Where are we with Place of Birth? Call for papers for a special issue

Planning place of birth is arguably one of the most important decisions that women and birthing people make during pregnancy. Place of birth has a clear impact on birth experiences and outcomes, although this varies by country, model of care and in relation to women's characteristics.
Women want greater choice of midwife-led birth settings, because these can offer autonomy, personalized care and a focus on supporting physiological birth (Scarf et al., 2018; Vedam et al., 2017). Birth settings include home birth, midwife-led units (often known as 'birth centres') and hospital labour wards or delivery rooms.

Some women and birthing people prefer to plan birth in a hospital labour ward. Reasons given for choosing hospital birth include perception of safety, preference for multidisciplinary team care, and access to epidurals or other pharmacological pain relief (Chadwick and Foster, 2014; Cheung, 2002; Coxon et al., 2017). In many settings, particularly low- and middle-income countries, women have little or no choice of place of birth. Access to midwifery units in lower resource settings is limited but has the potential to improve outcomes, as these provide care for women from otherwise under-served and marginalised populations (Bazirete et al., 2023). For many in lower resource settings, giving birth at home, often with a non-qualified birth attendant, is still the only option. As has been long recognised, even when facility birth is recommended, women often encounter transport or cost barriers and concerns about the likelihood of being treated disrespectfully if they access birth in a facility setting (Kassa et al., 2020; Thaddeus and Maine, 1994).

In high resource settings, women have more opportunities to choose a planned place of birth, including midwifery unit and homebirth. A Midwifery Unit (MU) is a '*location offering maternity care to healthy women with straightforward pregnancies in which midwives take primary professional responsibility for care. Midwifery units may be located away from (Freestanding) or adjacent to (Alongside) an obstetric service*' (Rocca-Ihenacho et al., 2018) (p.7). In some European countries, women can opt to give birth in a midwifery unit which is part of a national and publicly funded health service. In other countries, such as Germany or France, some MU care is covered by insurance but often women must pay towards those services. In USA**,** birth centres are often private, but may be covered by private health insurance or government-provided insurance. In Australia and New Zealand, public hospitals provide birth centres, but women accessing MU care from private midwives or doulas must pay, where these are not covered by Medicare (federal or state insurance).
Planned home birth is variably available in high resource countries, although rates of uptake are generally low, and women often need to pay privately for midwifery care. In some countries

homebirth is strongly discouraged, with possible legal repercussions for women and midwives. In recent years, we have also witnessed the growing phenomenon of free-birthing (electing to give birth without a health professional being present) (Jackson et al., 2012).

The options available in any setting are affected by provider-side issues including how maternity care is organised, a country's geography and history of maternity care provision, national or federal policies and legislation, use of private, publicly funded healthcare or a mixture of these, and the extent to which midwives are licensed, supported or insured to practice in different settings (Backes and Scrimshaw, 2020; De Vries, 2001). Remote and rural regions in high resource settings often have long traditions of birth in home or community settings, although such services are increasingly being withdrawn (Patterson et al., 2017; Pitchforth et al., 2008). In lower-resourced settings, efforts to reduce maternal and infant mortality have focused on increasing access to facility (rather than home or community) birth and skilled birth attendance, despite the reality that hospital birth does not necessarily result in high quality, respectful maternity care (Gwacham-Anisiobi and Banke-Thomas, 2022; Larson et al., 2020). Ultimately the level of choice women have in any setting is linked to the level of misogyny in the country. Multi-layered '*patriarchal structures and professional, socio-cultural and economic barriers*' (Renfrew et al., 2019)(p.4) limit women's access to midwife-led care and choice of birth settings.

Why it matters.

Midwife-led birth settings that are well integrated within wider maternity services are associated with optimal outcomes, positive service users' experiences and cost-effectiveness (Birthplace in England Collaborative Group, 2011; de Jonge et al., 2015; Homer et al., 2014; Hutton et al., 2016; Scarf et al., 2018). Such settings use a bio-psycho-social philosophy of care (Dooris and Rocca-Ihenacho, 2019; Foureur and Harte, 2017; Rocca-Ihenacho et al., 2021) which offer a holistic approach focused on the needs of the family. Experiences of care are better and women describe feeling able to make informed decisions, that their autonomy is respected and have access to birthing pools (Coxon et al., 2017; Macfarlane et al., 2014; Newburn, 2012; Wood et al., 2016).

Globally, there is an acute lack of midwives and the latest '*State of the World's Midwifery 2021*' report emphasised the need for 900,000 more midwives (Nove et al., 2021). In Europe, midwives are in crisis due to unprecedented pressures and many are leaving the profession (Cull et al., 2020; Hunter et al., 2019). As settings which provide opportunities to develop relationships with women and provide continuity of care are associated with positive experiences for midwives and job

satisfaction (Bloxsome et al., 2019; Cull et al., 2020), scaling up births in these settings could offer a solution for the high level of professional burnout.

Making sense of the evidence about maternal and infant outcomes by planned place of birth. Conducting research on maternal and neonatal outcomes in relation to planned place of birth presents many issues. Key quality features of birth settings outcomes research include identifying the intended birthplace at the onset of labour, using 'intention to treat' analyses (that is, reporting outcomes by planned rather than actual or eventual place of birth), identifying when women included are eligible for midwife-led care and using consistent ways of defining this across different studies, controlling for confounding factors, and if cross-national, ensuring there is an analysis of maternity care systems, level of integration for midwife-led settings and training level of midwives (Scarf et al., 2018; Olsen and Clausen, 2012). There is nevertheless a reasonable evidence base with studies using good quality observational designs, most of which has been conducted in high resource countries. A systematic review and meta-analysis of births amongst low risk women in high income settings found that planned births in birth centres and at home were as safe for babies as planned hospital birth (specifically, there was 'no statistically significant impact on infant mortality') and that care for women was safer, with lower rates of morbidity and obstetric intervention (Scarf et al., 2018) (p.240).

This body of research has several important gaps. It does not provide evidence about the safety of babies when women and birthing people opt to give birth at home or in midwifery units when these settings are not recommended for clinical reasons, or to freebirth, so the evidence to support women and clinicians in these situations is scant. Similarly, the evidence to date does not consistently account for outcomes when there are additional clinical, obstetric, social (exclusion from health care services, lack of access to culturally aligned, safe care), financial (exclusion by terms of health insurance from midwife-led settings or home birth, costs of accessing private care), organisational (exclusion from midwife-led services due to service gatekeeping, closure or lack of staff) or geographical risks (particularly delayed access to acute care if needed). There is also a considerable gap in evidence about outcomes for planned births in midwife-led settings in low- and middle-income countries. Bazirete et al.'s research identified that midwife-led birth centre care is available in many low and middle income countries (Bazirete et al., 2023), and such settings improve women's experiences of sensitive and women centred care (Nabirye et al., 2024), but comparative evidence on safety and wellbeing for women and babies in these settings is not yet available to our best knowledge.

As research on clinical and birth outcomes generally relies on secondary analysis of large data sets, reports depend on the range of outcomes and confounding date items which have been routinely collected, and the quality of the data inputted at source. There have been calls for randomised controlled trials of birth settings to minimise bias, but women and birthing people tend to have an instinctive preference for birth setting, and being randomly allocated to planned home birth, obstetric unit or birth centre has proved unacceptable where trials have been attempted (Olsen and Clausen, 2012). The 'Birthplace in England' Research Programme provided the 'next best' study design, being the first prospective cohort study to examine safety of planned birth in midwife-led settings or at home compared with planned hospital obstetric unit birth for babies of healthy pregnant women using an 'intention to treat' analysis (Birthplace in England Collaborative Group, 2011).

The *Birthplace* study found that planned birth was safe for babies of women at low risk of complications in a midwife-led unit or in planned home births, and safer for women due to lower rates of obstetric interventions compared to planned birth in an obstetric-led unit (labour ward). In a sub-group analysis by parity, 'Birthplace' found an increased risk of a serious adverse outcome for babies when a home birth was planned in a first pregnancy. The increase was small in terms of absolute risk but statistically significant. This finding has not been replicated in large national dataset studies conducted in the Netherlands (de Jonge et al., 2015; van der Kooy et al., 2017), or in Scarf et al.'s (2018) systematic review, suggesting it may have been related to the context of care in the UK, and demonstrating that international data analyses and meta-analyses can lack external validity. A further issue is that these studies are all based on historical data which is now over a decade old (fifteen years in the case of '*Birthplace*') and subsequently women, clinicians and policy makers and the research community are less confident that the findings remain dependable. Many countries have made extensive alternations to maternity care provision during and since the covid-19 pandemic, including closure of midwife led settings and large-scale shift to using online and telephone appointments in addition to 'in person' care, and so the transferability of these historic findings to current maternity care post-covid is, to say the very least, uncertain.

Because of these uncertainties, and the frequent politicisation of the 'birth place' debate, much of the evidence of safety, reduced costs, improved experience of birth and better clinical outcomes for women and babies in non-medical settings is subject to contestation. Similarly, women's decisions are often challenged by maternity care providers (and by those close to them) throughout pregnancy,

even when women are at low risk of complications, have been comprehensively counselled and make an informed decision to plan birth in a birth centre or at home (Coxon et al., 2017).

Philosophy and models of care in research on planned place of birth

A further issue with birthplace research is the focus on a limited number of short-term outcomes and a lack of a wider study of the impact of birthplace in the longer term and at family or population levels. The Global Strategy for Women's, Children's and Adolescents' health (2016–2030) (United Nations Every Woman Every Child Co-ordination Group, 2015) is designed to initiate change so that women, girls and others facing discrimination are enabled to 'Survive, Thrive and Transform'. This requires establishing a vision for maternity services which focuses not only on maternal and child survival but enables women and birthing people to thrive and experience a transformed social context, including elimination of all harmful practices, discrimination and violence (ibid, p.46).
A bio-psycho-social philosophy of care can contribute to this strategy's aims by catering for the biological, psychological, social and spiritual needs of women and their families (Rocca-Ihenacho, 2024) (Rocca-Ihenacho, 2024).

Call for new evidence: A Second Special Issue on Place of Birth

In the UK's NHS, choice of place of birth remains central to national maternity care policy, a position unchanged over 30 years. In the years following publication of *Birthplace*, policy targets meant that providers worked to increase choice of different birth settings, and this had some effect; by 2020, around one in five births took place in a midwife-led birth centre (18%) or at home (2%). Since the Covid-19 pandemic however, this has reduced considerably, and the most recent national figures (NHS Digital, 2022) show around 12% of women gave birth in a midwife-led unit and 2% at home (Office for National Statistics, 2022). Whether this is due to reduced availability of alternative birth settings, reduced demand from women or increased rates of induction and caesarean is unclear, but it is likely that all these contribute. In the US, and the Netherlands, by comparison, community home birth rates increased during the pandemic (MacDorman et al., 2022; Verhoeven et al., 2022), though it is not clear if these trends have been maintained.

There have also been some marked societal changes in the past decade; the #blacklivesmatter campaign and grassroots organisations in UK, Canada and US have raised awareness of the ethnic disparities in poor maternity care outcomes in the UK, disparities also reflected in a series of UK MBRRACE national reports (Knight et al., 2023, 2022, 2016). In the UK, women who plan home birth tend to be white and more affluent than their peers (Birthplace in England Collaborative Group,

2011); in US and Australia, insurance may not cover home birth or care by a midwife, and this restricts access to these services by women without the means to pay. Women from marginalised communities are less likely to be offered choices or supported to access these (Cheyney, 2008; Vedam et al., 2024, 2019). The move towards a cultural safety approach within maternity care that is respectful of indigenous cultures including birthing beliefs and family-based relational care (Churchill et al., 2020) provides a means to offer respectful care and personalised choices to women and birthing people, but few of these initiatives have yet gained traction, and if anything the momentum is towards increasingly high-volume, high turnover hospital based care.

Another major change is the international increase in interventions in birth, induction of labour and use of surgical and operative birth, in high, middle and low resourced settings (Boerma et al., 2018; Miller et al., 2016). This means that fewer women and birthing people feel in a position to choose where to give birth, as so many are channelled into hospitals. Whilst this is clearly vital when it corrects a lack of access to acute lifesaving care, in many cases there has been an increase in intervention without improvements to outcomes for women or babies, and the consequences for women's perinatal mental health, experiences of birth as traumatic, and delayed recovery from surgical and operative births are becoming ever clearer (APPG, 2024; Select Committee on Birth Trauma, 2024).

It is in this context that we are opening a call for papers for a second special issue on place of birth. We welcome papers from across the world which present research about place of birth, and are especially interested in those which provide current, post-pandemic knowledge from different settings. We would be interested to hear about how (or whether) different maternity systems are addressing this and where there is evidence of grassroots or other service-user led movements seeking to improve post-pandemic access to choice of place of birth. Papers reporting research by or with midwives, obstetricians, skilled attendants, doulas, traditional birth attendants are welcome, along with contributions from policy makers or NGOs working in this area. We noted in the first special issue the lack of research from lower-resourced settings and would be particularly keen to hear of any research undertaken in such settings which seeks to extend access to choice of birth setting, or reports (such as commentaries) on the complexities of achieving this. Research involving or led by service users and advocacy groups is particularly welcome.

Submitted manuscripts should provide clear explanations about the types of birth settings being discussed and any models of care which are operating, to allow an international readership to

understand application and transferability to different settings. The call will be open until June 2025 and we plan to launch the special issue at the UK International Labour and Birth Research Conference in September 2025.

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