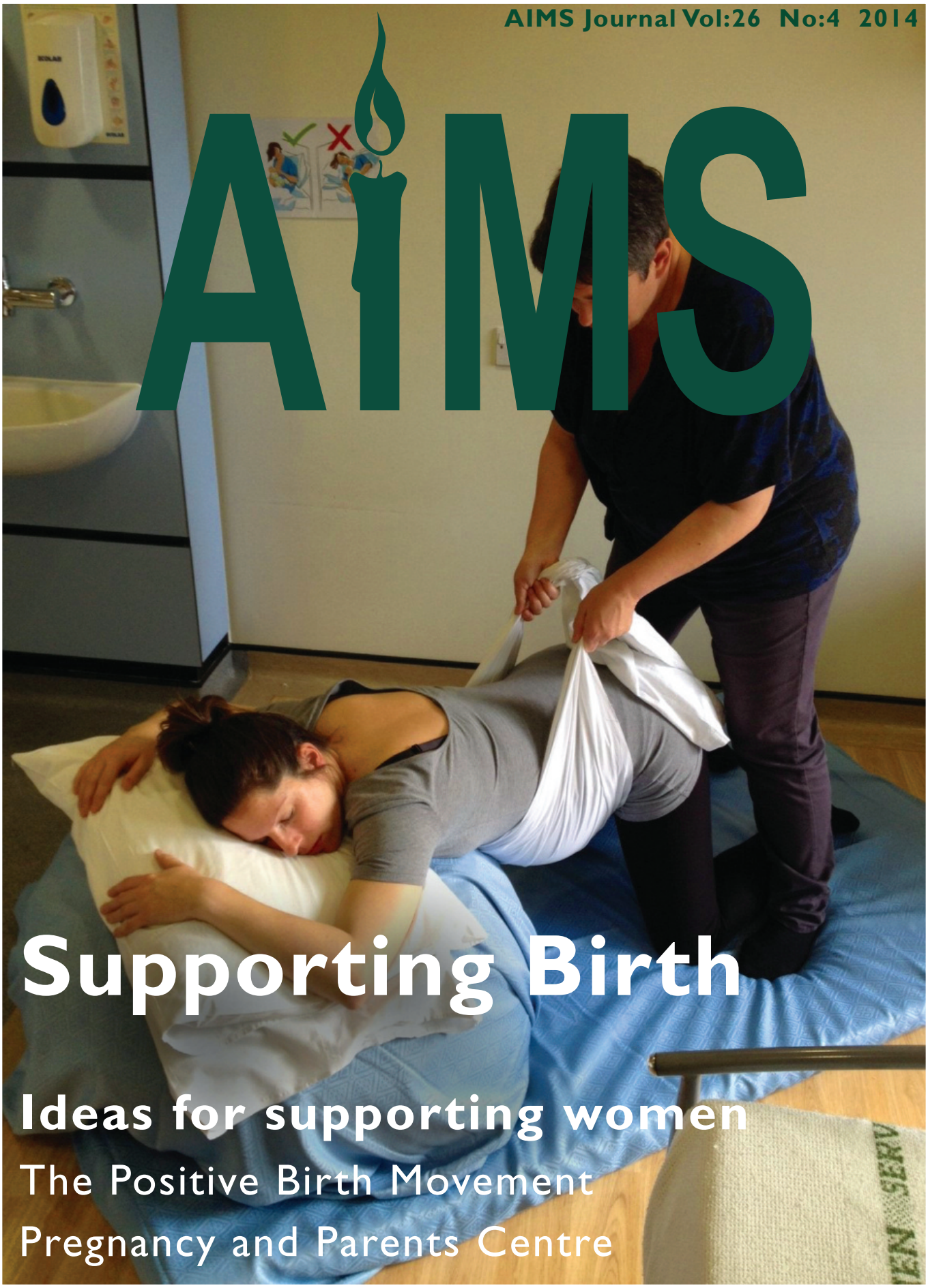
Association for Improvements in the Maternity Services

AIMS Journal Vol:26 No:4 2014

AIMS



Supporting Birth

Ideas for supporting women

The Positive Birth Movement

Pregnancy and Parents Centre

www.aims.org.uk

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Diary

AIMS Meetings

January 2015 (date to be confirmed)
London
Friday 24 April 2015
Sheffield

All AIMS members are warmly invited to join us. For further details, to let us know you are attending or to send apologies please email secretary@aims.org.uk

AIMS Talks

Beverley Beech
January 2015 (date to be confirmed)
London
Mavis Kirkham
Thursday 23 April 2015
Sheffield

If you are interested in attending please email talks@aims.org.uk

Please always check our website or contact us to confirm details as sometimes things change.

Breech Birth study day

Fordbridge, Birmingham
Saturday 31 January 2015
Tutor: Joy Horner

Topics include:
Normal breech birth, supporting women's choice, breech mechanisms, scenarios and different variations of breech.

midwiferynursingonline.co.uk/index.php/studydays/1-all-study-days/4-breech-birth

Doula UK Conference 2015

Positive Birth. Supporting Families

Ramada Sutton Coldfield, Birmingham
Tuesday 24 March 2015

Speakers include:
Jill Bergman, doula, 'kangaroula' & partner to Dr Nils Bergman
Professor Soo Downe OBE
Kate Evans, author
Rebecca Schiller, doula, writer and Chair of BirthRights
Mark Harris RM
Michelle Every, doula & Supporting Every Birth workshop facilitator.

doula.org.uk/content/doula-uk-conference

UCLan

Normal Labour and Birth

The Grange Hotel Conference Centre, Grange Over Sands, Lake District
15 - 17 June 2015

Please contact Liz Roberts, Conference Officer, UCLan Conference & Events
telephone 01772 893809
email
healthconferences@uclan.ac.uk
www.uclan.ac.uk/conference_events/normal_labour_birth_2015.php

Association for Improvements in the Maternity Services
founded in 1960
by
Sally Willington 1931 – 2008

AIMS

campaigning for better maternity services for over 50 years

AIMS

Hon President
Jean Robinson

AIMS Research Group
A group has been established to review research for the Journal. If you are interested in joining the team, please email research@aims.org.uk

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Cover Picture:
Using rebozo in pregnancy.
© Jude Davis

Contents

Microbirth

Released globally on 20 September 2014

An audience largely made up of birth workers and mothers – some with child in tow – gathered in Bristol for the screening of One World Birth's new feature-length documentary. This event was one of hundreds held worldwide to mark its global release and one of 17 held by AIMS volunteers across the UK.

Most of us already agreed with British film-maker couple Toni Harman and Alex Wakeford's credo *Save Birth, Change the World. W*e were about to be shown new evidence to support the potency and truth of the statement.

After their film Freedom for Birth – which highlighted human rights abuse in childbirth – their new production Microbirth investigates the microscopic unfoldings around the time of birth and explores their role in shaping the short-and long-term health of the newborn, as well as their implication for the health of generations to follow.

Normal, undisturbed birth is likened to a 'programming event' during which a complex interplay of bacterial, hormonal and genetic processes are triggered to give the child the best start in life. The film focuses primarily on the transmission of bacteria from mother to child through vaginal birth, immediate skin-to-skin contact and prolonged breastfeeding. It explains how the seeding of this colony of bacteria, known as the microbiome, helps prime and educate the baby's immature immune system and metabolism. It also describes how caesarean sections and other interventions in childbirth are proven to interfere with this seeding and the increasing evidence that links an incorrectly seeded microbiome to the development of one or more non-communicable diseases later in life. These diseases include asthma, obesity, cardio-vascular disease, coeliac disease, some cancers and mental health disorders and currently account for 60% of global deaths.

Could safeguarding normal birth be the simple solution to a problem projected to bankrupt the world's healthcare systems by the year 2030?

I am excited by the film's invitation to reconsider our relationship with bacteria. In light of the research on the human microbiome, we now know that our bodies consist of ten times more microbial cells than human cells; a symbiotic cohabitation that has evolved over millennia and ensures our species' survival. This natural defence system against pathogens should be cherished as our 'maternal inheritance' and our birth choices and indiscriminate use of antibiotics and all things anti-bacterial examined with scrutiny.

Microbirth assembles an impressive panel of experts to discuss some emerging, cutting-edge research. It recently received some recognition from the scientific community by taking home the top prize at the Life Sciences Film Festival in Prague. However, the film somewhat loses focus in trying to take on too much science; the subject of epigenetics and oxytocin in childbirth are touched upon but would both deserve an hour-long exploration in their own right.

The film's overall tone was perceived as alarmist by a few audience members but I find it serves well to underline the urgency of the situation. With an estimated one third of our microbial diversity already lost, there is no sugar-coating the fact that we run the risk of breeding a weakening society.

Ecologists will remind us that diversity is key in maintaining a healthy ecosystem and parallels with the current environmental situation are inescapable, as is the fact that we might pay a high price for not heeding these early warnings.

Guilt surrounding their own birth experiences prevented some viewers from seeing the bigger picture that the film strived to portray. If mothers were the target audience, the issue of perceived judgement could have been dealt with more sensitively in order for the film to have a maximum impact with a lay audience, particularly as caesarean deliveries worldwide still far exceed the WHO's recommended 10-15% of births.

One of the guest speakers at the event urged mothers to adopt a global rather than personal perspective on this matter. Indeed the film appears to target a wider audience: those currently absent from the debate who might not otherwise be sensitive to the subject of birth. By emphasising the socio-economic ramifications of the issue, it hopes to show policy-makers just how crucial birth is in shaping society and highlights the work that remains to be done on structures surrounding birth as well as the need for funding the appropriate research.

This is an ambitious and thought-provoking film that has the capacity to start an important conversation. I would recommend it to anyone interested in birth and indeed the future of humanity. Yet the scale and complexity of the problem addressed detract from the potential simplicity of its solution. Should we really be looking at technology, research or yet another intervention to save us? Or should we follow the lead of our guest speaker, Amanda Rayment, and ask ourselves: what would happen if we left birth alone?

Muriel Chvatal

See www.microbirth.com

Wonderful AIMS supporters raised the funds needed for us to buy 10 licences for Microbirth, and we were very generously donated another two licences by the film-makers. Due to additional requests to screen the film on behalf of AIMS, we bought another licence, and other generous supporters used their own for us. We have reached about 1,000 people with our screenings, including pregnant women, birth supporters and lay birth workers, midwives, obstetricians, paediatricians, biologists and more! We raised over £2,000 for AIMS, raised awareness of the work of AIMS and most importantly helped to share the really fascinating topic of how birth may affect us with really influential people.

Changing birth support

Gill Boden, Debbie Chippington Derrick and *Shane Ridley* remind us what it is all about

'Husbands are welcomed at this hospital and are invited to stay with their wives during labour – if a husband cannot come a 'substitute' is provided in the form of a student doctor.'

AIMS Newsletter 2, page 2

This snippet is from the second AIMS Newsletter, written in 1960, illustrating the problem that arose in hospital births of providing a suitable birth companion. Throughout human history, birth has been women's work, where female family members help and support and often banish the father. Then, for a generation characterised by hospital-based births, male partners have overwhelmingly been the sole birth companions. In the 21st century we must enable women to plan births that encompass their needs and those of their partners and families.

The TV series, Call the Midwife, showed a picture of 1950s community midwives cycling around their neighbourhood, which changed radically following the Peel Report[1] in 1970 when birth moved overwhelmingly to hospital. Women then had to cope with being alone in a strange environment with unfamiliar midwives and predominantly male doctors. Many have argued that at this point birth stopped being woman-centred and became subject to the needs of a male-dominated institution. It also meant that fewer women had any experience of birth before they had their first baby.

The articles on Hypnobirthing (page 12) and Shiatsu (page 9) show ways of preparing women and their partners for an unknown experience, focusing on their own strengths and abilities.

AIMS was founded in 1960 as a response to a plea in the Observer from Sally Willington who wrote movingly about cruelty to birthing women. One of its first campaigns was to 'allow' male partners into hospital so that they could advocate for the women (and stand up to the doctors).

'The Duchess of Kent opening the Nursing Conference in London in October spoke of the need for "more voluntary helpers in hospitals". Mrs Campbell, A.I.M.S. Regional Organiser in Purley is trying to compile a list of voluntary "sitters in" ….'

1960 AIMS Newsletter 3, page 2

The following year AIMS was recommending setting up voluntary systems to help women by accompanying them to hospital, looking after their other children while they were 'confined' (often for two weeks), and helping out at home postnatally. Although some women welcomed the move to hospital birth as the opportunity to have a rest, it created or exacerbated many problems for women without helpful family around.

Since the 1960s, work outside the home has increased; fewer other women are available to help voluntarily, and the phenomenon of the paid doula has appeared. Fathers are expected to be present at the births of their babies, but when limits are placed on the number of companions then the experienced mother, sister or friend has had to wait outside, while the sometimes reluctant, anxious father is ushered in. AIMS has been helping to challenge this, and more couples are again benefitting from the support of a female birth supporter.

Goer and Romano have a chapter in their excellent book, Optimal Care in Childbirth,[2] that they call Supportive Care in Labor: Mothering the Mother Versus Serving the Doctor, in which they show that the *'stronger beneficial effects of continuous one-to-one female labor support are seen with providers who are not hospital staff members and in environments more conducive to physiologic care'*. They explain the need for doulas in the following passage:

'When a social system allows some individuals unrestrained dominance over others mistreatment and abuse will inevitably follow. Stepping onto the labor and delivery unit women all too often find themselves in an environment where society accords them no protection from what would be considered inhumane treatment, if not criminal acts, outside its doors. Once over the threshold women depend solely on the kindness of strangers and if that fails, in an authoritarian system they have no redress.'

They are writing in the US but here too fathers can be co-opted into supporting staff, midwives can lose their true role of being 'with-woman' and doulas have helped women challenge medical orthodoxy.

AIMS often hears from birth companions who have witnessed bad practice and on page 17 Beverley Beech considers what action might be taken. Women need midwives to work well with their chosen birth supporters, and Ilana's birth on page 23 shows the difference this can make, particularly when the woman does not already know the midwife.

In the UK we have a strong tradition of autonomous midwifery and, despite the attrition of experienced midwives, we have plenty of highly motivated and qualified new entrants within a climate of growing acceptance of the safety and benefits of out of hospital birth. The article about the use of Rebozo within an NHS setting (page 6) shows how it can be used to enable midwives to provide a technique that allows the mother and midwife to work together, even if they have not had time to build a relationship previously.

Our campaign is for every woman to have a midwife who she knows and trusts to be with her throughout pregnancy, birth and beyond, but women also need to be able to choose to be accompanied by friends, family or doula, to allow birth to be a positive life event.

Gill Boden, Debbie Chippington Derrick and Shane Ridley

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1. Ministry of Health (1970) Domiciliary Midwifery and Maternity Bed Needs: the Report of the Standing Maternity and Midwifery Advisory Committee (Sub-committee Chairman J. Peel). HMSO. London
2. Goer H and Romano A (2012) Optimal Care in Childbirth: The Case for a Physiological Approach. Classic Day Publishing. Seattle, Washington.

Rebozo in an NHS setting

Jude Davis encourages those supporting births to increase their confidence

A Rebozo is a versatile piece of woven cloth which is commonly worn by women in Mexico and Guatemala. Often brightly coloured and sometimes decorated with tassels, it not only provides warmth as a shawl or blanket, but may be used to carry babies, older children, firewood or shopping, and has many other uses, most interestingly those employed by traditional midwives. Rebozos are more than long enough to go around the body and are about 70cm wide.

I was first introduced to the Rebozo by Mexican midwife Naoli Vinaver at a Midwifery Today conference in 2006. This inspirational midwife demonstrated how traditional Mexican midwives use the Rebozo in a variety of ways during pregnancy, birth and postnatally. I subsequently learned more from Debra Pascali Bonaro in her doula training, Gail Tully in her 'Spinning Babies' workshop, and more recently from Mirjam de Keijzer and Thea van Tuyl at the Midwifery Today conference inBlankenberge in 2013.

Mirjam and Thea have co-authored a book about Rebozo with Naoli[1] and run Rebozo workshops for birth workers such as midwives, doulas and childbirth educators. They are passionate about Rebozo use and continually discover new ways of using the cloth.

As well as teaching the more gentle rhythmic movements produced by the cloth, the workshops also share ways in which traditional midwives use Rebozo to encourage breech babies to turn cephalic and posterior babies to turn anterior. I do not teach, advocate or use any of these 'advanced' uses of Rebozo, which use strong jerky movements. The uses I demonstrate are aimed at producing relaxation or gentle movement.

Most of the uses are likely to be appreciated in-between rather than during contractions, with the exception of the Helping with Breathing technique, which is specifically designed to help during contractions. If a technique is uncomfortable or a woman is not enjoying it then it must be stopped immediately. I try not to be prescriptive about the timing of Rebozo use. Any application that promotes movement and relaxation and which the woman is enjoying should be beneficial.

One further word of caution: sometimes teaching midwives and other birth workers new tricks can have the potential to cause their overuse. It is empowering to teach women and their birth partners skills to facilitate normal birth. However, when we as practitioners are considering using the techniques in the labour room we need to remain aware that any intervention is an intervention. We need to keep our default position of guardians of normal birth as predominantly 'sitting on our hands' unless there is good reason to be using those hands.

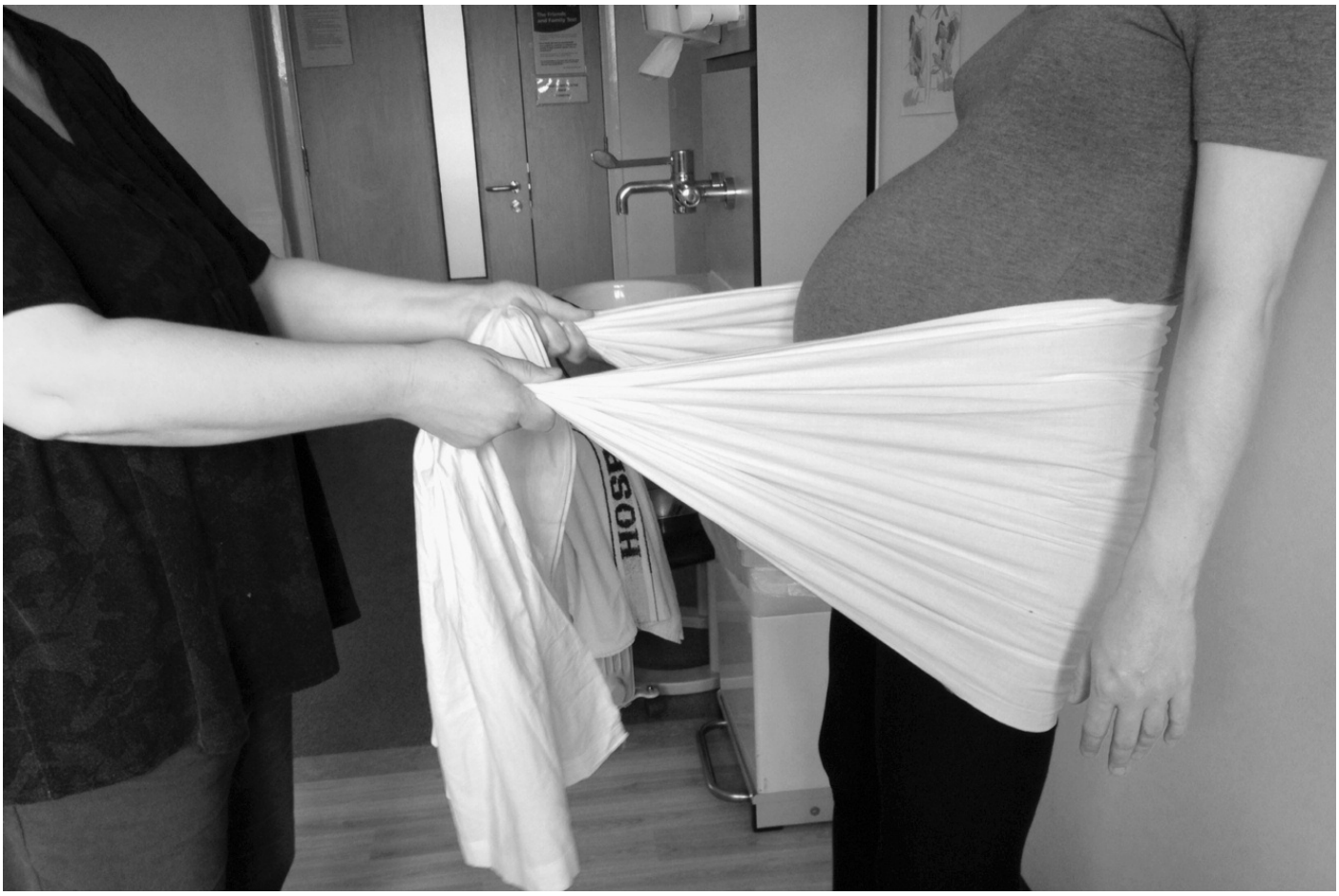
I've worked as an NHS midwife for nearly seven years now and although I've known about the techniques, I've been a bit shy to introduce Rebozo use into practice. Previously I worked in a hospital where the bed was very much the focal point of the labour rooms and I felt that the environment was not especially conducive to physiological birth. As a newly qualified idealistic and passionate midwife, I wanted to make so many changes, but quickly discovered trying to make them all at once just got on too many of my colleagues' nerves! I needed to consider one area of 'challenge' at a time and especially focused on increasing the water birth rate within that consultant-led unit.

When I moved to a new job in an NHS free-standing birth centre where the environment was specifically designed with physiological birth in mind and the water birth rate was high, I felt ready to move on to a new area of innovation. The birth centre runs an Active Birth Workshop to help prepare parents for physiological birth. I got involved in the workshop and found its format to be a little tired and sometimes more like a lecture than a workshop. This provided me with an ideal opportunity to develop it by sharing many of the tips and tricks for normal labour learned in various workshops and doula training, to help empower women in their pursuit of physiological birth. Rebozo use is now a popular part of the class and is being met with a lot of enthusiasm from parents-to-be, students and midwives.

My 'Rebozos' aren't beautiful coloured woven cloths, but ripped-up hospital sheets

My 'Rebozos' aren't beautiful coloured woven cloths, but ripped-up hospital sheets and a few pashminas and other long scarves I have acquired. The pashminas are prettier, but actually don't work as well as the cotton sheeting because they tend to be shiny, which makes them slippery and less effective. To satisfy any infection control concerns, I wash my plain cotton sheet Rebozos between workshops and encourage women to search their scarf collections to find their own suitable piece of cloth to apply the techniques at home. When teaching larger groups, I request that students bring in their own long, wide scarves to use.

I shall describe some of the techniques here, but also would definitely encourage anyone to attend a study day to learn them properly.



Rhythmic movement called 'sifting'

Have the woman lean against a wall with only the top part of her back touching it. Her feet are hip-width apart, her body is fairly straight and her bottom is not touching the wall. The middle of the Rebozo is placed behind her, covering the area from the bra-line to just below her bottom. The partner stands facing her holding the Rebozo near the front of her abdomen. Spending time ensuring that there is good tension in the cloth makes all the difference to the techniques because if the cloth is saggy in places it will be uncomfortable and ineffective. Tension is then taken up in the cloth further by the birth partner before the motion begins. The movement is called 'sifting' and the cloth is moved from side to side to provide a pleasant rhythmic movement of the pelvis which can promote relaxation and may facilitate some useful movement of the baby. Most women enjoy this technique very much.

Relaxing the broad ligament

US homebirth midwife Gail Tully suggests that tension within the pelvic ligaments may impact on the space the baby has to move in within the uterus and this technique is aimed at reducing that tension. With the woman in an all fours position (or resting her upper body on a beanbag, birth ball or chair) stand above her, facing the same direction and place the Rebozo around her belly ensuring the whole 'bump' is within the cloth [see our beautiful cover illustration]. Inform the woman that you will be using the same movement as above, but this time to relax that big broad ligament that lies across the front of her uterus. Encourage her to let her belly hang down and think about the relaxation. Ensure there are no baggy or loose sections of the Rebozo, pull the cloth towards you to increase the tension a little, then begin the sifting movement.

Helping with breathing

Slowing down a woman's breathing in labour is key to her feeling more able to manage contractions. This technique involves placing the rebozo around the woman from the waist to below her bottom before she sits deeply in a chair. Take up the tension in the cloth then observe her breathing. On her in-breaths, pull her towards you with the Rebozo – not enough to lift her from the chair but so that there is a strong tension in the cloth.

As she breathes out, slowly let go of the tension as she sinks back deeply into the chair. As you continue this rhythm of working together with the breath, begin to linger on the out-breath before taking up the tension again with the in-breath. This will encourage the out-breath to be longer than the in-breath and so help her to avoid hyperventilation.

continue this rhythm of working together with the breath

Shaking the apples

The woman kneels and puts her head on the floor, the cloth is placed over her bottom and the ends of the cloth are held close to her. In this position, the shape of the cloth on her bottom resembles a toffee and one student at a recent workshop sweetly re-named this technique the 'toffee wiggle'. All of the other techniques described employ the fairly slow and gentle 'sifting' motion; however, this one is a more brisk 'shaking' movement. Be sure to have a good tension in the cloth to cause a good wobble; this should never be a 'sawing' motion that drags on the flesh, but an application of cloth to gain traction on a wide area and movement that causes the buttocks to wobble. It always raises a smile in class, but women also see its benefits in promoting the relaxation of those big muscles.

promoting the relaxation of those big muscles

Head massage

A simple head massage is easy to apply with the Rebozo folded and placed under the head. It is important to keep the head in line with the body. I have found a slippery fabric or the woman's hair being particularly well-conditioned and shiny both prevent this technique from being effective. First the tension is taken up in the cloth, then one side of the cloth is slowly raised, allowing the head to gently turn to the side and then repeated on the opposite side. After a while, the head can be gently lifted a few centimetres from the floor in the cloth and the same movement repeated for an even more relaxing technique.

Remember, Rebozo massages such as this relaxing head massage can be used with non-pregnant people too, and any relief of anyone's stress in labour or otherwise is beneficial.

Hopefully these examples will create further interest in Rebozo use within the NHS setting. It has long been known that massage can promote relaxation to aid childbirth, but now we see that this massage with a cloth can provide further benefits.

Interest in the techniques is growing and new applications are continually evolving. I have now taught the techniques to some midwives studying for a 'Normal Birth' module of their Masters degree and to some undergraduate midwives. I have also returned to the lovely midwife colleagues in my previous jobs to show them my active birth workshop in the hope that they will be encouraged to embrace new (old) ways of facilitating physiology.

Gail Tully states in workshops that since employing a variety of active birth techniques, she no longer finds women in her care having such long latent phases of labour and believes this is because activity and movement promote fetal engagement, rotation and descent. It is great to give those having a long latent phase at home not just something to do to ease the tension and to promote comfort, but something which has the potential to help a labour progress from a latent to an active phase. I'm delighted to be using it with women in the classes and (cautiously) in birth rooms and I'm increasingly convinced of its benefits.

Jude Davis

Jude is an NHS midwife who spent her first five years of midwifery in a consultant-led unit and now works in the community and in a free-standing birth centre.

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1. De Keijzer M, van Tuyl T (2010) The Rebozo Technique Unfolded: work book rebozo massage. Rebozo, 2010

Shiatsu and birth support?

Suzanne Yates introduces the principles of what shiatsu can bring to pregnancy and birth

Often people think of shiatsu (meaning 'finger pressure') as simply a physical touch type of massage technique which uses the meridians and points of acupuncture. Well, it is that, but the way of touching and accessing these points involves having an awareness of the whole body, both of the person giving and of the person receiving.

This means that during birth it can give to both the mother and her birth supporters (partner or midwife):

- Tools to aid physical symptoms, such as pain relief, back ache and, tiredness
- A connection to the process of birth including an awareness of the baby
- An awareness of breathing and posture
- A sense of being supported through touch or through a relaxed physical presence
- A greater connection with the physical body and the emotions
- A greater awareness of one's relationship to the birth environment in a way which can be supportive

In order to give the static pressure, which is one of the main tools of shiatsu, there needs to be a leaning from the physical and energetic centre of the body, the pelvis, which the Japanese (who developed shiatsu) called the Hara. In order to use the body in this way, the person giving shiatsu needs to be relaxed. This involves first connecting with the centre through breathing and then allowing the rest of the body to relax around this centre. Shiatsu is not done from the shoulders, which tend to put people into their head and upper body and away from their centre. Working from the Hara encourages a more 'whole' and penetrating way of touching.

To connect with her Hara, the mother can place her hands on her abdomen and breathe out and feel her hands being drawn in. She can feel how much pressure to give and how long to stay. Her breathing tends to slow and of course she tends to become more aware of her baby. The baby often moves in response to this touch. Once the mother has a sense of how much pressure feels good for her and her baby to receive, she tends to become very aware of her baby. Her attention shifts inwards. Some women become aware of the physical position of their baby, others even start to become more aware of their baby's emotional response. The partner can then place their hands over the mother's Hara and be guided to give appropriate pressure. This is a great tool to support antenatal bonding, but once women use this regularly, during labour they can use it to tune in to what is going on for their baby. During birth this can help the mother and her partner to be aware of how the baby is experiencing labour, and this focus on their baby and his/her journey, rather than focusing on

Picture of partner leaning on the mother's sacrum (from *Beautiful Birth* by Suzanne Yates)

pain or on contractions, can be helpful and help tune to what they need to do. It can also be a useful support for relaxed breathing.

If the mother then leans over her partner, they can experience how giving is actually receiving. It is a mutual relationship and both benefit! This is a way of encouraging whole body communication between the mother and partner, as well as being relaxing for them both. The partner can then learn to apply this leaning to specific techniques such as sacral pressure.

As we know, if the woman experiences physical intensity or discomfort in labour, it is often in the sacral area. Pressure here tends to relieve this. It also supports the baby to move, the birth supporter to relax and the mother to breathe more deeply and have focus. The mother is encouraged to shift position as and when she feels but this shifting comes from an internal awareness of what needs to happen both for her and for her baby.

Basic principles of shiatsu:

- Breathing from the Hara (centre),
- Relaxation
- Whole body leaning

Once these basic principles are learnt, specific points can be shown. Points can aid both physical and emotional release. There are points that can help settle the emotions, have a direct effect on the uterus and help regulate contractions. Although shiatsu uses points, it is about the whole body. When the mother connects to both her body and her baby, she is more able to experience fully the birth of a new life.

Suzanne Yates

Suzanne is a shiatsu practitioner and teacher who has been specialising in shiatsu and maternity care since 1990. She has written Beautiful Birth and co-written Shiatsu for Midwives which have lots of practical shiatsu techniques for birth support www.shiatsusociety.org

Positive Birth Movement

Melissa Thomas, Jenny Hallam and *Chris Howard* share feedback for Positive Birth Groups

The Positive Birth Movement (PBM) is a community group started by Milli Hill in 2012 with the aim of informing women of their birth choices, sharing positive birth stories and offering support for women during and after their pregnancy. The group is a non-profit organisation and pregnant women and mothers are invited to attend regular meetings held in their area free of charge, although if a hall is hired a group may share the cost between them.

Anyone can create a Positive Birth group and become a facilitator, so facilitators have a wide range of backgrounds, some are trained doulas and midwives, others are women who are passionate about birth and want to offer support to women in their community. The idea is simply to make it easy for women to gather, communicate, support each other and share information. Positive Birth Movement meetings are open to all pregnant women, mothers and birth professionals and are guided by a different discussion topic each month, which is set by the online umbrella group.

Currently there are over 170 regional groups within the UK and a number of groups worldwide. Consequently, the Positive Birth Movement can be considered to be a grass-roots organisation which aims to empower pregnant women through information and authentic birth stories. Within the group, a positive birth is conceptualised as any birth in which the woman felt empowered through access to information and freedom of choice, so any birth from a homebirth to a caesarean can be positive.

In 2013 Melissa Thomas, the facilitator of the Derbyshire Positive Birth Movement, carried out a set of interviews to explore women's birth experiences with specific reference to the support they received before, during and after the birth and their experiences of the Positive Birth Movement. Prior to carrying out these interviews, she received training in research ethics and interviewing skills from Dr Jenny Hallam at the University of Derby. Melissa went on to facilitate face-to-face interviews with six women who attended PBM meetings. Each interview lasted between one and two hours and was transcribed verbatim for analysis. The women had a range of birth experiences and this led to them sharing a diverse range of birth narratives.

Five women between the ages of 25 and 39 were interviewed. One was expecting her second child and the others all had two children. They had all joined the PBM after the births of their first baby, except for one who had joined following her second birth.

Experiences during pregnancy

Most of the women spoke about the importance of accessing information during their pregnancy relating to birth choices and what to expect during their birth experience. However, many of the women reported that their midwife and other healthcare professionals offered limited support and information and women reported that they had to be proactive and find out information for themselves during pregnancy.

'You shouldn't have to work so hard to get that information and like I say I appreciate the midwives don't have all the time in the world and they don't, they don't have every resource in the world but even if they can just signpost you to places where I could've got that information, you know.' Vicky

Many of the women were left to find information themselves, paying for private antenatal classes. Women reported mixed experiences of these. Comments included private antenatal classes focusing very much on pain and medical intervention.

'The private antenatal class was very focused on pain relief options and what can go wrong. They didn't want to kind of, they were supportive about birth plans but they said, "but it will probably change on the day."' Sarah

Groups such as pregnancy yoga were spoken about positively.

'The best support I got was through the pregnancy yoga with a lady called Stella who was amazing. She taught me all about the breath, about understanding what your body goes through in birth, how you might feel, how you can help yourself, how you can gain control. Not about controlling the birth but how you can help yourself to birth naturally.' Teresa

Women found much of the information they were able to find was unhelpful, with negative birth stories setting expectations that the birth would require medical intervention.

'I think there's too much negativity surrounding pregnancy and birth in the media and within our society. I think there's a lot of assumptions made that are taken as the norm which need to be dispelled so that most women have positive birth experiences, instead of just a few.' Jessica

Communication style

Women spoke about the way in which the medical staff communicated with them and their birth partner and how it played an integral role in shaping the birth experience. There was a real split in the birth narratives as the women recounted practices that led to very positive or negative experiences. Good practice was aligned with healthcare professionals giving the birthing mother choice, clearly explaining her options and only taking action when clear consent was expressed. This disrupted traditional doctor power relationships and enabled women to play an active role in the decision-making processes from a position of power.

'They explained very well, they explained what they were doing, they always gave me a choice, they never did an internal without my permission, they never took Emma away from me without my permission, in fact they actually helped me with establishing breastfeeding, kind of like, can I touch you? Is that alright? They never just kind of man handled me.' Teresa

Bad practice was discussed in terms of closed and forceful communication, shrouded in medical jargon.

'It became a very real threat which made me worried and it kind of put up all the old feelings again. I was very scared.' Alison

Being treated with respect during the birth experience

Respect was a key element that shaped birth experiences. The women spoke about respect in two ways. First, it was discussed in terms of receiving personalised care. Some of the women likened giving birth in hospital to being part of a production line.

'It was just like a flow chart for them and there's the outcome and you just have to work your way down this flow chart and without ever thinking that anything else might help. It was very medical, rather than anything else. It was just, each step was just another medical step for them.' Alison

Other women spoke about the personal connection they developed with the midwives who attended their births. Acts such as holding the birthing mother's hand and providing words of encouragement were valued as it was seen as evidence of genuine care and compassion. The mother felt as though she was being treated like a person.

'At the time I think I felt quite comforted by the fact that there were people there to take over, to help me and they were really nice people, they kept saying really positive things, you know, they kept calling me a "super star" which makes me laugh now but it was really nice at the time because it felt like I was doing well, I was being supported and they were pleased and everything was going well.' Jessica

Secondly, respect was discussed in relation to birth plans and the women spoke about the importance of being listened to and having their birth choices respected. Positive birth experiences were closely linked to the medical staff listening to the woman's choices and respecting them. During these experiences, the midwives had acted as an advocate and ensured that birth plans were implemented.

'We made a decision to come off all the monitors and go into the bathroom so I could refocus and get away from everything and she actually, although I got the impression she didn't 100% agree with what we were doing, she did spend a lot of time on her hands and knees in the bathroom with a hand held Doppler listening to Molly's heartbeat because the consultants were saying that the heart beat was dropping and they wanted me to be on continuous monitoring. So she did support us in that way.' Sarah

These women stressed the importance of personalised care and a connection with staff who demonstrated genuine care and compassion. They spoke about the personal significance of the birth experience and the importance of this being reflected in the care they received.

The role of the Positive Birth Movement

The women spoke about their experiences of the Positive Birth Movement. Meetings were presented as a valuable source of social support where pregnant women and mothers could meet like-minded people.

'I think it's been lovely to meet like-minded people, to meet people who've had positive birth experiences, you know, that have been really different from mine, but still really positive and I think it's always nice to share these experiences. It gives hope to other women, I think it's been really lovely when there've been pregnant women in the group who haven't had babies before or who are having second or third babies and want a more positive experience, I think that's fantastic. It's a brilliant social group as well as a support group for me and for lots of women who I've met.' Jessica

The relevance of the group was also discussed for women who had suffered birth trauma as it provided a supportive space in which these mothers could work through their feelings.

'My mum, she ended up with an emergency caesarean in the end and you know she did have a tough time and I think maybe had and I know we're going back thirty two years now, but had she been able to come to a group, get the support, let go, have a chat, work out, you know, what was positive about it maybe she'd feel very differently about that experience.' Vicky

Positive Birth Movement meetings were also presented as a space in which women could access information relating to pregnancy and birth that empowered them to make informed birth choices and learn about their rights.

'... when someone says, "oh, my god, so I can say no to that?" And you're like, "Oh yes! You can! Say no to it, you don't have to do it." And it's, it's quite, it must feel absolutely daunting for them. 'cause I guess for me, my, all my research and my confidence in saying no has built up over four years between Rowan's birth and my impending second birth.' Harriette

Finally, the women spoke of common misconceptions about the Positive Birth Movement, that the group may be viewed as an extremist organisation which places women under pressure to have 'natural' births. The women discussed how this was very different from their experiences of the group as a space that supported women's birth choices whatever they may be.

'Yeah, definitely and I think some people do get the impression the Positive Birth Movement is women saying "you must do this, you must have homebirths, you must give birth up against a tree in a wood" and it isn't like that, it's about women saying "these are the choices you have, these are the options you've got, you choose what is right for you" and there's no judgement in there.' Sarah

Women spoke about the group as an empowering space in which the mothers who were sharing their birth stories were able to educate and women hearing the stories received knowledge about birth and their rights, and the positive birth stories discussed in meetings were a valuable alternative to negative birth stories which are prevalent in western society.

We acknowledge that there are limitations to this piece of work. Firstly, this is a small group of women from a particular Positive Birth Movement group and, as such, self-selecting, which may lead to differences between them and the general population. However, their experiences are similar to those found in other research.[1] Also, as the interviewer was also the group facilitator, there may have been a reluctance to give negative response about the group.

The women's experiences of the Positive Birth Movement meetings suggest that the group could be a valuable space for pregnant women as it enables them to gain access to information about birth that may not be offered by the NHS. Information about birth choices and rights could facilitate positive birth experiences by helping women approach birth from an empowered position. This in turn could enable them to establish a good relationship with their midwife and receive the personalised care they want.

Melissa Thomas, Jenny Hallam and Chris Howard
University of Derby

Reference

1. Rance S, McCourt C, Rayment J et al (2013) Women's safety alerts in maternity care: is speaking up enough? Quality and Safety in Health Care 22: 348-355

Hypnobirthing

Katharine Graves shows the power of deep relaxation and positive thought in birth

Hypnobirthing is based on simple and profound logic. It provides women with the tool to have a good birth and I have not seen anything else make such a profound difference to birth for women and babies.

That said, let us look at what it is not. Hypnobirthing is NOT a method of pain relief in labour. This may sound strange, as it is often included in the pain relief session of NHS antenatal classes, but to think of it as a method of pain relief in labour is fundamentally to miss the point, although women who come to a hypnobirthing class do usually have a much more comfortable labour.

Hypnobirthing works on the premise that it is unnatural for pain to be there in the first place. This may seem an outrageous statement to people who have acquired their view of birth from dramas on television or the movies, or to midwives who have seen many women in extreme agony and for whom a large part of their work is relieving pain. But we have all heard stories from time to time of a woman who has given birth completely comfortably, and all midwives will have seen this from time to time. We often hear of it in what we wrongly call a primitive culture. A pregnant woman is working in the fields, goes off for an hour to have her baby, returns with her baby strapped to her back and continues working. And we say, *'Isn't that amazing?'*

So if one woman can do it, a woman's body must be made in such a way that it can be done. So, given normal circumstances, any woman could do it, and the real question should be, 'What has gone wrong with our society that birth is generally considered to be an uncomfortable, if not a painful experience?'

A hypnobirthing course will explain the logic of this claim, with reference to how the muscles of the uterus work in harmony with the mind and the hormones, and it provides tools to facilitate this process. Working on the premise that a woman's body is created to give birth efficiently and comfortably, hypnobirthing provides tools to achieve this.

What happens in a hypnobirthing course?

Most women come to hypnobirthing classes expecting to learn a great many techniques to help them to raise her pain threshold, go into some spaced out state so the pain just wafts over her, not notice the pain, etc.

A hypnobirthing course certainly includes breathing and visualisation techniques, and relaxations, but these have been around for years and, though they are undoubtedly good and useful, they don't make the difference that hypnobirthing makes, so what is the difference? There are three things:

- Work to release fear and build confidence. However much a woman is looking forward to having her baby, everyone 'knows' that birth is painful. Every movie we see and every book we read portrays a woman screaming and writhing around in agony as she gives birth. As this is the underlying reality in our subconscious, the work to release fear is a fundamentally important part of hypnobirthing.
- Takes a woman into a very deep state of relaxation, much deeper than a short relaxation that she might do at the end of an antenatal class.
- Provides a structured practice routine. This only takes about 15 minutes a day, but rather than being sent away from a class and told to practise, the woman is given a definite routine to do. And 15 minutes a day is not long for something as important as having a baby.

In fact, rather than being a process of adding on, hypnobirthing is more a process of letting go. Usually, when we have something important in our lives like an exam, we add on more and more. We learn lots of facts and add more and more. We do a trial run to see how well we are doing. Then the night before the exam we brew up endless supplies of black coffee and cram in all we can. And then we produce it on the day.

Hypnobirthing is exactly the opposite: it is a process of letting go of our stresses, of releasing our fears, so that by the time we give birth, the perfect system – which is already in place, hidden at the moment below all the layers of stress and fear – can shine forth and work in the way it is designed to do.

a process of letting go of our stresses, of releasing our fears

How does hypnobirthing work?

In only 10 years, hypnobirthing has become so well known that every midwife has heard of it and many NHS hospitals are adopting it. Initially there is widespread suspicion of the word 'hypno'. People expect to come to see tree-hugging hippies sitting cross-legged on beanbags and chanting. Nothing could be further from the truth. Parents are presented simple and irrefutable logic. Originally a few mothers came because their fear of birth was so great that anything was worth a try. They did the class, thought it was wonderful and, when they had their babies, it worked! It worked so well that they told their friends about it, so more women came to the course, and it worked for them too. And that is how it grew. It is a

powerful grass-roots movement which started with mothers and, when midwives saw how hypnobirthing affected a birth, they were amazed at the difference. Time and time again, a midwife will exclaim after her first hypnobirthing birth: 'I couldn't believe how calm she was!'

What brings a couple to hypnobirthing is the birth reports from other hypnobirthing couples. The fathers, in particular, arrive sceptical and leave the staunchest advocates, and it is reports from other fathers which often bring them to classes.

As well as the work that is done in class, the practice that a couple does at home is extremely important. It is a little like learning to play a musical instrument. You can go to the lessons and make progress, but if you do the practice in between you will really progress well. All the best and most enthusiastic birth reports from hypnobirthing mothers will say, '… and I practised lots.'

Hypnobirthing works because, by helping us to let go of our fears, it enables the body to work in the way it is evolved to do, efficiently and comfortably. The principle is very simple, and the result is very profound.

Birth is the most formative experience of our lives and, if a mother is calm and drug-free, her baby will also be calm and drug-free. Instead of birth being a difficult or traumatic experience for both mother and baby, it will usually be a gentle, natural experience with few interventions, which mothers describe as the most wonderful and empowering experience of their lives. The baby will arrive in the world to be greeted by a mother who is calm and alert and ready to receive it. This is how it forms its first relationship in this world, which is the blueprint for every other relationship throughout its life, and will have an effect on it throughout its life and indeed on everyone it meets. Time and time again, people observe that hypnobirthing babies are different from the majority of babies. It is difficult to define, but there is a calmness and an alertness about them. They have been observed to start to put on weight straightaway, whilst many babies lose weight for a few days while they recover from the difficult experience of birth, before beginning to put on weight. There are often reports that hypnobirthing babies are very calm babies who sleep through the night sooner. As the children grow up, they seem to take life in their stride and remain calm and happy.

Though women come to hypnobirthing for a more comfortable birth, which time and time again it has been shown to deliver, in the long run the benefits for the baby are even greater, and the significance of this cannot be over-estimated.

Katharine Graves

Useful websites
www.kghypnobirthing.com
www.thehypnobirthingassociation.com
www.hypnobirthing.co.uk
www.natalhypnotherapy.co.uk
www.thewisehippo.com

Feedback from a Positive Birth facilitator

My name is Elle and I have been running the Manchester Positive Birth Group from around the time the PBM began.

Ours is a lovely group, held in the cafe of a community centre. The meeting is family-friendly, as is the cafe. We tend to eat lunch at the same time, the children play – it's very informal.

Other groups have different settings and outlines, but that's what works for us. We get a mixture of pregnant mothers, women with babies and toddlers, and midwives. Even a dad came along once!

I am a doula, but I facilitate as a peer. That's something I love about the meetings, that everyone's voices are equal. Women sharing their experiences is always a powerful thing, and there's something really special about women seeking information and finding it from each other. We used to pass on knowledge and advice in this way, amongst our own community, and I'm glad that hasn't been lost.

After introducing ourselves and saying a little about what brings us to the meeting, I explain what the month's topic of discussion is and that we don't have to stick to it. Sometimes the expectant women have questions, and it's important that they don't leave with them! But it can be really helpful to have the topic to return to. The themes are intentionally broad, so I like to leave them open to the interpretation of the women in attendance. I am fascinated by the perspectives presented at our meetings, and always take away something to think on.

There is no one way to achieve a positive birth, and the group isn't there to recommend any particular type of birth. After all, there is no guarantee that any setting or method will provide a satisfying experience. But a group of women sharing what has served them well is an antidote to the fear-tension-pain cycle that so many mothers perpetuate, sometimes without even realising. The meetings are a space where women can safely explore their options, minus the scare stories, and with absolutely no judgement.

Feeling empowered comes from within, and sometimes all it takes is a spark. Hearing how someone refused a routine procedure, or insisted on something that was important to them, inspires the listener to think about what they would really like for themselves, and how they might go about getting it. We all gain wisdom when we give birth, and Positive Birth Groups, where mothers meet from many walks of life, are the perfect place to share it.

Elle James

Pregnancy and Parents Centre

Nadine Edwards shares an example of the difference good support can make

The Pregnancy and Parents Centre, or PPC (www.pregnancyandparents.org.uk), formerly the Birth Resource Centre or BRC, is a community-based charity in Edinburgh which offers practical and emotional support to pregnant women, dads-to-be, new parents and their families. It provides a range of groups, workshops and drop-in sessions, one-to-one support, alternative therapies, a library, birth pools, nearly new maternity and baby clothes and more.

The Centre had its beginnings in 1985 when I began to run pregnancy groups in my home. It has continued to grow, and now has its own two-storey premises between garages and warehouses, beside the Union Canal in central Edinburgh. It is managed by a group of voluntary Trustees, and is run by a co-ordinator and two administrative staff. Over 400 parents, babies and young children attend the Centre's daily activities led by facilitators and volunteers, each week.

The drop-in groups – for those new to Edinburgh, for mothers with very young babies, the home birth support group and the La Leche League group – are free and open to anyone. Some of the sessions are run by suggested donation and some ask for a fee. But our central premise is that no-one should be excluded for financial reasons.

The Centre is used by many women whose first language is not English and the weekly group for those new to Edinburgh is vital in providing support, friendship, local information about maternity services and other local services and resources for families.

The excerpts from the two stories below, published in full in volume 4 of Sara Wickham's Midwifery Best Practice' series, perhaps epitomise the Centre's underlying philosophy of support and sharing knowledge and experiences.

Jane's story

Jane had suffered severe mental illness. She and her husband wanted a family, and at the age of 35 she felt that she could wait no longer:

It happened surprisingly quickly. I immediately stopped taking the tablets, and wanted to know if taking medication for the first three weeks of my pregnancy could have caused any problems. Nobody seemed to know (or care).

As I entered the second trimester, my mood began to sink lower and lower. Severe antenatal depression set in.

Things became so bad that the GP and psychiatrist recommended that I go back on the medication. They believed my mental state was more threatening to myself and the baby than the risks of abnormality from the drugs. With support from my husband, I refused, although every day felt like a lifetime and I just wanted to escape from my own mind.

During this time I began attending NHS parenting classes. At the end of the session I spoke to one of the midwives and explained a little of my situation. She suggested I opt for a nice easy birth with an epidural, as traumatic birth has been shown to increase the risk of postnatal depression. This made sense to me and I decided to take the advice.

I did discover at these sessions that health visitors were available to support women antenatally. No one had offered me anything other than drugs before. This was to be my turning point. My health visitor had previously worked as a midwife and gave me a whole afternoon of her time every two weeks. When I was 26 weeks pregnant, she brought me a flyer for the Birth Resource Centre. 'I think you should do some classes here,' she said. 'The yoga would be good for you, I think it would help.'

Nervously, I called the number and began to attend class every Wednesday morning. At each class we began by introducing ourselves, then we performed gentle yoga-based exercises and relaxation, as our facilitator gently told us to listen to our bodies, do what felt right, and tune in to our babies. After this, we had tea and talk. Someone in the class usually had a question, an issue to discuss or a parenting book they had read, and we learned from each other while the facilitator skilfully and imperceptibly deepened knowledge or dispelled myths. Women who had given birth returned to show off their babies and tell their stories. They were eagerly questioned and their experiences added to our knowledge.

I was beginning to trust my body and my baby

Gradually I realised that I was relaxed and happy during these classes. I was beginning to trust my body and my baby, and it was then that I realised that an epidural as first resort would not be right for me. I had learned of the risks associated with epidurals: how could I spend months trying to protect my baby to then expose him to unnecessary intervention?

Having been told that she could not use the midwifery-led unit at the local maternity hospital because of her age, Jane says:

With my newfound confidence I phoned the normal delivery unit myself. I spoke to a midwife who said she would be delighted to book me there. With my husband's full support and belief in my ability to birth my baby, I began to feel calmer and, as forty weeks approached, I felt serene, powerful and whole.

My labour was calm and beautiful. I couldn't stop smiling as I welcomed each contraction [...] in the normal delivery

unit, with soft lights and a single midwife, I travelled to my innermost being and birthed our first baby in consciousness and strength. And the power of this glorious birth has achieved what no doctor could. I now have three beautiful children and have never since taken any medication for mental illness.

The support I had from the BRC [PPC] was huge. It helped my relationship with my baby, with my husband, with my whole life.

Fiona's story

Fiona explains that she was 'somewhat at sea' during her first pregnancy and how she felt 'held' by the Centre both before and after the birth of her daughter.

None of my friends had children, and I had never held a baby, yet I was to have one of my own. The Birth Resource Centre was to become my anchor.

I loved the yoga classes and never missed a single one. They were the highlight of my pregnant week. The exercise and relaxation were wonderful, but the tea and chat at the end were the key. Information was acquired almost by osmosis – there was no set 'curriculum' but through conversation and questions and answers, those of us at the class found out what we needed to know to help us on our journey through our pregnancies into motherhood.

I thought of the birth rather as a bridge that would take me from my present life to my new life with a child. I was excited, but also rather apprehensive about what I would find on the other side. One of the important things for me about the BRC was that there was a wide range of postnatal sessions as well as the antenatal classes, so I would have somewhere to go back to with my new baby. I did not intend to return to my old job after I had had my baby, so I knew I needed to make new friends and forge a new life around being a mother, and the BRC felt like a community to which I could belong. That was exactly what it proved to be for me.

We know that there are parents who still meet together, who first met through the pregnancy groups in the 1980s. These friendships have supported and sustained both women and men as they faced the joys, uncertainties and challenges of parenting. The friendship and sense of community that is consciously developed at the Centre, especially through the social time at the end of each group or workshop, has been described as a 'lifeline' or 'sanctuary' by numbers of women:

'It's been such a privilege coming along to the classes and learning about impending motherhood in such a supportive nurturing environment! I also cannot praise the dads-to-be course enough. With the section my husband has needed to take the lead on bathing and some of the early nappy changes and the course gave him the confidence and practical skills to cope with this – it's been an absolute lifeline.' (First-time mother)

'The classes were a sanctuary in the week where everything else seemed to disappear.' (Mother of three)

The aim of the PPC is to provide support and information in a non judgemental environment where everyone's knowledge and experiences are valued and where everyone is accepted, no matter who they are.

Parents' comments confirm this:

'I was desperately searching for somewhere friendly and supportive to take my often cross and wailing baby. After weeks of rushing away from groups and coffee mornings feeling tearful and lonely, as my daughter was the only fretful baby there, I was told about the baby music group at the PPC. Immediately I felt welcome and supported. For the first time I was able to talk honestly about my feelings as a new mother. Funnily enough my daughter was always notably cheerier and more content in this environment too and Tuesday afternoons became a haven for the both of us.' (pregnancyandparents.org.uk/about-the-brc/comments/)

The Centre provides a holistic approach to pregnancy, birth and parenting, acknowledging that it is a physical, social, emotional and perhaps spiritual, life-changing journey, during which parents need to be nurtured and enabled to explore possibilities and find their own confidence.

'I wanted to thank you for the phenomenal support ... the reading material you pointed me in the direction of has been – well life changing! I went from an overwhelming sense of panic at the prospect of another labour, to actually looking forward to it.' (Third-time mother)

'I came to the PPC pregnant for the first time and relatively naive about the politics of pregnancy, what my options were and the difficult choices I had about where and how I would give birth to my children. I never could have imagined what a life changing experience those yoga classes would be, ultimately for both my partner and me and our experience of becoming parents.' (Mother of three)

'The workshops and the support of the PPC helped take the fear out of birth, and changed it into something we could own as an experience.' (Father expecting second child pregnancyandparents.org.uk/whatweoffer/active-birth-workshops/).

The Centre also has a political dimension. For example, one of our Trustees is a member of the local Maternity Services Liaison Committee and we host some of its meetings. We attend and present at conferences, and respond to policy documents. We are involved with midwifery education and supervision and provide a placement for student midwives. We meet with local midwives and those involved in other services for new families, and our Birth Project Group works with the University of Edinburgh, Edinburgh Napier University and Trinity College Dublin, running workshops for student and newly qualified midwives and others. As one of our volunteers remarked:

'The BRC is a beacon. It is hugely politically significant. If birthing autonomy is to remain a reality and not just a pie in the sky concept, communities like the BRC need to be sustained – beacons need fuelling.'[1]

Nadine Edwards

Reference

1. Armstrong F, Clayton L, Crewe J et al (2006) The Birth Resource Centre: A Community of Women. In Wickham S (Ed) Midwifery Best Practice Volume 4. Elsevier 106-11.

AIMS homebirth survey

Nadia Higson shares the results of an exploration of what is on offer to women

Most women who want one are able to achieve a homebirth – but all too often this is in the face of obstruction from their carers, and more than half of pregnant women are never offered this option. These are the main findings of the AIMS homebirth survey. Although this was an informal, exploratory survey, it raises a number of concerns and we believe that more systematic research is needed to understand the extent of the difficulties that women currently face in exercising their choice for a homebirth.

Women were recruited to take part in the survey by email invitation and by a link on the AIMS website, and were also asked to forward it to other women who might be willing to share their experiences. The invitation stated:

'AIMS is concerned at the increased numbers of appeals from women who are having, or who have had, problems booking a homebirth, or getting a midwife to attend when they called in labour. In order to better understand what is happening around the country we would like to hear your experiences, particularly if you have had a baby in the last year.'

A total of 571 women completed the survey at least in part. As a self-selected group, their experience may not be representative of all mothers in the UK, especially as the wording of the invitation may have disproportionately attracted responses from those who had had problems gaining support for a homebirth.

Another limitation of the survey is that although the majority of the women gave birth within the last four years, some were recounting experiences from many years ago. However, there appears to be little difference in the experience of these women and those who gave birth more recently.

Homebirth was not offered to the majority of women

Whether or not the women would have liked to have a homebirth (and 92% of the sample would have done so), well over half of them (58%) were not offered this choice. Of those who were offered it, the vast majority (92%) received this information from a midwife, and this was usually fairly early in the pregnancy (almost 75% by 12 weeks). Around 3% of women stated their preference for a homebirth without waiting for it to be offered.

A fifth of women were told that they could not have a homebirth … and many had to fight to get one

It is clear that many carers did not recognise a mother's right to choose a homebirth regardless of any risk factors which may apply. Almost a fifth (104/525) of the women who wanted a homebirth were specifically told that they could not book one. The main 'gatekeepers' appear to be midwives (for 78% of the mothers who were told they could not have a homebirth), followed by obstetricians (39%) and GPs (16%).

For almost a quarter of this group (24/104), midwifery staffing issues or reluctance by midwives or the local health service to support homebirths were given as a reason. Comments included *'Midwives' lack of experience, distance from hospital (we are 8 miles away!!)'; 'The "quota" for homebirths for that month was already full!'* and *'We don't do them anymore'.*

Other main reasons given for not booking a homebirth were previous caesarean birth (25%), first baby (13%), 3rd or subsequent baby (9%), mother's BMI (9%) or a 'large baby' in this or a previous pregnancy (8%).

Although most of the women who had wanted a homebirth were eventually able to book one, and many were full of praise for the supportive care that they received from their midwives, more than one in ten (56/525) said that they were not able to book a homebirth; and for others it took considerable determination to achieve one. Just under a quarter (85/374) of the women who had a homebirth reported meeting resistance from midwives and/or consultants:

'Eventually my hospital accepted I was having a HB and accordingly sorted out an on-call rota ... but it took time, letters of protest and a lot of effort on my part to get them to change.'

'Getting homebirth felt like getting a visa for N Korea ... made pregnancy so stressful.'

'In order for me to have the homebirth I wanted I had to book a private midwife at considerable financial cost.'

A fifth of hospital transfers were because care was withdrawn

The majority of women in the sample who booked a homebirth were able to give birth at home (74.5%), but at least 3% transferred to hospital care during pregnancy, 12% at the start of or during labour and 3% for induction of labour. (The remainder did not answer these questions.)

'When I rang to say I was in labour and had booked a homebirth I was told that no midwives were available.'

Of the 60 women who transferred to hospital during labour, 22% did so solely or partly because care was withdrawn. This was most often due to a reported lack of staff to attend the woman at home and was the second most common reason for transferring, following lack of progress in labour (25%). The other main reasons were concern over the baby's well-being (20%) and because the waters had been broken for more than 24 hours (17%).

It is interesting that over a third of the mothers who transferred for reasons other than lack of staff were unhappy with that decision; and also that around half of those who transferred did not then require any medical interventions.

Mothers are strongly positive about their homebirths

Over 90% of those mothers who gave birth at home were very satisfied with the experience, rating it 8 or more out of 10. They frequently described it as 'amazing'. As one mother put it:

'It was quite simply one of the best experiences of my life.'

Almost all of the women who gave birth at home (98%) would choose to book a homebirth in another pregnancy, and so would a large majority (88%) of those who wanted to but did not give birth at home. This includes almost all of those who transferred to hospital care in pregnancy or labour.

Many women described how birthing in familiar surroundings at home had made them feel safe, relaxed and in control:

'It felt very natural to be at home in my most familiar and relaxed environment without external distractions. This allowed me to get into my own zone for giving birth.'

'I felt very safe and comfortable at home. All my wishes were respected.'

'I felt empowered to be able to give birth to our baby in our own home.'

Those who had experienced birth both in hospital and at home often commented on the differences:

'I had a previous poor experience in hospital where I felt abandoned and uncared for. I had a subsequent wonderful homebirth … the difference to my care was amazing.'

'My two previous labours and births were overly managed in my opinion and ended in caesarean sections due to a cascade of interventions.'

'in hospital … I was treated without respect and dis-empowered during my first labour.'

Women who birthed at home felt this made it *'a part of family life'* and *'made life with older child much easier to manage, he was also much more involved'*. They also appreciated not having to travel in labour or to stay alone in hospital afterwards, but rather being *'able to be at home with my new baby, husband and other children straight after the birth'*.

Another benefit for many was the reduced need for interventions and the fact that being relaxed at home helped them to cope better with the pain:

'Lack of pressure and home comforts made pain relief unnecessary.'

'The pain was manageable and the labour very quick.'

Most were very positive about the care they had received from their midwives, especially those who had used an independent midwife, but a few had experienced a lack of support in labour from NHS midwives.

Nadia Higson

Supporting those who witness bad practice

Beverley Beech makes some suggestions

It is not uncommon for those who are supporting a woman during childbirth to witness bad practice and then wonder what can be done about it. Here are some principles:

Advise the woman to obtain her own copy of her case notes (it is not uncommon for the notes to be at odds with what was observed).

Talk to those who also witnessed the incident and determine whether or not they would support your view of what occurred.

When you have a quiet moment, sit down and write an account of what you observed, who was present and what action was taken at the time.

Discuss what happened with the couple, if possible, and determine what they want to do about it. If the woman has been traumatised then it may be many weeks before you are able to raise the issue.

Support them with what they have decided they would like to do about it. If they do not feel able to make a complaint they may be willing for you to make a complaint on their behalf.

Obtain a copy of 'Making a complaint about maternity care' from AIMS.

Contact AIMS and discuss the options.

Then what to do? There are a number of options:

Discuss what happened with the staff concerned.

Arrange a meeting with the Head of Midwifery (HoM) to discuss your concerns.

Alternatively, particularly if you feel that the HoM will not take action, write to the Chief Executive with a copy to the HoM. This ensures that senior management are aware of the issue and there is a record of a previous concern should a similar event occur again.

If you observed malpractice or negligence, you have the option of reporting the member of staff to their professional body:

- midwives, nurses and health visitors – Nursing and Midwifery Council
- doctors – General Medical Council
- social workers – Health Care Professions Council

Beverley Lawrence Beech

Lancet series on midwifery

Andrea Nove gives an overview of the papers on the impact of midwifery on maternal health

At the international level, there is currently much discussion about why some countries have made much more progress than others in improving maternal and newborn health (MNH) and how progress can be maintained and, where necessary, improved in the years to come. A team of some of the world's leading academic and clinical MNH experts have collaborated on a series of papers looking at the contribution that midwifery does (and could potentially) make to MNH. Eventually there will be six papers in the series; the first four were published in the Lancet in June 2014.

Every year, hundreds of thousands of women die during or shortly after pregnancy and millions of babies are stillborn or die within a month of birth.[1, 2, 3] Millions more suffer poor physical and/or mental health.[4] The Lancet series suggests that midwifery has a major contribution to make to tackling the problems behind these statistics. The authors point out that although most deaths and poor MNH occur in low-income countries because services are under-resourced, poor care can and does also occur in high-income settings, particularly where interventions are over-used because the care system focuses on identifying and treating the 'problem cases', and thus treats all pregnancies as potential problem cases.

Having reviewed a large number of studies, the authors of Lancet paper 1 propose an evidence-based framework for MNH which applies in all settings.[5] The authors describe the framework thus: *'information and education were essential to allow [women] to learn for themselves, that they needed to know and understand the organisation of services so they could access them in a timely way, that services needed to be provided in a respectful way by staff who engendered trust and who were not abusive or cruel, and that care should be personalised to their individual needs, and offered by care providers who were empathetic and kind. Particularly, women wanted health professionals who combined clinical knowledge and skills with interpersonal and cultural competence.'* The authors point out that all women and newborns need the above and, additionally, those with complications need expert management of those complications.

Paper 1 goes on to review hundreds of studies relating to MNH care practices, identifying those which evidence shows to be effective. Most are effective in improving outcomes for some or all women (for example, antenatal perineal massage, upright positions in the first stage of labour, anti-D injections in pregnancy), but several are ineffective (such as artificial rupture of membranes (ARM) for shortening labour, bed rest for multiple pregnancy). Over half (59%) of the effective practices are within the scope of midwifery as defined in this series of papers. Given this, the authors argue that midwifery should be central to the way in which MNH services are configured. They suggest that midwifery can make a particular and cost-effective contribution in relation to: education, information, health promotion, assessment/screening, care planning, promoting normal processes and preventing complications. They do, however, acknowledge the main limitation of their study, which is that most of the evidence on which it is based comes from high-income countries, and it focuses on the short-term effectiveness of various interventions rather than longer-term impacts.

How much difference would this new MNH framework make if implemented on a global scale? Paper 2[6] uses a mathematical model to estimate the number of lives that would be saved if midwifery was scaled up in the 78 countries which together account for 97% of the world's maternal deaths and 94% of newborn deaths. The authors estimate that midwifery interventions (including four or more antenatal care visits, skilled birth attendance, breastfeeding support) could prevent 83% of maternal deaths, stillbirths and newborn deaths if they were available to all in these 78 countries, with the strongest impact in the least developed countries. Key among these interventions is contraception, because most of the averted deaths would be due to the prevention of unwanted pregnancy.

In many low-income countries, it is unrealistic to imagine that midwifery interventions could be scaled up to be available to all within the next ten years because the existing infrastructure is so poor (a fact that has been brought tragically into focus by the recent ebola outbreak in West Africa) and there are limited resources to invest in developing the health system. But as the authors point out, even a modest scaling-up of midwifery interventions (a 10% increase every 5 years) would result in a huge number of lives saved, so there is no call for fatalism.

Paper 2 also reports some additional analysis of the effect of scaling up specialist MNH services such as safe abortion, management of ectopic pregnancy and caesarean section and finds that the effect, while also beneficial, is less pronounced than the equivalent scaling-up of midwifery interventions. In other words, midwifery provides 'more bang for your buck', but it is not a panacea and needs to be situated within a functioning MNH care system in order for the benefits to be maximised.

It is also important to note that the authors refer to midwifery interventions, rather than midwives. In all of these papers, a distinction is made between 'midwifery' and 'midwives'; the former is a system of care which is usually provided by suitably-trained midwives, but can be provided by other skilled health workers, including doctors, when appropriate. However, using case studies from three countries, the authors point out that obstetrician-led care without midwives might reduce death rates and poor physical health, but it also tends to increase the cost of MNH services and can reduce quality of care (as defined in these papers, including values and philosophy of care as well as technical interventions). They also point out that the midwife is the only health professional whose scope of practice covers the entire continuum of care from family planning through pregnancy, childbirth and the postnatal period and therefore is the person best placed to bring women and their families into the system at the most appropriate time and place.

The modelling tool used in paper 2 is called the 'Lives Saved Tool' or 'LiST'. LiST works by estimating the impact of particular interventions on the number of deaths. The assumed size of the

impact is evidence-based where high-quality evidence exists, and otherwise based on the opinion of a panel of experts.[7] One of the implicit assumptions of LiST is that as coverage of interventions increases, so does quality of care, which is not necessarily true. For this and other reasons, the tool has its critics, but is generally regarded as one of the best available for this type of calculation.

As noted earlier, deaths and stillbirths are generally regarded as the 'tip of the iceberg' when it comes to MNH; and Paper 2 does not attempt to estimate the effect of scaling up midwifery on the physical and mental health of women and babies who do not die. Because most high-income countries currently have low rates of maternal and newborn deaths and stillbirths, LiST models have little to say about the impact of implementing the new MNH care framework in the developed world. For this reason, Paper 2 also includes a short discussion of how midwife-led care has been shown to improve outcomes and cost-effectiveness in high-income countries.

Paper 2 uses a theoretical model, and Paper 3 documents what can happen when the theory is put into practice.[8] It examines the experiences of four low- and middle-income countries which have deployed midwives as a core component of their strategy to improve MNH. Although the four countries have gone about this process in different ways, the authors identified some commonalities, including the broad order in which they have introduced changes to the MNH care system. Stage 1 is to build up the number of health centres and hospitals so that women do not have to travel too far to get to them. Stage 2 is to staff these health facilities with sufficient skilled health workers. Stage 3 is to remove the need for women to pay for MNH services at the point of access. Stage 4 is to make improvements to quality of care.

In these four countries, there is evidence to suggest that the implementation of stages 1–3 has resulted in large increases in uptake of MNH services, indicating that women are more likely to seek care if they can do so without excessive inconvenience and cost, and if they can be confident that they will be seen by a trained provider. All four have also recorded significant reductions in numbers of maternal and newborn deaths. However, their progress has been limited as a result of lack of consideration given to quality of care, resulting in insufficient focus on technical standards, competencies, equipment and coordination between different parts of the health system. The authors identify two 'blind spots' which they see as barriers to improving quality of care: (1) policy-makers not judging quality of care to be as important as availability of care and (2) a tendency towards over-medicalisation.

Paper 4[9] draws the series together by considering the implications for MNH decision-makers if they are to create an environment in which the framework described in Paper 1 can be implemented. These include:

- different types of MNH care providers (doctors, midwives, nurses) should be part of a single, multi-disciplinary team
- all MNH care providers should be able to practise to their full competence
- midwifery should be scaled up so that it can make a greater contribution to efforts to improve MNH, particularly in sub-Saharan Africa, the only region of the world where the number of pregnancies is projected to increase significantly over the next 20 years, MNH services need to run to stand still and sprint to make improvements
- at the same time, to improve quality of care, investment must be made in the key areas of education, regulation and human resource management
- quality of care should be monitored to assess the effectiveness of efforts to improve it
- the wider health system should be strengthened so that midwifery providers have effective back-up when needed (for example when complications need specialist care)
- service users should be involved in the design and delivery of MNH care

To assist with the decision-making process, the authors call for more research in three areas: (1) how to ensure that skilled providers are deployed to where they are needed, including remote areas; (2) how to improve productivity among midwifery providers in different settings, without losing sight of quality; and (3) how to manage the increasing commercialisation of childbirth (for example, the growth of for-profit services that can lead to over-medicalisation).

All the evidence presented in these papers leads to the conclusion that the scaling-up of midwifery is a key part of the solution to the problem of how to provide high-quality MNH care for all. It will require significant investment, but the evidence indicates that the return on this investment will be massive.

Andrea Nove

Andrea is a researcher and statistician with a special interest in maternal and newborn health. She has a PhD in social statistics from the University of Southampton, and currently works for Instituto de Cooperacion Social Integrare (Barcelona) and Options Consultancy Services (London) specialising in sexual, reproductive, maternal, newborn and child health and health systems, mainly working with developing countries. Her recent projects have included an analysis of rates of maternal death among adolescent girls, the State of the World's Midwifery report and an analysis of urban/rural inequalities in access to healthcare. Some of Andrea's colleagues are authors of papers in the Lancet series.

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Midwifery in Tanzania

Rose Mlay gives a view from the ground

In Tanzania women believe that it is a bad omen to tell other people you are pregnant. Even when pregnancy can be seen, we do not want to discuss it. The 'expected date of delivery' (EDD) is not in a Tanzanian woman's vocabulary.

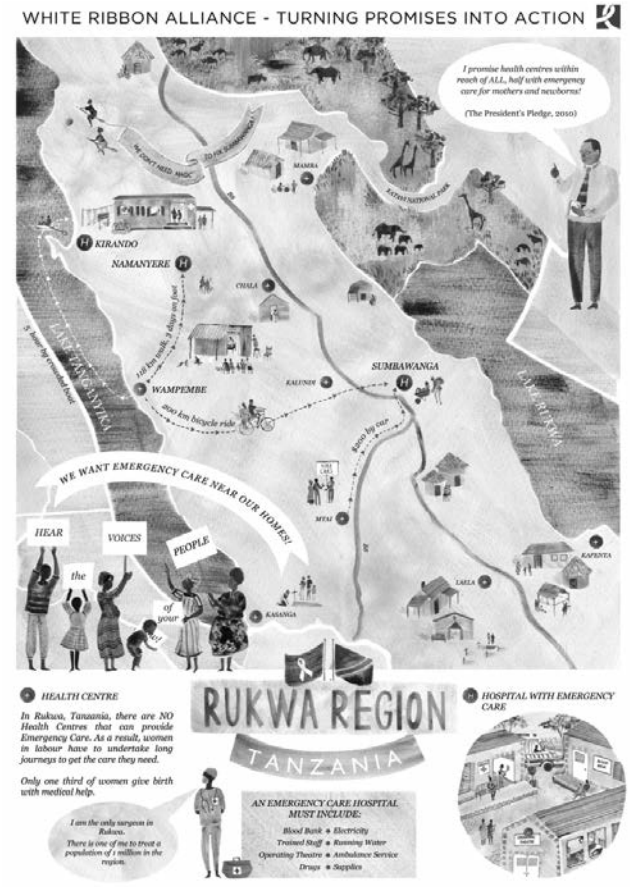
Instead, we say to each other, 'ni mja mzito' (she has become heavy), but no one wants to know when she is going to become light again. Only the midwives want to know, because they have learned how important this is.

So why is this, why the hiding? It is simply because women fear they might die. They have seen friends, relatives and other mothers dying in childbirth, and they do not know why a healthy woman should die. We have a saying that 'a pregnant woman has one foot in the grave,' so to speak of the impending birth is a bad omen.

This is why I welcome the recent Lancet report, and the slogan of the International Confederation of Midwives that today 'the World Needs Midwives More Than Ever'.

As a midwife, as a mother and as national coordinator of the White Ribbon Alliance in Tanzania, I know the crucial role of midwives in preventing disabilities and deaths related to pregnancy.

As an advocate in Tanzania, I call for action to end the global scandal in which 99% of the world's maternal deaths occur in developing countries, many of these in sub-Saharan Africa including my own country. It is high time our governments became accountable for these needless deaths. We are urging them to invest in women and midwifery, just as more developed countries have done over many decades. For example, while developed countries such as Sweden have a maternal death rate of less than 4 per 100,000 live births, Tanzania has 454 maternal deaths per 100,000 live births. Why? Sweden has 11.9 nurse-midwives for every 1000 people compared to Tanzania which has 0.2 nurse-midwives for every 1000 people.[1, 2]



Midwives have a crucial role in reducing maternal and newborn deaths. AIMS readers will know that obstructed labour and ruptured uterus are highly dangerous, and globally they contribute to 70% of all maternal deaths. Ditto, high blood pressure leading to eclampsia, severe bleeding before and after pregnancy, infection, fetal distress and asphyxia are all potentially lethal – especially in countries where up to half of women give birth alone at home or with only a neighbour or relative to help. In developed countries, an ambulance is often on hand to assist a birthing woman if needed. In my country, a woman may face a two-day walk to reach the nearest hospital – yet she can die of bleeding within two hours.

The way to prevent these deaths is to invest in the professional midwives who will be the first to recognise when a woman or her newborn are at risk from complications.

This is the path that Sweden followed when it took responsibility for safe birth by being accountable to its citizens and investing in midwives. Sweden, as a result, dramatically reduced its maternal deaths from 900/100,000 in the 18th century to 4/100,000 in 2010.[1]

Realising this, the White Ribbon Alliance for Safe Motherhood Tanzania (WRATZ) has been campaigning for our government to increase the numbers of qualified staff as the best strategy to reduce maternal and newborn deaths. In 2006, we protested to our government that Tanzania had many midwives who were either unemployed or doing other work, due to the lack of salaried government jobs. They heard our call and decided to lift the employment ban which had been imposed on health staff. As a result of White Ribbon Alliance advocacy, the government changed its policy in order to employ all new midwives so that they went straight to work as soon they graduated from their training.

However, WRATZ then found that the pool of graduating midwives was not large enough – and so for the past three years (with funds and other support from the Bill and Melinda Gates Foundation and others, sourced by the WRA Global Secretariat), we started a campaign to boost the career of midwifery. Our theme is *'be in science; choose midwifery'*.

As a result, tens of thousands of secondary school youths were informed of the situation – that in our country, mothers are dying alone or with unskilled personnel during childbirth.

As a result of our campaign, the government built science laboratories in secondary schools and provided loans to university students to become science teachers. Many students subsequently decided to study science and choose midwifery so that they could help to save the lives of women and newborns.

This campaign is ongoing, with White Ribbon Alliance Youth Clubs in 12 secondary schools so that new students are helped to make informed choices.

Until recently, too, our joint nursing and midwifery curriculum meant that midwives worked in medical and surgical wards as well as labour wards, gradually losing their midwifery competencies. But now, midwifery degree courses have started in Tanzania so that we have the opportunity to build a truly expert midwifery workforce.

Yet it can still be very demoralising if these students become midwives and/or medical doctors eager to save lives, only to find they cannot do so because of poor health facilities, lack of other trained staff and terrible working conditions.

In order to save women's and newborns' lives during childbirth, we must have not only skilled health workers in place, but also Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities.

CEmONC includes immediate access by women with complications to the required life-saving medications and services such as blood transfusion and caesarean section. This means there must be a functioning operating theatre available, 24 hours a day, seven days a week.

Our President did promise in 2008 that these services would be available in half of our health facilities. And this is precisely what the WRATZ is now calling for in our campaign '***wajibika mama aishi***' (be accountable so that mothers and newborns can survive childbirth). We have now won the support of our Prime Minister and many Parliamentarians as well as other government leaders. Citizens of Tanzania – through petitions, public meetings and media appearances – are now calling for a specific budget line for CEmONC, to make sure that 50% of health centres in Tanzania can provide CEmONC by 2015, as was originally promised.

When we began in 2013, White Ribbon Alliance members in the rural area of Rukwa surveyed their own health facilities and found that, in this region of a million people, there was not one health facility providing CEmONC. Since we have made that widely known, involving politicians and the media, we have seen rapid changes.

The results of our recent monitoring and evaluation of this campaign in Rukwa show that all the Comprehensive Council Health Plans (CCHPs) of the four districts of Rukwa now have a budget line item for CEmONC – for the first time in the history of Tanzania. We have not been able to check all districts of Tanzania, but we believe it is likely – given the national directive issued by the Prime Minister – that they all now have this budget line item.

The most recent and exciting part of our story, is that in our latest meeting on 27 August 2014 (which included the top leadership and implementers of all four districts of Rukwa), it became clear that because of the White Ribbon Alliance campaign, five out of the ten government health centres will provide CEmONC by 2015.

And so it appears likely that by the time our students choose midwifery, they will be able to fulfil their roles as midwives and be happy to save lives of mothers and newborn babies during childbirth!

I want to thank all those – globally and nationally – who have joined our efforts to support the pregnant women of Tanzania so that both their feet are on the ground, and so that they and their newborn can survive childbirth.

We all have to '***wajibika mama aishi***' (be accountable so that mothers and newborns can survive childbirth).

People from all walks of life are interested in forming a coalition and pulling the pregnant woman's one foot from the grave and help her stand on two feet and live.

Please see a film about Rukwa and the health facilities here: whiteribbonalliance.org/campaigns/promotion-midwifery/

Rose Mlay

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About White Ribbon Alliance

Healthy mothers make a healthy world. White Ribbon Alliance unites citizens to demand the right to a safe birth for every woman, everywhere.

Who are we?

Over a decade ago, White Ribbon Alliance formed because the voices of women at risk of dying in childbirth were not being heard. We rapidly grew as thousands of people and groups joined the network, speaking as one voice. We are the biggest citizen-led coalition for maternal health and we campaign nationally as well as on the global stage to persuade Heads of State to keep their promises and deliver on their commitments to maternal health.

We have a small global secretariat in London and Washington DC, as well as secretariats in Tanzania, Nigeria and Uganda, helping to coordinate our large global network of volunteer activists.

What do we do?

We mobilise citizens and provide a platform for women and men to demand change.

In our experience, the first step in bringing about change is to locate power at the community level and recognise citizens as the most effective agents of change. Lasting change in society comes about when enough people join forces to demand that their government adopts and implements the right national policies, and devotes sufficient resources to deliver those policies.

Social accountability is essential to progress. WRA has a decade of evidence on how this works, including generation of demand for rights and better services, engaging intermediaries to legitimise the demand of poor and marginalised women, and sensitising leaders and health providers to respond to women's needs.

How can you help us?

Please join White Ribbon Alliance: www.whiteribbonalliance.org – membership is free.

Please fundraise or make a donation to support the work of members such as Rose.

Maternal mortality

Magdalena Ohaja and *Jo Murphy-Lawless* highlight the complexities in sub-Saharan Africa

The reasons that lie behind each woman's death in pregnancy and birth are unique, yet they add up to a distressing picture of maternal mortality which is very complex with overlapping social, economic and political factors at the heart of the matter. Women in sub-Saharan Africa (SSA) face exceptional challenges in this regard and the poorer and more marginalised they are, the more difficult it is for a woman to enjoy good health to begin with and for her to hope that because she is healthy, childbirth will be straightforward and uncomplicated.

The WHO tells us that the immediate physical (medical) causes for maternal mortality break down into the following categories: abortion (7.9%), embolism (3.2%), haemorrhage (27.1%), hypertension (14%), sepsis (10.7%), other direct cause (9.6%) and indirect causes (27.5%).[1]

For women in sub-Saharan Africa the statistics are broken down as follows: abortion (9.6%), embolism (2.1%), haemorrhage (24.5%), hypertension (16.9%), sepsis (10.3%), other direct causes (9.0%) and indirect causes (28.6%).[1] These figures vary in different countries. Unfortunately, 62% of all maternal deaths occur in SSA alone, where the lifetime risk of maternal mortality is 1 in 38.[2]

The painfully slow movement in reducing these figures over the last fourteen years since the Millennium Goals on maternal health were devised is deeply troubling for women, their families and communities who are poorly supported and for whom the lack of care has such grave consequences. For midwives, including those who are informally trained and without whom women would be even more poorly supported, the everyday circumstances of pregnant women fill them with dismay. If midwives work in formal healthcare settings, they themselves are unsupported. Regional and national health policy planners seem unable to overcome major care deficits in their systems.

All of the above are working against a background of growing global inequalities with a specific impact on health inequalities. These are a result of the combined impacts of brutally uneven outcomes in respect of how economic globalisation has evolved, of climate change, and of austerity policies imposed since the international financial crisis of 2007, all of which have targeted the poorest and most vulnerable. Global Health Watch (GHW), the organisation which exists to help activists to exchange case studies and experiences internationally, with an emphasis on practical interventions at local and national levels, lays out this detail. Importantly GHW also attempts to develop the theoretical analyses to strengthen our understandings about how we can have greater and more effective impact in giving people genuine collective agency. In its 2011 report, GHW describes the global economy as a systemic failure with an unworkable *'economic architecture'*.[3]

In relation to maternal mortality, GHW argues that the challenges are to reach priorities *'according to the objective and subjective definitions of women's needs, and to make these priorities a part of a larger development programme. Unfortunately, public health issues in specific contexts and locales have been ignored in an attempt to present a homogeneous framework of "universal" reproductive health rights. This raises a critical question about the classification of the causes of maternal mortality. In this quest, however, the epidemiological basis of maternal health, the immensity of women's health problems, and the social constraints on women's lives reveal the inadequacy of an isolated strategy about maternal mortality.'*[4]

GHW plead for attention to be focused on a huge range of underlying issues: food security, poverty, the inadequacies of public systems and public governance in countries of the south in dealing with basic healthcare, women's needs for land rights, basic minimum wages and safety from atrocities. These core issues, rather than what it terms any *'superficial intervention strategy'*, are what must be comprehensively responded to in order to make a difference. As matters stand, there is a persistent disconnection between global health policies, which primarily focus on how to address the physical causes of maternal mortality (as outlined above), and these entrenched and worsening local complexities.

Given the fact that recorded progress is not sufficient to achieve Millennium Development Goal 5 (MDG5) in 2015 as planned,[2] local realities must therefore be key to solutions as distinct from western imported strategies, if we are to witness substantial improvements in achieving reductions in maternal deaths post 2015. By this we mean that maternal health strategies should begin to tackle the issues outlined by GHW as a matter of urgency. Also as deliberations are ongoing across the world about strategies to improve MDG5 and its sustainability post 2015, one would hope that those whose lives it touches most will be included and not be forced to remain voiceless. It is no longer acceptable for women, particularly those in the most affected area, SSA, to be relegated to the role of spectators when issues about their well-being are discussed,[5] and it is crucial to pay astute attention to the non-clinical aspects of maternal healthcare, place of care notwithstanding.

Magdalena Ohaja and Jo Murphy-Lawless

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Neri Winterstein-Minnigin

Ilana Winterstein shares her birth story of 3 April 2014

I've always had a fear of hospitals so a homebirth felt very natural, especially as my sister had an unplanned but amazing homebirth. Aaron, my husband, and I both felt we'd like some extra support throughout so hired Ly as our doula.

Neri, our daughter, arrived 12 days past her due date. Although I felt instinctively that everything was fine, I began to feel a mounting pressure towards medical induction as the days passed. Ly was brilliant at talking everything through and made sure I was aware that any decisions were mine and Aaron's to make.

At 1am on 2 April I woke with dull aching pains in my back. The contractions were irregular and eventually stopped, which was disappointing. However by 5pm the surges returned, lasting 45 seconds and coming 5 minutes apart. The pain was still concentrated in my lower back, which was a surprise as the baby had turned back-to-back for labour.

We let Ly know labour had started but spent the next few hours together just Aaron and I, feeling excited and filling the birth pool. At around 9pm we asked Ly to come over as I felt things progressing. I also spoke to Selina, the community midwife on call, who was very reassuring, advised me to take two paracetamol and said she'd speak to me again in a few hours to see how it was going.

From Ly's arrival onwards the order of events gets hazy, though at some point Selina and Hannah, a student midwife, arrived. Between 9pm and 6.55am on the 3rd, when my daughter was born, I crabbed sideways up and down stairs, lunged on chairs, squatted, rocked on all fours, shook my hips, did pelvic tilts against the wall and more to try and get the baby to turn. If I got low to the floor or held one position for more than a few contractions, labour seemed to slow, so Selina and Ly had me moving and changing position constantly to keep labour progressing.

To ease the back pain Aaron or Ly applied pressure to my sacrum during contractions. It also helped to make low sounds, though I remember wondering what the neighbours were making of all the noise.

Everyone was very respectful of our hopes for the birth and at one point I asked Aaron why I hadn't been offered gas and air. He reminded me that I'd written in my birth plan not to offer it unless I asked. This made me feel better and I carried on without.

When I got into the pool it was lovely and warm, so much so that I fell asleep between contractions. Selina and Hannah checked my signs and felt my pulse was too high and things had slowed down. Selina was wonderful at giving information in a way that left me calm and without any sense of panic. Ly and Selina discussed what to do together and I'm grateful that at a point where fairly serious things were being discussed, I felt in safe hands and it was clear that everyone was working together with mutual respect. I resumed sideways crabbing on the stairs and took two more paracetamol to try and lower my pulse and some homeopathic pills Ly gave me, and things got going again.

Towards the end I laboured in our tiny toilet under the stairs with Aaron. Suddenly something shifted and I felt the baby was coming. Slightly panicked I asked Aaron where everyone was and Selina appeared saying she could happily deliver the baby in the toilet, to which I said 'no way' and we returned to the living room. I remember saying it was feeling a bit intense, and Selina's response 'You're having a baby, love' reminded me it was natural and I could get through it.

I stood, leaning on Aaron during a contraction and there was a pop and my waters gushed all over the floor. Then everything slowed up at the point of crowning. I remember smiling and feeling ready to meet our daughter, exhausted but so close to the end.

I felt such relief and awe

Selina monitored our baby's heart rate and said it was dropping so it was time to get her out. I didn't feel instinctively like pushing at this point but, in a supported squat with Aaron holding me, I pushed with everything I had and delivered our baby. Our daughter didn't cry though both Aaron and I did. I felt such relief and awe looking at her as we waited for the cord to stop pulsing before Aaron cut it. I was on such a natural high and felt so much love from everyone around me – despite subjecting them to a world yoga CD on a loop for 13 hours as none of the music I'd planned felt right!

I had quite a bad tear so Aaron held Neri as the midwives asked if I wanted gas and air before the stitches. Having achieved a back-to-back labour with only paracetamol I refused, thinking why have gas and air now that she's out? In hindsight, after nearly breaking Ly's hand from squeezing it so tightly, I know why they got the cylinder out of the car!

Following the birth I felt so empowered and strong. Ly, Selina and Hannah worked as a great team and Aaron was a constant support throughout. I trusted everyone in the room, and I feel very lucky to have had such a positive experience and grateful for the support and love I felt throughout which helped make it happen.

Ilana Winterstein

Ilana and Aaron, their doula's story

Doula *Ly Malnick* gives her account of Neri's birth

As a doula, I am often asked about the relationship between the attending midwives and myself. For me this is a question of really understanding roles. I am not a midwife. My training is not clinical, and my presence at a birth does not replace the need for a midwife. I see my role as providing both emotional and physical support to the mother, and her partner, before, during and after birth.

I do have a deep understanding of the physiology of labour, and I draw on this knowledge when attending a birth. I am always keen to work with the midwife, though I may also at times be required to support my client in opposing something the midwife is suggesting.

Ilana's birth story illustrates a situation in which this relationship really works.

I arrive at Ilana and Aaron's house at 10pm, having been called out just under an hour ago. It's been a while since I've been at a birth, having taken time out to look after my youngest child. How will I be? I take some time to slow my breathing, and to settle myself before I knock. I try to put aside my own judgements, my own agenda about how things should be. I want to enter into the space that Illy and Aaron are creating, feel my way into it, in order to respond fully to Illy's needs and wishes about how her birthing could be.

When I enter the space I see Illy labouring beautifully. Her contractions slow a little, most likely in response to the new energy in the room, and I hold back, observing quietly, finding a space for my bag and various bits and pieces, waiting to get a feeling for how I can be most supportive to her. After some gentle encouragement and reassurance, her contractions pick up again and Illy turns toward them, focusing on her breathing and moving her body with the energy of the surges. As she is feeling it especially in her back, she finds sacral pressure helpful, so either Aaron or I are constantly on hand to apply pressure during her contractions.

I turn my attention to preparing some nourishment for her. I offer her homemade chicken broth (a fantastic trick I learned from a midwife friend for nourishing and hydrating a labouring mum) and other bits of food. I also suggest she tries a manoeuvre I learned from Gail Tully of Spinning Babies, to help bring the baby down into the pelvis. I suspect baby might be back to back, given the contraction pattern and where Illy is feeling them, and I suggest Illy walk up and down the stairs as she labours.

After a few hours they are wondering when they should ring the midwife. I think it's probably a good time, and Selina arrives at about 2am with a student. I welcome them at the door, mildly apprehensive. Although I've been well received by the midwives at previous births I've attended, some of my colleagues have had more difficult interactions with midwives and the response to doulas is varied.

I needn't have worried; Selina seems delighted to see me. She and her student enter the space in an utterly calm, considerate and unobtrusive way; she introduces herself and her student, Hannah, to Illy and then quietly goes about setting up her things whilst silently observing.

Although the sequence of events is difficult to recall, what stands out for me the most is Selina and me encouraging Illy to keep active and changing things up ... it seems very much that her labour slows as soon as she settles into any one place or way of moving. She labours in the bathroom, she does the crab walk up and down the stairs, she does lunges using a chair, and she swings her hips in wide circles, assisted by Selina who encourages her to really give it some oomph!

After labouring awhile, she says to Selina: 'It's really intense!' To which Selina replies: 'You're having a baby, love!' It feels to me that her response, delivered with straightforwardness and humour, really helps Illy to let go into the intensity she is feeling.

More time passes, and Selina suggests doing a vaginal examination, explaining her reasons to Illy and what information she is hoping to glean. I remind Illy that she can refuse this, and I also suggest that if she is happy to go ahead with it, she may request not to be informed of her progress.

Illy agrees to this suggestion. Selina is respectful and warm in her approach, and I feel this is a great example of how a VE can be performed in an unintrusive way. I believe it is the only time I've heard from a mother that the VE wasn't too uncomfortable!

The mutual respect and Selina's lack of ego, despite her vast experience, mean there is no awkwardness in working with her. We completely focus on supporting Illy and Aaron. We both are able to make suggestions, and share views and knowledge, and I feel free to speak about what is on my mind.

As a birthing couple, Aaron and Illy work so well together, and I feel completely inspired by them. I try to support him to do the lovely work he's doing. He is completely available to her, breathing with her and making low sounds to encourage her to keep her energy moving downwards. There are many moments where Selina and I are hanging out in the kitchen, smiling as we listen to Aaron 'moo-ing' encouragingly along with Illy while she labours in the bathroom.

When Illy feels ready to push, she adopts a supported squat, with Aaron behind her. I then feel slightly baffled … the spacing between her contractions seems very long, which Selina declares to be a 'rest and be thankful'. I had always thought this was something that can occur before the pushing stage began, so this was fascinating for me to witness.

Aaron tries nipple stimulation to encourage the contractions to pick up, at Selina's suggestion. Selina also asks if I have anything in my bag of tricks, and so I dig out a few homeopathic remedies. It seems pretty clear, though, that this baby is in no rush! After a little while, Selina is a bit concerned about the heart rate, and encourages Illy really to

bear down during her contractions. We watch as baby slowly makes her way down through the birth canal. When she finally comes there is that glorious moment, tears and smiles and laughter as the couple greet their gorgeous baby girl.

Mum and baby have immediate skin-to-skin, and the placenta is birthed after the cord completely finishes pulsating; Selina and Hannah check the cord carefully to ensure that there is no pulse left before clamping and cutting.

The sun rises over the next couple of hours, as we focus on helping Illy breastfeed and get comfortable. As I prepare to leave, Selina approaches and offers me a hug, saying what a pleasure it was to work together and thanking me for what she had learned from me. Once again, her humility leaves me completely dumbstruck! This is the lesson I shall take away from Selina, and why Illy's birth shall stay with me: all these tricks belong to none of us – we all learned them somewhere – but to rest in a state of openness, really to work as a team and to allow our primary concern be for the birthing mother we stand to be of greatest service.

Ly Malnick

Ilana and her baby Neri

Ilana, a midwife's story

Selina Blackmore gives her perspective as the on-call midwife

As the on-call midwife, I was asked to assess Ilana at home as she had planned a homebirth and was in labour. Following a conversation with Ilana it was apparent that her labour seemed to be progressing, and that I should make my way over to her house. She had consented to the presence of a student midwife, and we arrived together at about midnight.

We were met at the door by Ly, her doula, who introduced herself. Ly had been supporting Ilana and her partner, Aaron, at home prior to our arrival. The environment was calm and relaxed, the lighting dimmed and the music softly playing in the background, all known to facilitate a normal birth. There were positive affirmations displayed around the house. We were aware that this environment was important to maintain and we were keen for our presence not to alter it.

After a while, I asked Ilana if I could examine her, so that I could make a full assessment of her progress in labour and prepare for the birth.

Ilana and Aaron were happy for the examination, but only if I agreed not to share my findings as Ilana felt positive and in control, and didn't want this sense of empowerment altered in any way. Ilana was happy for me to share my findings with Ly.

Fundal height measured appropriately for term, longitudinal lie, cephalic position. On vaginal examination the cervix was 6cm dilated, presenting part at the spines ROP (right occiput posterior) position. She was contracting strongly, 2-3:10 (2 to 3 contractions every 10 minutes). So, contracting and dilating well with the baby's head low in the pelvis, with the baby in a back-to-back position.

Prior to this point it felt as though we had been supporting Ilana and Aaron for a normal birth, by encouraging them to remain mobile and relaxed, but I felt we now needed to be more proactive to help facilitate rotation of the baby.

Ilana was keen to stay as mobile as possible, the energy remained really positive and both Ly and I suggested different positions to aid rotation.

Ilana was encouraged to walk up and down stairs, and to continue with pelvic rotation whilst elevating a leg on a chair.

The contractions remained strong and frequent and Ilana managed beautifully with the support of her partner and breathing techniques to have a normal birth of a lovely baby girl in the OA (occiput anterior) position.

The whole experience was a delightful one for me. Picking up on the positivity of the energy in the house, the supportive relationship that Ilana had with Aaron, and indeed the relationship they had both built with Ly.

Ly and I worked together really well and I believe it was because we kept Ilana as our focus. We remained open with each other and receptive to ideas each other had. Our roles were well defined, I had ultimate responsibility for Ilana's care, and Ly was there as a support, and, to a degree, a critical friend.

We need to remain open and respectful of each other if we are to move away from the idea that one role somehow interferes with the other.

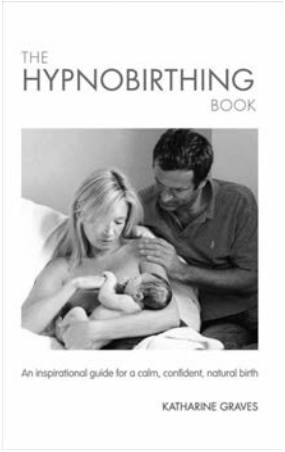
I left the birth feeling uplifted, excited and delighted for Ilana and Aaron. A really positive experience for all of us.

Selina Blackmore

Reviews

The Hypnobirthing Book: An inspirational guide for a calm, confident, natural birth

By Katharine Graves
Katharine Publishing 2012
Publisher's recommended price £12.99
Some versions are also available with an accompanying CD.



This book is offered to women searching for a good companion for their journey through pregnancy, birth and the early postnatal period. If hypnobirthing is a new concept for the potential reader, then the key to understanding the aim and content of the book is in the subtitle. In pregnancy, we know that many women claim to desire such a 'calm, confident and natural' birth. But we also know that the reality is often very different. So what might make a difference?

The hypnobirthing approach is explained early on in the book. We are told it is a form of hypnotherapy, and asked to put aside any preconceptions of the hypnotists of the Music Hall tradition. *'Hypnotherapy is merely the use of words: words used in a more focussed and positive way to help people let go of some of the negative ideas that they have acquired in life.'* Thus, much of the book is about encouraging women, together with their chosen birth partners, to prepare the way for birth via a series of frequently practised guided meditations/visualisations. The purpose of these is to clear the mind of doubt and fear, in preparation for a calm and peaceful birth. There is no attempt to conceal the commitment that couples are advised to make to this preparation during pregnancy. The extent of this 'pre-labour labour' may be off-putting to many, but it will be the reader's choice about the extent they wish to engage with the advice offered.

In encouraging women to engage in this form of birth preparation, on the basis that *'it always makes a difference, and a very big difference',* this book offers advice that perhaps runs counter to our mainstream culture, where birth events are commonly seen as quite unpredictable, a discourse which subtly acts to disengage women from their responsibilities in preparing for the physiological process of birth. Rather, this book is clear about the centrality of the woman's role in achieving a good birth. That said, it is careful not to offer glib guarantees of a perfect pain-free birth but explains how the approach can help in all sorts of circumstances: *'a calm mother can help her baby even during a complex or challenging birth.'*

In addition to its focus on the hypnobirthing approach, this book covers a good range of topics around preparing for birth generally. It has strong sections on birth physiology, linking neatly with advice on exercise, posture and nutrition in pregnancy. The focus on responsibility and choice is done well, including around the vexed issue of labour induction. I particularly liked the advice not to get too fixated on (and to never tell people exactly) your estimated due date. I was unsure about the section devoted to perineal massage, as I fear that this is yet another 'birth technology' which might subtly act to reduce women's confidence in their body's ability to birth well. There is excellent advice on strategies to adopt in labour, including making a clear announcement to the staff attending you that 'we are doing hypnobirthing', to reduce the possibility of disturbance. This would seem to be a good assertive addition to the phrasebook for birthing women, although it does highlight how our maternity services do not have protecting the physiological birth process at their core, and, of course, why should only 'hypnobirthing women' receive calm, quiet and unobtrusive care?

If 'First, do no harm' is a baseline criterion for book recommendations for pregnant women, then this book, subject to one significant concern, must pass with flying colours. The approach may come across as a bit 'airy-fairy' to some, especially when most of us have little experience in guided meditation. But for the vast majority of pregnant women, a thoughtful reading of this book should make a positive difference to their birth experience. My main concern is that it will undoubtedly come across as unwelcoming to some pregnant readers, given its very obvious presumed audience of heterosexual married couples in highly-functional and stable relationships, and more specifically women whose partners are willing to join them in daily meditation practice. It would be good to see this addressed in a second edition, while maintaining the insistence on the importance of a birth companion whose role during labour is to 'protect your space and be your advocate' (sadly a role which midwives within the NHS system too often seem unable to perform).

This book is one of a growing range of hypnobirthing books on the market; the UK focus makes it particularly good for a UK audience, and the experience, warmth and care of the author make for a very comforting book. The title could be off-putting for many, who may only have a vague idea of what hypnobirthing means. But it would be a shame if the book were only read by those 'in the know'. It is an accessible, supportive and friendly guide to preparing for a positive birthing experience, and I believe that it deserves a place on all good birthing book lists and on the shelves of local birth resource centres. I wish someone had given it to me a few years ago!

Jo Dagustun

Stephen Gaskin

AIMS was saddened to hear of the death of Stephen Gaskin (16 February 1935 – 1 July 2014) in July. Stephen was the husband of our sister, long-term AIMS supporter and protector of women's birthing rights, Ina May Gaskin.

Together with a small group of like-minded activists in 1970, Stephen and Ina May founded The Farm, a spiritual intentional community in Summertown, Tennessee with an international reputation for spiritual, woman-centred midwifery with unrivalled outcomes.

Stephen was a prominent American counterculture icon and self-labelled professional Hippie. He was a freethinker, author of over a dozen books, a political activist and a philanthropic organiser. He was also an acclaimed speaker on magic, energy, life in community and service to humanity.

On his leadership of The Farm, he famously said: *'I'm a teacher, not a leader. If you lose your leader, you're leaderless and lost, but if you lose your teacher there's a chance that he taught you something and you can navigate on your own.'*

He was possibly most well known in the UK as US Green Party presidential primary candidate in 2000, with a manifesto including campaign finance reform, universal healthcare, and decriminalisation of marijuana.

AIMS sends our condolences to Ina May and to the rest of Stephen's family, friends and community.

Mary Ann Cahill

AIMS also pays tribute to Mary Ann Cahill (10 June 1927 – 26 October 2014), one of the seven founders of La Leche League.

Giving birth, breastfeeding and mothering became the foundation of La Leche League, an organisation that spread, from a small group of mothers offering grass-roots support in 1956, to become an international organisation at the forefront of breastfeeding promotion, support and education.

LLL describe Mary Ann's talent for connecting people and quote her as saying: *'My first love was always with the group, meeting with other mothers, sharing the wonders of babies and breastfeeding.'*

Mary Ann was a true pioneer in the field of peer support, that vitally important network of women simply supporting other women. The power of such a gift should not be underestimated, nor should the difference that simple act of reaching out can make. Mary Ann understood, and it may well be one of the reasons that LLL has reached so many women and made a difference to so many mothers and babies over the years.

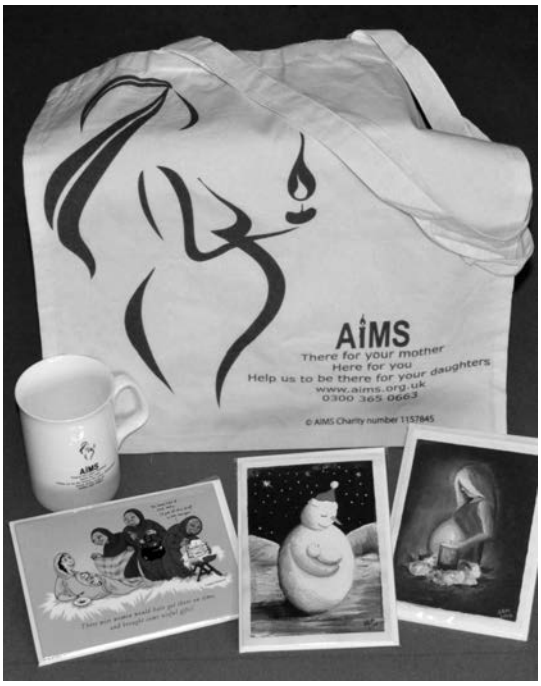
Cards, bags and mugs

We have been very busy over the summer sorting a range of AIMS items for you. We have two Christmas card designs by AIMS member and artist Susan Merrick and cartoonist Kate Evans. We also have another card design by Susan, Expectations, with the image used on the the updated AIMS leaflet. This card has been left blank for your message.

The mugs and bags carry a new image and the words:

There for your mother
Here for you
Help us to be there for your daughters

Details are on the AIMS website www.aims.org.uk/?pubs.htm – you might have to scroll down a bit to see everything we offer.



Homebirth in Norfolk

'West Norfolk women could choose to give birth at home again' was the headline in the Eastern Daily Press on 24 October 2014. It went on to say that *'Mums-to-be have been forced to give birth at hospital or spend up to £3,000 on a private midwife, since the Queen Elizabeth Hospital (QEH) in King's Lynn suspended its home birth service in February. The 500-bed QEH said that it did not have enough midwives.'*

It appears that the journalist involved has missed a number of fundamental issues. Firstly, if women are told that the homebirth service is suspended, they should immediately complain to the Department of Health, as this action is contrary to government policy, and ask what the Minister is going to do about it.

Secondly, every woman has the right to give birth at home if she wishes. Had a mother made her intentions clear in writing to the Chief Executive of King's Lynn Hospital, a midwife would have been provided.

Thirdly, had she contacted AIMS, we could have put pressure on the hospital to provide the service.

Unfortunately, women are unaware of their rights and the responsibility of hospitals to provide midwifery cover for homebirths. Claiming that there is a shortage of midwives is not good enough; King's Lynn has been making this excuse for the last ten years, at least, and has had more than enough time to make it a priority. That it does not wish to do so is a reflection of its determination to continue to ignore the evidence that homebirth is the safest option for fit and healthy women and babies, and provide them with appropriate care. No woman needs to spend £3,000 on private care while the NHS has a responsibility to provide a midwife for a homebirth, when called.

Beverley Lawrence Beech

Supporting AIMS

AIMS has just become a Charity, so please watch out for notices as we explore new ways of raising money. Please remember that AIMS has no paid staff – our committee and volunteers give their time freely. All monies raised go towards providing women with support and information.

How you can help AIMS

If you are not already a Member, you could join.

The benefits of Membership include four AIMS Journals a year – these provide valuable updates and information including research on childbirth and related issues. Authors of articles are from a wide range of backgrounds and countries, giving their insights, views and experiences.

Visit www.aims.org.uk

As a Member, you will be given access to the AIMS Members Yahoo Group. You will be able to stay in touch and have more of a say in what AIMS is doing. You will receive updates from committee meetings and early notice of events such as AIMS talks, as well as being able to contribute to discussions of current issues.

Join at health.groups.yahoo.com/group/aimsukmembers or email egroup@aims.org.uk

If all our Members just encouraged one other person to join, we would double our membership and income!

If you do not already have our range of AIMS publications, you could buy them.

Are you sure you have the up-to-date version?

Our publications cover all main aspects of pregnancy, including second and third stage of birth, breech birth, vaginal birth after caesarean (VBAC) and induction of labour. There are publications helping you to plan the birth you want – the best selling Am I Allowed? and What's Right for Me? Others cover the safety of childbirth, ultrasound, Vitamin K amd Group B Strep Explained. There is also one helping you to make a complaint about your care. We sell other authors' books about homebirth.

Most of the publications are on Kindle. Visit **www.aims.org.uk/?pubs.htm** – don't worry if you don't have a Kindle, they can also be read on other devices.

We are always adding to our collection of publications and books, so visit our website for up-to-date information and catch the latest special offers for discounted bundles of books.

If you are ordering from Amazon, please do so via the AIMS website as AIMS will then receive a donation from Amazon for each order placed. **www.aims.org.uk/amazon.htm**

If you are a Member and you have all our publications…

Please think about fundraising for us or donating. Now that we are a charity, we can benefit even more from your efforts. Other people have done sponsored cycle rides or sold our publications at conferences. If you come up with an innovative fundraising event, please let us know! We may be able to offer small raffle prizes.

A really easy way for everyone to help AIMS is to order your Christmas cards or notelets from our website www.aims.org.uk and consider giving the new canvas bag or mugs for presents.

A big thank you, whatever you can do!