Royal College of Midwives

The Re:Birth Project, Final Report

July 2022

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Introduction: Why Re:Birth?

In the UK, and particularly in England, there has been an increasingly heated debate around the term ‘normal birth’. The word 'normal' is universally used to describe a range of other physiological states, such as 'normal blood pressure’, ‘normal lung function’ or ‘normal fetal growth’. Similarly, its use in relation to labour and birth has evolved as a standard way across the world of describing the physiological process of labour and birth. It is included in the ICM definition of the midwife’s role.

The ‘Ethical Framework for Respectful Maternity Care During Pregnancy and Childbirth’[1], produced by the International Federation of Obstetrics and Gynaecology prescribes ‘supportive, individualised and value-based’ care, ‘served as a partnership model between health care practitioners and the ‘MotherBaby–Family’ as well as a requirement to ‘promote practices proven to be beneficial in supporting the normal physiology of labour, birth and the postpartum and neonatal periods’.

However, some have argued that the term ‘normal’ suggests that other births: those that don’t conform to particular criteria, may be viewed as ‘abnormal’, despite a positive outcome for both mother and baby. Others have asserted that interest in this type of birth has led some maternity professionals to steer women towards or away from certain choices.

These public conversations have raised questions about all the terms we use to describe different types of birth. How can we ensure that the language we use helps support safe and high-quality care? Which terms serve our maternity community best? Many of those involved

[1] International Federation of Gynecology and Obstetrics. (2021). ‘*FIGO Statement: Ethical Framework for Respectful Maternity Care During Pregnancy and Childbirth*’. Available from: www.figo.org/resources/ figo-statements/ethical-framework-respectful-maternity-care-during-pregnancy-and-childbirth .

in maternity care, including the Royal College of Midwives, believe that this language needs to be reviewed and, in a sense, reborn. Hence, Re:Birth.

Organisation and governance of the project

The UK-wide Re:Birth project was led by the Royal College of Midwives (RCM) and a multidisciplinary, multisectoral Project Oversight Group (POG). The POG brought together representatives from service user organisations Sands, Birth Trauma Association, NCT, AIMS, Maternity Engagement Action, Five X More, Make Birth Better and Birthrights; professional organisations including the Royal College of Obstetricians and Gynaecologists (RCOG), National Maternity and Perinatal Audit, International Confederation of Midwives, NHS England, Lead Midwives for Education Network, Consultant Midwives Network, Obstetric Anaesthetists' Association, British Association of Perinatal Medicine and Doula UK, plus clinicians, maternity researchers and those involved in developing maternity policy. The POG met quarterly, with regular interim correspondence by email, contributions to the development of the methods and feedback on draft documents. The POG's independent chair was Shirley Cramer CBE. The full list of Group members can be found in at the end of the report.

Dr Mary Ross-Davie was the lead for the project from within the RCM. She is a midwife and researcher. The project was coordinated and facilitated by Dr Juliet Rayment, RCM, Re:Birth Research Fellow, who is a sociologist with a background in maternity services research.

The project aims and values

At the start of the project, the Oversight Group defined their hopes for the project:

We, the Project Oversight Group, hope that the project will:

1. Place the voices of families/ service users at the centre
2. Lead to a clear, mutually respectful consensus about the language we use about types of birth cross all parts of the maternity community through real listening
3. Support progress towards maternity services that have a clear shared aim and work in a truly collaborative way – with service users and between professions – to ensure that individualised needs and preferences are respected and addressed.
4. Enhance understanding of the role of midwives in providing universal care to all women regardless of their complexity or risks and in supporting normal physiological processes.

In response, the project was founded on five core values:

Collaboration – we want to work with everyone involved with or who cares about birth

Inclusivity – we would rather include more voices than exclude

Openness – we are open to any outcome

Listening – we prioritise listening

Evidence-based – we will ensure the process is rigorous and evidence-based

Brief background and context

This report focusses on the findings of the qualitative and quantitative elements of the Re:Birth consultation. We have published two accompanying papers, which offer more background on the role of the term 'normal birth' and 'normality' in UK maternity policy and other influences on contemporary midwifery practice. The first paper discusses the use of the term 'normal' to describe the scope of midwives' practice in Midwives Rules and Standards (1980 to the present) and a sample of the two core midwifery textbooks: Mayes and Myles. The second looks at the concept in UK maternity policy since 1993.

The review of the Rules and Standards found that there has been a significant change in what is expected of both women and midwives in maternity care during the last 40 years. This period has seen a rise in expectations of informed choice, women's rights and decision-making, which is reflected both in the Rules and Standards for midwives and how decision-making is described in midwifery textbooks through that time. The role of the midwife has also changed and developed to include providing universal care for all women, including those requiring medical interventions and in promoting public health and mental health.

The term 'normal birth' has not been part of the statutory definitions of the role of the midwife over the last 42 years, but a central element of her role has been to 'support physiological processes', including when medical intervention is carried out. The term has featured increasingly in midwifery textbooks since the 2000s and is also used widely to describe 'normal physiological processes' such as 'normal lung function', 'normal kidney function' or 'normal blood pressure'. The use of the term across the world to describe a particular type of birth has evolved from the ground up, through everyday talk, and as such is now a loose and variable definition.

Several Anglophone countries, including the USA[2], New Zealand[3], Canada[4] and the UK[5], as well as the World Health Organisation[6], have published definitions, or consensus statements on 'normal birth' to try and pin down the concept and aid data collection and monitoring of this type of birth. However, there are broad differences between these definitions, such as inclusion of induction, epidural analgesia, active management of the third stage and maternal and neonatal outcomes.

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[2] American College of Nurse-Midwives, Midwives Alliance of North America, National Association of Certified Professional Midwives. (2012). 'Supporting healthy and normal physiologic childbirth: A consensus statement by ACNM, MANA and NACPM'. Available at: https://mana.org/sites/default/files/pdfs/Physiological-Birth-Consensus-Statement.pdf (Accessed July 2022)

[3] The New Zealand College of Midwives (2006) 'Consensus Statement: Normal birth'. NZCM. Available at: https://www.midwife.org.nz/wp-content/uploads/2019/05/Normal-Birth.pdf. (Accessed July 2022)

[4] Society of Obstetricians and Gynaecologists of Canada, The Association of Women's Health, Obstetric and Neonatal Nurses of Canada, The Canadian Association of Midwives, The College of Family Physicians of Canada, and the Society of Rural Physicians of Canada (2008). 'Joint Policy Statement on Normal Childbirth'. Journal of Obstetrics and Gynaecology Canada 2008;30(12):1163–1165

[5] NCT/RCM/RCOG (2009) 'Making normal birth a reality Consensus statement from the Maternity Care Working Party our shared views about the need to recognise, facilitate and audit normal birth'. NCT/RCM/RCOG. Available at www.oaa-anaes.ac.uk/assets/_managed/editor/File/Documents/2009_normal-birth-consensus-statement.pdf. (Accessed July 2022)

[6] WHO (1997) 'Care in normal childbirth: A practical guide'. World Health Organisation, Geneva. Available at: https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2413/2014/08/WHO_FRH_MSM_96.24.pdf (Accessed July 2022).

The language of maternity care

There has been long attention on some of the everyday words used in maternity services, particularly the use of 'delivery' and 'delivered' in place of 'birth', but also other terms that attribute negative, often anthropomorphic, qualities to women or their body parts such as 'incompetent cervix', 'geriatric pregnancy' or 'poor maternal effort'. Attention on this type of language has increased over recent years, with a number of articles and social media challenging its use and discussing the impact on women and birthing people's experience of maternity care, labour and birth, including Peanut's 'Renaming Revolution Glossary', Leigh Kendall's work for MatExp: "Language Matters!"; Natalie Mobbs, Catherine Williams, Andrew Weeks' article 'Humanising Birth: Does the language we use matter?' and Vimalesvaran et al's recent (2021) Lancet commentary 'Mind your language: respectful language within maternity services'[7].

This project was set up to look specifically at terms used to describe types of labour and birth: words like 'normal', 'straightforward', 'caesarean section', 'forceps delivery, etc. It was not intended to look at other difficult language – the 'failure/incompetent' words, nor inclusive language around gender. However, both issues did arise. In the case of the 'failure' terms, this was so great we chose to further incorporate a discussion of perspectives on this language in the project findings.

The role of the midwife

Midwives have many different roles in caring for women, birthing people and babies during pregnancy, labour and birth, as well as supporting the health of the community. The scope of the midwife's work is defined by the NMC Standards of Proficiency. This document describes how midwives provide universal care for 'all women and newborn infants' by supporting their physical, psychological, social, cultural, and spiritual safety, and 'optimising normal physiological processes' in all circumstances. This work is important throughout a woman's care and is invaluable when medical assistance or interventions are needed. This legal and practical role of the midwife is not affected by this project or any of its findings.

Methodology

The approach we used reflected the project's core values and sought to be iterative and open: our starting point was the stories we heard, rather than our own position or preferences. We aimed to give as much opportunity as possible for people to share their views, using their own words, whilst also sticking to the scope of the project. We used a combination of qualitative and quantitative methods to make space for the complexity and nuance in this debate, whilst also enabling us to identify preferred terms for some specific labour and birth scenarios. The qualitative work also aimed to provide invaluable context for the interpretation of the quantitative findings.

As part of the project, the team spent time reflecting on our personal experiences, including our own labours and births. We were supported and challenged throughout by the diverse perspectives of the POG. This was a consultation, not a research project, but it drew on research expertise and common research methods and was designed to be systematic and rigorous.

[7] Vimalesvaran, S.; J. Ireland, M. Khashu (2021) 'Mind your language: respectful language within maternity services'. The Lancet, 397(10277): pp. 859-86

Method

The consultation process had three, interlinked, stages: Listening Groups, the Voices Survey and a final survey. Full details on the methods used and the characteristics of the participants can be found in the methods and technical report.

1. The Listening Groups

Eleven small group discussions were hosted online. Participants were invited through POG networks, professional contacts and social media and around 130 people registered their interest and were allocated by anonymous ballot. Five groups were a combination of postnatal women and birthing people, midwives, obstetricians, neonatologists, obstetric anaesthetists, maternity support workers, doulas, antenatal educators and other birth workers (n=35); two with some members of the POG, as experts in maternity care provision and policy (n=9); four groups with under-represented communities: Black women, LGBTQ+ service users, volunteer doula supporters in a diverse area and those who had mental health difficulties around birth. (n=16) and then two workshop discussions with student midwives (n=51, this included a full cohort of 3rd year student midwives).

These conversations were 'held' and loosely guided by the facilitator, but largely followed issues that participants themselves found important, as they arose. A 'parking sheet' was used to record important points that were outside the scope of the project.

During the group, all participants were asked to think of as many terms as possible to describe a birth in line with the Maternity Working Group Definition[8] (i.e. one without induction, augmentation, forceps/ventouse, epidural/spinal/general anaesthetic or episiotomy). They then each chose one preferred term from the list their group had generated. These responses were collected across all 12 groups and were ranked according to how often they were preferred. The six most preferred terms were brought to the voices survey for further polling.

2. The Voices Survey

The Voices Survey was an online survey open for three weeks in December 2021-January 2022 that could be responded by text or voice. It was promoted through the POG networks and social media and 764 people's stories were included in the final analysis. Around 10 per cent of respondents chose to reply by voice.

The single survey had two arms that streamed respondents to different questions depending on whether they were:

- Service users (postnatal women, people who had supported the birth of a partner, friend or family-member) and representatives from organisations that supported service users, or;
- Health professionals (midwives, obstetricians, other doctors and health professionals, antenatal educators, doulas and anyone else who had supported a birth in a professional capacity).

[8] NCT/RCM/RCOG (2009) 'Making normal birth a reality Consensus statement from the Maternity Care Working Party our shared views about the need to recognise, facilitate and audit normal birth'. NCT/RCM/RCOG. Available at www.oaa-anaes.ac.uk/assets/_managed/editor/File/Documents/2009_normal-birth-consensus-statement.pdf

Respondents were asked to rank the six most preferred terms generated from the listening group in order of their preference, and to describe their reasoning. There were three additional open questions for service users and two for health professionals and some demographic questions. The full list of questions can be found in Appendix 1.

3. The Final Survey

The final survey was online for four weeks in Spring 2022, asking for preferred terms that should be used in clinical notes, research and audit. It was circulated through POG contacts, and on social media. 6,948 people responded.

The survey presented five labour and birth 'vignettes', including one that might be described as 'normal', a complex labour, a birth involving forceps, an 'emergency caesarean' and an 'elective caesarean'. There was also a question relating to 'caesarean'.

In total, 25 terms were presented across the six scenarios. We did not include terms that could not offer enough distinction between modes of birth, for example, 'birth' or 'vaginal birth'. We also added 'assisted' and 'unassisted' and 'with/without interventions' as these have been increasingly used in audit and reports in recent years. The complete vignettes and terms can be found in Appendix 2.

Participants were asked to choose their one preferred term for each scenario, indicate those they didn't mind, and those they thought shouldn't be used.

Participants

The project heard from a total of 7,822 people between the listening groups (n=110); the voices survey (n=764) and the final survey (n=6948).

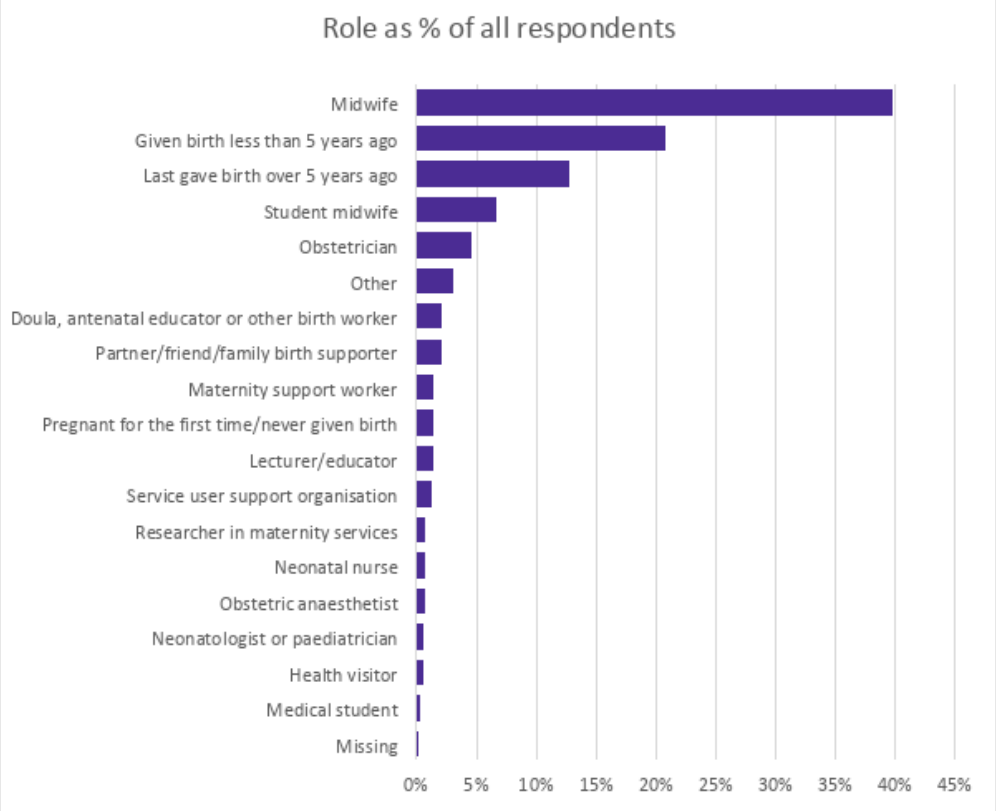


Chart 1: Role of Re:Birth participants (percentage of all respondents)

Ethnicity

Around 72 per cent (n=5512) of survey participants (N=7712) were from a White British or Irish background and 12 per cent (n=935) were from a minoritised ethnic community, as compared with 14 per cent of the UK population.

	Re:Birth survey participants			Population		
Ethnicity	% of Final Survey (n=6948)	% Voices Survey (n=764)	% of all survey (n=7712)	England and Wales	Scotland	Northern Ireland
White English, Welsh, Scottish, Northern Irish or British or Irish	71%	72%	71%	82%	93%	98%
Another non-UK White background	5%	7%	5%	4%	3%	
Mixed or multiple ethnic background	2%	4%	2%	2%	<1%	<1%
Black, African or Caribbean background	2%	1%	2%	3%	1%	<1%
Indian, Bangladeshi, Pakistani, Chinese or other Asian background	2%	2%	2%	8%	3%	1%
Prefer not to say	1%	2%	1%			
Other	1%	<1%	1%	1%	<1%	<1%
Gypsy or Irish Traveller background	<1%	<1%	<1%	<1%	<1%	<1%
Missing	17%	12%	16%			

Table 2: Ethnicity of Re:Birth participants compared with UK population

Representation from across the UK

Re:Birth was a UK-wide project and we aimed for a representative population from across the four UK nations. Our data showed that participants from the Celtic nations were slightly over-represented as compared to those in England.

Socio-economic status

We used the Index of Multiple Deprivation as a proxy measure for socio-economic status, showing that, for the data we had, respondents were weighted towards those from less deprived groups, although all quintiles were represented.

Gender

Participants were asked ‘what is your gender?’ in an open text question, in order to be able to count any people who had given birth but who did not identify as female. Non-binary individuals were determined by self-disclosure. Trans people were identified by self-disclosure, or as a participant who identified their gender as ‘male/man’ but had also given birth (female sex).

Gender (What is your gender?)	Voices Survey	Final Survey
Woman	66%	80%
Man	1%	2%
Non-binary	<1%	<1%
Agender		<1%
Trans man	<1%	<1%
Trans woman		<1%
Trans non-binary		<1%
Prefer not to say/unclear	1%	1%
Missing data	32%	18%

Table 3: Gender of survey participants

Disability and impairment

Eighteen per cent (n=117) of Voices Survey respondents had a physical or mental health condition, disability or long-term illness. For 75% of these people, their condition impaired them carrying out their day-to-day activities: 63 per cent ‘a little’ and 12 per cent ‘a lot’.

Key qualitative findings

A shared vision

Women, obstetricians, midwives, doulas and everyone else who came to these sessions all wanted the same thing - for labour and birth to be physically and psychologically safe. That is, for women and babies to have good outcomes and feel like their labours and births were a high point of their life and that their wishes were listened to, heard, understood, respected and responded to.

In the Voices Survey we asked health professionals (all those supporting birth in a professional capacity) the question: ‘when the women and families you cared for are later talking about their labours and births, what one word do you hope they use?’. Their responses were dominated by the terms ‘positive’, ‘empowering/empowered’ and ‘safe’, both for midwives and for obstetricians and other health professionals.

The importance of language

The language healthcare professionals use in conversations with service users and with each other can help ensure safe care and offer reassurance, but also potentially cause misunderstanding and distress. Autonomy, choice and agency during labour and birth were central to our discussions with service users. Informed choices depended upon women having clear and appropriate information. When health professionals used language to describe a woman’s birth that she did not recognise, it made her feel a lack of agency, or that the caregiver did not understand her experience:

> ‘The consultant I saw to 'approve' my home birth [of my second child]: (…) I explained to her that I wanted to have a home birth to protect my mental health because I felt that being in a medicalised environment would trigger me or upset me, and she said to me "oh, it looks like this was a birth that I attended and it seemed quite straightforward to me"’. (Service User, Listening Group)

‘Normal labour and birth’ have had a working definition amongst midwives and other health professionals as a labour and birth that progresses without medical assistance. For others, it is used to describe any vaginal birth. The discrepancies in what the term means has created challenges for women and birthing people, and for care providers:

> “A lot of us talk about 'normal birth' as just ‘a vaginal birth’ though, and that's been alluded to already, hasn't it? And within that they may have had a stretch and sweep, their membranes may be broken, they may have an epidural, they may be on the bed

> and not moving, and they may have given birth with her legs in lithotomy, or with Valsalva directed pushing, with augmentation and an episiotomy, and *that* would be a normal birth. So for those people, that is pretty -- perhaps traumatic, and it's a 'normal birth' and so normal birth has been bandied around as a term that is now a dangerous situation, normal birth, because *that* is dangerous, that's dodgy. And we can't differentiate" (Midwife/Antenatal Educator, Listening Group).

The boundaries of what constitutes 'help' or an 'intervention' were also hard for people to define and articulate, further muddling the collective understanding of what a 'normal birth' might be:

> Anything can be an intervention, can't it? Even just having a sweep is an intervention and, you know, that doesn't necessarily mean that you're not then going to go on and have a spontaneous vaginal birth so, you know, it's, you wouldn't categorise that outside the realms of the physiological normal, so I think intervention's not really (pause) it's like, it's like, it's it's so difficult. (Student Midwife, Listening Group)

> "It's hard to understand where you draw the line of like what we consider then a 'normal birth' because even like - are natural forms of induction considered like, you know, nipple stimulation can cause contractions, is that considered another form of induction? So it's quite… like, I wonder where the line would be?" (Volunteer doula supporter, Listening Group)

These different perceptions of what is 'normal labour and birth' can result in a lot of talking at cross purposes, including between health professionals and women. One woman described being labelled a 'normal birth' by midwives on a postnatal ward after a forceps birth and severe PPH that lead to sepsis. She later developed PTSD and attributed this directly to the inconsistent understanding between her and her midwives of what made a 'normal birth'. Her story illustrates the importance of clear, consistent, commonly understood language to maternity safety:

> "I'd had a lovely set of midwives and obstetricians through pregnancy that I really, really, respected. I invested a lot in their opinion. So when they were saying to me 'you're fine' and my body was screaming 'you're really not' I didn't know who to listen to and it's actually left me with a long-term health anxiety as well as developing PTSD from that period" (Service User/Rep, Listening Group)

In her case, she felt that 'normal' was a used as a shorthand by overstretched midwives to try and distribute limited resources on the postnatal ward:

> "They told me to 'get a grip', 'pull my socks up', 'man up', which actually made me laugh out loud, because I was too much of a bother and they were short staffed and there were midwives on that ward who were lovely, like genuinely lovely people. I work with them now doing maternity committee stuff, absolutely – if you could pick a midwife; absolutely wonderful. But in that environment where they are pulled in twenty different directions, they want to be able to categorise you easily as not needing that much of them and that 'normal' gives them that easy language of, you know, 'you won't be a bother, you'll be fine'".

Other difficult terms

Whilst this project was established to review the terms used to describe labour and birth, participants in our listening groups were also keen to tell us about the impact of other types of words they heard during their care.

Sometimes, the people who spoke to us found their triggers in common, supposedly mundane words – for one, whose baby was very unwell after a difficult forceps birth, the need to repeatedly use the word ‘forceps’ when describing that birth to multiple health professionals afterwards, was very difficult. For another, the ‘emergency’ in her ‘emergency caesarean’, triggered her feelings of fear and vulnerability around the birth, during which she thought her, or her baby, might die.

The everyday language of maternity services can be highly emotive - for example in terms like ‘failure’ or ‘emergency’ - or come across as judgemental of women and birthing people - for example ‘poor maternal effort’. The evidence we have showed that these are still commonly used and had long term impact on how some women saw themselves and their labours and births:

> “I was introduced to an obstetrician by a midwife as the 'failed home birth'. These are the words that were used around me. These are the words that I then used to describe what happened” (Service User, Listening Group).

> “So I picked up my notes and I was looking through my notes and ‘query maternal effort’ got me like a dagger to my heart” (Service User, Perinatal mental health Listening Group).

> I was classed as 'failure to progress' and I have felt like a failure ever since (Service user, Listening Group).

The terms ‘delivery’ and ‘section’ were also widely unpopular. The use of ‘birth’ to describe all types of birth was seen to help make sure that all births were recognised and that women themselves felt they were at the centre of whatever birth they had. With ‘birth’, the woman was seen as the active agent, as these two quotes illustrate:

> It's really important that we refer to birth as birth and not deliveries by calling it a delivery, you are suggesting that the mother, the woman has not played her part in it. (Midwife, Voices Survey)

> “I think what's still what's important with a caesarean birth though is that we're still calling it birth but it's always still birth and that it's not just an operation and something that's happened to you”. (Service User, Voices Survey)

Feelings of failure

Difficult birth experiences were frequent amongst the Listening Groups and Voices Survey, as compared with the Final Survey respondents. The women in the Listening Groups and Voices Survey widely expressed feelings of failure around their labours and births. Where problematic language was used by others around them, this exacerbated an already challenging experience:

> “A lot of these births come over to my care as a 'failed induction' or a 'failed homebirth' or even, you know, when we're going -- moving away from normal birth,

'failed forceps' and that that gets transcribed into the notes, that goes home as a diagnostic label, that comes as an experience". (Obstetric Anaesthetist, Listening Group)

"I ended up having a really long 'failed' induction, failure to progress. So there was lots of the word 'failure' on my notes, and being used around me as well. (…) I feel as though there is a lot of -- again the language that's used, including the whole concept of 'normal birth' being used in my mode of birth meeting -- that did make me really, really doubt myself. But in terms of what *I* want and the safety of my baby, etcetera, I'm set on an elective caesarean this time around". (Service User, Listening Group)

Health professionals were clear that when there were difficult or unexpected outcomes, whilst the failure was with the services, it was common for women to be left feeling that they themselves were to blame:

"Can I just comment about the so-called 'fails'? It's not you failed, the -- sometimes it's the health professional failed and you are made to feel it is *you* rather than the health professional". (Obstetrician, Listening Group).

"The blame has been put on the woman completely and utterly, there's no doubt about that. And we have failed to understand what's going on in the birth, that makes it go awry, and this is the problem. And we've blamed the woman for that." (Midwife/Antenatal Educator, Listening Group)

In some cases, postnatal women attributed their 'sense of failure', to unrealistic expectations set by gaps (or what some saw as bias) in antenatal education or in discussions with health professionals during pregnancy. Some women felt they had not been giving adequate information antenatally about what could happen in labour and birth or on the risks and benefits of all types of birth:

"In terms of informed consent, even at booking - I just wish that I had had more information about the risks and benefits of *all* modes of birth, they were just laid out there, on the table, from day -- whatever, nine weeks, seven weeks, whenever you go and you tell the midwife you're pregnant. I just -- I think that would actually help to take away this push for normal birth". (Service User, Listening Group)

In addition, much of women's antenatal education took place informally, through hearing friends and family birth stories and from social media. Often, people felt underprepared for the reality of birth. Others described a fine balance between wanting to prepare women for birth by sharing realistic stories, but also not wanting to scare them, or leave them with a lack of trust in themselves. This appears to have led to a situation where new parents with difficult birth stories feel like they need to 'protect' pregnant women from the details, *and* those with positive birth experiences avoiding speaking about them in public for fear of being judged:

[A woman I was caring for] went to send a photo and she was like "oh, I shouldn't be bragging about it", because somehow if you have a straightforward, normal, physiological, whatever it is, you are also judged, and you shouldn't be bragging about it. So, I think, you know, it's toxic on the side of women feeling like a failure; but

> also there are women having those kinds of birth, they are somehow glorified in their imagination, but they also don't feel they can speak about it because it means bragging". (Midwife, Listening Group)

Some women described in the Voices Survey how they purposely chose to speak positively about birth to counter what they felt was a dominant negative narrative:

> "If I'm talking to a friend who is about to encounter her first labour I always use positive words or phrases as mothers like that do not need to hear anything horrendous and negative I can guarantee you that they've already had Sally from down the road tell you the horror birth story"

> "I have celebrated what I felt were positive experiences as opposed to the many negative and/or traumatic experiences I have heard from many other women".

> "Giving birth was something I looked forward to. I loved it. I describe the births like this because that's how they happened and how I felt, too often all that is heard are the dramatic births, I am aware these happened but somehow the straightforward positive birth experience gets lost".

Whilst there were concerns that antenatal education failed to prepare women for unexpected interventions, others felt strongly that women were not educated about physiological processes and how to optimise them. They saw a mismatch between the message that physiological birth was 'optimal' for women, and a maternity system that did not support this type of birth, leading to unrealistic expectations for birth within that setting.

A hierarchy of birth

Service users used many different terms to describe their own and others' labours and births, but often preferred broad terms over specifics. Many liked to describe their own births as simply 'vaginal' or 'caesarean' because these kinds of terms felt factual, they encompassed different types of birth and did not imply a hierarchy, where one mode was favoured or valued over another:

> "I am very keen to use 'vaginal' as opposed to natural/normal as it makes more sense labelling a vaginal birth as what it is instead of moralising a mode of birth". (Service User, Voices Survey)

Listening Group and Voices Survey participants widely described what they felt was a hierarchy within the maternity services and the community, that celebrated 'normal' birth over any other kind. The main problem for them was the negative impact this had on women who did not have that type of birth:

> "Any time that we kind of give this like 'golden standard' of what a birth is, or should be, you set it up for actually people feeling really bad that that's not then what's happened and [you need to give] people realistic expectations of what could, and does, happen". (Service User/Rep)

> "There's this kind of hierarchy of births, and you know, they're all these people out there that are kind of, yeah, able to achieve this certain kind of like natural birth and if you can't achieve it, then oh, you know, it's all a bit of a sort of disappointment thereafter, which is just totally not the case at all" (Service User, LGBTQ+ Listening Group).

Service users felt that using ‘descriptive’, ‘factual’ language in discussions between them and health professionals could help alleviate the hierarchy:

> “I mean my view is that -- well, the language that's used should, wherever possible, try to avoid putting any kind of value-judgement on the type of birth. (…) So you know, from my perspective, using the language around 'vaginal birth' or 'abdominal birth', that removes all of the kind of hierarchy” (Service User, Listening Group).

> “I think non-emotive/manipulating language is paramount. There should be no hierarchy of birth. Women and their babies require respect, care and safety to navigate pregnancy and then both during and after labour. It should be an empowering experience and not dependant on a value placed on a ‘type’ of birth or impacted by a sense of failure due to not meeting the desired birth” (Service User, Voices Survey).

Within their work, health professionals are asked to use evidence-based care to support normal physiological processes, whilst also supporting women’s choices and not leading them to feel blame when they don’t have this type of birth. This is a complex issue that was touched upon by several midwives:

> “I just sometimes feel like the semantics of it are getting -- it's sort of losing the fact that actually an undisturbed or physiological birth has an evidence base around the health benefits. (…) You know, when we're having discussions with women, and there's always that guilt isn't there. There's always that guilt that's in -- you know, we're always worried about either making women or birthing people feel guilty” (Midwife, Listening Group)

> “There is something weird going on that dismisses the idea that normal physiological birth is a thing and it is valuable and health enhancing for women and babies. ‘Normal’ is a common term in medical and health care – ‘normal blood pressure’ for example. The idea that women may feel stigmatised from not having a normal birth is a misrepresentation - and as a grief and trauma researcher and counsellor it misses the point that many women blame themselves for the experience and outcome of pregnancy AND as a connected idea many women experiencing a traumatic birth do not easily see that they were let down or betrayed. This leads to internalising that their experience was inevitable.... necessary even.... and then they need to rationalise that 'what was must be best' (post hoc rationalisation)… and it is all about failings of the system of maternity care”. (Midwife, Voices Survey)

In search of a shared language

Listening Groups and Voices Survey

A key aim of the project was to find an agreed set of terms that could be used to describe different types of birth. The project took a systematic, stepped approach to this.

Step 1: Listening Group participants collectively elicited thirty-four synonyms for the term 'normal birth'[9].

Step 2: Each Listening Group participant (n=110) voted for their preferred term out of those generated by their group or event. This resulted in six unranked preferred terms :

- Straightforward
- Physiological
- Spontaneous (Vaginal Birth)
- Normal
- Natural
- Vaginal

Step 3: Voices Survey participants (n=764) were then asked to rank these in order of preference. Overall, 'Spontaneous Vaginal Birth' was the most preferred, with health professionals preferring 'Physiological'[10].

	Health professionals[11]	**Service Users[12]**	**All respondents**
1 Most preferred	Physiological	Spontaneous vaginal birth	**Spontaneous vaginal birth**
2	Spontaneous vaginal birth	Vaginal	**Physiological**
3	Vaginal	Straightforward	**Vaginal**
4	Straightforward	Physiological	**Straightforward**
5	Natural	Natural	**Natural**
6 Least preferred	Normal	Normal	**Normal**

Responses to specific terms

The qualitative evidence from the Listening Groups and the Voices Survey provided valuable context for this ranking. The diversity of responses, feelings and opinions on all of these terms showed that they were all problematic in some way to some people. It was clear that there was no one term that was preferred by all, and even selecting one was, for many people, a forced choice.

[9] In line with the Maternity Working Group definition, as without induction, augmentation, forceps/ventouse, epidural/spinal/general anaesthetic, episiotomy.

[10] The combined ranking was created by making a simple count of the number of participants who chose each term at each rank. These were weighted by multiplying by 6 for the most favoured, by 5 for the next most favoured and down to x1 for the least favoured. These results are presented in order of the weighted numeric total for each term.

[11] Here, 'health professionals' included anyone providing care or support for women in labour and birth in a professional capacity: midwives, obstetricians, obstetric anaesthetists, neonatologists, doulas and other birth workers.

[12] 'Service Users' included anyone receiving care or representing service users: Those who had given birth, birth supporters (partners, family and friends) and representatives from service user organisations.

In many cases, qualities that were positive to some, were a negative point for someone else, for example having a broad term encompassing many different types of birth:

> "I'm not keen on the term 'normal' as it is used to mean anything from truly physiological with no intervention of any kind to any vaginal birth without instruments" (Voices Survey)

'Straightforward' felt non-judgemental to some, and offensive to others. Similarly, 'physiological' was felt by some to be clear: "I think the phrase 'physiological birth' is descriptive and uncontestable, it just is what it is", and by others to be unclear: "There's a huge proportion of society that won't know what physiological means" (Voices Survey).

Some felt that 'normal' was an appropriate way to describe what they saw as a biological norm:

> "Normal isn't a dirty word'. Women were designed to birth out of their vaginas, this is the NORM and as such is NORMAL. Anything outside of this is a surgical (c/s) or assisted (forceps etc) birth. Also, why the focus of which hole the baby comes out of?" (Midwife, Voices Survey)

Similarly, some described 'Natural' as a positive term that described 'what nature intended' in a non-judgmental, factual way: "I think that natural is a lovely way of describing a vaginal delivery because it is the biologically natural way of giving birth".

However, many respondents were concerned that terms like 'natural' and 'normal' were judgmental and exclusionary, implying some other births were 'unnatural' or 'abnormal':

> "The terms 'normal' and 'natural' imply anything outside of that is abnormal and unnatural and that's just not true in birth." (Midwife, Voices Survey)

The term 'vaginal' was seen as, "factual and anatomical" (Service User, Voices Survey), but it was clear that it still held stigma, particularly for some communities:

> "In general talk I wouldn't tend to use 'vaginal', perhaps this is a cultural/religious preference" (Service User, Voices Survey).

> "Just bringing 'vagina' into the talk kind of shocks people, doesn't it?" (MSW, Listening Group)

> "I don't use name of private parts" (Service User, Voices Survey)

Language in conversations between health professionals and service users

These findings from the Listening Groups and Voices Survey led the project team to the view that we could not support or recommend the use of any particular term over another in conversation with women, birthing people and their families.

Instead, service user participants asked for health professionals to reflect the language they themselves used when speaking to them about their labours and births.

Women and service users asked for terms to describe labours and births that are:

- Descriptive and technically accurate

- Non-judgmental, non-hierarchical, nor value-laden
- Reflect their actual experience, not what others might assume their experience to be.

We also need to ensure that everyone having the conversation understands what is meant by any terms being used as it was evident that definitions and assumptions about certain terms, varied widely.

Language for clinical notes, research and audit

Health professionals, and others, supported this kind of personalised approach when talking to pregnant women. However, in formal records, consistent language is important. It supports safe and accurate clinical handover and enables audit data to be shared and compared. Health professionals needed specific terminology to describe different types or modes of birth so the range of short-, medium-, and long-term outcomes can be monitored. This meant that appropriate care could planned in subsequent pregnancies, based on previous birth history:

> "It's really important to have woman-centred language that is sensitive to people's experiences, and values, and needs, and all of that. *And* it is important, I think, to have definitions that are used for comparing the way birth is managed in different places, so that we know and can describe the difference between what goes on in different maternity units, and what is different about birth in a midwifery unit or birth centre compared with an obstetric unit, or indeed a planned home birth" (Service User Representative/Researcher, Listening Group).

Health professionals asked for terms that are:

- Consistently understood between individuals and professional groups
- Clear, descriptive and unambiguous
- Allow for the identification of some granular differences in the mode of labour and birth (e.g. 'vaginal' would not be distinctive enough).

In the light of these conclusions, the Final Survey was developed to evaluate terms specifically for use in clinical notes, audit and research. We asked everyone about this, not just health professionals or researchers. During Listening Group conversations, service users described how difficult phrases such as 'poor maternal effort' appeared to 'spill out' into everyday talk around women and their partners. Women read their own notes, overheard professional conversations or were spoken to directly with words such as these. We also wanted service users to be satisfied with any terms used to describe their labours and births in their clinical notes.

The respondents to the final survey (n=6948) were grouped into four categories and responses weighted to give each group 25% of the total weight:

1. Service Users (Women who have given birth, birth supporters – partners/friends/family, those who have been pregnant, those who are currently pregnant, those who are planning pregnancy) (n=2517)
2. Midwives, Student Midwives, MSWs (n=3363)
3. Obstetricians, Obstetric Anaesthetists (n=345)
4. Others (All other health professional, doulas, antenatal educators, birth workers, researchers, lecturers, all others) (n=723)

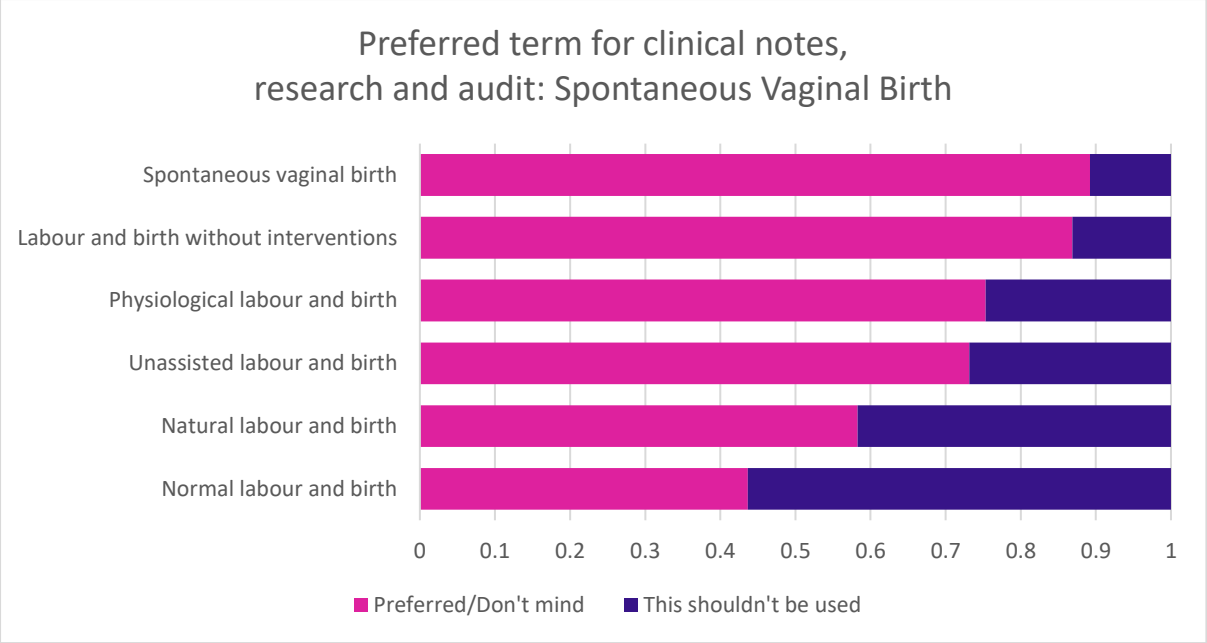
The following table shows the vignettes and the terms that were 'preferred' or that respondents 'didn't mind':

Recommended term	Scenario/survey question
Spontaneous Vaginal Birth (n=5020, 89%)[13]	Lily was close to her due date when her labour started on its own. She laboured without needing help, apart from the support of her midwife and partner. Lily's labour progressed without any drugs to speed it up (no syntocinon infusion) and she gave birth to her baby vaginally without forceps or ventouse. Lily and her baby were both well afterward.
Birth with Forceps (n=5314, 93%)	Chantelle's labour started on its own (without an induction) when she was close to her due date. She laboured without needing any help apart from the support of her midwife and birth companion. At the end of the labour, Chantelle, with her midwife and obstetrician, decided she needed help with forceps to give birth. For Chantelle's story, we are interested in describing her BIRTH (not her labour). What do you think about the options for describing this sort of birth?
Induced and/or augmented birth (n=5157, 89%)	Aisha's labour was started through an induction and she had drugs during her labour to strengthen her contractions (syntocinon infusion). She decided to have an epidural to help with her labour pains. She gave birth to her baby vaginally without the need for forceps or ventouse. For Aisha's story, we are interested in the terms used about her LABOUR, not her birth. Which terms do you prefer to describe this type of labour, that included syntocinon and an epidural?
Unplanned caesarean birth (n=4733, 83%)	Sarah's labour started on its own, when she was close to her due date. But, as time went on, Sarah and the people caring for her agreed that she needed to birth by caesarean, which is how her baby was born. This caesarean could be described as 'emergency', 'unplanned' or 'in-labour'. What do you think about these terms?
Planned caesarean birth (n=5761, 99%)	While she was pregnant, Jo and her care team agreed that her baby would be born by caesarean. This caesarean could be described as 'elective', 'planned' or 'pre-labour'. Which do you prefer?
Caesarean birth (n=5560, 97%)	There are lots of other terms in use for what we often call a 'caesarean'. These can be used with the words from the previous questions to describe both types of this birth. Which terms do you prefer?

The following charts give more detail about the choices made by the respondents in the Final Survey[14] and Appendix 2 shows the results separately for each of the four groups.

[13] n=the number of respondents who preferred or didn't mind this term, as % of responses to that question.

[14] The data has been weighted based on the study population.


Preferred term for clinical notes, research and audit: Spontaneous Vaginal Birth
Spontaneous vaginal birth
Labour and birth without interventions
Physiological labour and birth
Unassisted labour and birth
Natural labour and birth
Normal labour and birth
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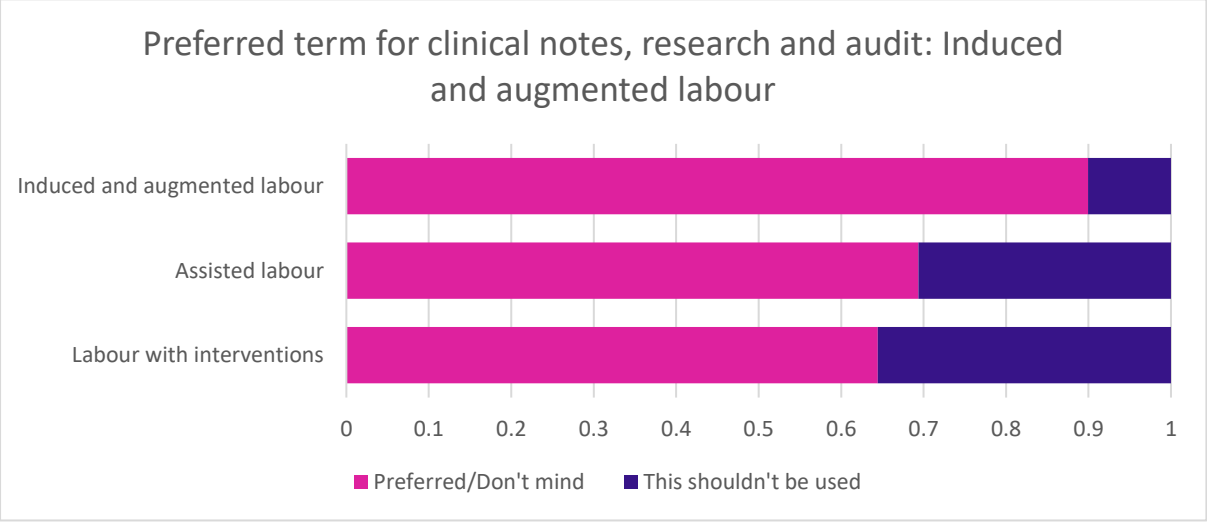
Preferred/Don't mind
This shouldn't be used


Preferred term for clinical notes, research and audit: Induced and augmented labour
Induced and augmented labour
Assisted labour
Labour with interventions
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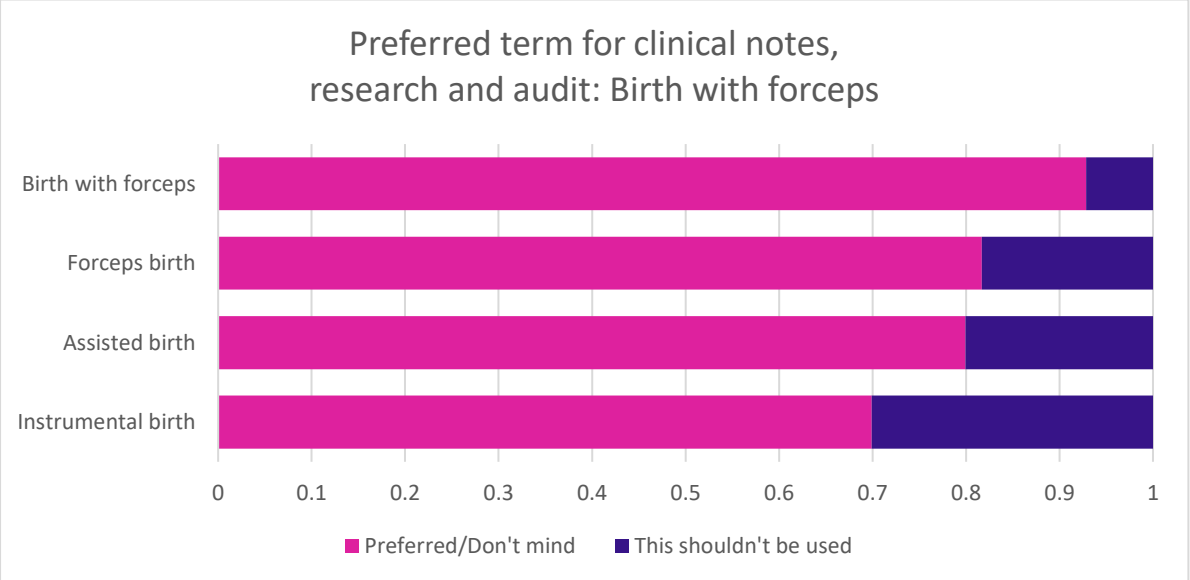
Preferred/Don't mind
This shouldn't be used


Preferred term for clinical notes, research and audit: Birth with forceps
Birth with forceps
Forceps birth
Assisted birth
Instrumental birth
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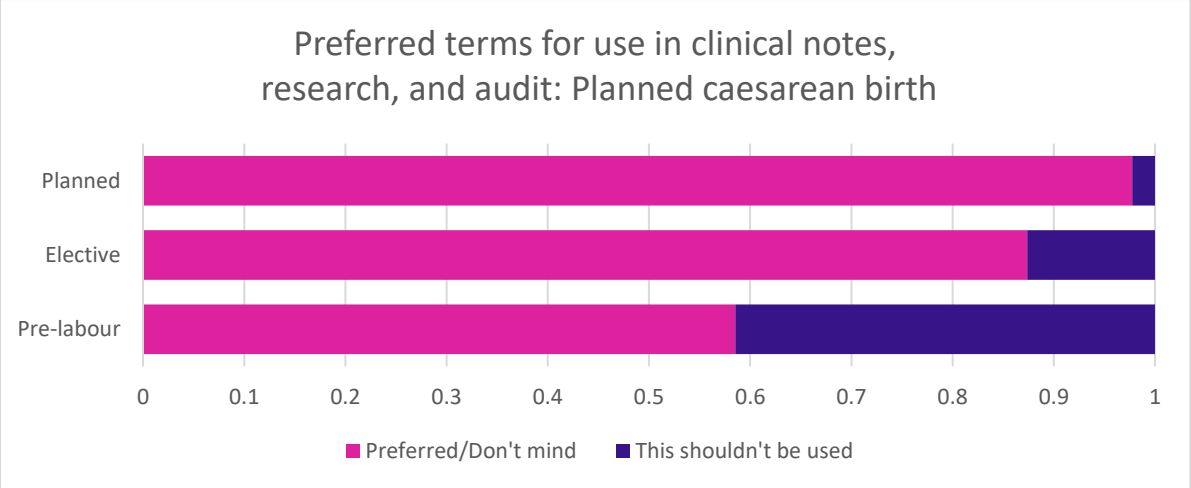
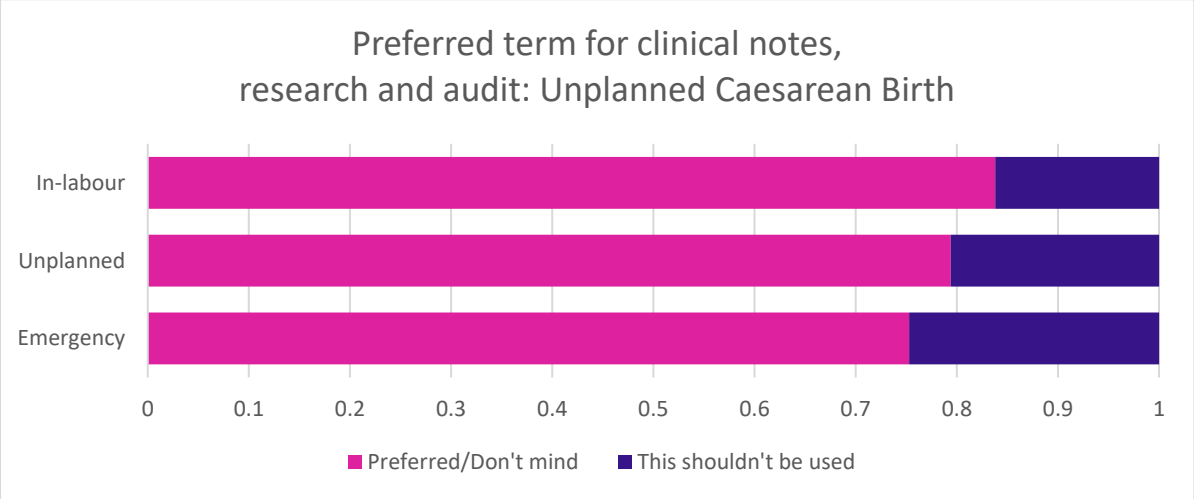
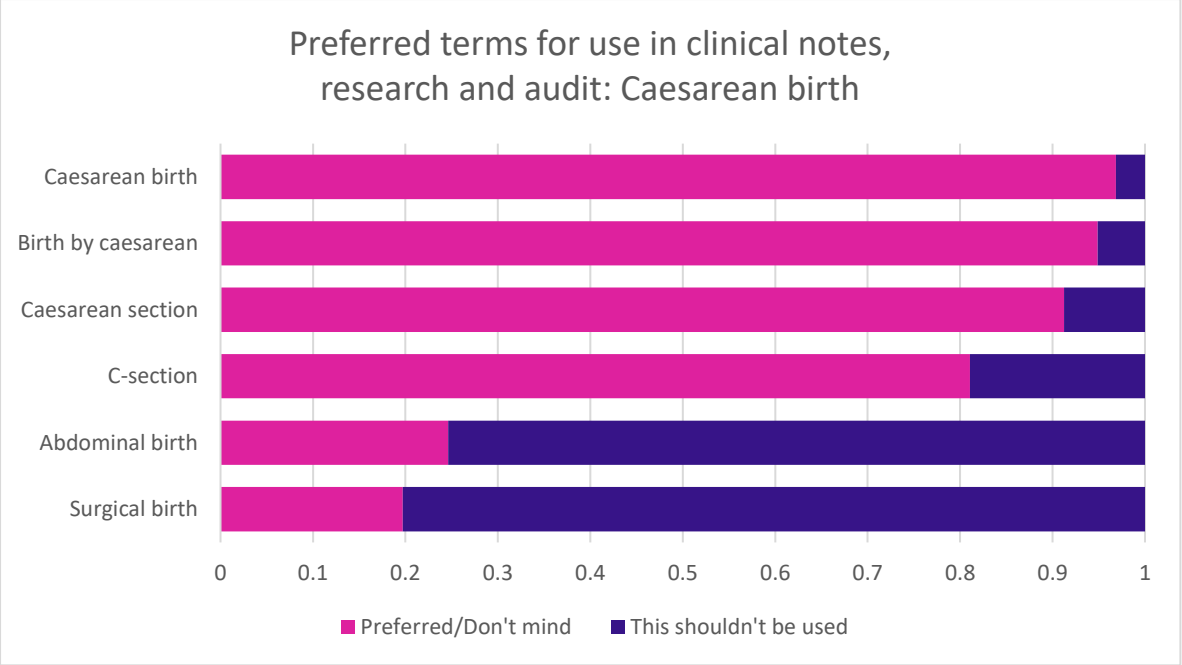
Preferred/Don't mind
This shouldn't be used





Both ‘unplanned’ (n=4733) and ‘in-labour’ (n=4664) were popular terms amongst the Final Survey respondents to describe this type of caesarean birth. Obstetricians preferred 'in-labour' whilst other groups preferred 'unplanned'. We recognise the shortcomings of both and that they are not always equivalent. However, after discussion, the Project Oversight Group supports the use of either term where appropriate, especially ‘unplanned’ in conjunction with 'planned caesarean birth'.



Influences on experience of language and preferred terms

The listening groups and voices survey showed how individual preferences for language were very varied between individuals. There were a number of potential influences on individual preferences and we explore three of these here in more detail.

1. Role in the maternity community

Appendix 2 shows the results of the final survey for each of the four groups of respondents. The qualitative evidence suggested that health professionals approached the final survey with different requirements for language in notes, research and audit than the people in their care.

There were some differences in the preferred terms for different groups of respondents.

Spontaneous Vaginal Birth was slightly more preferred by health professionals (midwives 96 per cent; obstetricians 94 per cent) than service users (81 per cent), although all groups largely preferred or didn't mind this term.

'Induced and augmented labour' was preferred or not minded by the majority of respondents, but this was strongest amongst health professionals (midwives and obstetricians = 99 per cent) as compared with service users (78 per cent).

Birth with forceps was universally preferred at >90 per cent for all groups.

A substantial minority (34 per cent) of obstetricians did not think that '**unplanned**' should be used to describe this type of caesarean section, in contrast to around 12-20 per cent of midwives, service users and others. Concerns were raised about using this term as a synonym for 'in-labour' when some unplanned caesareans would be carried out before labour (for example in the case of an antenatal placental abruption). There were other concerns that the term 'unplanned' had negative connotations similar to 'disorganised'.

Planned was universally approved to describe an 'elective' or 'pre-labour' caesarean birth (95-99 per cent).

Both **‘birth by caesarean’** and ‘caesarean birth’ and were preferred or not minded by over 93 per cent of respondents in each group with little difference by role.

2. Culture and ethnicity

Birth is not just a physiological, but a profoundly cultural event that each family will approach with their own norms and expectations. The responses we had from the Voices Survey and the Listening Groups showed a variety of expectations around birth that were shaped by individuals’ social norms in their community, previous birth experience, others’ birth stories and family norms around choices, such as whether babies are usually born in hospital or in another place, such as a midwifery unit or at home.

These norms are likely to have an impact on care choices, place of birth and attitudes to risk and also influence preferences around terminology, for example stigma around the term ‘vaginal’ within certain communities and in responses to the term ‘normal’:

> “I've put normal at the top because while I've had a caesarean birth and three vaginal births, I'm not in the least bit offended by the word normal. I don't think that my caesarean birth was abnormal because a straightforward birth is a normal one. I think actually, that is the human norm is to give birth vaginally, without assistance, and I don't think it is unreasonable or wrong to call it that” (Service User, Voices Survey)

> “Calling vaginal births normal is triggering for the increasing number of those who have c-sections for medical reasons or traumatic vaginal deliveries. It's disingenuous as a society to sugar coat 'normal' births when historically and even currently it's the most risky and or deadly activity for otherwise healthy women”. (Service User, Voices Survey)

For some participants, their own birth culture was profoundly affected by their everyday experiences of stigma and discrimination with UK society. For example, in the case of the Black women we spoke to, their experiences of every day racism left them wary of the maternity system. They felt that midwives and others were quick to make assumptions about their birth choices, without taking time to hear their stories:

> “I'm black, I wear a niqab and I, and the minute I started my appointments or stepped foot in that hospital, I felt like I was being looked at as a third-class citizen, you know, and I had comments from doctors like ‘your husband can't tell you what to do. You need to make your own choices’ and just this assumption that I must be choosing to home birth because my husband is controlling me and I have no choice in the matter. I have no autonomy, sort of over my own body (…). It's supposed to be birth choices, but I'm not really being given a choice. My choice was birth in hospital or let your baby die; what kind of a choice is that?” (Service User Listening Group, Black women)

In some cases they felt that their ethnicity was made a barrier to health professionals building relationships with them:

> “You see the rapport with other women of other ethnicities. how they laugh and make small talk and your turn comes, its quick quick, out”. (Listening Group, Black women)

Which in turn had an impact on how they received information to make decisions about their care:

> It's their job to earn our trust, it's not our job to earn their trust. And I think that's kind of how it it seems, when a woman goes to them and says ‘I'm interested in this birth

centre', they should be saying, 'I'm so sorry nobody gave you all your options before. Let me help you with that'. Not, 'oh who told you about that? You're not supposed to know', you know. (Listening Group, Black women)

3. Previous experience of labour and birth

The Listening Group discussions strongly suggested that the group participants were over-represented by people who had had difficult, or in some cases traumatic, birth experiences. This could be expected for a project that explored birth experience, as these people were more highly motivated to participate. We wanted to test whether experience of birth as positive or difficult influenced thoughts, opinions and perspectives on the language around birth in the surveys.

All respondents to the service user arm of the voices survey, and all respondents to the final survey who had given birth (including health professionals), were asked to respond to each of a series of adjectives to describe their labour(s) and birth(s). We recognised that an individual's labours and births may each have been very different, but we worked on an assumption that these diverse experiences would collectively inform their feelings about labour and birth and would still be meaningful within this one scale.

The question was: "From 'Not at all' to 'Extremely', how have your experience of labour/s and birth/s been?" The adjectives were: Exciting, Pleasant, Difficult, Satisfying, Traumatic, A challenge, Embarrassing, Exhilarating, Enjoyable, Exhausting and Anxiety-provoking[15] and were presented on a 7-point Likert scale.

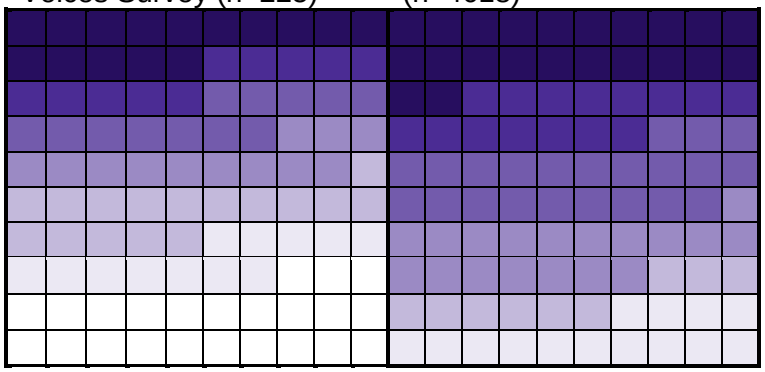
The following waffle charts show how experiences were distributed through the survey populations (Voices Survey n=225; Final Survey n=4618), where each small square corresponds to 1% of the dataset. The charts show that the final survey respondents had proportionately more positive experiences of labour and birth than the Voices Survey. The Voices Survey responses included many accounts of very traumatic births. In a few cases these stories had little to do directly with the question but were from people who had had birth injuries or whose babies had died, wanted their story to be heard and had not felt heard by any other means. Many other people responded to the questions and were particularly invested in participating because of their traumatic experience. This should be taken into consideration when interpreting this data. We include a sub-analysis looking at the preferred terms of those who had negative and positive birth experiences separately to see if there were any differences.

[15] The adjectives were supplied by Dr Susan Ayers, Professor of Maternal and Child Health, City, University of London.

Exciting

Voices Survey (n=225)

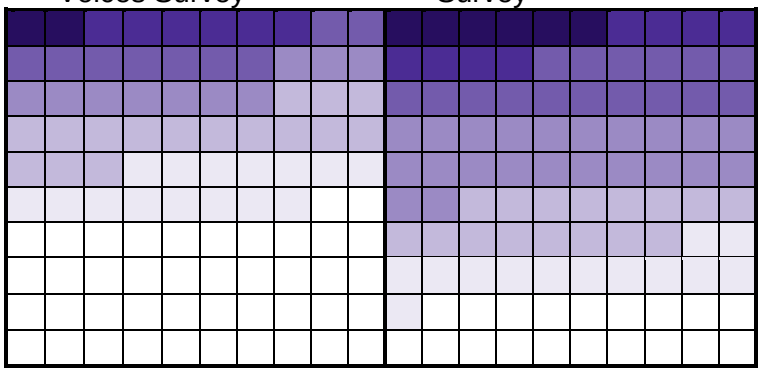
Final Survey (n=4618)



Pleasant

Voices Survey

Final Survey



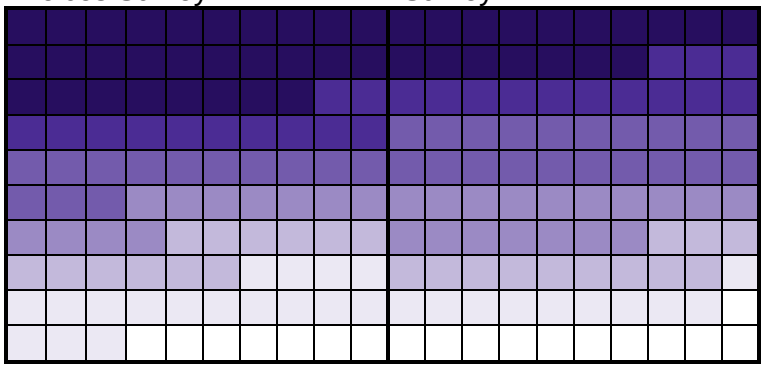
Extremely

Not at all

Difficult

Voices Survey

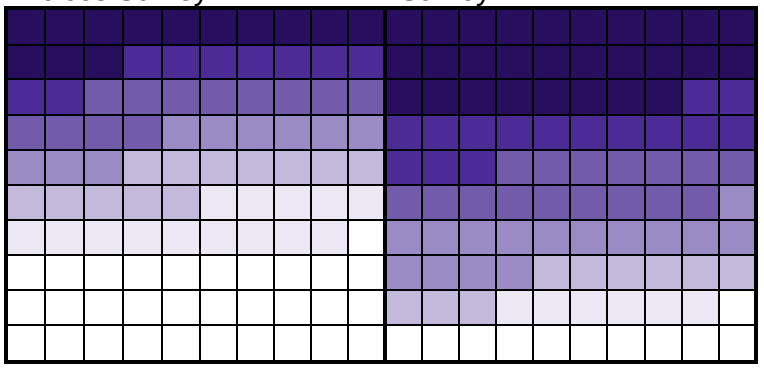
Final Survey



Satisfying

Voices Survey

Final Survey



Traumatic

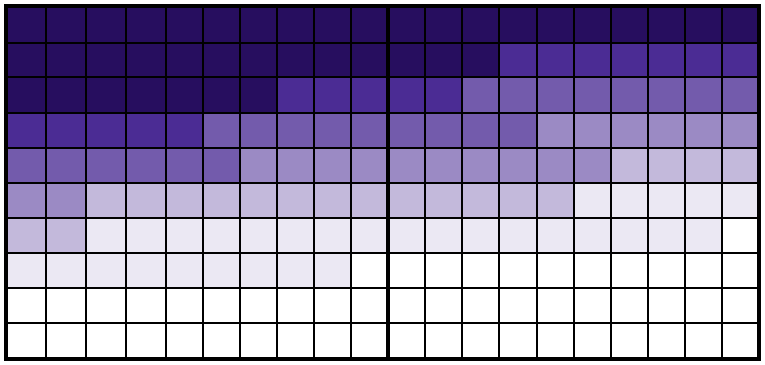
Voices Survey

Final Survey

A challenge

Voices Survey

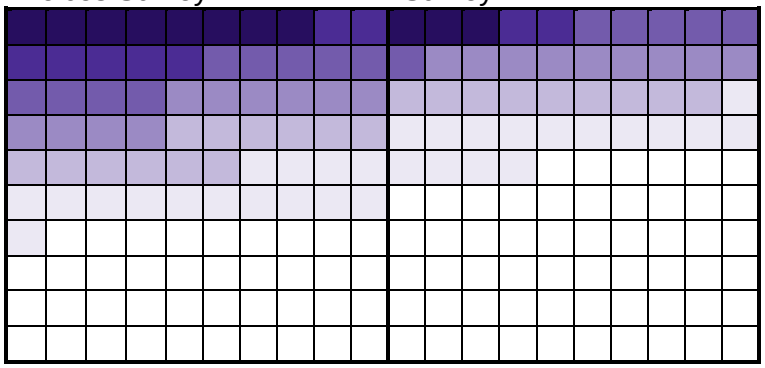
Final Survey

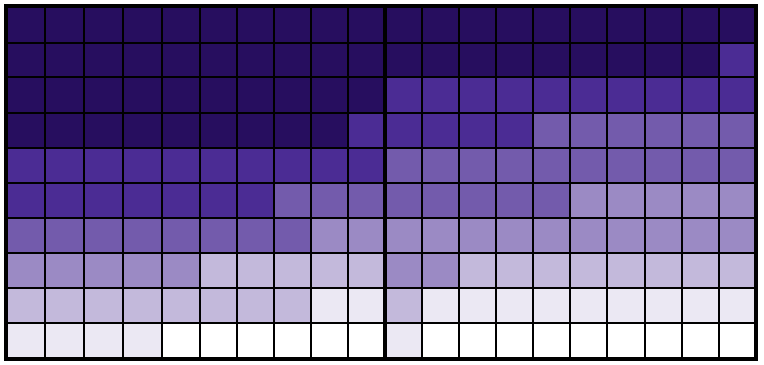


Embarrassing

Voices Survey

Final Survey

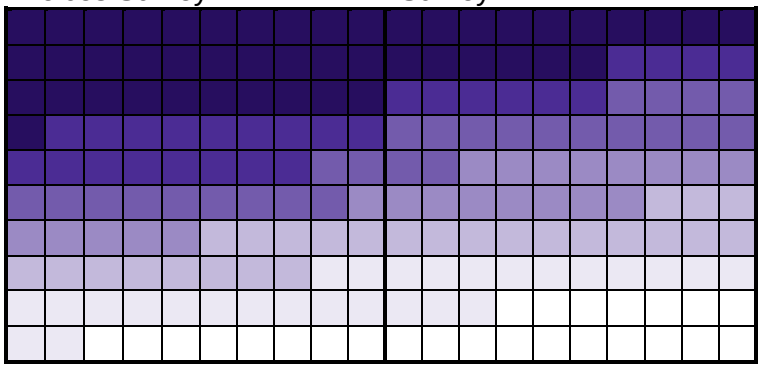




Anxiety provoking

Voices Survey

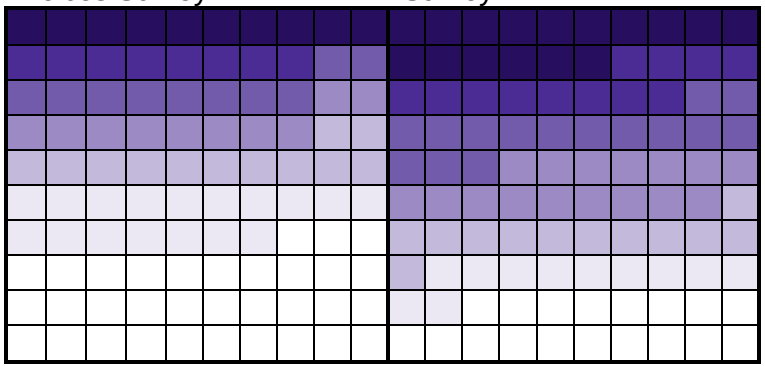
Final Survey



Exhilarating

Voices Survey

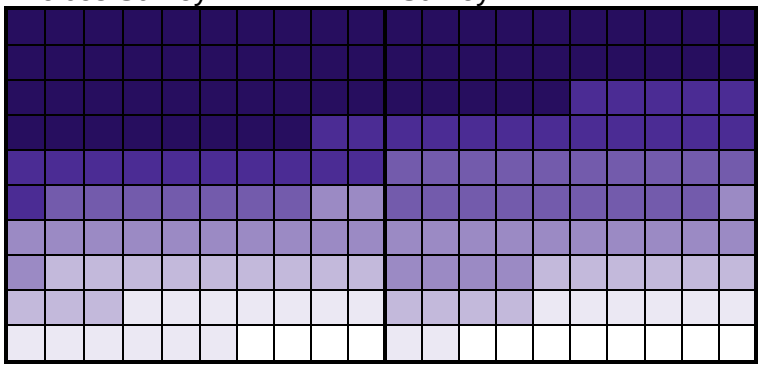
Final Survey



Exhausting

Voices Survey

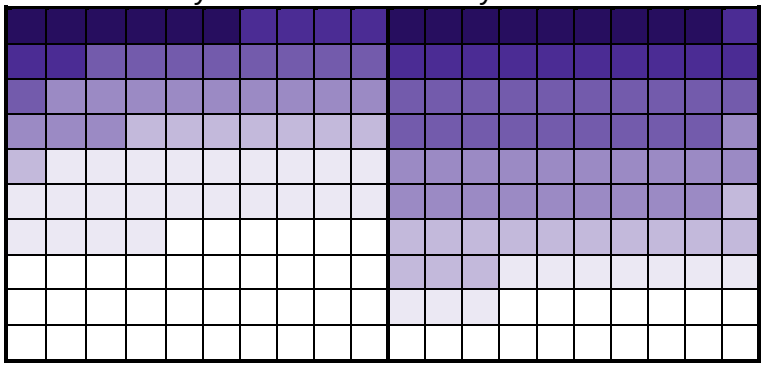
Final Survey



Enjoyable

Voices Survey

Final Survey



During the Listening Groups, and in the open text responses to the Voices Survey, respondents described birth trauma caused by a number of factors, including a breakdown in trust and relationships between them and those caring for them; lack of adequate information to make informed choices; feelings of lack of control or autonomy over their body; a disconnect between personal experience and how this is described by others and fear for themselves or their baby.

There was evidence that those who had had unexpected outcomes, particularly where there was birth trauma, found terms such as 'natural' less acceptable:

> "I now find natural is quite a difficult term. And I think, in a way, not having had a vaginal delivery did make me feel a little bit like a failed to do what was natural and part of, like, human instinct". (Service User, Voices Survey)

The women who responded very positively to the term 'natural' (23% of service user respondents in the final survey listed it as their most preferred term and 17% of women ranked it highest in the Voices Survey), also in the main described having their own experiences of such births:

> "I had 2 normal vaginal deliveries. I describe it this way as I believe this to be the natural way a woman was designed to give birth" (Service User, Voices Survey – preferred term: 'Natural').

> "I gave birth to both of my children naturally without any pain relief except a TENS machine and the support of my partner and a midwife. I use the word 'naturally' because it all happened pretty much as nature intended" (Service User, Voices Survey – preferred term: 'Natural')

'Normal' was more broadly challenged. In the Voices Survey, 7% ranked it first and 44% ranked it last and in the final survey only 7% of women felt it was their preferred term. This pattern was repeated amongst those who had both difficult and positive experiences (although these were small numbers) and similarly in the much larger Final Survey cohort.

The widespread sensitivity around language was likely to be exacerbated by experiences of birth trauma, as this participant explains:

> "Essentially the words are not the issue at all, it's the system. And you know, if we had a decent system in place from the get-go, and trauma rates weren't as high as they were, would people even be bothered about the language? Perhaps not. (…) What's happening to women on the daily is traumatising and therefore you know, if you have been traumatised, then those words [such as 'normal birth'] are going to have a bigger effect than if you haven't been" (Service User, Listening Group).

The accompanying table of responses to terms gives more detail about participant responses to specific words showing that those with more positive birth experiences were generally less polarised in their response to each term. This resulted in stronger feelings about terms amongst the Voices Survey cohort, which had a higher proportion of difficult birth experiences, than the broader final survey cohort.

Voices survey preferences

Difficult birth experiences (n=66)

	6 Most pref	5	4	3	2	1 Least pref
Vaginal	27%	27%	20%	9%	6%	9%
Straightforward	18%	27%	29%	8%	2%	2%
Spontaneous vaginal	30%	26%	14%	18%	8%	3%
Physiological	11%	14%	29%	23%	12%	11%
Normal	5%	3%	6%	23%	56%	56%
Natural	9%	9%	6%	14%	42%	18%

Positive birth experiences (n=31)

	6 Most Pref	5	4	3	2	1 Least pref
Vaginal	10%	19%	10%	26%	13%	13%
Straightforward	26%	6%	29%	16%	6%	6%
Spontaneous vaginal birth	16%	26%	19%	16%	16%	6%
Physiological	19%	16%	16%	16%	10%	23%
Normal	6%	6%	19%	16%	45%	45%
Natural	19%	16%	32%	10%	16%	6%

>=25%
20-24%
15-19%
10-14%
5-9%
<5%

Final survey preferences

Preferred terms for Clinical Notes, Research and Audit

	Difficult birth experiences (n=1374)			Positive birth experiences (n=1215)		
	Pref.	Don't mind	Shouldn't be used	Pref.	Don't mind	Shouldn't be used
W/o interventions	32%	51%	11%	19%	60%	14%
Spont. vaginal	25%	55%	13%	31%	56%	7%
Unassisted	18%	56%	20%	12%	52%	30%
Physiological	15%	49%	28%	30%	51%	13%
Natural	12%	41%	40%	17%	46%	30%
Normal	6%	29%	59%	8%	38%	49%

>=50%
40-49%
30-39%
20-29%
10-19%
<10%

Conclusion

This project was characterised by the complexity and diversity of perspectives brought both by 8,000 participants and the collaborative Project Oversight Group. Despite this, we have

shown that there is always common ground.

The maternity community was united in their desire for birth to be a safe, positive and empowering experience for all. Although there was disagreement throughout on specific preferred terms for labour and birth, the core principles were shared. Participants asked for language that is:

- **Descriptive and technically accurate**
- **Non-judgmental, non-hierarchical, nor value-laden**
- **Reflective of their actual experience, not what others assumed their experience to be.**

For health professionals, this language also needed to be accurate and detailed enough to enable the identification and record of all types of birth.

The evidence we have on the impact that language can have on decision-making and labour and birth experiences shows the importance of personalising language alongside other aspects of maternity care. Terms that are meaningful for some, can be deeply offensive to others and defaulting to any one term when speaking to all women, birthing people and families, runs a risk of harm.

The commonplace feelings of failure amongst the project participants and their sense of a birth 'hierarchy' within services, suggests that current modes of communication are being received as unnecessarily judgmental and prescriptive, regardless of good intentions. The development of the term 'normal' to describe what we might otherwise call a Spontaneous Vaginal Birth, has occurred from the ground up, and for most health professionals it does not hold the judgment that accompanies it in the community. However, we have shown that this ethos is not translated to how this and other terms are received.

Midwives, alongside other health professionals, continue to work to support physiological processes in all circumstances, including during medical interventions, but the findings from this project have led to the question:

> **How, can we create a maternity service that supports normal physiological processes, regardless of the type of labour and birth, and leaves women feeling positive and empowered?**

Answering this is highly complex and out of the scope of Re:Birth, but exploring this and other related topics will need future supportive platforms for open, honest, respectful conversations and a willingness to listen and hear other perspectives.

Strengths and limitations

This is the first project of its kind to consult the maternity community directly on their preferred language to describe labour and birth.

This project has been limited by time and resources and has made pragmatic decisions around method. The terms we consulted upon were restricted to those generated by early stages of the project. Participants were only asked to respond to five vignettes, which do not represent all possible labour and birth scenarios, however, in combination with the qualitative findings, we have been able to identify some key principles relating to language

that can be used in many other contexts. Further future analysis of this dataset could contribute to more understanding around the interplay of language and birth experience.

The project's core principles of collaboration, inclusivity, openness, listening and a rigorous method guided the choices we made around both methodology and method. The project was designed to balance rigour with accessibility, and to facilitate an open approach within the limitations of time and the scope of the project. The project was characterised by complexity, nuance, respectful disagreement, debate and reflexivity and the Project Oversight Group supported and challenged throughout. These factors have contributed to the rigour and reliability of the findings.

The Project Oversight Group

Professor Alexander Heazell	Consultant Obstetrician and Clinical Director of the Tommy's stillbirth research centre, University of Manchester
Amanda Smith	Maternity Engagement Action
Dr Angela Kerrigan	Consultant Midwives Network
Clea Harmer	Sands
Clotilde Abe	Five X More
Diane Keeling	British Association of Perinatal Medicine
Elizabeth Duff	NCT
Professor Helen Cheyne	RCM (Scotland) Professor of Midwifery
Dr Jan Smith	Make Birth Better
Professor Jane Sandall	NHSE/I Head of Midwifery and Maternity Research
Dr Jen Jardine	Royal College of Obstetricians and Gynaecologists
Dr Jenny McNeill	Lead Midwives for Education Network
Dr Jo Dagustun	AIMS
Jo Tanner	RCM Director of Communications
Dr Juliet Rayment	Re:Birth Research Fellow, RCM
Karen Jewell	Midwifery Advisor, Welsh Government
Maria Booker	Birthrights
Dr Mary Ross-Davie	Re:Birth Project lead, RCM
Maureen Treadwell	Birth Trauma Association
Mavis Afriye	Clinical midwife
Nuala Lucas	Obstetric Anaesthetists' Association
Sally Pairman	CEO International Confederation of Midwives
Shirley Cramer	Independent Chair
Professor Soo Downe	Professor of Midwifery Studies, University of Central Lancashire
Dr Susie Crowe	Consultant Obstetrician/National Maternity and Perinatal Audit
Verena Wallace	Nursing and Midwifery Council

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Appendix 1: Voices Survey text

Introduction

Welcome!

How doctors and midwives speak to families about labour and birth matters. It can make the difference between a positive or challenging birth experience, and can shape the decisions women and birthing people make about what happens to them and their babies.

The Re:Birth Project is all about those words both health professionals and families use to talk about different types of labour and birth, like 'normal', 'physiological' or 'operative' and how they make people think and feel. This survey takes around 10 minutes to complete. There are five quick questions for service users and three for health professionals and you can share your experiences by voice message, or by text. If you're having any trouble with the recorder, it might work better on your phone. Thank you for taking part.

1. **[ALL] What is Re:Birth all about?**

Introductory video

2. [ALL] The Re:Birth Project (Royal College of Midwives) would like to use what you have to say to help doctors and midwives have good conversations about labour and birth with families.

   You can read the RCM's Privacy Policy at www.rcm.org.uk/privacy-policy-terms-of-use. Please tick the following:

   - I understand that what I say is anonymous and no one will know who I am or anything about me except what I choose to share in my answers.
   - I understand that by answering these questions I am agreeing that the Re:Birth project can share my words (anonymously) in writing
   - I am also happy for the Re:Birth project to use my voice recording (anonymously) in presentations.

3. **We would like to know about your connection with maternity services. If you fit more than one of these, choose one to respond as.**

   I am a midwife
   I am a student midwife
   I am a midwifery support worker
   I am an obstetrician
   I am an obstetric anaesthetist
   I am a neonatologist
   I am a medical student
   I am a doula or other birth worker
   I have given birth in the UK in the last five years
   I have supported a partner, friend or family-member's birth
   I am a representative from an organisation that supports maternity service users

4. **[Service Users only]** The next few questions ask how you talk about and describe your labour/s and birth/s.

   Imagine you are telling friends or family about the labour and birth. What would you say? What words would you use to describe the labour/s and birth/s?

   Can you tell us why you describe them in this way?

5. **[Service Users only]** How far do you use different words to describe your labour/birth when talking to different people (e.g. friend, mother, midwife, doctor)?

6. **[Service Users only]** We're interested in your opinion of some words that are often used to describe a labour or birth without any technical interventions. This means a labour and vaginal birth without drugs to start or speed up labour, without forceps or a vacuum cup, without epidural or spinal pain relief or general anaesthetic, and without using an episiotomy (a cut).

   Below is a list of terms often used.

   Please put these in the order that you prefer them, where 1 is the one you prefer the most. There are no wrong answers!

   Use the red button to tell us a bit about your preferences and suggest other terms.

   - Physiological
   - Straightforward
   - Natural
   - Vaginal
   - Normal
   - Spontaneous vaginal

7. **[Service Users only] All births are different and everyone experiences birth differently. We'd like to know a bit about your experience of birth.**

From 'Not at all' to 'Extremely', how have your experience of labour/s and birth/s been? Scroll across to see all the options.

Exciting?
Enjoyable?
Satisfying?
Pleasant?
Exhilarating
A challenge?
Anxiety provoking?
Embarrassing?
Exhausting?
Difficult?
Traumatic?

8. **[Health Professionals Only]** We're interested in your opinion of some words that are often used to describe a labour or birth without interventions. This would be a labour and vaginal birth without:

- Induction
- Augmentation
- Forceps/ventouse
- Epidural/spinal/general anaesthetic
- Episiotomy

Below are some of the commonly used terms to describe this type of birth. Please put these in your order of preference, where 1 is the one you prefer the most. There are no wrong answers!

Hit the red button to tell us a bit about your choices, give us any other suggestions and why.

- Straightforward
- Spontaneous Vaginal
- Natural
- Physiological
- Normal
- Vaginal

9. **[Health Professionals Only]** When the women you work with are later describing their labour and birth to their friends and family, what one word would you hope they use?
10. **[ALL]** Is there anything else you think we should know about the language we use to describe different types of labour and birth that we haven't already asked you?
11. **[ALL]** Thank you! The following questions are about you. We are asking these to make sure we're hearing from a range of people.

Firstly, what is your ethnic group?

12. **[ALL]** What is your gender? [open text]
13. **[ALL]** Do you have a physical or mental health condition, disability or long-term illness?

Yes/No/I'd prefer not to say

14. **[ALL]** Do any of these conditions reduce your ability to carry out day-to-day activities?

Yes, a lot/Yes, a little/No, not at all

15. **[ALL]** Do you live in…? [select one]

Scotland
England
Wales
Northern Ireland

16. **[ALL]** If you don't live in the UK, which country do you live in?

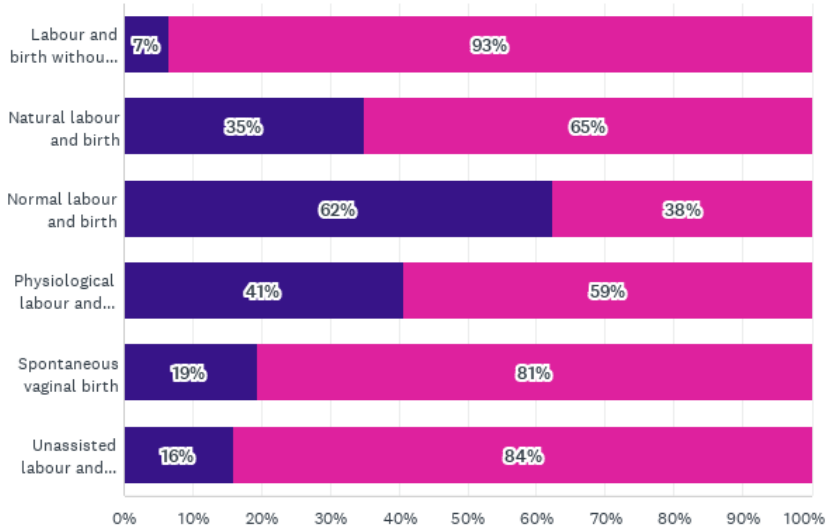
17. **[ALL]** What is your postcode? We won't use this to contact you.

Appendix 2: Preferred terms for Clinical notes, research and audit by role of respondents (Final Survey)

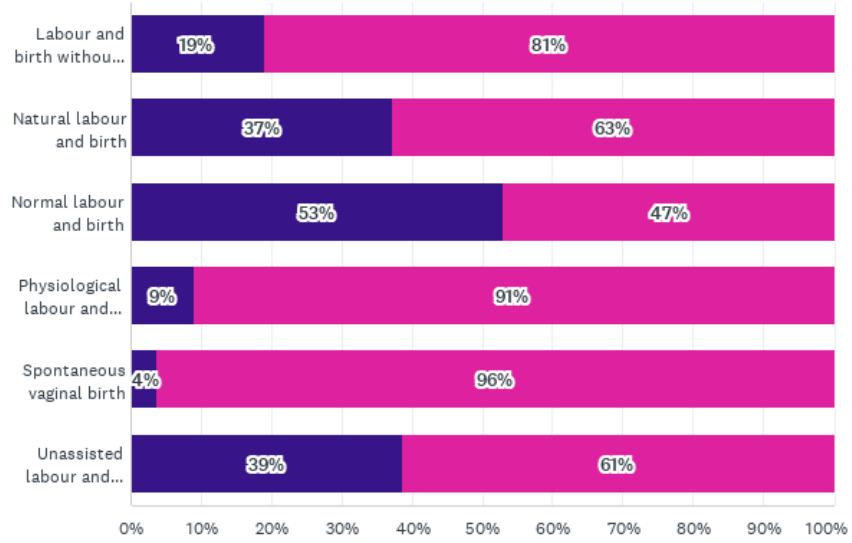
Lily was close to her due date when her labour started on its own. She laboured without needing help, apart from the support of her midwife and partner. Lily's labour progressed without any drugs to speed it up (no syntocinon infusion) and she gave birth to her baby vaginally without forceps or ventouse. Lily and her baby were both well afterward.

This shouldn't be used
Preferred term/don't mind

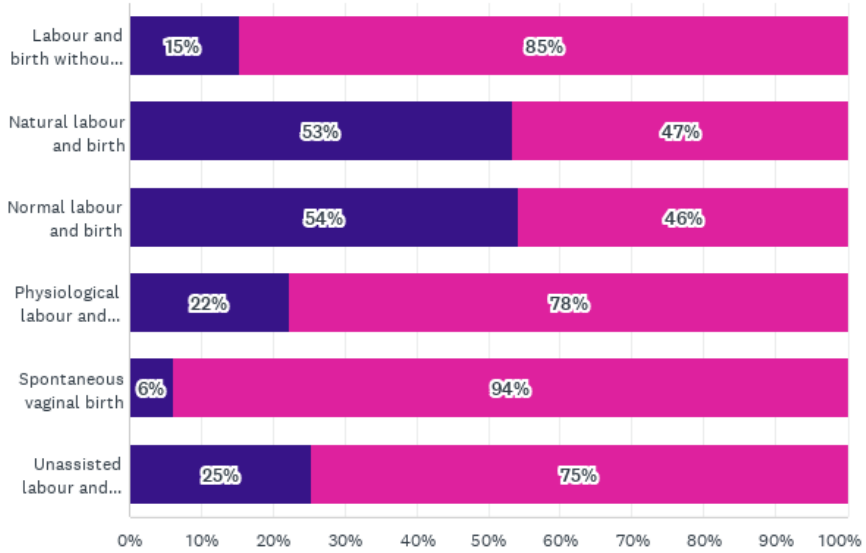
Service Users (Given birth, supported a birth (partner/friend/family), been pregnant, hopes to be pregnant) (n=2115)



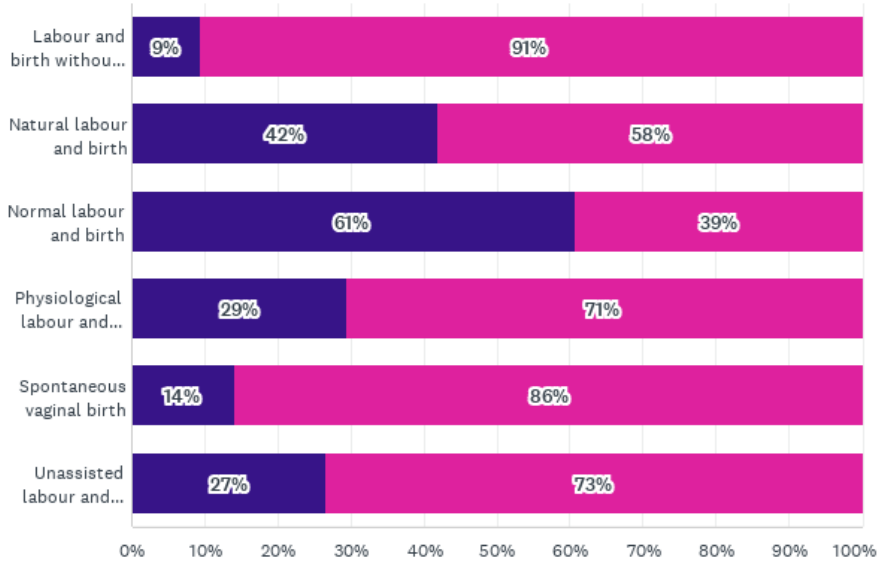
Midwives, Student Midwives, MSWs (n=3073)



Obstetricians, Obstetric Anaesthetists **(n=350)**

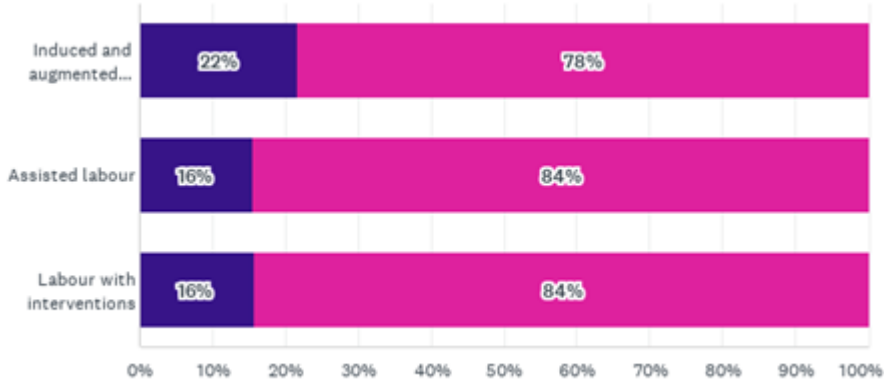


Others (Other health professional, doula, antenatal educator, researcher, lecturer) **(n= 494)**

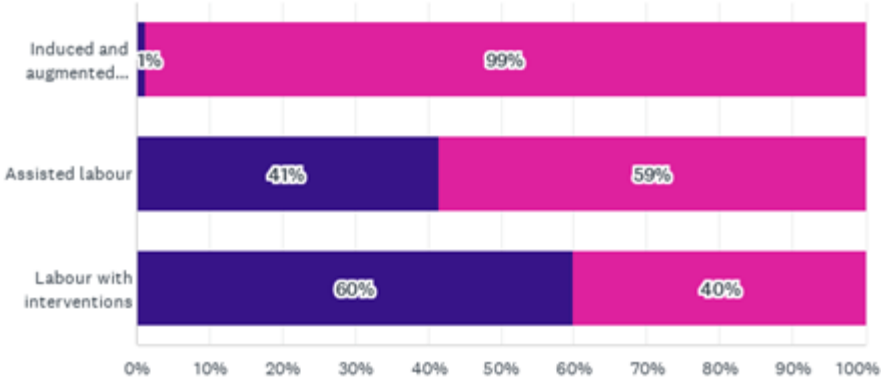


Aisha’s labour was started through an induction and she had drugs during her labour to strengthen her contractions (syntocinon infusion). She decided to have an epidural to help with her labour pains. She gave birth to her baby vaginally without the need for forceps or ventouse. For Aisha's story, we are interested in the terms used about her LABOUR, not her birth. Which terms do you prefer to describe this type of labour, that included syntocinon and an epidural?

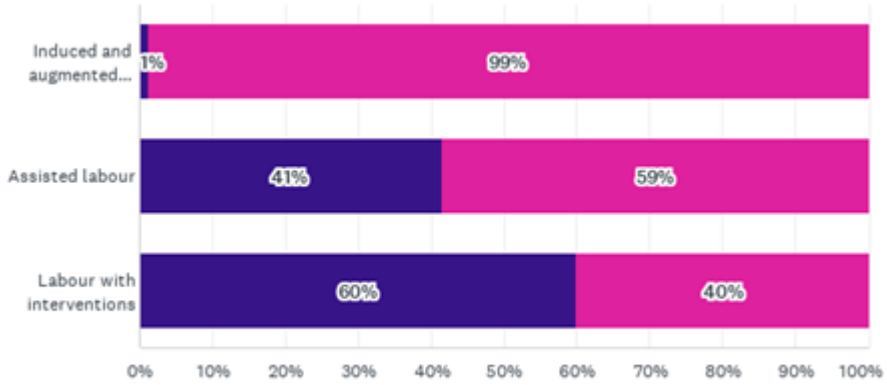
Service Users (Given birth, supported a birth (partner/friend/family), been pregnant, hopes to be pregnant) (n=2111)



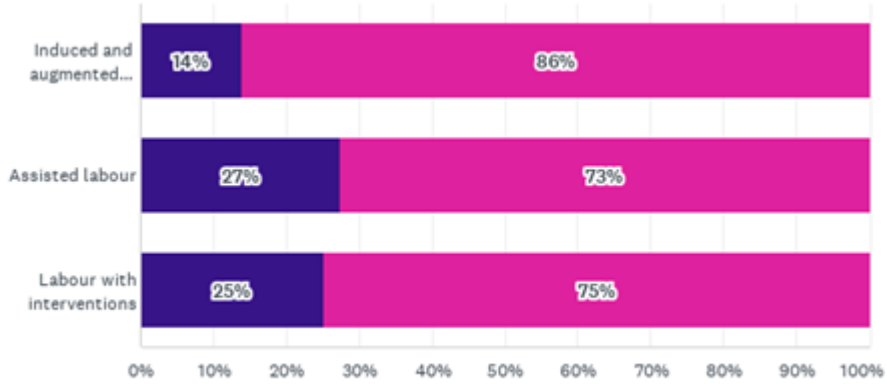
Midwives, Student Midwives, MSWs (n=3068)



Obstetricians, Obstetric Anaesthetists **(n=350)**

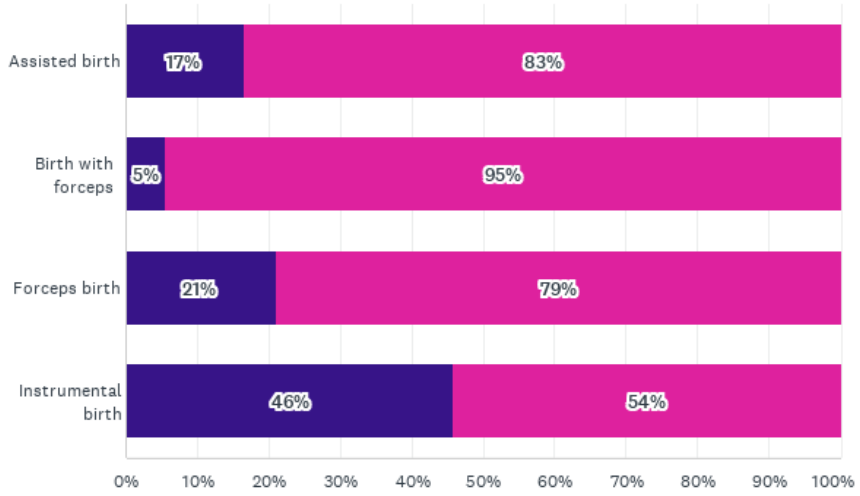


Others (Other health professional, doula, antenatal educator, researcher, lecturer) **(n=491)**

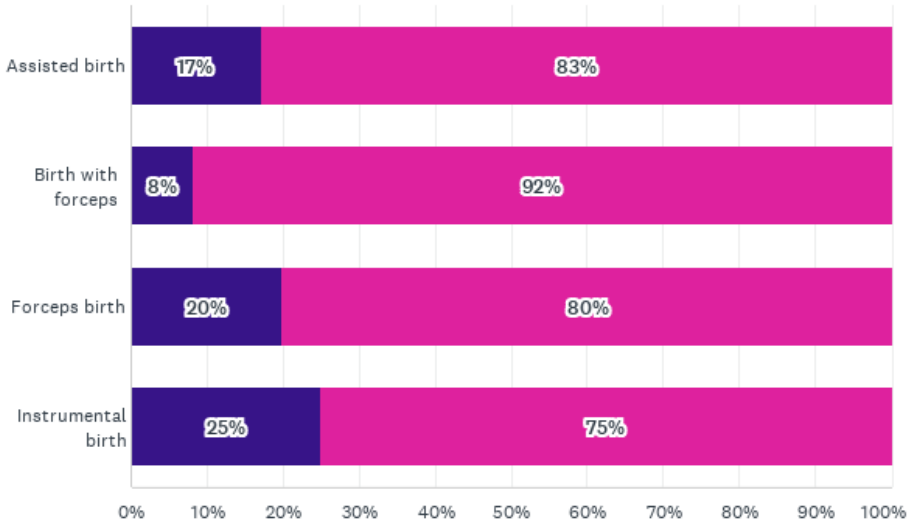


Chantelle's labour started on its own (without an induction) when she was close to her due date. She laboured without needing any help apart from the support of her midwife and birth companion. At the end of the labour, Chantelle, with her midwife and obstetrician, decided she needed help with forceps to give birth. For Chantelle's story, we are interested in describing her BIRTH (not her labour). What do you think about the options for describing this sort of birth?

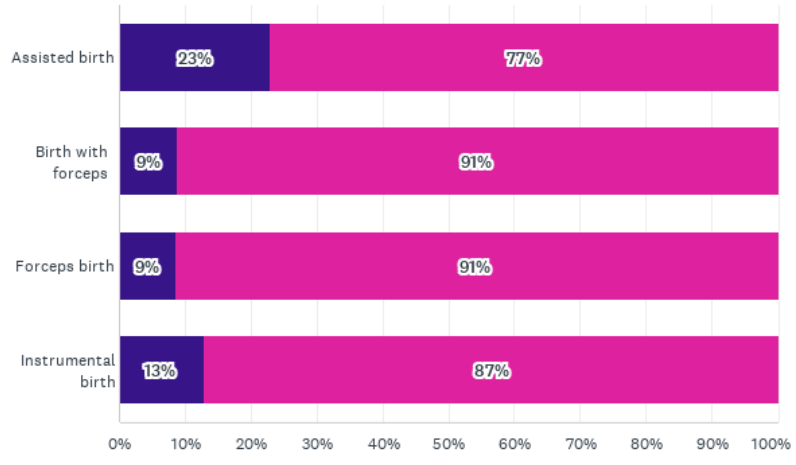
Service Users (Given birth, supported a birth (partner/friend/family), been pregnant, hopes to be pregnant) (n=2113)



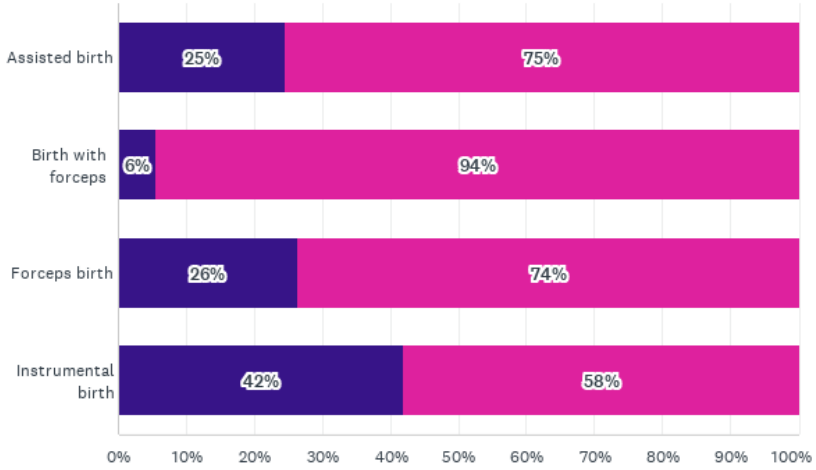
Midwives, Student Midwives, MSWs (n=3068)



Obstetricians, Obstetric Anaesthetists (n=351)

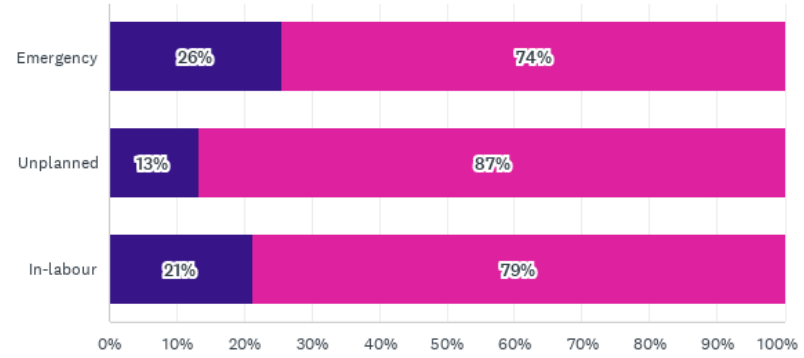


Others (Other health professional, doula, antenatal educator, researcher, lecturer) (n=492)

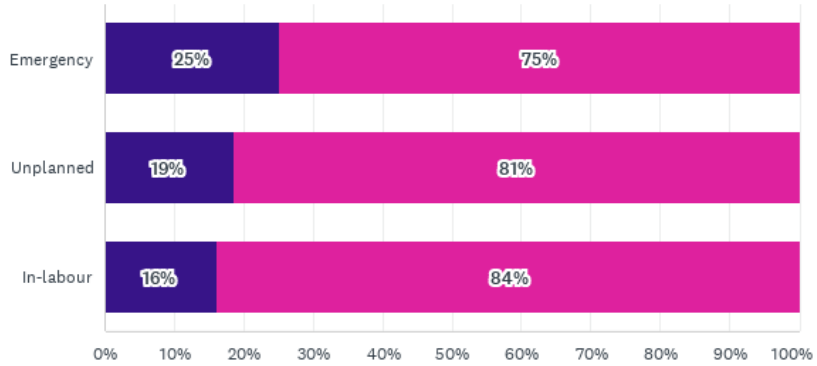


Q6: Sarah's labour started on its own, when she was close to her due date. But, as time went on, Sarah and the people caring for her agreed that she needed to birth by caesarean, which is how her baby was born.This caesarean could be described as 'emergency', 'unplanned' or 'in-labour'. What do you think about these terms?

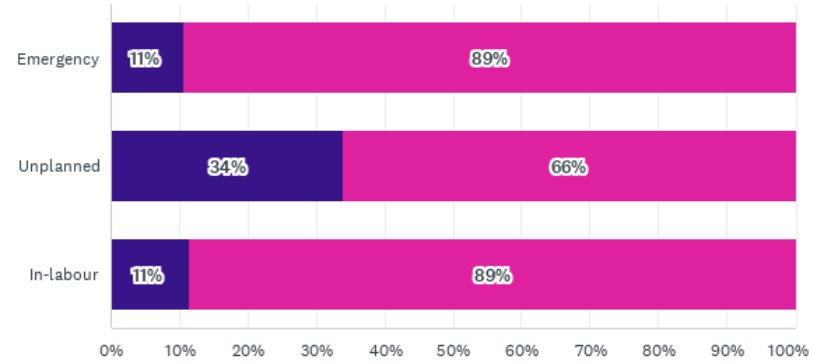
Service Users (n=2111)



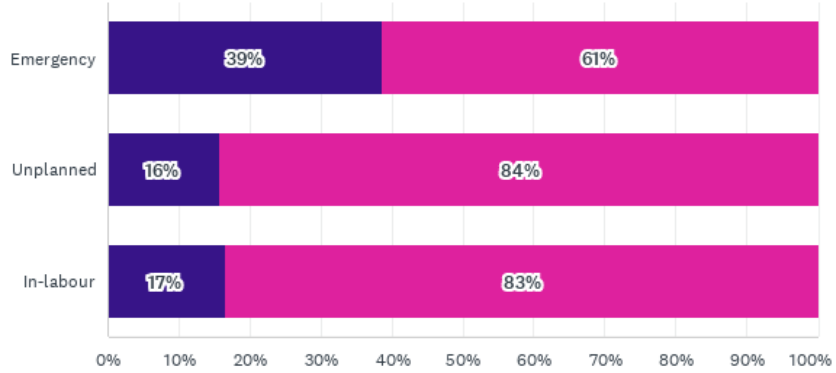
Midwives (n=3061)



Obstetricians (n=349)

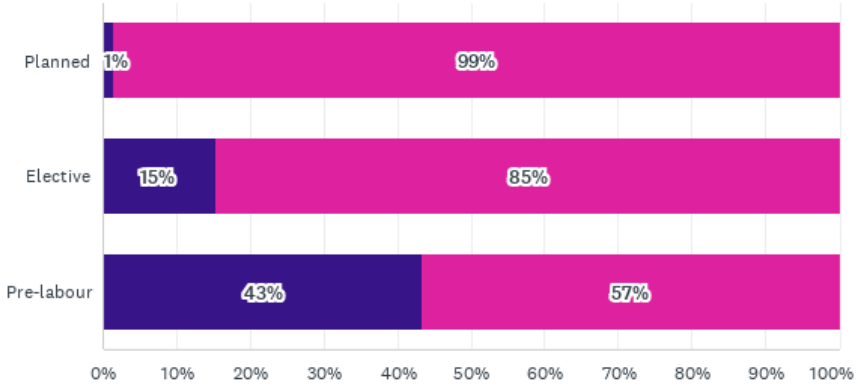


Others (n=492)

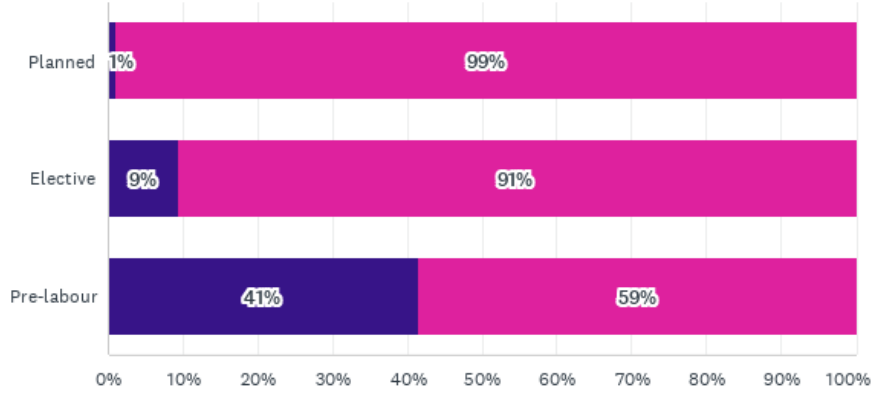


Q7: While she was pregnant, Jo and her care team agreed that her baby would be born by caesarean. This caesarean could be described as 'elective', 'planned' or 'pre-labour'. Which do you prefer?

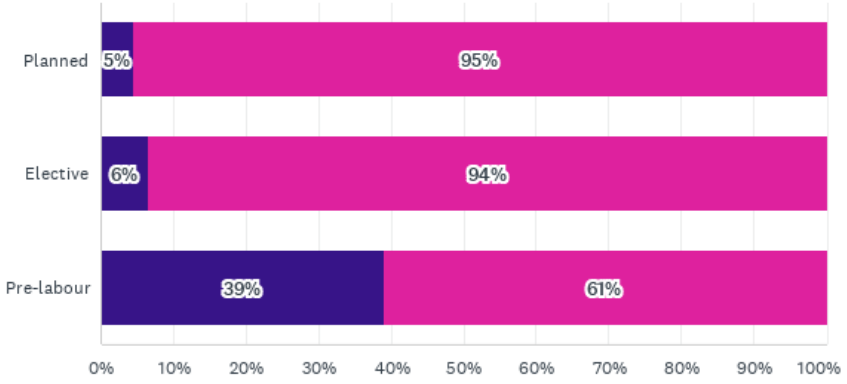
Service Users (n=2113)



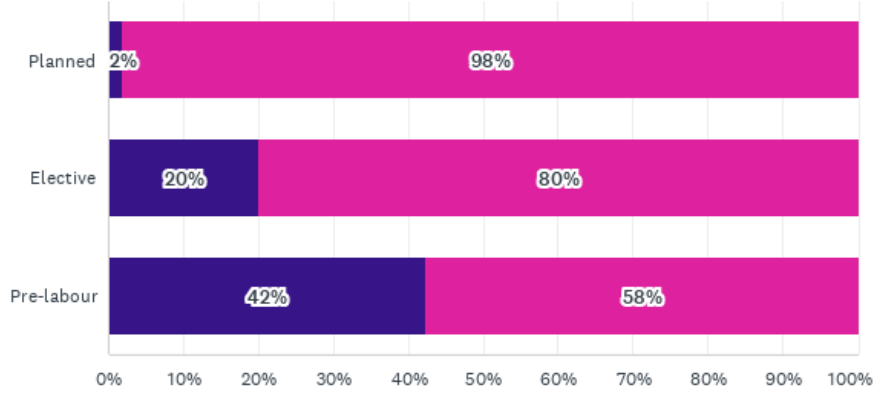
Midwives (n=3072)



Obstetricians (n=349)

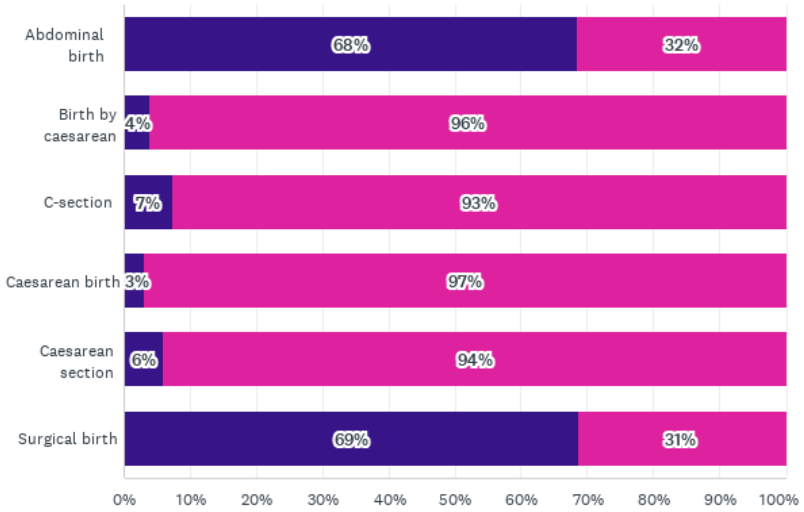


Others (n=491)

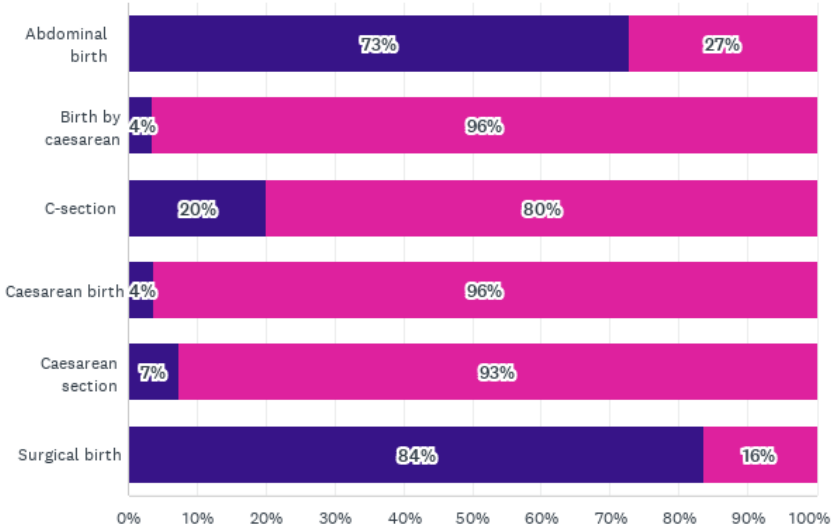


There are lots of other terms in use for what we often call a 'caesarean'. These can be used with the words from the previous questions to describe both types of this birth. Which terms do you prefer?

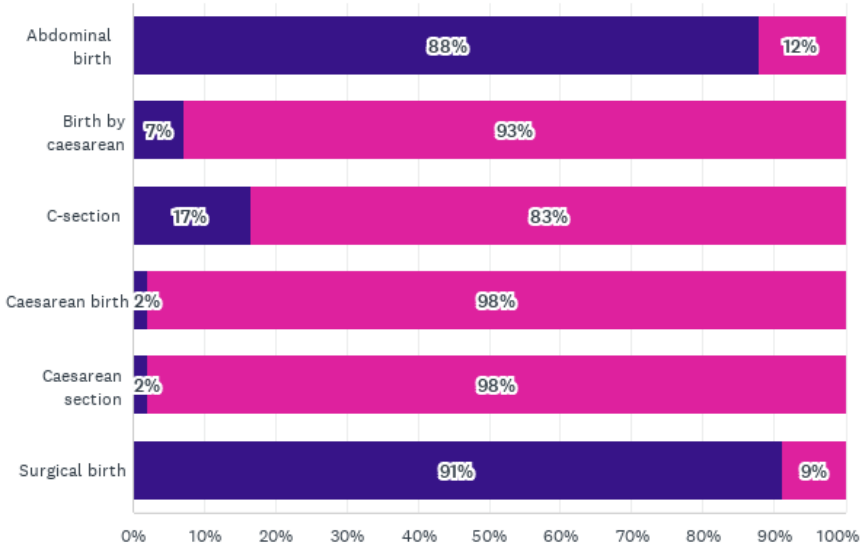
Service Users (Given birth, supported a birth (partner/friend/family), been pregnant, hopes to be pregnant) (n=2116)



Midwives, Student Midwives, MSWs (n=3072)



Obstetricians, Obstetric Anaesthetists (n=351)



Others (Other health professional, doula, antenatal educator, researcher, lecturer) (n=494)