All women in labour should...

If we truly wish to make birth healthier and more satisfying for mothers and babies, to enhance job satisfaction for midwives and if we are honestly committed to restoring normality in birth, then every woman without major complications should be offered the opportunity to labour and give birth in water.

Water is an excellent form of pain relief and has been shown to significantly reduce the need for epidurals and pethidine (Cluett et al, 2004). Muscular tension throughout the body decreases, conserving energy and reducing pain. As anxiety fades and the woman's catecholamine levels drop, her flow of pituitary hormones is enhanced. Water stimulates oxytocin for efficient contractions (Odent M, 1997) which can significantly shorten the active first stage (Otigbah et al, 2000) and avoid interventions to augment labour (Cluett, 2004). Endorphins help her relax even more deeply and manage the pain. In the pool she feels more empowered and less exposed.

There is almost never a need for episiotomy during waterbirth and severe tearing may be avoided (Geissbuhler et al, 2004), probably due to the softening effect of the warm water and her ability to relax her perineum more completely. The upright positions which she assumes easily in the pool helps to align the baby to move smoothly through her pelvis. Instrumental delivery is rarely necessary (Cluett et al, 2004).

Waterbabies have been found to have as good or better Apgar scores (Geissbuhler V et al, 2004) and there is no increased risk of perinatal morbidity or mortality (Gilbert and Tookey, 1999). Birth under water is physiologically safe for uncompromised babies (Johnson, 1996) under the care of skilled practitioners.

The calming atmosphere of a pool room benefits everyone involved. When a woman feels less pain and anxiety, then her partner can also relax, and her baby is less likely to become distressed. Her midwife can offer the intimate, continuous care that is 'with woman'.

Despite being a safe, inexpensive form of pain relief and a valuable aid to normal birth, birthing pools are still an underutilized resource. In 2000 the RCM reported that 60% of UK hospitals had a pool installed, though usage varied from only 15-60% (RCM, 2000). Many standard units either do not possess a pool, or have only one. So, midwives are not able to gain the skills they need to feel competent and confident during waterbirth.

At present, in order to guarantee the use of a pool, a woman must choose a place where active, physiological birth is integral to the philosophy of care: a midwifery-led low risk unit, the right private birth centre or home. These are wonderful options, but they may not be available, and why shouldn't her local NHS unit be able to offer the same?

Waterbirth has been practised safely and to enormous benefit in UK hospitals for over two decades. Despite strong endorsements, including the government's 1993 Winterton Report recognising every woman's right to choose a waterbirth where practicable (Winterton, 1992), and the UKCC's 1994 statement that waterbirth must 'fall within the duty of care and normal sphere of the practice of a midwife' (UKCC, 1994), it is still not mainstream enough. It is absurd that almost every labouring woman and baby can be infused with hours of narcotic or opiate derived drugs, with their great financial, physical and emotional costs, yet we still hesitate to fill the pool. The NCT's 2003 Better Birth Environment survey reported the voices of 2000 women, the majority of whom said that access to a bath or birthing pool enhanced labour (NCT, 2003). With the national rate of normal birth not even 50% (DH, 2004), mothers, babies and midwives really need to get into the water.


Gilbert RE, Tookey PA. Perinatal mortality and morbidity among babies delivered in water: surveillance study and postal survey. BMJ 319: 483-7


have the choice of waterbirth

In Europe there seems to be little historical evidence for birth under water and there is no reference to it in historical books about birth, for example, Donnison, (1988), Towler and Brammell (1986) and Rhodes (1995). Therefore, as a means for birthing it does not appear to be supported by any rigorous or traditional evidence in the UK, though Garland refers to these practices occurring historically in the indigenous populations in the Pacific and the Americas (Garland, 2006).

The development of enthusiasm for birth under water may be considered to be either a 20th or 21st century fad. Fads in maternity care have been introduced over the centuries, for instance women birthing on their backs with their legs in the air. Birthing in bed was introduced by Paré in 16th century France. This trend has only begun to wane in the last two decades, as women and midwives are altering their ideas on birth positions, waterbirth is being introduced.

What needs to be considered is the difference between labouring in water and birthing in water. My argument here pertains to birthing in water. Using water for pain relief in early labour is a time honoured and proven way of reducing pain. This is different to expecting a woman to have her baby born under water.

A well-known obstetrician in the early 1990s was attributed with saying that women are not dolphins and therefore not designed to birth under water. This is evidenced by the many criteria that have been designed to ensure that water birth is safe. Midwives have to be ‘specially trained’ to care for a woman who births under water. If the birthing process is a physiological phenomena with an outcome expected of a normal birth then it is surprising that midwives require extra training to assist them in supporting women to accomplish a safe delivery.

It is possible that women are asking for a waterbirth as they know that they will receive attention from a midwife on a one-to-one basis. Currently there are pressures in delivery suites with minimal staffing so that there is not one midwife allocated to every woman. Waterbirth is one way of ensuring a constant companion and support from a midwife. Waterbirth may also appear a less interventionist option to women.

Similarly I would suggest that waterbirth might be an easy option for midwives in caring for women at birth. On dry land a midwife uses well developed expert skills to assist women, but in the process of waterbirth she observes with careful inactivity. Those special skills of supporting women in labour and delivery on dry land may be draining and physically tiring but also may be lessened through using waterbirth as an option for care. Birth pools are used to provide a tranquil and peaceful birth in a supportive environment. They are used because we cannot create such an environment in our labouring/birthing rooms. Just as the NCT has campaigned, perhaps we should do far more to create this atmosphere without a pool.

Birth pools are expensive to install in labour rooms and are now designed with careful attention to plumbing and size for safety. There are sales and marketing strategies developed to capitalize on women’s wishes for a satisfying birth. This is appealing to a materialistic society. Perhaps issues of psychology and spirituality are the real needs to be met for women antenatally and in labour.

We all know that there is an issue with hygiene of water pools for birth. It is amazing to ponder that although our water systems are stated to be purified we do not consider the chemicals in the water that so make it. It is known that water from some water authorities is constantly recycled and in order to render it safe it is subject to cleansing and chemical formulas that are harmless for adults. A baby at birth has been in a sterile environment and we are careful to sterilize everything that s/he is likely to ingest at birth apart from breast milk. It is therefore surprising that the first mouthful of ingested water experienced by a baby born under water is full of chemicals and we do not even consider this a problem.

As waterbirth has not been subject to rigorous analysis for evidence of its efficacy surely we should await the result of the Oxford Brooke’s study before promoting it further (Burns, 2006).
