

Midwifery Unit Network – Policy research briefing 1

Philosophy of care and policy on midwifery unit care

Mary Newburn, Sheena Byrom, Lucia Rocca-Ihenacho, Felipe Castro Cardona

This policy research briefing sets out what is meant by a midwifery unit and some of the history and philosophy behind midwifery unit care. It describes how midwifery-led units, or birth centres, have been established in many countries and documented in research. The paper introduces the current policy context in the United Kingdom (UK) and Europe, with some reference to international developments. There are references to the benefits of using a midwifery unit, including lower rates of intervention. The Maternity Unit Network policy research briefing *Evidence of clinical effectiveness*, provides more detail on birth outcomes.

Midwifery units and philosophy of care

A midwifery unit is managed by a midwife and staffed by midwives and maternity support workers. Guidance for running the unit, including eligibility criteria and clinical protocols, are often developed collaboratively by a multi-disciplinary group led by the lead midwife. In the UK, midwifery units can be ‘freestanding’ in a community setting or ‘alongside’ acute hospital services including anaesthetics, obstetrics and paediatrics. Midwifery units are often referred to as birth centres and have a distinctive philosophy of care, sometimes described as a social model of care.

The birth centre concept was first developed in the US as part of the ‘alternative birth movement’. Birth centres were created as a response to extensive medicalisation in hospital-based maternity care (Devries et al, 2001; Newburn, 2009). The founders of birth centres set out to do things differently. They worked within a social model of maternity care, with the purpose of promoting mental and social well-being rather than ‘merely the absence of disease or infirmity’ (WHO cited in Bradshaw, 1994). Midwifery units often aspire towards this vision, too (Walsh and Newburn, 2002a, 2002b).

Shallow considers a social model of maternity care to involve three key beliefs. First, rather than being an isolated medical event, birth is viewed as a part of the woman’s and the family’s social life leading to parenthood. Secondly, women’s bodies are seen as being well designed for labour, birth and nurturing a baby, so there is an expectation that the process will usually proceed without complication. Thirdly, ‘interventions are kept to a minimum and only used ... when complications do arise’ (Shallow, 2003). This was reflected in the statement of the UK Birth Centre Network:

Birth centres have a ‘commitment to pregnancy and birth as normal processes and to personalised care that recognises and respects the rights and wishes of individual women and their families, aimed at empowering

them to take responsibility and retain control of this significant life event’ (Rogers et al, 2005).

Midwifery units in the UK generally have explicit eligibility criteria, based on nationally-agreed guidance for women at ‘low risk’ of developing complications (NICE, 2014). The care is considered a positive option for healthy women with a straightforward pregnancy. Midwifery units or birth centres offering a social model of care with a focus on optimal care to protect and promote health and wellbeing can now be found in most European countries, in the US, Canada, Japan, Australia, New Zealand and Brazil (Esposito, 1999; Kirkham, 2003; Hodnett et al, 2012; Cunningham, 1993; Koiffman et al, 2009).

The way the vision of a more holistic model of care has been realised in practice has been documented in overviews (Kirkham, 2003); commentaries from specific settings (Groh, 2003; Shallow, 2003); qualitative research (Annandale, 1987, 1988; Coyle et al, 2001a, 2001b; Creasy 1997; Deery et al, 2007; Esposito, 1999; Walsh, 2006a, 2006b, 2006c, 2007) mixed methods studies (Saunders et al, 2000), and systematic reviews (Hodnett et al, 2012; Walsh and Downe, 2004). However, more than a generation since the alternative birth movement began in the United States, the model is still not the mainstream care option for healthy women with an uncomplicated pregnancy.

In the UK and across the world, many healthy women whose pregnancy is progressing normally have care in an obstetric unit. Though their care may be ‘midwife-led’ in some cases, the way that care is provided to ‘low risk’ women in obstetric units is different from care in midwifery units. Women have a different experience of labour and birth; they are less likely to have a spontaneous birth, without an episiotomy, ventouse, forceps or surgery (Hollowell et al, 2011; McCourt et al, 2014). Women booking for care in a midwifery unit are more likely to use a birth pool during labour and are less likely to need an epidural for pain relief (Hollowell et al, 2011).¹

Policy context - UK, Europe and internationally

In the UK it has been a central part of maternity policy that women should have access to midwifery-led care and choice of place of birth since 1993 (Department of Health, 1993). This has been supported by successive governments in all four UK countries (e.g. DHSSPS, 2012). Both in the UK and other countries women as service users have demanded more humanised services that enable them to feel in control and enjoy giving birth. *Maternity Matters* in England includes ‘choice guarantees’, including choice of access to a hospital unit, a midwifery-led unit or birth centre, and home birth (Department of Health, 2007). The government policy said ‘these units promote a philosophy of normal and natural labour and childbirth’. Current evidence-based guidance from NICE says that:

All women should be supported in their choice of setting wherever they choose to give birth. Women who are healthy with a straightforward pregnancy (low-risk) should be advised that ‘planning to give birth in a

¹ There is further detail on midwifery units as an emerging model of care in Newburn (2009).

midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit'. (NICE, 2014)

In Europe, where most countries have a fertility rate below two, 'limited family friendly services' is one of the factors cited as contributing to reduced family size (Iversen, 2015). While the principles of women's empowerment and informed decision-making, are valued (Avery, 2015), evidence shows 'large variations in the role, scope and funding of midwives' across Europe (Sandall, 2015). Though size of maternity units is recorded, there are currently no Europe-wide data on midwifery-led units (Sandall, 2015). The World Health Organisation calls for strengthening of midwifery and involvement of 'women and advocacy groups in the planning and monitoring of services to keep the core focus on the needs of women, infants and families' (Renfrew et al, 2015).

Internationally, there are growing concerns about the rise in birth interventions, the associated human and financial costs and health consequences (Renfrew et al, 2014; Holloway et al, 2011; Schroeder et al, 2011, NICE 2014, Sakala and Newburn, 2014). Midwifery researchers and others are asking urgent questions about how birth is managed, and the impact of intrapartum care on seeding of the human biome (Dahlen et al, 2014), the immune system and other health outcomes (Cho and Norman, 2013; Dahlen et al, 2013).

The Lancet midwifery series, which complements the State of the World's Midwifery 2014 report, highlights variation in midwifery-led care (Renfrew et al, 2014). In some countries with excellent outcomes, like New Zealand, skilled midwives attend 80% of all births. In the United States, in contrast, skilled midwives attended less than 10% of all births in 2012. Midwifery-led units tend to be created where midwifery-led care is both embedded in policy and well established in practice.

Even in countries which have had midwifery-led care for some time, there can be tensions between the established services and newer ways of working. Waldrenstrom argued that given the relative autonomy of midwives in Sweden, and their established role in relation to normal childbirth, establishing the birth centre concept should 'not (have been) a great challenge, but it was' (Waldenstrom, 2003:145). She identified tensions between the alongside midwifery-led birth centre and the obstetric unit staff regarding integration versus independence; management of primiparous women and outcomes for their babies; and an 'us and them' feeling (Waldenstrom, 2003). Related issues emerged from a recent UK study (McCourt et al, 2014). The researchers said:

'The alignment of physical, philosophical and professional boundaries is inherent in the rationale for midwifery unit provision, but poses challenges for managing the service to ensure ... quality and safety are maintained'.

In summary, this introduction to the history and philosophy behind midwifery unit care suggests that there is a need to:

- raise awareness about midwifery-led care and midwifery units that meet women's physiological, and psycho-social needs, and promote women's ability to give birth with midwifery care and support;
- share good practice, to explore tensions and ways of resolving them, and involve women and families in developing safe and satisfying services.

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