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Parent Education Today: Walking the Walk

Practice Pointers from the Conference Workshops

Supporting mums with learning disabilities

Fathers and breastfeeding

Helping with excessive crying

Making music with infants

FAQs about home birth

A supplement to 'Contemporary Parent Education: Walking the Walk', IJBPE Conference, March 21st, 2016

On March 21st, the International Journal of Birth and Parent Education ran a highly successful conference hosted by the University of Worcester. The conference, entitled 'Contemporary Parent Education: Walking the Walk' attracted midwives, health visitors, birth and parent educator and Children's Centre staff from across the UK. As well as plenary sessions, delegates had the opportunity to attend three of seven workshops. Many delegates contacted me to say that they would like to know about the workshops they were unable to attend, and to have some notes about the workshops in which they participated. In addition, some people who couldn't come to the conference asked me if I could send them briefings from the workshops.

To meet these requests, this supplement to the Summer issue of the IJBPE offers readers summaries of the conference workshops written by the leaders themselves. We hope you find the information useful and inspirational.

Mary Nolan

Mary Nolan
Editor-in-Chief

Using the 'F-Word': Maximising fathers' support for breastfeeding

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Amidst growing concerns that the UK has one of the lowest rates of breastfeeding in the world, this workshop considered why fathers should be engaged to support breastfeeding, and how. It presented a new model of father support to promote breastfeeding, based on:-

- knowledge about breastfeeding
- positive attitudes to breastfeeding
- involvement in the decision-making process for breastfeeding
- practical support for breastfeeding
- emotional support for breastfeeding (Sherriff et al., 2014a)

BACKGROUND KNOWLEDGE/RESEARCH

Evidence demonstrates that fathers remain an 'untapped resource' for breastfeeding support. Our own research with colleagues has revealed that fathers from diverse backgrounds and circumstances are interested and want to be involved more broadly in preparation for, and support of, breastfeeding (e.g. Sherriff et al., 2014b; Sherriff et al., 2009). However, what is also clear is that many fathers face a number of barriers to being meaningfully involved. Amongst others, these barriers can be practical (e.g. timing of antenatal provision), attitudinal (e.g. concerns that fathers pose more of a 'risk' than a 'resource') and political (e.g. allocation of resources).

Our research exploring how fathers can be engaged to support breastfeeding has led us to conclude that initiatives to support breastfeeding focusing purely on mothers appear not to be sufficient.

Although there have been important increases in initiation of breastfeeding since the UK Department of Health first set targets in 2002, prevalence of breastfeeding at six to eight weeks has risen more slowly - 0.9% and 0.7% per year respectively for 2005-6 and 2012-13 (Oakley et al., 2014). Moreover, many mothers report that they did not receive the support they required and would have liked to breastfeed for longer (McAndrew et al., 2012). This mis-match between initiating and continuing breastfeeding is reinforced by data on breastfeeding drop-off rates which show that for every 100 women initiating breastfeeding, 41 had stopped breastfeeding by six to eight weeks in 2014-15, compared to 36 in 2011-12 and 2012-13 (NHS England, 2015). This means that the number of women who want to breastfeed but do not get the support they need to continue has changed little and may be getting worse. We argue that some of this 'missed' support could come from fathers or others in a co-parenting role. Such an approach may be particularly relevant in a climate where resources for health professionals and peer support have, and are being, reduced significantly (see https://ukbreastfeeding.org/open-letter).

Consequently, we have proposed that a different approach is required that would involve routinely and meaningfully engaging with fathers across the perinatal period to support breastfeeding. This does not take valuable and limited resources away from the mother; rather investing in fathers amplifies the support for mothers. Fathers can offer a continuity of breastfeeding support which overstretched and fractured support from health professionals (e.g. midwives, health visitors, maternity support workers, nursery nurses) can rarely provide.

IDEAS FOR 'PROMISING PRACTICE'

'Best practice' ideas are difficult to propose given there are few initiatives involving fathers and none, as far as we are aware, has been evaluated rigorously enough to warrant using the term 'best' or 'effective' practice. Therefore, 'promising practice' is used here to describe practice and interventions that appear to be important in light of emerging findings from research.

PROMISING PRACTICE
KNOWLEDGE ABOUT BREASTFEEDING

- Acknowledge the importance of a father's role in supporting breastfeeding (parents, health professionals, policy-makers).
- Target communications and information specifically to fathers.
- Assist fathers in 'learning the role' and challenge misconceptions/myths supportively.
- Help mothers/fathers manage their expectations of breastfeeding more realistically.
- Conduct activities to reduce the father's anxieties in relation to the mother's welfare and the baby's weight gain.

PROMISING PRACTICE
POSITIVE ATTITUDES TO BREASTFEEDING

- Address the sexualisation of breasts, particularly with younger parents.

- Assist fathers to challenge negative perceptions of breastfeeding from others.
- Improve attitudes of health professionals (and others) towards engaging with fathers by providing training. In the UK, such training is available from the Fatherhood Institute (www.fatherhoodinstitute.org).

PROMISING PRACTICE INVOLVEMENT IN DECISION-MAKING FOR BREASTFEEDING

- Encourage parents to discuss ideas about infant feeding early in pregnancy.
- Inform both parents about the key differences between breastmilk and infant formula and their non-equivalence.
- Help parents acknowledge that decisions regarding breastfeeding and alternative modes of feeding may need revisiting by both parents, including 'returning to breastfeeding' if breastfeeding gets off to a difficult start.

PROMISING PRACTICE PRACTICAL SUPPORT FOR BREASTFEEDING

- Engage with fathers to acknowledge, learn about and accept their role in providing practical support for breastfeeding. This means helping fathers understand that bonding between father-infant occurs through all aspects of childcare and not just through (breast)feeding.
- Encourage fathers to either anticipate or be directed by, the practical needs of the mother.
- Sign-post parents so that they can examine their parental/annual leave options to maximise flexibility in providing support.

PROMISING PRACTICE EMOTIONAL SUPPORT FOR BREASTFEEDING

- Help fathers to appreciate that breastfeeding can feel isolating; where possible, the father's physical (or even virtual) presence, can be helpful.
- Help fathers to understand and acknowledge the new mother's change of identity and its implications, and provide non-sexual affection and encouragement for breastfeeding.

CONCLUSIONS

Discussion in the workshop led to a broad consensus that involving men and fathers in breastfeeding support for the welfare of children in the short and longer term, needs to be normalised. Caution over including some fathers in ante- and post-natal services owing to concerns regarding 'risk' should not become a generalised exclusion of men and fathers. We need to go beyond the tokenism of referring to 'parents and carers' when actually we are only talking to and about mothers. At the end of the workshop, participants considered whether now is the time to be less wary of using the 'F-word', the father-word, in developing and implementing high quality support for breastfeeding. We think it most certainly is!

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Supporting mothers and fathers with learning disabilities

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This workshop provided an opportunity for participants to increase their awareness of the experiences and needs of mothers and fathers with learning disabilities, identify some of the opportunities and challenges for effective working and to be able to describe what 'good' looks likes when offering support. We also considered where to access further support and resources.

People with learning disabilities typically want the same things in life as everybody else: good friends, good health, their own home, a job and a family. And they have the same rights as everybody else to pursue valued social roles. One of the most valued of these is becoming a parent, and throughout the UK and abroad, there are increasing numbers of women and men with learning disabilities choosing to start a family.

Mothers with learning disabilities are amongst some of the most socially and economically disadvantaged women within society (Young & Hawkins, 2005). They are more likely to have experienced childhood abuse or neglect than the rest of the population, have difficult relationship histories, suffer from socio-economic hardship, be socially excluded; they are more likely to experience bullying and victimisation, live in poor housing, experience increased psychological distress and have poorer physical and mental health than their non disabled peers (McConnell et al., 2008; McGaw et al., 2007; McGaw & Newman, 2005). Their babies are more likely to have poorer birth outcomes - prematurity and low-birthweight rates being consistently higher (McConnell et al., 2008) and are at increased risk from inherited learning disabilities, psychological and physical disorders (McGaw & Newman, 2005; Rende & Plomin, 1993).

The majority of social workers, midwives, health visitors and allied health professionals will now have a parent with a learning disability on their caseload; yet professionals continually report that they are unsure how to adapt services to meet the needs of people with learning disabilities, often then failing to make reasonable adjustments to reduce serious disadvantage.

Evidence from studies in the UK suggests that between 40-60% of children born to women with learning disabilities are taken into alternative care (Emerson, 2005; Booth & Booth, 1994). This stark fact comes as no surprise when taking into account the complexities of the factors described above, and their impact on parents' abilities to manage the demands of raising children. The high level of care proceedings involving parents with learning disabilities has been directly linked to their greater experience of multiple problems and disadvantage (Cleaver et al., 2011). However, this statistic sits rather uncomfortably with two other research findings - that there is no clear relationship between parental competence and increased intelligence, and that parenting skills can be improved through education and support (Woodhouse et al., 2001; Booth & Booth 1994).

As part of the workshop, we watched a short film about one couple's journey to parent their child. The film can be accessed here: http://www.bristol.ac.uk/sps/wtpn/aboutwtpn/aboutparents.html

We used the film as a platform for discussing what good support might look like when working alongside mothers and fathers with learning disabilities-

- Work in co-production with parents – be a partner to them
- Believe in people's abilities to learn
- Make reasonable adjustments - it is a legal duty in the UK to offer reasonable adjustments so that disabled people can access goods and services
- Allow some extra time and listen
- Involve family carers (with consent)
- Offer simple but evidence-based information – check with parents what types of information they find most helpful
- Be very practical and direct in your communication
- Provide hands-on learning opportunities
- Offer repetition and reinforcement
- Write a care plan together
- Know your local support services; these might include advocacy, peer support, community learning disability team, acute liaison nurse (based in most acute hospitals), pregnancy outreach workers, health facilitators (based in many learning disability health teams (ask your local Clinical Commissioning Group (CCG) which services are available in your area), doula projects, consultant midwife, breastfeeding counsellor, third sector specialist organisations, Children's / Family Centres
- Be honest and consistent in the care and support that you offer

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Understanding and responding to excessive crying

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This workshop aimed to help participants to understand the characteristics, causes and impact of excessive crying in infants. Participants were each given a photograph.

'This is Isla,' they were told. 'She cries a lot. Why do you think she is crying?'

The participants were all given a different photograph. Many had a picture of a small baby, but some had a picture of a toddler, a child, a teenager or an adult. Those who had a picture of a baby were more likely identify a cause of the crying, such as a sore tummy or problems with feeding or digestion. In contrast, participants with a picture of the older child or adult were more likely to say, 'We don't know why she's crying. We'd need to know more about what is happening for her...'

This exercise (which is very effective in parent education groups) shows how we assume that we know why babies cry, and how common it is to attribute their crying to physical causes. In fact, we are no more likely to know why a baby is crying from a single photo than why a teenager is. Just as for the teenager, there could be many things going on in the baby's life which are causing her to cry. Therefore, it would be more appropriate to adopt the same curious stance; to think about what is happening for the baby and wonder why she is crying.

'Excessive crying' is the term used to describe babies who cry a lot in the first three months of life. The term 'colic' is also often used which misleadingly suggests that the crying is related to stomach or digestive problems. The research shows us that, whilst 10-20% of all babies cry excessively, only 5-10% of this group have a digestive problem (Kale et al., 2011; Gormally, 2001).

Excessive crying is a behaviour, not a disorder. The crying doesn't necessarily mean something is wrong with the baby (Barr, 2001). It could be the symptom of an underlying problem, but we won't know this without further investigation. Possible causes of excessive crying might include, but are not limited to:

- Digestive problems such as milk intolerance
- Reflux
- A 'difficult' temperament
- Heightened sensitivity
- Feeding problems (e.g. latch problems)
- Parenting decisions and behaviours (e.g. around sleeping or feeding) which do not meet the baby's needs.

Whatever its causes, excessive crying can be very worrying and stressful for parents. It is associated with an increased risk of a range of poor outcomes for parents including depression, low self-efficacy, exhaustion, guilt, frustration and partner conflicts (e.g. Megel et al., 2011; Vik et al., 2009; Murray and Cooper, 2001; Papousek & von Hofacker, 1998). Excessive crying can also have an adverse impact on parent-infant interactions, and on children's likelihood of later emotional and behavioural problems (eg. Canivet, 2002; Raiha et al., 2002). However, studies suggest excessive infant crying is more likely to have an adverse impact on parenting and child development when mothers have lower social or emotional capital and have fewer resources to 'buffer' the impact of the crying (Paulussen-Hoogeboom et al., 2007; Murray & Cooper, 2001; Papousek and von Hofacker, 1998; Crockenberg & McCluskey, 1986).

The workshop ended with a discussion of how to prepare parents for a baby who cries a lot, and how to support those whose baby is crying. Participants learned about programmes such as the NSPCC's Coping with Crying DVD, which is shown to parents in the perinatal period to prepare them for the stress they might feel when their baby cries, and to help them to keep calm (Coster et al., 2016).

Practitioners were encouraged to support parents to consider why their baby is crying, and to test possible responses based on these reflections. The workshop drew on a helpful article by St James Roberts (2008) which summarises important elements of care for families with a baby who cries excessively. These include:

- Challenging the idea that crying means that there is something 'wrong' with the baby
- Viewing the first three months as a developmental transition
- Reassuring parents that it is normal to find crying stressful
- Discussing ways to soothe the baby
- Highlighting positive features of the baby and
- Considering available support for the parents

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Cabinets of Curiosity – 'Eye gates' of play for babies

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This workshop explored the potential of Cabinets of Curiosity as 'eye gates' for babies' play, that is, as visual stimuli that draw the baby on to further sensory experiences. Building on the established discourse of using sensory experiences to optimise babies' development, the workshop exposed participants to assemblages of matter that open an eye gate for babies' exploration. Potential applications of the approach were then discussed by participants within their unique settings of practice.

The thinking behind this workshop was inspired by a chance encounter with a child at play at the local Doctors' surgery. In a moment of playfulness, a toddler of 18 months was presented with a book. He flicked its pages as if he was swiping a smart phone. His mum was quickly distracted from her own smart phone at the sound of pages being crumpled and she gathered the child onto her lap in order to share the book together. This encounter stirred some unease in me. Goddard Blythe (2015) suggests that technology has many advantages and this is not in question; however, consideration of what it stops us from doing is crucial. This insight generated a reflective process which led to the following question being presented at the start of the workshop: 'What does technology do for babies and parents, and what does it stop them from doing?'

The question provoked exploration of the needs of babies both in terms of their neurological development and of the importance of a playful environment. Balbernie (2001) highlights the importance of the environment in creating functional neurons within a baby's brain. This is supported by Sutton Smith (1997) who suggests that maximisation of the baby's brain development can be achieved through playful encounters.

Within the Early Years sector, skilful practitioners who work with babies have developed practice that builds upon the work of Goldschmied and Jackson (2004) in relation to providing sensory experiences for young children through heuristic play opportunities. Lindon et al. (2006) suggest that sensory experiences that capture the gaze of babies enable development to occur. This thinking, coupled with 'affordances of environment', as described by Gibson (1979):

'The affordances of the environment are what it offers the animal, what it provides or furnishes, either for good or ill' influenced the development of 'assemblages of matter' that, coming together, become Cabinets of Curiosity for babies' play.

CABINETS OF CURIOSITY
An assemblage of matter which includes atmosphere, spaces, surfaces, items and individuals. The baby is seen as part of the assemblage of matter. A Cabinet of Curiosity brings together aspects of the environment into a sensory experience where each aspect has importance in creating the experience (Deleuze & Guattari, 1987).

At the workshop, the available space, the people present and the time available to them, coupled with objects such as tubes, bottles, natural items, wooden spoons, fabrics, pebbles, shells, baskets, colanders, pipe cleaners and sensory bottles, were examined as a potential 'assemblage of matter' and a Cabinet of Curiosity for stimulating babies' play and exploration.

'SPENCER' AND THE CABINETS OF CURIOSITY

Spencer is the youngest child in a family of four boys – all under the age of seven. I worked with Spencer and his family to develop Cabinets of Curiosity. Taking time to explore the Cabinets with both Spencer and his mum highlighted for her that she could give a small amount of focused time to notice where Spencer was in his development and this inspired her to consider how she could build such time into their existing routine.

Workshop participants discussed how, for many of them, the current climate of austerity is having an impact on the opportunities that they can offer to families with young children. Consideration was given to the potential of a Cabinet of Curiosity provided by a tummy tray.

TUMMY TRAY

A collection of matter designed to be placed in front of a baby whilst lying on her/his tummy. The tummy tray presented at the workshop was themed around the sea. Items included a piece of blue organza, a collection of shells (large and small), a natural sponge, some coloured feathers, a small toy duck and a bottle of bubbles.

The tummy tray encourages engagement of the parent with the baby by offering an assemblage of matter within a context of time and space for sensitive interaction. The feedback from workshop participants highlighted that the minimal cost of providing such an opportunity was highly advantageous. Participants felt that the sea-themed tummy tray could offer a sensory, but not over-

stimulating, approach to babies' play and create an opportunity to educate parents about what a sensory experience could be in terms of its context and content. The idea of parents designing tummy trays and then swapping them with those provided by other parents to take home was also appealing.

INVITATION

If the idea of Cabinets of Curiosity interests you in relation to your work with parents, please contact Michelle Malomo (m.malomo@worc.ac.uk) as she is looking for groups of parents/practitioners to further develop the concept.

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Me, You and Baby Too

Kate Nicolle,
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This workshop gave delegates information about the pilot of 'Me, You and Baby Too' which trained a cohort of Health Visitors and Midwives across a number of areas in the UK. The training programme aimed to prepare practitioners to deliver relationship education directly to new and expectant parents within existing antenatal and postnatal provision.

The transition to parenthood can be a stressful time for couple relationships; the challenges that having a baby can bring may often be the cause of conflict between a couple. 'Me, You and Baby Too' training shares with practitioners activities and relationship insights they can use with parents to encourage them to talk to each other about their parenting expectations and how they are going to look after the health of their relationship.

During the workshop, we looked at the relationship insights that are shared with couples, that help them to understand the theory behind how human relationships work. We talked about what practitioners can do to encourage parents to discuss and agree how they are going to care for each other's needs as parents. A difference in expectations of life with a new baby can be the cause of conflict between couples.

Couples are reminded that the changing stages of a relationship (see the Box below) are normal and that things can become challenging but they can also get better again. At each stage, there is an increased risk of conflict.

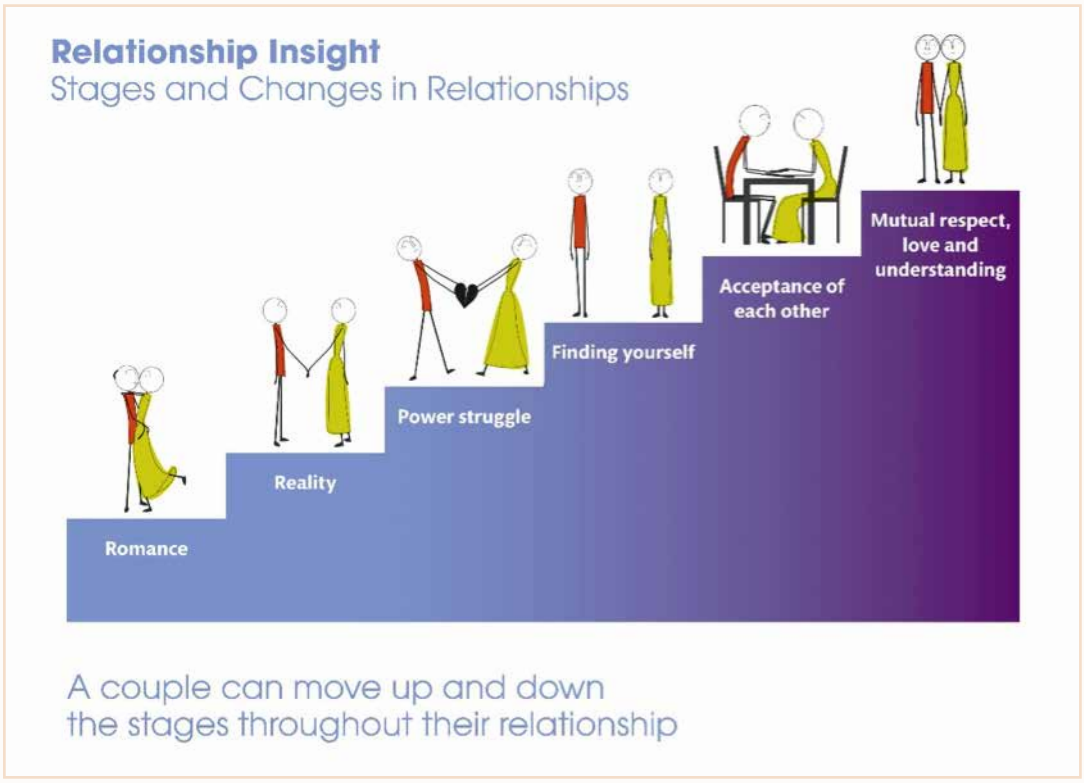
People can often reach these stages at different times so it's worth being aware that each partner may be at different places on their emotional journeys.

ROMANCE
The couple are building a sense of togetherness. Differences are often overlooked and everything seems perfect.

REALITY
Differences start to appear and the couple have to adjust.

POWER STRUGGLE
Arguments are more frequent and intense as each partner grows in independence.
Finding oneself and gaining independence
Couples may feel they are drifting apart because they are doing their own thing. This is a time when some couples separate.

RECONCILIATION
Couple have survived the difficult stages and now accept each other's independence.
Mutual respect and love
Each partner feels fully accepted by the other, warts and all, and the relationship feels stronger.



RELATIONSHIP INSIGHT: HIDDEN ISSUES

Arguments about money, in-laws, disciplining the children, sex and housework are rarely just about that. There are often deeper underlying issues affecting the way the conversation goes. Supporting a client towards being able to identify for themselves what their hidden issue might be enables them to be clearer about a way forward.

TALKING TO PARENTS

Talking to parents about their relationship can feel like a daunting conversation. Many practitioners report having to use their personal experiences in response to parents reaching out to them about relationships issues. Doing this can feel unprofessional and uncomfortable.

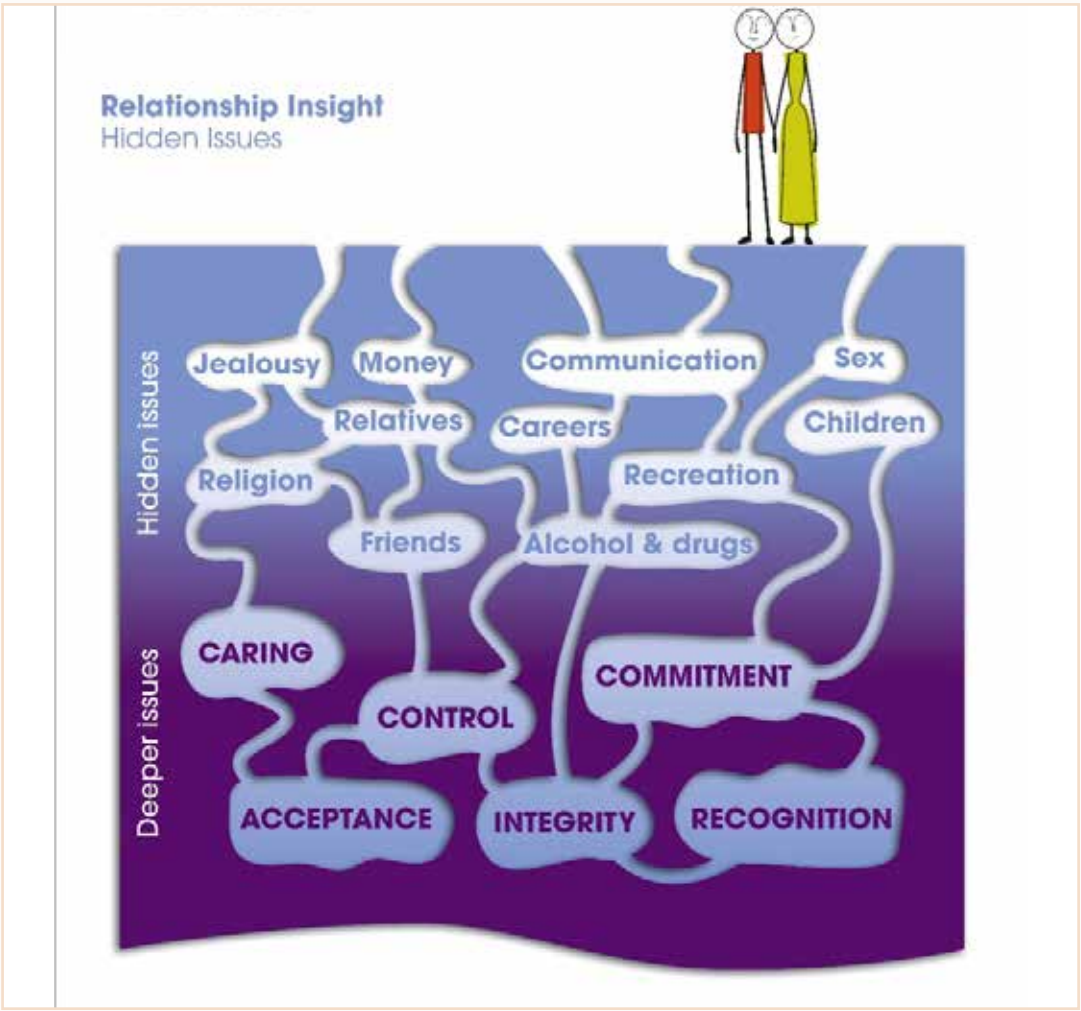
What does best practice look like when providing relationship support? Here are some guidelines.

- Try to resist 'fixing it' for a parent.
- Effective relationship support is about active listening (and resisting the temptation to ask too many questions).
- Reflect back the facts and feelings you are hearing, summarising to the parent using insights you have gained.
- Use solution focused questioning to help the parent to find their own answers. We are not working towards dependency on support from the practitioner but independent, resilient and stable couple relationships.

For more information, contact kate.nicolle@oneplusone.org.uk

RESOURCES AND MORE INFORMATION ABOUT RELATIONSHIP SUPPORT, AVAILABLE FROM:

OnePlusOne: http://www.oneplusone.org.uk/
The Couple Connection: http://thecoupleconnection.net/
The Parent Connection: http://theparentconnection.org.uk/



Engaging with families through musicality

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Musicality is a word often used to describe how 'musical' a person is, how talented or skilled, for example, at playing an instrument or singing. But it is a term which has also been used to explain the exchanges and rhythms of early communication, for example between adult carers and their babies. Colwyn Trevarthen and Stephen Malloch call this 'communicative musicality', emphasising how young children have a need to grow and learn and to feel secure within their culture. Babies and young children are predisposed to reach out to others and to want to communicate with the world around them. Their urge to relate, to smile and to babble and move is a powerful force that compels others to engage with them, often sharing their babies' energy in playful games like 'peekaboo' and rhymes and songs that can both excite and soothe them. Alan Fogel (1993; 2004) reminds us that these exchanges are inter-dependent and evolve in patterns of co-regulation, where how we are depends on how we are seen and heard by others. Research shows that from around 20 weeks' gestation, the foetus is able to hear the voices of his/her immediate family and will have become acquainted with the sonic 'scape' of their home. So, the rhythmic patterns of speech, the soothing and rousing tones of their friends and relations, as well as the sounds from the TV, digitised toys and media in the home, can all influence the way young children express themselves with their voices and bodies.

THE IMPORTANCE OF SINGING TO BABIES AND YOUNG CHILDREN

Singing with children at home can have a range of meanings. For some people, it is about connecting emotionally. Singing helps parent and child understand more about each other's feelings. Sometimes it also relieves parents' own stress when coping with a wakeful distressed child. Sometimes it is about passing on well-known stories and family histories, drawing on memories of places and people nearby or far away. Across many cultures, there are songs for play, for bouncing on the knee, for helping babies to sleep and for teaching them the names of body parts, animals, local flowers, customs, and expectations of family roles. Songs and rhymes are therefore valuable ways of helping children to learn, and for adults to express their feelings, hopes, fears and memories. Songs for different routines with babies through the day and night, through hardships and happy times, are common across the world, and often hold different meanings according to the context in which they are sung.

MUSIC IN DIVERSE CONTEXTS: ENGAGING WITH FAMILIES

When we recognise and value the diverse cultural, social and emotional identities of the families with whom we work, practice can become more meaningful for children, parents and the professionals involved. Peeple is a charity working with parents and carers to support development and learning from birth and has used musical activities with a range of parents and their young children, many of whom are isolated because of culture or language. We have worked through two action research projects with South Asian parents to support them both with their children's early learning and also in their own feelings about identity and belonging. Through exploring our different memories of childhood songs and stories, we bring them from the closed environment of home into a wider context. So our participatory memories of being young and closely or poorly attached gain significance when articulated in stories or songs. Notions of feeling 'different', of expectations of family and traditions, can be aired. Some songs and rhymes have a dramatic frankness about them, or deal with love, desire, loss and longing. They remind us that childhood is short and that there are many different childhoods. Singing can express our emotions and help to define who we are.

PEEPLE RESOURCES

'Singing Together' Song books 1 and 2 with CDs - composed and collated by Alison Street.
'Singing Together in Urdu and Punjabi: Songs and lullabies for babies and young children', CD with commentary in English, Urdu, Punjabi Shahmukhi and Punjabi Gurmukhi and sung by Nuzhat Abbas,
Both available via www.peeple.org.uk.

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Home birth: FAQs and myth-busting

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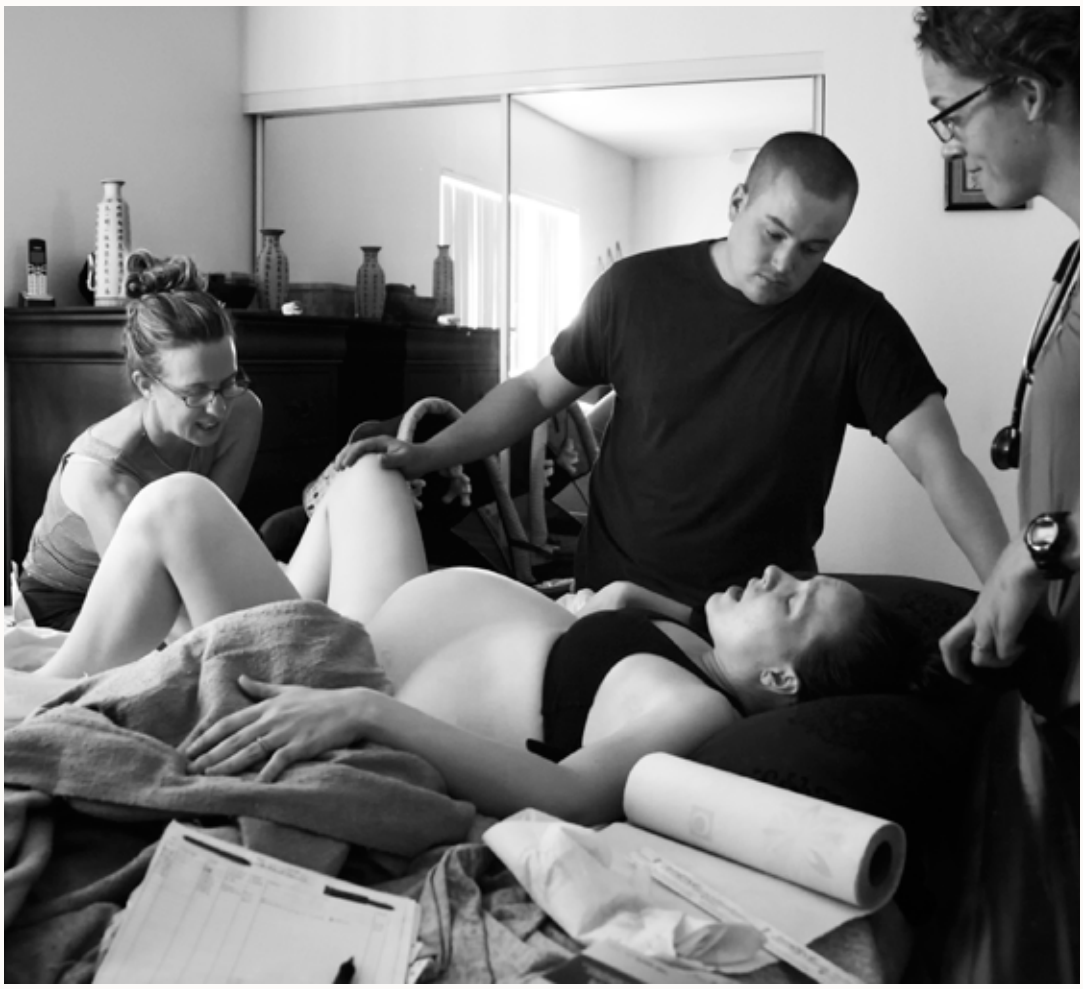
The decision about where to birth is a critically important one for pregnant women, as the outcome for mother and baby, physically, psychologically and socially, can be positively or negatively affected (Better Births, 2016). The Birthplace study (Birthplace in England Collaborative Group, 2011) found that low risk multiparous women's outcomes are significantly improved if they choose to birth at home, compared with any other low risk setting or a consultant led unit. Despite this robust evidence and a national drive to increase the homebirth rate in England by organisations such as the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, there has been no national increase in the rate of homebirths, which remains at 2.36% (Office for National Statistics, 2014). This may be owing to a deeply embedded culture favouring hospital birth. Indeed, the National Health Service (NHS) has advised three generations of low risk women to birth in hospital because hospital birth was believed to be safer. Many maternity stakeholders, therefore, have a profound fear and mistrust of homebirth.

At Birmingham Women's Healthcare NHS Trust in the UK, the home birth rate has increased from 0.31% to 1.2% in two years. This is the result of the valiant efforts of a skilled, passionate and dedicated Home Birth Team (HBT) and supportive commissioners, coupled with a vigorous media strategy, collaborative working with two local universities and extensive engagement with the community. The Home Birth Team's success can be at least partly attributed to dispelling some of the common misconceptions surrounding birth at home. Listed below are the most frequent questions that the HBT has encountered and some of their ideas on how to allay fears and respond to concerns.



Common Misconception	Response	Resource
Homebirth is not safe.	**NOT TRUE.** In fact, for some pregnant women, homebirth is a safer option. If you have just seen a midwife in your pregnancy and are fit and well, then you can consider homebirth as an option. If you are a second time Mum with a healthy pregnancy, the benefits associated with home are that there is a higher chance of your having a normal birth; you are less likely to have interventions such as episiotomy and forceps and less likely to need drugs for pain relief. Homebirth is as safe for babies of second time Mums as hospital.	On the front page of every woman's notes is a sticker signposting her to the place of birth where, research indicates, her outcomes are likely to be the best. All low risk multiparous women have a sticker saying 'Home'. This may be different from their chosen place of birth which, of course, takes precedence and is clearly written on their birth plan.  Discuss local figures for normal birth and intervention rates.
Homebirth is only for second time Mums.	**NOT TRUE.** Whilst we promote homebirth for second time Mums, homebirth is an option for first time mums, too, as long as they have healthy pregnancies. The outcomes for first time Mums are better at home than in hospital as they are less likely to need a caesarean, forceps, an episiotomy, an epidural for pain relief, or to have their labour speeded up with a hormone drip. First time Mums are also more likely to use water for pain relief, to use fewer drugs for pain relief, and are more likely to breastfeed their babies for longer. However, the risk for their babies of an adverse outcome is slightly higher at home than hospital. According to recent research, 991 out of 1,000 babies born at home to first time Mums will be well compared with 995 out of 1,000 babies born in hospital.	
Homebirth is messy!	**THERE IS SURPRISINGLY LITTLE MESS!** Every birth involves some bodily fluids, such as blood and amniotic fluid (water), but the majority of home birthing families are pleasantly surprised at just how little mess there is and how quickly it is cleared away by the midwives. All clinical waste is taken back to the hospital. Your midwife will talk to you while you are pregnant about how to protect your furnishings and floors. We advise families to buy a dust sheet as additional protection for the sofa or bed. If you choose to give birth in a birthing pool, the mess will be contained and is easy to dispose of.	Link to homebirth video, which discusses preparing for birth, setting up a pool and equipment used at home. https://www.facebook.com/HomebirthwithBirminghamWomens/
Home birth is for Hippies!	**THERE IS SURPRISINGLY LITTLE MESS!** Every birth involves some bodily fluids, such as blood and amniotic fluid (water), but the majority of home birthing families are pleasantly surprised at just how little mess there is and how quickly it is cleared away by the midwives. All clinical waste is taken back to the hospital. Your midwife will talk to you while you are pregnant about how to protect your furnishings and floors. We advise families to buy a dust sheet as additional protection for the sofa or bed. If you choose to give birth in a birthing pool, the mess will be contained and is easy to dispose of.	Link to our Facebook page and women's experience of homebirth https://www.facebook.com/HomebirthwithBirminghamWomens/

Common Misconception	Response	Resource
Hospitals are cleaner than my home.	Giving birth at home reduces the risk of infection for both mother and baby. You are regularly exposed to the germs in your home – they are 'friendly' germs, whereas the germs present in hospital can be unknown to your immune system and therefore present a much bigger threat.	Show statistics for hospital versus home infection rates.
I cannot have a homebirth, because my house is not suitable.	If your home is where you are intending to bring your baby up, it is suitable.	
If I choose a homebirth, I can't have any pain relief.	**NOT TRUE** Pain relief options are available; for example, you might wish to consider a birthing pool. You can also use gas and air, which the midwife will bring and self-administered aromatherapy oils. You can learn hypno-therapy techniques for labour which your midwife will support you to use. You cannot have an epidural at home, because it is a medical procedure that requires an anaesthetist. However, research shows that women who birth at home need less pain relief than women who birth in hospital. This is thought to be because they are more relaxed, able to move around freely and have as many or as few people around them as they choose.	Share stories of different types of homes where women have given birth - flats, caravans, shared houses etc.
What if it all goes wrong? Doctors and not midwives are qualified to deal with emergencies.	**NOT TRUE** Midwives are highly trained and skilled to deal with emergencies at home. Safety data supports this. Every step possible is taken to reduce the chances of an emergency occurring at home. Only women with healthy pregnancies are actively encouraged to birth at home. The need to transfer to hospital is relatively common, but most transfers are for non-emergency reasons, such as a longer than expected labour; some concerns about how the baby is coping with labour; waters breaking and not being clear. In an emergency, midwives have first line drugs and skills to cope at home until transfer to hospital.	Share information on the benefits of water in labour and birth pools. Share transfer data.
Even if I start my labour at home, the chances are I will end up in hospital.	What is important is that you are in the right place at the right time. There is always a chance of transferring into hospital should complications arise. Transfer would be either in your own car or an ambulance depending on the reason. • Approximately 45 in every 100 women expecting their first baby transfer • Approximately 12 in every 100 women expecting their second or subsequent baby transfer Very few transfers are for blue light emergencies.	Provide Home Birth leaflet
It's not good to birth at home with children present.	This is a personal decision for you and your family to make. Lots of children are present at a home birth and it is a very positive experience for them. The midwife will recommend that there is an adult on hand to look after a child should s/he become upset. Whatever you decide, it's important that you feel free to focus on your labour rather than worrying about a child.	