The Re:Birth project: Methods and technical report

Introduction

Public conversations in the UK on terms such as 'normal birth' have raised questions about all language used to describe different types of birth. The Re:Birth project was set up to find common, acceptable terms for types of labour and birth that could be shared and understood both by those delivering maternity care and those receiving. We wanted to ensure that the language we use helps support safe and high-quality care and to identify which terms serve our maternity community best. This report outlines the methods and participant characteristics of the project, and is intended to be read alongside the summary briefing report, available here.

Organisation and oversight

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 consisted of 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 additional 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.

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, who is a sociologist with a background in maternity services research.

Core values

The Re:Birth 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

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. The project aimed to explore the experiences and perspectives of the maternity community in the United Kingdom, across all four countries.

The consultation process had three, interlinked, stages: Listening Groups, the Voices Survey and a final survey.

The Listening Groups
Aims: To understand the most important issues relating to the language of labour and birth for the maternity community. To identify as many alternative terms as possible for what might otherwise be called a 'normal labour and birth'.

Participants: To support open conversation, the groups were limited to no more than 12 participants. Participants were invited through POG networks, professional contacts and social media and around 130 people registered their interest. Participants were allocated by anonymous ballot, firstly prioritising those from minority ethnic communities, younger service users (under the age of 25) and those living outside of England and then at random (using a random number generator) to include a mix of people with different roles.
The groups were:

- Five public groups with postnatal women and birthing people, midwives, obstetricians, neonatologists, obstetric anaesthetists, maternity support workers, doulas, antenatal educators and other birth workers. (n=35)
- Two groups with members of the POG, as experts in maternity 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)
- Two workshop discussions with student midwives (n=51, this included a full cohort of third year student midwives)

Method: The Listening groups offered a space for in depth and wide-ranging, facilitated conversations between individuals who may not usually have the opportunity to hear each other's perspectives. The groups were all held online via Microsoft Teams. They began with an invitation to service user participants to explain how they describe their own labours and births and why. The conversation was 'held', but loosely guided, by the facilitator – following

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[1] (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.

The discussions were recorded and anonymously transcribed. Participants gave consent to take part when they registered their interest. They gave further verbal consent to recording, transcription and the use of their anonymised quotes in project outputs at the start of each group.

The Voices Survey

Aim: The voices survey was an online survey designed to allow people beyond the small listening groups to share their stories. It also polled on the six most preferred terms to describe a birth without medical intervention.

Participants: The survey was open for three weeks in December 2021 and January 2022, promoted through the POG networks and social media. Although use of open text responses allowed us to collect a large number of detailed, personal stories, this structure is demanding for respondents. Consequently, the drop off rate from this survey was high. A total of 1818 people clicked through to the survey. Of these, 20% (n=367) did not answer any questions and 38% (n=687) did not respond to any questions beyond their role in maternity services. These were excluded from the analysis. In total, 764 (42%) people's stories were included in the final analysis. Around 10% of respondents chose to reply by voice.

Method: The voices survey was hosted by Phonic (www.phonic.ai) and the questions were audio recorded and accessible by reading or by listening. Individuals could also respond by text or by voice recording. The survey was open to anyone who had given birth in the last five years, supported a birth, or worked professionally around birth, but was limited to those with sufficient English to understand and respond to the questions, either by reading/writing or listening/speaking.

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).

Respondents were asked to rank the six most preferred terms generated from the listening groups 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.

Participants gave consent to participate, to have their words anonymously shared in writing and to have their voice recordings used anonymously in project outputs. They gave or denied consent to each element independently.

The final survey

Aim: The final survey aimed to reach as many people as possible to hear their preferences for specific terms that could be used in clinical notes, research and audit.

Participants: The survey was hosted by Survey Monkey for four weeks in Spring 2022. It was circulated through POG contacts, and on social media. 6,948 people responded, with an 84% completion rate (where all questions were completed). All responses were included in the analysis.

Method: 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', an 'elective caesarean'. There was also a question relating to 'caesarean'.
In total, 25 terms were presented across the six scenarios. These were generated by the listening group discussions. 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.

Coding and analysis

The Listening Group transcripts and open text responses to the voices survey were coded using NVivo 12 software. This involved careful reading and the identification of common themes. The relevant text was then 'tagged' to identify where those themes arose.
The coding was done iteratively, which means we started with a 'blank sheet' and responded to the themes in the stories, rather than imposing a ready-made framework on them. The responses were then analysed by theme to look for significant trends, where people agreed, where there were conflicting views and why that might be. A sample of listening group and voices survey responses were also coded by an independent researcher, Dr Georgia Clancy, University of Warwick, to check for any significant disagreement. The analysis looked at a cross section of responses by theme, rather than at an individual's whole response as a complete narrative. This was a pragmatic decision due to the limitations of time.

The analysis of the demographic questions and the preferences for terms in both surveys was carried out in Microsoft Excel.

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=6,948).

Role in maternity services

Over a third, 37% (n=2885), of survey participants were service users: that is, women and people who had been pregnant, given birth or supported their partner or family member's birth. Around 50% of these had given birth in the last five years. Nearly half of the survey participants, 48% (n=3,732), were midwives, student midwives or maternity support workers, five% (n=403) obstetricians or obstetric anaesthetists and 10% (n=799) were a range of other people, including other healthcare professionals, doulas, antenatal educators, birth workers, researchers and lecturers.

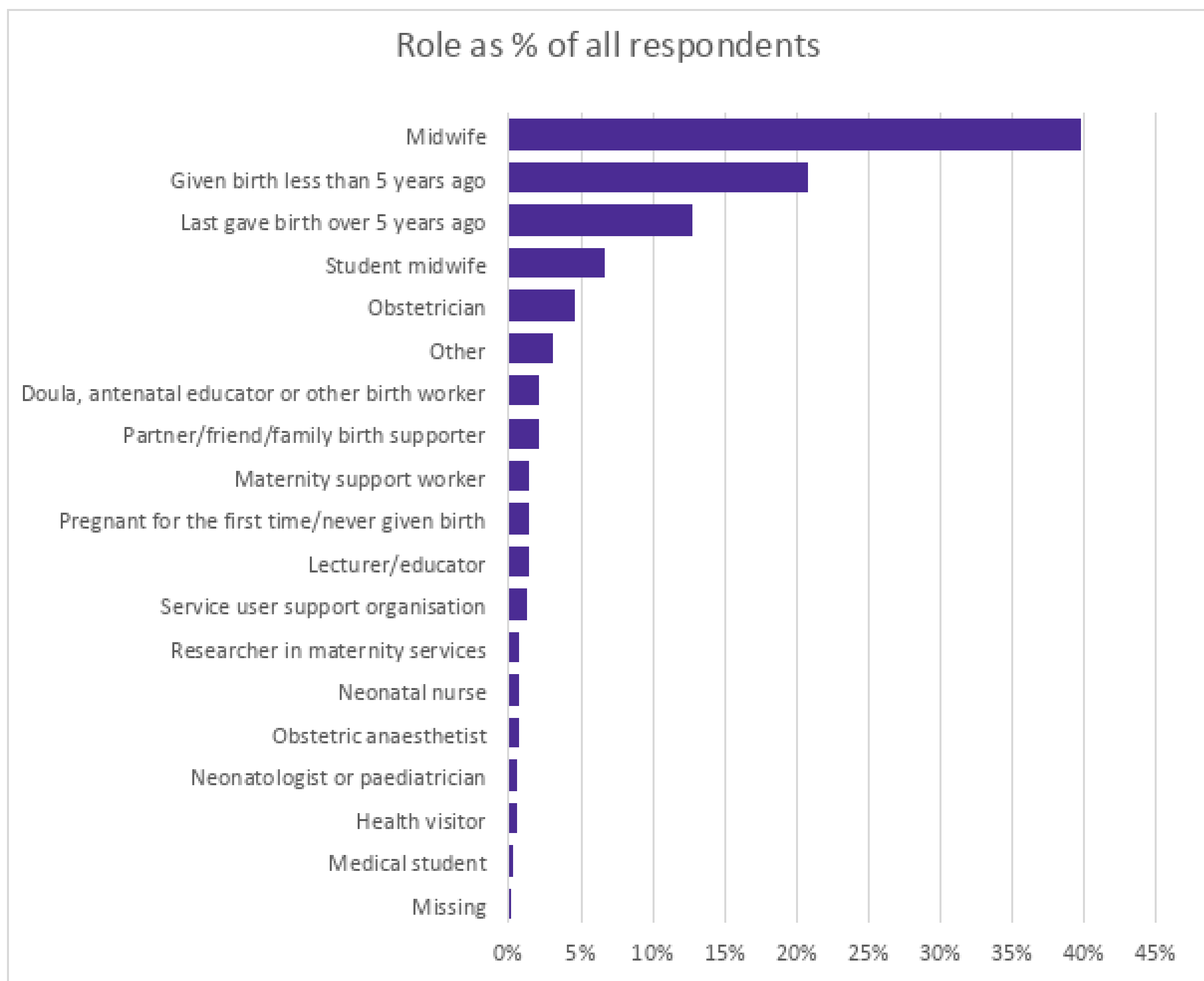

Chart 1: Role of Re:Birth participants (percentage of all respondents)

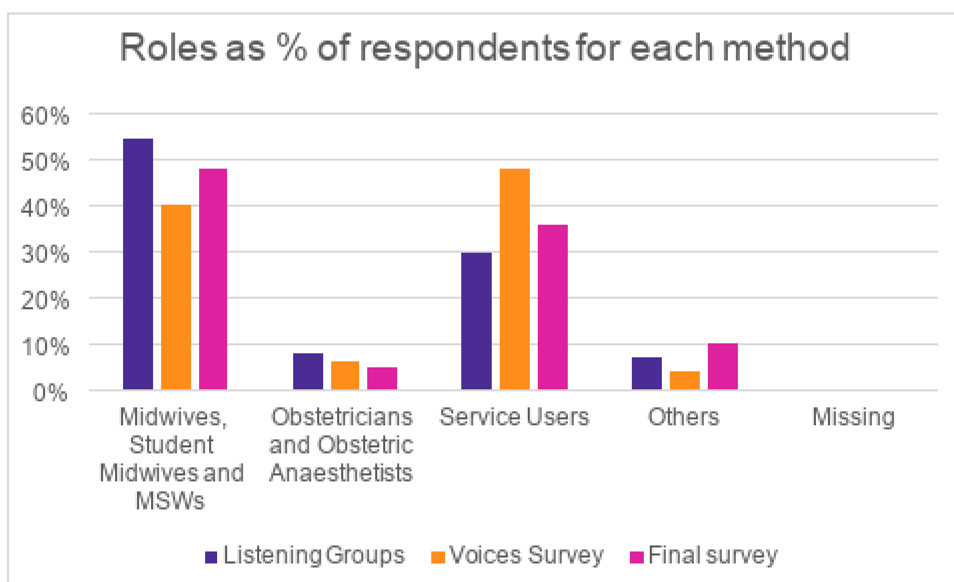

Chart 2: Role of Re:Birth respondents (comparison for each method)

	Listening Groups		Voices Survey		Final survey		Total	
	%	Count		Count	%	Count	%	Count
Midwives, Student Midwives and MSWs	55%	60	40%	309	48%	3363	48%	3732
Obstetricians and Obstetric Anaesthetists	8%	9	6%	49	5%	345	5%	403
Service Users	30%	33	48%	370	36%	2517	37%	2920
Others	7%	8	4%	33	10%	723	10%	764
Missing	0%	0	0%	3	0%	0	0%	3
Total		**110**		**764**		**6948**		**7822**

Table 1: Role of Re:Birth respondents (comparison for each method)

Ethnicity

Around 72% (n=5,512) of survey participants (n=7,712) were from a White British or Irish background and 12% (n=935) were from a minority ethnic community, as compared with 14% 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. A small number of people from other countries (n=147) responded to the surveys and were included in the analysis.

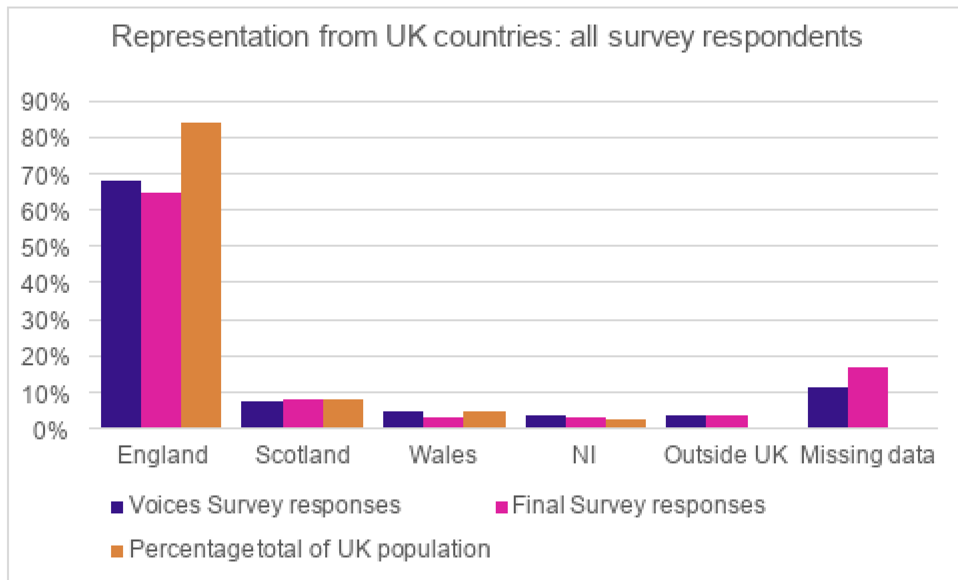

Chart 3: Proportion of survey respondents from UK countries compared with UK population

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.

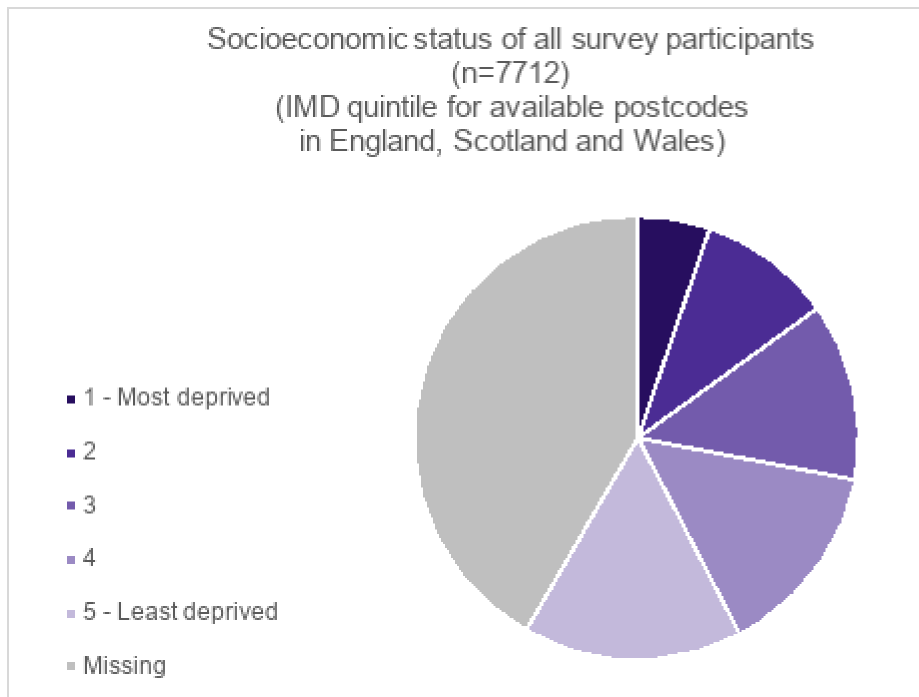

Chart 4: Socio-economic status of all survey participants (IMD quintiles for England[2], Wales[3] and Scotland[4])

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, as were trans people or as a participant who identified their gender as 'male/man' but had also given birth (female sex).
Responses were coded and tabulated:

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 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% 'a little' and 12% 'a lot'.

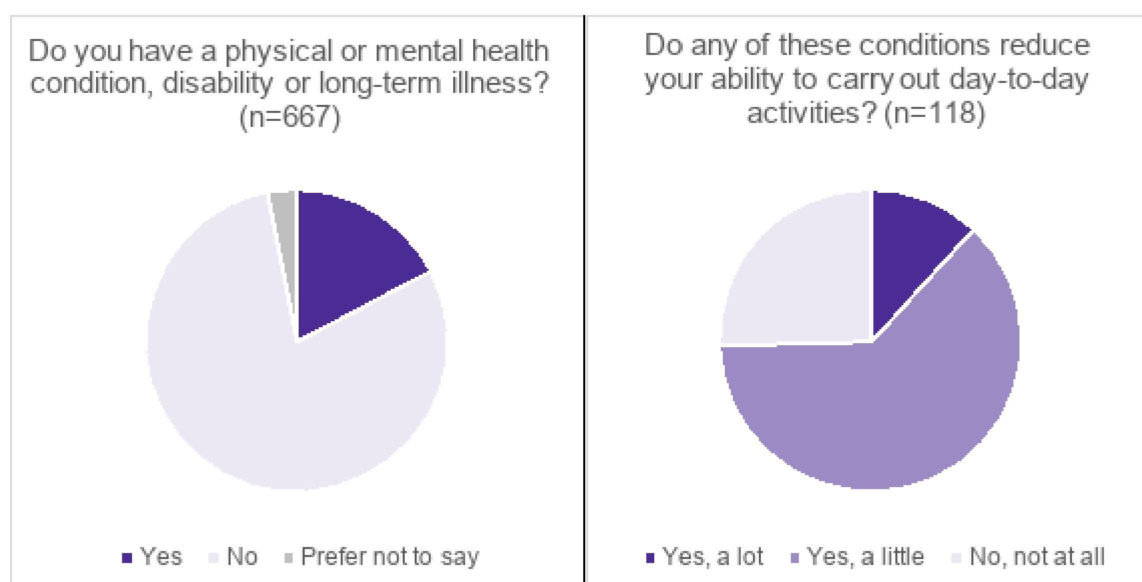

Chart 5: Disability and impairment of voices survey respondents

Previous experience of birth

The listening group discussions strongly suggested that the listening 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

labour and birth as ether positive or difficult may influence thoughts, opinions and perspectives on language.

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-provoking5 and were presented on a 7-point Likert scale.

The findings from this and a sub-analysis of perceptions of terms by birth experience are included in the main report.

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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.

The project's core principles of collaboration, inclusivity, openness, listening and evidence-based 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.

Re:Birth
June 2022

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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.

END

Appendix 2

Final survey vignettes and options presented

Options presented (in no particular order)	Scenario/survey question
Unassisted labour and birth **Physiological labour and birth** **Labour and birth without interventions** **Normal labour and birth** **Natural labour and birth** **Spontaneous vaginal birth**	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.
Instrumental birth **Assisted birth**	Chantelle's labour started on its own (without an induction) when she was close to her due date. She

Forceps birth **Birth with forceps**	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?
Labour with interventions **Assisted labour** **Induced and augmented labour**	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?
Emergency **Unplanned** **In-labour**	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?
Pre-labour **Elective** **Planned**	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?
Surgical birth **Abdominal birth** **C-section** **Caesarean section** **Birth by caesarean** **Caesarean birth**	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?