RCM Clinical Briefing Sheet: 'freebirth' or 'unassisted childbirth' during the COVID-19 pandemic

Topic

Guidance for midwifery services on 'freebirth' or 'unassisted childbirth' during the COVID-19 pandemic
(The term 'unassisted childbirth' will be used throughout the rest of the document, which also refers to the commonly used term 'freebirth')

Potential impact of COVID-19 in this topic area

As a result of staff shortages and service pressures in maternity and related services, including the ambulance service, during the COVID-19 pandemic, some maternity services have made the difficult decision to pause the availability of home and/or midwife led birth services in some areas. This means that some women may not be able to access the type or place of birth that they had planned. Women in this situation will be supported by services to adapt their birth plan to the different circumstances in a hospital maternity unit or any available midwife led unit. As a result of this reconfiguration of services during the COVID-19 pandemic, there are anecdotal reports that an increased number of women are choosing to have an unassisted birth in the UK during the COVID-19 pandemic due to the reduction in birthplace options.

A small number of women may find the prospect of a hospital-based birth very distressing and unacceptable to them, and therefore indicate to local maternity services that they intend to give birth at home without assistance.

Midwives are understandably concerned about women giving birth at home without assistance, as it brings with it increased risks to both the mother and baby. Skilled midwifery care during childbirth reduces the risk of neonatal and maternal morbidity and mortality (WHO, 2019; Renfrew et al, 2014).

Current key guidance for this topic – clinical care

Understanding why women choose to have an unassisted birth

There is a significant amount of evidence about why women choose to give birth 'outside the maternity system', either by choosing to have an assisted homebirth outside of guidelines or by having a birth without a healthcare professional present.

Some women choosing to have an unassisted birth have had a previous negative personal or traumatic experience of maternity services; they perceive the risks of attending a hospital to give birth as being greater than giving birth unassisted at home and they see 'interference' in the birth process as a risk.

Women may feel that freebirth is the only way that they can retain choice, control and autonomy over their bodies during the birth process (Feeley and Thomson, 2016; Holten and de Miranda, 2016; Plested, 2014; Jackson, Dahlen and Schmied, 2012).

During the COVID-19 pandemic there may be additional reasons why women do not wish to attend hospital to give birth; these relate to concerns about them or their baby contracting the virus; or because they fear their partner may not be able to be with them during labour and birth (particularly if their partner has symptoms of COVID-19).

<u>Considerations</u>

- When a woman indicates to her midwife that she plans to give birth without assistance, the maternity service should reach out to the woman to build a dialogue.

- This should include arranging for a midwife to spend time talking with the woman (and her partner, if appropriate) to understand more fully their concerns and reasons. This can be done virtually through a video call in order to adhere to social distancing guidance. It is likely to be beneficial and make dialogue easier if the midwife who is known to the woman and already has an established positive relationship conducts the discussion. If this is not possible, it is likely to be beneficial if the midwife has experience of supporting women in similar circumstances, for example a senior midwifery manager, PMA (Professional midwifery advisor), specialist or consultant midwife.
- If possible, provide continuity of midwifery carer during the antenatal period to enable a relationship of trust to build and support ongoing dialogue.
- During the conversation(s) give time for the woman to share what is important to her in relation to her psychological and physical safety.
- Explore why she wants to have an unassisted birth.
- The midwife should ensure that there is an opportunity to have a one to one conversation with the woman about her wishes and plans, without the presence of a partner or other family members. Consideration should be given to the possibility of coercion or pressure being placed on the woman to have an unassisted birth.
- **If coercion or domestic abuse is suspected, consider your safeguarding obligations and pathway for referral and support**
- Spend time explaining the evidence about any particular individualised risk factors for her and her baby of her intended birth plan.
- Ensure that the woman and her partner are aware of the need for safety of midwives when providing care, particularly in relation to exposure to possible or confirmed COVID-19. This will include explanation of infection control procedures and the wearing of PPE by midwives in homes or hospital settings.
- During the conversation(s), identify any previous trauma and consider the potential benefit of offering psychological support from an expert in birth trauma through an online conversation.
- Identify any misconceptions or misunderstanding about current practice or service provision in the area and provide the woman with accurate information. This is likely to include the possible timelines for the current service configuration, for example, if the homebirth service has been temporarily suspended, and the systems and policies in place in the maternity unit to reduce the risk of virus transmission in all settings.
- Ask the woman what plan for the birth would feel safe and acceptable to her and consider options of how to provide an individualised plan of care for her, while considering and explaining the impact on safety for other women of an individualised plan.
- Reassure the woman that she will continue to be offered usual antenatal and postnatal care even if she decides to have an unassisted birth.
- Give the woman time to reassess her decision and review conversation again.
- Advise the woman how to register the baby's birth, if she has had an unassisted birth.
- Document the discussion fully.

Understanding the law

Midwives should ensure that women have an understanding of their own rights in relation to childbirth and about the law in relation to unassisted birth and place of birth.

- It is not illegal for a woman to give birth unattended by a midwife or healthcare professional. Women are not obliged to accept any medical or midwifery care or treatment during childbirth and cannot be compelled to accept care unless they lack mental capacity to make decision for themselves (Birthrights, 2017).

- It is not appropriate for healthcare professionals to refer a woman to social services with concerns about the unborn baby, solely on the basis that she has declined medical support, as she is legally entitled to do (Birthrights, 2017).

It is illegal for anyone present during the labour or birth, to be undertaking the roles of a midwife or doctor. According to Article 45 of the Nursing and Midwifery Order (2001), it is a criminal offence for anyone other than a midwife or registered doctor to 'attend' a woman during childbirth, except in an emergency. Birth partners, including doulas and family members, may be present during childbirth, but must not assume responsibility, assist or assume the role of a midwife or registered medical practitioner or give midwifery or medical care in childbirth.

The role and responsibilities of the midwife

A number of key sections of the NMC Code set out the responsibilities of midwives, that can be related to caring for women who identify that they wish to give birth without assistance or choosing to give birth at home outside of recommendations for homebirth:

Prioritise People

- Treat People as individuals and uphold their dignity
    - Treat people with kindness, respect and compassion.
- Listen to people and respond to their preferences and concerns
    - Respect, support and document a person's right to accept or refuse care and treatment.

- Act in the best interest of people at all times. To achieve this you must:
    - Balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment. (sections 1, 1.1, 2, 2.5, 4 and 4.1 of the NMC Code, NMC, 2018)

Preserve Safety

- Recognise and work within the limits of your competence.
- Always offer help if an emergency arises in your practice setting or anywhere else.

To achieve this you must:

- Only act in an emergency within the limits of your knowledge and competence.
- Arrange, where possible, for emergency care to be accessed and provided promptly (Sections 13, 15, 15.1, 15.2, NMC, 2018)

Considerations:

- It is natural that midwives will feel anxious about the safety of women and families in their care and have a sense of responsibility for outcomes, even if they have no control over them.
- Women have the right to choose care that goes against the advice of their midwife. If a woman chooses to have an unassisted birth, the midwife has a responsibility to inform her about the risks of that decision. The midwife is not responsible for the outcome of the unassisted birth.
- If a woman chooses to have an unassisted birth, the service will need to ensure that the woman is informed that a midwife may not be available to be sent out to her at home during labour and birth, if she changes her mind and wishes attendance during the birth. If the woman decides she wishes to have professional care during labour and birth, she may need to attend the maternity unit.
- If a midwife is caring for a woman planning to have an unassisted birth or wishing to have a homebirth with risk factors that would suggest she would be safer to give birth in a hospital, the midwife should be offered the opportunity to discuss their concerns and plan of care with their manager. Midwives will also benefit from seeking support through midwifery supervision or professional midwifery advisors (PMA) or other peer support.

Service provision during the COVID-19 Pandemic

Midwifery service leads will need to use judgement and guidance to seek to provide safe, high quality maternity services during the pandemic for the women in their care and this will, on occasion, require making difficult judgement calls about what services can be safely provided.
The rights of women to choose their preferred place of birth will need to be balanced against the rights of all women to receive a safe level of midwifery care.
Where a service lead is making a decision about temporary suspension of some services, including homebirth, as a result of the pandemic, they should inform their Trust Board or NHS Board and commissioner and seek advice from their local legal department. Principle 6 of the NHS Constitution identifies that the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. As the NHS is funded by public money, this principle highlights the importance of using this funding fairly in a way that benefits everyone the NHS serves. The NHS seeks to maximise benefits within the constraints of limited resources.

Maternity service leads should ensure that clear information is provided to all women booked to give birth in their service about current service configuration that is updated regularly, through the service website, social media and through the service's Maternity services liaison committee (MSLC) or Maternity Voices Partnership (MVP).
Senior midwifery managers should be informed of any woman who is planning to have an unassisted birth. The senior midwifery management team should then assess what individualised, flexibility of service provision might be possible to avoid an unassisted birth as far as possible.
Current guidance from NHSE, RCM and RCOG recommend that services should use a phased approach to service configuration based on judgements around staffing shortages, skill mix and the accessibility of paramedic and ambulance services in an emergency. This approach should ensure that any cessation of homebirth or midwife led services is only short-lived and provision is reassessed continually. Such an approach should reduce the possibility of an increase in unassisted birth.

Current Evidence base

References and links to online and virtual support and guidance

Birthrights (April 2017) Unassisted Birth Factsheet. Available at https://www.birthrights.org.uk/factsheets/unassisted-birth/
Birthrights (April 2017) Information about consenting to treatment and assessment of mental capacity: https://www.birthrights.org.uk/factsheets/consenting-to-treatment/

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The Nursing and Midwifery Order (2001) http://www.legislation.gov.uk/uksi/2002/253/contents/made

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Rigg et al (2017) Why do women choose an unregulated birth worker to birth at home in Australia: a qualitative study; BMC Pregnancy and Childbirth, vol 17, no 99 https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-017-1281-0

Renfrew et al (2014) Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. The Lancet, vol 384, no 9948, pp 1129-1145 https://www.ncbi.nlm.nih.gov/pubmed/24965816

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