon it may well be too late. Why aren't we doing it now?

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