Association for Improvements in the Maternity Services

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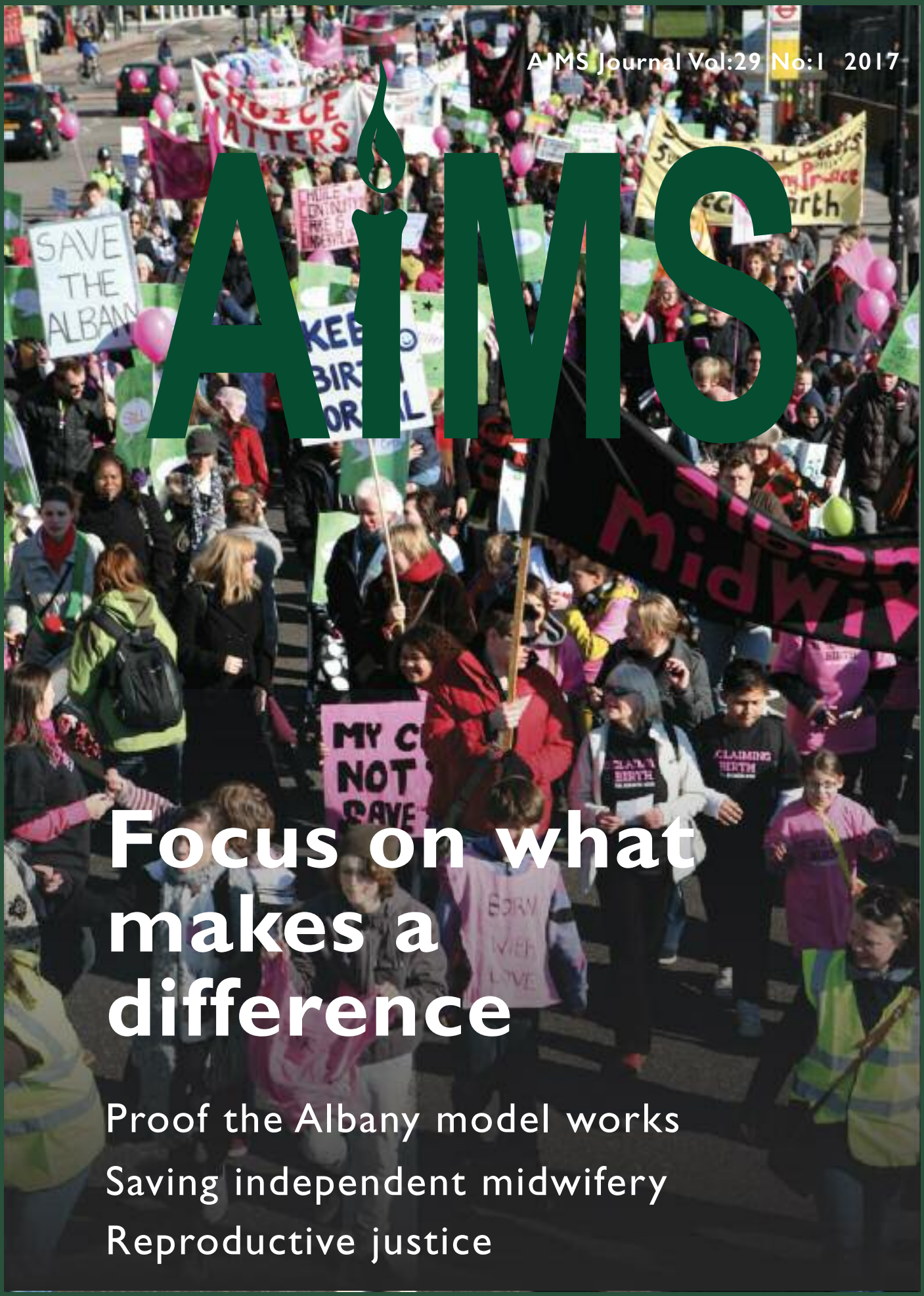
AIMS



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Diary

AIMS meetings

AIMS meetings are scheduled every two to three months.

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

Always check our website or contact us to confirm details as sometimes these change

A General Midwifery Council
London
5 May 2017
Join the demonstration for a new General Midwifery Council to ensure continuing safe midwifery practice and healthy mothers and babies.
11.00am - Gather outside the NMC HQ, 23 Portland Place, London, W1B 1PZ
Contact:
caroline.midwife@gmail.com

Policing Pregnancy
Who should be a mother?
Canterbury Christ Church University
18 May 2017
Sessions will explore changing ideas about pregnancy, motherhood, responsibility and risk, and the impact of these ideas on women's experience and professional services
£45 – free places for students
www.canterbury.ac.uk/event-booking/book.aspx?event=102403

Achieving the 5 Year Forward View in Perinatal Mental Health Services
De Vere West One Conference Centre, London
3 July 2017
Practical information and inspiration to take back to your organisation and utilise in implementing and improving perinatal mental health care in line with the NHS 5 Year Forward View.
A 20% discount is available to AIMS members by quoting ref: hcuk20aims when booking.
For further information and to book your place visit
www.healthcareconferencesuk.co.uk/perinatal-mental-health-services-conference
or email nicki@hc-uk.org.uk
Follow this event on Twitter #PerinatalMH

Midwifery Today
Trust, intimacy and love
The chemistry of connection
Helsinki, Finland
4-8 October 2017
Speakers:
Elizabeth Davis, Gail Hart, Tine Greve, Thea van Tuyl, Sally Kelly amongst others
www.midwiferytoday.com/conferences/Finland2017/

When you have read this journal spread the word and hand it to a friend.

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

AIMS
campaigning for better maternity services since 1960

AIMS

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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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Continuity in action.
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Funding from formula

Patti Rundell of Baby Milk Action is outraged and AIMS asks you to support the campaign

Following the announcement of the decision of the Council of the Royal College of Paediatrics and Child Health to accept funding from manufacturers of breastmilk substitutes, the Lancet has published a strong comment from Dr Anthony Costello and colleagues at the World Health Organisation.

The comment is unequivocal, stating that; *'This decision raises serious concerns about the college's impartiality and sets a harmful precedent for other health professional organisations.'*

The statement concludes; *'The RCPCH has forfeited an opportunity to be a standard bearer and champion for children and young people globally and to exemplify implementation of the WHO International Code and Guidance. Instead, RCPCH is sending a strong message to its members and others worldwide that benefitting from funding from BMS manufacturers is acceptable.'*

What prompted this condemnation?

At its Annual Conference in April 2016, RCPCH members passed a motion that the College should *'decline any commercial transactions or any other kind of funding or support from all companies that market products within the scope of the World Health Organisation (WHO) code on the marketing of breast milk substitutes.'*

The Council's decision to ignore this and instead conduct a postal vote, that resulted in its new policy accepting such funding has divided RCPCH members, with many worried that corporate funding risks damaging the integrity, reputation and ability of the RCPCH and its members to be an independent advisor to parents.

Parents are targeted with misleading health and nutrition claims and aggressive marketing and, as a result, baby foods and formulas are now the fastest growing food sector with global sales predicted to rise to US$ 70.6 billion by 2019.

Health experts recognise that poor diet is now the biggest underlying cause of ill health and disease globally - far bigger than tobacco, alcohol and lack of physical activity, and early child feeding is a critically important factor. The sweetened and flavoured products being so aggressively promoted to parents, not only undermine breastfeeding but also affect children's acceptance of healthy, unprocessed family foods. In this context parents need independent and sound scientific advice from health professionals to see through the false messages. This is not a time for professional bodies to increase dependency on profit-driven corporations.

The International Code of Marketing of Breastmilk Substitutes, and World Health Assembly Resolutions (The Code) were adopted to protect all children – those who are breastfed and those who are not. In the human rights context the Code and the Convention of the Rights of the Child (CRC) place no obligation on women – who will always remain fully sovereign over their own bodies.

It's a favourite corporate tactic to personalise these issues – with the implication that the blame should be placed on individuals (in this case parents) for making the wrong 'choice'. They know that such thinking diverts attention from badly needed weak or non-existent regulations – and that it also fuels the anger parents rightly feel when they are misled, let down and unsupported. So of course, pressure must be brought on corporations to respect child rights and end harmful marketing.

Thanks to the WHO staff for recognising this and highlighting the need for a radical rethink of the professional bodies' funding policies everywhere. It is so urgently needed.

Full information on the issue is available from Baby Milk Action at www.babymilkaction.org/archives/11135.

AIMS Comment

Many paediatricians including Neena Modi, President of the RCPCH, don't see a problem in accepting funds from manufactures of breastmilk substitutes (BMS) towards their research. They believe, I'm sure genuinely, that they will not be influenced in any way by this. Similarly we, as mothers, tend to see our decision over feeding our babies as individual ones, maybe influenced by our families and surroundings but as Gabrielle Palmer shows so eloquently in her book, Why the Politics of Breastfeeding Matter, (see book review on page 27) when governments apply the Code on Marketing of Breast Milk Substitutes with vigour breast feeding rates go up dramatically. We cannot insulate ourselves from powerful commercial interests, much as we might wish we could and so the decision by the RCPCH to overturn its conference decision is an unwise one, risking much damage to its reputation for integrity. We have drafted the open letter below; it is simple because the Royal College will be aware of the evidence for the fact that commercial interests offer funds in the knowledge that they are effective in influencing policy. Letters from parents expressing their dismay may help the members of the college who clearly disagree with this decision to overturn it. So, do write a letter and encourage the President to reconsider.

An open letter to
Neena Modi, President of the RCPCH
5-11 Theobolds Road, London WC1X9SH.

Dear Neena Modi,

I urge you to reconsider your position on accepting money from companies who stand to gain every time a woman decides not to breast feed her baby. Of course the manufacture of breastmilk substitutes is necessary, but your argument that the college can accept relatively small donations from the large profits made without sacrificing credibility is not convincing. Parents understand that, whatever safeguards you are able to put into place, a conflict of interest becomes inevitable; your reputation and ability to act as independent advisors to mothers on feeding their babies will be damaged.

Yours sincerely

Reforming maternity

Gill Boden and *Beverley Beech* talk about maternity transformation

The Maternity Transformation Council, chaired by Baroness Julia Cumberlege, (who also chaired the National Maternity Review) is working to enable change that will ensure the majority of women have a midwife who will care for them antenatally, during labour and postnatally: this would provide real continuity of carer. As we have said so often, the research demonstrating the benefits of case-load midwifery and community based care is growing by the day and the government has finally accepted that for a fit and healthy woman a home birth or birth in a Free-standing Midwifery Unit is safer than birthing in an obstetric unit. These are the most important changes we could envisage to improve and transform the experience of birth for women.

There is an urgency to this process, not just for the sake of women, but also in the interests of the profession of midwifery. Midwives have been drawn into hospitals over the last 50 years and come under pressure to change from midwives skilled at observation, examination and support into obstetric nurses who pride themselves on their ability to read a fetal heart monitor tracing, set up a drip and an epidural and then leave the woman alone with her partner, friend or husband.

Mavis Kirkham (see page 6) describes the fundamental contradiction between the current centralised maternity services based on business models and women-centred midwifery models, resulting in a clash of values when the need for 'efficiency', economies of scale, and standardisation is imposed on midwifery models that provide trusting relationships, empathetic care and better outcomes.

trusting relationships, empathetic care and better outcomes

Midwives, under-staffed and over-worked, have become unable to give the kind of one to one support and midwifery care women ought to have. Yet free-standing midwifery units (FMU) where this kind of care is available are vulnerable and still being closed with the excuse that they are not being used despite having better outcomes. Last year in a heartening development a small group of midwives committed to supporting and promoting midwifery units have set up a network, with the objective of supporting the midwives and encouraging innovation so that each unit will no longer feel isolated. See www.midwiferyunitnetwork.com for more information.

Some skilled and caring midwives who have challenged institutional pressures to maintain the principles and skills of midwifery have left the profession, sometimes after seemingly punitive and long drawn out Conduct and Competence procedures, conducted by the Nursing and Midwifery Council (NMC), or have simply burned out.

The Midwifery Committee of the NMC which has been relied on by women and midwives to safeguard standards and practice, has been slowly whittled away and has now been disbanded; and there is just one midwife on the Nursing and Midwifery Council itself. The NMC has presided over diminishing education standards for midwives. Students learn about normal birth in the universities, but they do the majority of their practice in centralised obstetric units where they are lucky if they see a single normal birth by the time they qualify. When on the Midwifery Committee, as a lay member, Beverley Beech suggested that student midwives should be required to attend at least five home births during their final year. Indeed, those units that claim that they do not have sufficient midwives to attend a home birth could ease their problems by ensuring that the second midwife is a third year student.

Emma Ashworth, (page 9) and Shane Ridley (page 11) describe the effects on mothers and midwives of the NMC's ruling that Independent Midwives UK's insurance scheme is insufficient, but the NMC refuses to indicate what they would accept as sufficient. Mari Greenfield explains the results of her survey of the effects on those mothers and midwives involved (page 12). Sarah Davies summarises the long-awaited analysis of the Albany Midwifery Practice outcomes (page 23). These outcomes show, without doubt, the enormous benefits that this model of care provides. There is no longer any doubt that maternity care has to return to the midwifery values grounded in relationships which, as Mavis Kirkham points out *'works best where midwives have trusting relationships with clients and colleagues'*. The huge body of research relating to continuity of midwifery care is now so clear it is unethical not to implement it nationally.

If change is to happen then women have to make their voices heard, not only at an individual level but also collectively. The Maternity Transformation Council has enabled the voice of the users to be heard at the highest level and the need to ensure effective user involvement locally can be achieved through Maternity Services Liaison Committees, now to be called Maternity Voices, which when properly set up and supported, offer a means for midwives and women to negotiate change. If you are not on an MSLC then investigate how to get on one at www.chimat.org.uk/resource/view.aspx?QN=MSLC_ABOUT

The opportunity for change is here, but it will not happen unless women and midwives act now.

Gill Boden and Beverley A Lawrence Beech

Fundamental contradiction

Mavis Kirkham explains why the business model does not fit midwifery values

Midwifery is beset with problems at present and, as we seek to deal with each crisis, there is no time to look at the source of the problems. As I am a retired academic and no longer practicing, thanks to a set-to with our statutory body which I will not go into, I have time and feel the need to stand back a bit and to look at this.

It seems to me that there is a clash of values. Midwifery is rooted in relationships and a tradition of generosity, which research and long experience has shown to have excellent clinical and social outcomes. Most women can birth well if they are surrounded by people who value them, listen to them and nurture their self-confidence. The NHS is now run on a commercial model: the imperative being to get more for less input. In industrial terms this is called efficiency: maximum productivity for minimum cost. In any other context it is seen as meanness.

Centralisation

Maternity services have been centralised into large hospitals. Applying principles seen as 'sound' in business terms, units have been closed which would have been seen as large ten years ago. Centralisation produces economies of scale or more output for less input and in maternity care the main input is staffing. So midwives are part of a large body of staff who can be moved wherever they are needed and the traditional ebb and flow of smaller scale units is ironed out to a situation where staff permanently feel they are working flat out. This is reputed to be a very efficient way to run a factory based on a production line; but we are dealing with people.

So many studies have shown that women feel they are on a conveyor belt, which they see as synonymous with not being treated as a human being. Midwives feel they are treated as a cog in a machine and not as people. Midwives value relationships with their clients and with colleagues, so that trust can develop and the bigger the unit and the more staff are moved about the more relationships are fragmented. So trust does not develop and fear flourishes in the absence of trust.

Control and standardisation

If a large organisation is to be run for maximum efficiency management control is required to monitor and ensure that efficiency. Midwives cannot be trusted to do midwifery or to decide a woman's care in response to her needs as this might lead to care being given beyond the 'efficient' norm. Thus standardisation is required.

Standardisation requires care to be defined as a series of tasks which can be monitored rather than a continuing supportive relationship. If the required tasks are performed then women can logically be neglected between tasks and the midwife's attention given to other women, even when they are feeling most vulnerable in labour. Defining labour care as a series of standardised tasks makes it possible to give midwives such heavy workloads that they cannot give individualised care, especially as such care is required to be thoroughly, time-consumingly justified. Standardisation is justified as preventing really bad care but it also prevents really good care from being the norm; though many midwives strive to give good care, often at great cost to themselves. This approach is often described as being evidence-based, but research deals with the general, never stating what an individual needs and much evidence is based on a consensus of those thoroughly versed in cost-saving.

Ironically, a considerable bureaucracy is needed to monitor the efficiency of a large organisation, so costs rise, which leads to further cuts to keep costs under control. Such cuts are seldom due to the bureaucracy, which is seen as essential.

Staffing

These pressures damage midwives, as individuals and as a workforce. We have plenty of research on this. Lack of occupational autonomy distresses midwives.[1] Midwives leave because they cannot give the care they would wish to give,[2,3] which leads to less staff which puts further pressure on those who remain and this leads others to leave. As this vicious circle produces job vacancies, the opportunity is often taken to reduce jobs and thereby save resources. Outside London, I am not sure whether the problem is a shortage of midwives or a shortage of midwifery posts.

With increasing financial pressures, specialist posts are cut back. This removes midwives who have found their niche and built up expertise and a degree of autonomy in a specialist role and moves them back onto the conveyor belt where they are more likely to leave.[4] It also reduces the help available to mothers.

Commodification and technology

The commercial model is about selling products. With the pressures of cuts to the NHS, this means that parts of the service which can be identified become separate products. Thus NHS antenatal classes in many places have been cut to the extent that women have to pay for them outside the NHS. 'Special' antenatal classes, such as hypnobirthing, often have to be paid for. NHS midwives cannot give continuing support to childbearing women, so they employ doulas. Breastfeeding support is available, at a price.

This commodification of what was once seen as midwifery care provides a safe, if commercially vulnerable, haven for a few midwives and other workers. But it discriminates heavily against those who cannot afford the extras. It also prevents integration of services and continuity of carer.

On a larger scale, there are massive pressures from the producers of technical products. We still use electronic

fetal heart monitors in many circumstances where research has shown they do not help and may hinder women in labour. Commercial pressures and the value our society places upon technology have created a real fear of not using all the technology available. Yet this can have damaging results for individuals and can greatly increase costs, as with increased caesarean rates with EFM,[5] and that money has to be saved elsewhere.

The status which comes with technology may be one reason why midwives have embraced so many additional, technical tasks over the years. Thus a cloak of technology is cast over a very basic human service and midwives come to be seen as skilled technicians who are 'checking not listening'[6] to women. We cannot do everything, though we try hard, and basic supportive care fades in significance or moves into the role of the doula or support worker. Thus we neglect what research shows works best.

Insurance

Insurance is probably the ultimate example of a product so well marketed that it appears unethical not to have it. Yet its main beneficiaries are the insurance companies. Once insurance is required for practitioners, the insurance companies can control clinical practice. In the USA, managed care is packaged and defined by insurance companies. In this country the conditions of insurance determine who can receive care from independent midwives, thus excluding many women who seek independent midwives because they find themselves damaged by previous NHS care. And, if regulators decide that insurance is insufficient, care can be removed from women as happened here recently.[7]

Above all, this system is unjust. If a child needs special care, that care should be available because the child needs it, not if it can be funded because someone can be blamed. No fault compensation works in New Zealand. New Zealand midwives do not understand the problems with insurance here because, once liability for the care of a child is removed, the cost of clinical negligence insurance is manageable for them.

As well as being unjust, insurance is horrendously expensive, accounting for a high proportion of the cost of each NHS birth. How can clinicians provide an economic service if they have to carry this massive cost?

Midwifery values

Midwifery is grounded in relationships and works best where midwives have trusting relationships with clients and colleagues. To achieve this we need a degree of professional autonomy and continuity in our relationships with clients and colleagues. Present values of fragmentation and management control thwart these relationships. Midwives' professional commitments to their clients simply leads to their exploitation in the context of commercial values. This is shown where so many work extra unpaid hours rather than abandon vulnerable women.

Trapped in this contradiction between their professional values and those of their employers, NHS midwives are torn apart. They continue trying to do the impossible. Their leaders speak the rhetoric of midwifery while clinical midwives work within the reality of a service aiming for maximum efficiency. They see the needs of the clients but their workload is such that they cannot respond to these needs. This is not a healthy way to live. It damages midwives, makes the most rewarding job in the world highly frustrating and is not acknowledged as a problem.

Care and its impact

Midwifery is a public service which can have a long term impact on the lives of families. This is achieved through care – showing how to change a nappy or modelling for women who have only interacted with adults, the ways in which they can relate to a tiny, totally dependent baby, or just providing approval and safe space for them to get to know their babies. In Meg Taylor's words:

'...the midwife metaphorically holds the mother so she can both literally and metaphorically hold her baby. It is obvious that when women are in labour they need a high level of care and attention, but I think a particular quality of attention continues to be required in the postnatal period ... [thus] *... providing this kind of holding.'*[8]

generous, loving care which makes its recipient feel safe

In providing such holding, the midwife models the generous, loving care which makes its recipient feel safe. This crucial holding is not possible where care is fragmented, labour care is divided into a series of monitoring tasks and postnatal support is minimised and thereby seen as efficient. Where care is fragmented, the midwife's attention is on the task in hand not the individual mother and the long term value of the midwife-mother relationship can be lost.

If midwives are to model trusting relationships and provide empathetic care, they need to receive such care themselves and be trusted in their role. This is not the experience of most NHS midwives and may become less likely as we lose the role of supervisor of midwives.

The future

Tight control and penny pinching may work in business, though some experts dispute this, but a different ethic is required for public services.[9] Addressing only short term, easily measurable outcomes is not a commitment to the next generation.

A society based on commercial values neglects care at its peril. This can be seen in many areas of life[10,11] but nowhere is this clearer than at the beginning of life. This is especially clear as birth is something that most women can do supremely well if they are trusted and supported and a good start in life has positive outcomes throughout the life of a family.

Nursing and Midwifery Council
Is it time for a General Midwifery Council?

Criticisms of the NMC continue to grow, and have now reached a level where Jeremy Hunt has ordered an inquiry into the actions of the NMC following the Morecambe Bay disasters where 16 babies and three mothers died. An inquiry is long overdue, but should not be restricted to Morecambe Bay; the NMC's activities over the years have been a constant source of criticism.

In order for midwives to practice safely and successfully they need a governing body that prioritises the interests and safety of mother, baby and maintains the standards of midwifery practice. Until recently the Midwifery Committee of the NMC played a large part in guiding the NMC in this process. Unfortunately, over the years the strength of the Midwifery Committee has been eroded to the point where it has become little more than a cypher and despite the fact that its existence has been guaranteed by statute there are plans to abolish it.

In 1983 the Central Midwives Board was absorbed into the UK Central Council for Nursing, Midwifery, and Health Visiting (later the NMC) and, as a sop to those who protested the move, it was agreed that a Midwifery Committee would be established within the NMC to advise the Council on all matters affecting midwifery. The initial committee had over 20 members, predominately midwives, and over the years reduced to seven members, only one of them was a midwife, and she was not in practice. The plan is to replace the Midwifery Committee and instead have a 'Panel' advising the NMC Chief Executive, and a single midwife on the Nursing and Midwifery Council.

Donna Ockenden has been appointed as senior midwifery advisor to the chief executive, but no matter how determined Donna might be she will be a single voice for the whole of midwifery and, unlike the Midwifery Committee which was established by statute, the NMC has no requirement to pay any attention, whatsoever, to what she says. Furthermore, few Trust Boards have a senior midwifery presence, nor does NHS England.

If the NMC plans go ahead unchallenged there will not be a midwifery profession because of the NMC's lack of awareness, and understanding, of midwifery as an autonomous profession. If women and babies are to be protected then the time has come to establish a General Midwifery Council to properly serve the interests and safety, of women, babies, and midwives.

Beverley A Lawrence Beech

STOP PRESS

As a result of the NMC's claim that Independent Midwives did not have sufficient insurance, and its refusal to indicate what would be sufficient, Independent Midwives UK has served notice to apply for a judicial review. This is an expensive process, and not available to most midwives who want to challenge NMC decisions, so they are crowd funding. See www.gofundme.com/Independent-Midwifery-Fighting-Fund.

Alongside the contradiction between the values of business and those of midwifery lies the further irony that, for most women, midwifery care has excellent outcomes and may well be cheaper than heavily managed hospital care.[12]

In supporting normal birth, working in primary health and strengthening family ties,[13] midwifery provides a sustainable service and can be seen as a *'truly ecological and socially responsible profession'.*[14] (Davies et al 2011 p2). Yet so much that midwives are required to do flies in the face of this. We hear midwives being criticised because they lack resilience. I think it is far more useful to see our current dilemmas as manifestations of a fundamental clash of values and the logic which follows from those values, rather than blaming the individuals who suffer these contradictions. The logic of business and the logic of caring represent a fundamental contradiction that lies at the very heart of our maternity services.

Professor Mavis Kirkham

Mavis would like to thank Anna Fielder for her constructive comments on an earlier draft of this article.

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More information is available from Association of Radical Midwives – because midwifery matters! www.midwifery.org.uk #savethemidwife

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IMUK and the NMC

Emma Ashworth talks about why midwifery is in crisis (again)

On a Friday, four days before last Christmas, the nursing and midwifery regulator, the NMC, decreed that independent midwives who were relying on the indemnity policy provided through IMUK – the only indemnity policy for independent midwives – must not continue to practice. The NMC has claimed that this policy may not have sufficient cover for very badly birth-injured babies.

IMUK has stated that its indemnity does offer sufficient cover, and has asked the NMC to advise what would be adequate. The NMC has replied, *'The NMC does not approve indemnity schemes or hold a list of approved insurers.'* The NMC has still not said what is sufficient, and what is actually wrong with the policy.

Does the NMC understand independent midwifery?

The NMC has persistently shown its lack of understanding of what an independent midwife (IM) actually is. In an LBC interview with journalist Beverley Turner,[1] Jackie Smith, the NMC's chief executive, continued the erroneous claim seen in letters from the NMC that IMs can be employed via a private organisation or by an NHS Trust. While this employment may be possible, depending on the midwife's location, this is not independent midwifery. As the name clearly explains, an independent midwife is not employed by the NHS or a private company. They are employed only by the women and families they care for. While some may choose to join a private or public organisation, by doing so they are then controlled by that organisation's needs, not solely by the needs of the women and families in their care.

Indemnity doesn't protect the public

AIMS has written a number of letters to the NMC pointing out that it is not, as it claims, protecting the public as its decision has created huge anxiety and put women at risk. AIMS asked for details of the legal basis of the NMC's decision and what it sees as an 'appropriate' level of indemnity. Its responses, which have not answered AIMS' questions, have been along the lines of similar letters sent to others who are writing to the NMC, such as, *'The NMC supports a woman's right to choose how she gives birth and who supports her, but we also have a responsibility to make sure that all women and their babies are provided with a sufficient level of protection should something go wrong and they are faced with the costs of ongoing care needed for a life-changing injury.'*

Indemnity insurance does not protect families, it is an illusion. The major beneficiaries of indemnity insurance are insurance companies, lawyers, and those who give medical opinions in court. The only families to have benefited from indemnity insurance are those who can prove that they or their baby have been damaged by negligent practice – not most of those for whom 'something goes wrong'. Those families who have babies who have been born with serious genetic disabilities or who had unavoidable complications during the pregnancy or the birth will not be 'protected' by indemnity insurance. An argument, perhaps, for no-fault compensation. Where there was no negligence on the part of the practitioner, or where negligence can't be proved, indemnity cover cannot be called upon to support the family.

The NMC's repeated claim that it is protecting the public is entirely at odds with the accounts that AIMS is collecting from women and families who are affected by this tragic decision. We are very grateful to those who have shared their stories, and have given us permission to share them in order to show how the NMC's position is actively causing public harm. We have nearly 100 messages from affected people and each one will be sent to the NMC.

the NMC's position is actively causing public harm

NMC's decision affects ALL midwives

In the previously mentioned interview with Beverley Turner, Jackie Smith states that the NMC does not represent midwives, and she is absolutely correct. With only one midwife on the NMC Council (and she is not in practice), the NMC is unable to understand properly the role of a midwife. This has led to an unacceptable situation where the NMC has stated in its correspondence about the IMUK ruling that all midwives – including those employed by the NHS or private companies – may not attend the births of women who are close friends or family. This leaves midwives not being able to be with their children at the birth of their grandchildren, friends not being able to support friends, mothers not being able to choose to have a friend or relative with them as a birth supporter if they're also a midwife, and perhaps in the worst scenarios, male midwives, or any other midwives whose partners are birthing, not being able to be at the birth of their own child if they've previously offered any kind of midwifery support in pregnancy.

This ruling has been challenged by a number of midwives who were intending to provide midwifery care to their daughter, friends or other relatives. A number of these midwives received the following response:

'As you are aware, as a registered midwife, you can only attend a woman during a birth if you have appropriate

indemnity cover. A registered midwife cannot choose to avoid this mandatory legal requirement by attending the birth in a "non-midwife" capacity. This is because your professional and legal obligations remain the same in these circumstances. Indeed, advocacy, advice and emotional support before, during and after hospital births is a common part of independent midwifery practice and the requirement for indemnity cover applies to all these parts of their practice.'

This created a confusion over what specific forms of antenatal care are acceptable as the NMC states that giving 'emotional support' is sufficient to prohibit it. It seems unlikely that there are many friends or family members of independent or employed midwives who won't receive 'emotional support' from them.

To confuse matters further, Independent Midwife Virginia Howes, who has been in discussions with the NMC about the forthcoming birth of her daughter's baby, was told by the NMC, that she can be at her daughter's birth as long as another midwife with appropriate indemnity insurance provides any midwifery services. This appears to be despite the fact that Virginia has provided all of her daughter's care to date. Given that Virginia's daughter does not want to have another midwife at her birth – as is her legal right to decide – this leaves Virginia and her daughter in a position where Virginia cannot legally provide the standard in-labour monitoring of her daughter and grandchild that is offered to all women by their midwife. It is hard to understand how this is public protection.

Following protests by AIMS, the NMC responded to us with the following:

'A registered midwife cannot choose to avoid this mandatory legal requirement [of indemnity cover] *by attending the birth in a 'non-midwife' capacity ... The only exception to this requirement is when a midwife attends a birth in an entirely personal capacity to support a family member or close friend as long as they do not provide any midwifery services. This is important as it avoids any blurring of the professional boundaries required of all nurses and midwives in the Code.'* (NMC letter, 15 February, 2017)

While the NMC may feel that this avoids any blurring of boundaries, it is hard to actually understand why a midwife cannot attend a birth in a 'non-midwife' capacity unless she attends a birth in an 'entirely personal capacity'. What, precisely, is the difference?

There is no doubt that this has been a poorly thought out decision, with dramatic and serious consequences for all midwives, and for the families close to them.

Emma Ashworth

I want to help – what can I do?

Save Independent Midwifery Facebook group has up to date information on campaigns and responses from the NMC and MPs.

Tell the NMC how you feel – write to them here: www.nmc.org.uk/contact-us/

Tell your MP. Some MPs are being very supportive and others need educating. Can you help with that? www.theyworkforyou.com/

Tweet your meme to #savethemidwife #nmcnotfitforpurpose @jackiesmith_nmc @nmcnews

Join the demonstration outside the NMC on the 5 May 2017, see page 2.

References

1. clyp.it/qwtc3pb3

What women really want

Shane Ridley shares observations of the Facebook campaign

AIMS was set up in 1960 to monitor, comment and campaign for the maternity services in the UK. I joined the Save the Independent Midwife (IM) Facebook page and have some observations. I have become increasingly concerned that many of the women supporting Independent Midwives, support them because of their own poor experiences of birthing in the NHS.

The message from the supporters is that IMs provide the Gold Standard of maternity care – one to one continuity of care. Women want the certainty of knowing who their carer is, they want to know that they will be listened to, that their birth plans will be respected, that home birth is very possible.

certainty of knowing who their carer is

They do not want several different midwives and doctors attending them and unnecessary inductions or other interventions. They do not want to have vaginal examinations by passing strangers, even if they are midwives or doctors. They do not want to be controlled by strangers when they are at their most vulnerable.

Women want home birth, they want home births after caesareans (HBAC), they want to avoid induction of labour and they want the opportunity to birth naturally when their baby is breech.

Some of the stories on the Facebook page paint a horrific picture of incidents in the NHS. There are many comments about language – phrases repeated over again – *'your baby will/may die if you don't do xxxx'*, use of that awful phrase *'failure to progress'*, verbal abuse such as being called silly or ridiculous and being told off, being told to toughen up, told to stop making such a noise. It is difficult to believe this language is still being used on our maternity wards as they echo many of the reports that women were making in the early days of the existence of AIMS.

Women speak of being bullied, coerced, threatened, suffering prejudice and suffering clinical abuse. They speak of being stuck in the timed, controlled system which is so common, often ending in a caesarean section. Many suffer still with PTSD (Post-Traumatic Stress Disorder) and or PND (Post Natal Depression) because of their experiences.

So, we are faced with a maternity service where women are in danger of being subjected to a spiral of interventions including induction of labour, where policies and guidelines mean that women don't fit the criteria, for example, too old to birth at home; where home birth services are cancelled, or closed and the service is described as a 'conveyor belt of care'.

But this is simply a lottery, women may also be very lucky and find the wonderful, brilliant NHS midwives who DO provide the services women need. They must have the best managers who enable the system to work properly – as in many hospitals which DO practise continuity of care. These managers must have shouted louder and ensured that the guidelines and protocols in their hospitals were more flexible, that they worked closely with their obstetric colleagues and they provided the service women WANT. NHS midwives often care for women with particular needs – those who don't speak English, teenagers, women suffering effects of substance abuse and those with challenging lives. But it is also clear from the Facebook page that IMs care for those traumatised by the 'system' and also attend women with complex pregnancies. See also the Albany research findings on page 23.

The excuses of low staffing levels and low morale are the result of lack of resources and poor management. For maternity services provided by trusts in the NHS to be of a similar standard throughout, so that woman are not faced with a lottery, more resources are needed; and we need to listen to women who want holistic care throughout their pregnancy and in the early days afterwards. They want a relationship with ONE midwife.

focus on the bigger picture

Save the Independent Midwife is a hugely important campaign, but we also need to focus on the bigger picture, that is the full implementation of Better Births 5-year Plan providing Continuity of Care in EVERY maternity unit in the UK.

Only then will all women be able to trust the system and the 'default situation' will be excellent. Birth will no longer be a battlefield.

Shane Ridley

AIMS Note: There have been many, many comments on the Facebook page and the author has taken a mixed sample of them to write this article. It is a closed (but easy to join) page, please do consider joining and having your say.

Article

IMs and insurance

Mari Greenfield explores the impact of the NMC's decisions on indemnity insurance

The decision by the Nursing and Midwifery Council (NMC) that Independent Midwives UK's (IMUK) insurance was inadequate in January 2017 resulted in the withdrawal of Independent Midwifery services to many women. This report provides information on the immediate impact of that decision.

Background

From 2014, it has been a legal requirement in the UK that all healthcare professionals have indemnity insurance in order to provide healthcare services. This was introduced following a full public consultation and impact assessment. Within the UK, midwives working in the NHS have cover provided through the NHS, private midwives employed by a private or community interest company are insured via their employer. Independent midwives (who are self-employed) are insured via IMUK. On 13 January 2017, the NMC issued a statement that said:

'The Nursing and Midwifery Council (NMC) today announced that it had decided that the indemnity scheme used by some independent midwives who are members of the organisation Independent Midwives UK (IMUK) is inappropriate.'[1]

The NMC statement for parents[2] affirms that its decision means:

'any IMUK midwife who is not covered by an alternative indemnity scheme cannot provide midwifery care'

The statement for parents goes on further to explain that it is the view of the NMC that midwives who are insured solely via IMUK cannot attend their clients during the intrapartum period in any other capacity, even if other midwives are present, because:

'A registered midwife can only attend a woman during a birth if she has appropriate indemnity cover. The midwife cannot avoid this legal requirement by attending the birth in a 'non-midwife' capacity'.[2]

An impact assessment was carried out by the Department of Health prior to the legislative changes in 2014. No impact assessment appears to have been carried out by the NMC prior to this series of decisions. However, the decisions had a direct impact on individual women, who had employed Independent Midwives to provide care throughout the perinatal period, including intrapartum care. The decision also directly affected Independent Midwives, with implications for their livelihood, and their careers. The Association for Improvements in Maternity Services (AIMS) wished to gain insight into the immediate effects of these decisions. This research by AIMS therefore provides a snapshot of the immediate impact these decisions have had on those directly affected.

Methods

To understand the impact on individuals, it was appropriate to use qualitative research methodology. However, understanding and reporting on the immediate impact also made speed of data collection and analysis a priority. For these reasons, an online questionnaire containing open questions was selected as the most appropriate methodology.

The online survey contained four questions. Two questions asked for contact details and locality, the other two were open text boxes. These questions are reproduced in Table 1 below, alongside figures showing how many individuals completed each question.

The survey was publicised online by AIMS, and cascaded through social media (including Twitter and Facebook) via Independent Midwives, doulas, AIMS members and various groups concerned with Maternity Services. It was distributed to AIMS e-mail lists, and via birth-related organisations e-newsletters. Both the methods employed, and the publicising mechanisms used limit the audience who were able to access the survey. However, the survey is not aimed at the general population, but at those directly impacted by the suspension of Independent Midwifery services in the UK. The majority of those directly impacted by the decisions would be reached in this way, and would be able to access an online survey.

Responses were collated by AIMS. The data relating to the locality and contact questions was removed to ensure confidentiality. The responses to the two remaining questions were then put into a text file and numbered.

Table 1

Questions	Completed entries
Please could you tell us, in as much detail as possible, about how the NMC's removal of the ability for IMs to practice affects you.	94
Please could you provide us with your name and email address.	94
It would be helpful if you could provide us with your county and local hospital name, and, if you know it, the name of your trust.	88
Is there anything else that you would like to add?	63

Numbers 1-94 were allocated to responses to the first question, whilst numbers 95-157 were allocated to the responses to the last question.

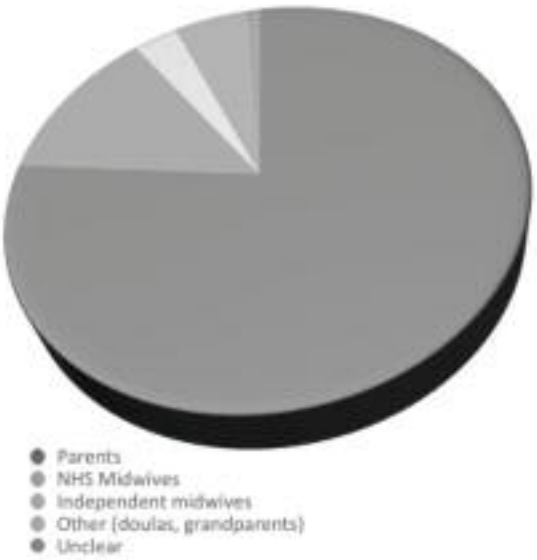
Thematic analysis, as described by Braun and Clarke[3] was used to analyse the data. Repeated readings of the data generated initial codes, which were used to search for themes. The data was then organised into the themes, and further re-coding of the data took place until a thematic map was produced. From this map, the themes were defined in relation to each other.

Responses

The survey remained open from 21 January to 9 March 2017. 94 responses were received in that time. The two open text questions were analysed separately. The first question had a 100% completion rate, with the shortest response at 13 words, whilst the longest was 1,373. Most responses to this question were 200-500 words. Responses to the fourth question were also analysed. The responses to this question were typically shorter than to the first question, with the shortest response being 4 words, whilst the longest was 356. Most responses to this question fell in between 100-300 words.

The identity of the respondents was not asked as part of the survey. However, from the answers given to the first question, it was possible to identify in what role respondents were contributing. The breakdown of respondents is shown in Chart 1 below.

Chart 1 Respondents



The majority of the responses received were from parents, and the majority of parents completing the survey were currently expecting a baby, or had a baby within the last few weeks, and had also employed an Independent Midwife to care for them, and were therefore directly affected by the NMC decisions.

Findings

The aim of the research was to understand the immediate impact of the decisions taken by the NMC in relation to IMUK indemnity insurance. The data was analysed thematically, in response to this aim. Three strong themes emerged from the data in relation to the impact of the NMC decisions. The first theme was the direct and immediate impact on currently pregnant women and their families. The second theme was the impact on Independent Midwives and other birth workers. The final theme relating to the impact was the sense of confusion that appears to exist about the decisions themselves.

Impact on parents

The predominant theme emerging from the data was concern for the impact on parents who had already employed an independent midwife to provide care throughout the perinatal period. The concerns included the health and wellbeing of the expectant mother, the alternative birth choices that were being made as a result of the suspension of Independent Midwifery services, and the financial impact for expectant parents.

The impact that the decisions were having on women's health were seen as wholly negative, and were described by a number of respondents, who reported feeling *'physically unwell and incredibly anxious'* (68).

Parents talked about the impact on their emotional wellbeing in particular, describing their distress in clear terms. One respondent discussed *'the devastation this decision has had on my family and my own emotional well being'* (79).

Some pregnant women who had existing mental health difficulties were clear that the decisions had a substantial negative effect on them *'There are severe mental health implications for those of us with birth trauma – to have choice taken away from us has very real life consequences'* (110).

Independent midwives replying to the survey also noted the physical health effects that the decisions were having on their clients *'The pressure during their pregnancy is too much and had resulted in physical symptoms of stress'* (93).

Parents who had planned a home birth with an Independent Midwife were having to change plans. Many felt that, as the NMC had made this decision, they should have provided women with information about the alternatives they had. *'I believe that an alternative should be provided for the families that have chosen IM'* (104).

This was particularly argued by women who were already at term, who felt the NMC had a responsibility to have produced a joint response with the NHS, directly communicating with the women whose birth plans were disrupted at a very late stage of pregnancy. The fact that no co-ordinated communication was received, and that women or their Independent Midwives had to approach the local NHS services themselves led to some women experiencing negative feelings about the NHS Maternity Services as a result of the NMC decisions. One woman explained that she felt *'badly let down by the NHS with my first birth… again I feel I'm being let down by the system and caught up in a politically motivated situation'* (48).

Others were unaware that the NMC and the NHS were not the same organisation. One respondent stated that the decisions had convinced her that *'The NHS is heartless and a bully when it comes to pregnancy and labour'* (106).

This is of particular concern, as many of these women will now need to access NHS Maternity Services.

Women who had approached their local NHS services sometimes found their birth choices were now restricted. A number of women were particularly concerned that their local NHS could not guarantee that a midwife would be available to attend their planned home birth *'My care has been transferred to my local maternity unit who may or may not be able to provide a midwife for my home birth.'* (88)

Other women felt that, even if their local NHS services would provide a midwife to attend them, they could not trust that an unknown midwife would support them as they needed. This left women with stark choices. Several women were making the choice to have a non-medically indicated caesarean birth as a result. *'I was planning on IM. If that isn't available I'll opt for an ELCS'* (65).

Another woman had developed a medical condition for which induction was recommended. She had been planning to have an induction in hospital, with her Independent Midwife present, but in the role of a birth companion. The second NMC decision referred to above, that midwives with insurance arranged through IMUK could not be present at a birth in a role other than that of midwife,[2] meant that her midwife was not able to accompany her as a birth companion. Now, *'As* [Independent Midwife]*'s not able to be present, I've now opted for c-section surgery as I feel ill equipped to go through an early induction without her.'* (29).

Vaginal births, in normal term pregnancies, provide benefits for both mother,[4] baby[5] and for any future children.[6] The rising caesarean birth rate in Western countries has been linked to rising maternal death rates, and is a concern for the NHS. From this research, it appears some women who would have preferred a vaginal birth, were now choosing elective caesarean births as a result of the NMC decisions.

Another birth option which was mentioned multiple times, especially by women who were currently pregnant, was that of 'freebirthing', or giving birth with no healthcare professional present. A doula expressed the view of many respondents that *'Freebirthing is a valid and informed choice for many women, but the possibility of others taking this route through fear of NHS midwives is scary and seems like tragedy waiting to happen.'* (77)

Midwives who worked both independently and for the NHS were concerned that *'the removal of this choice will lead to women taking matters into their own hands and reluctantly taking their chances alone.'* (16)

A number of women explained that they felt forced into making this birth choice, because they were *'having to decide between either having to battle with NHS or to freebirth with no professional support at all.'* (19)

The unacceptability of NHS maternity care to the women who had employed an Independent Midwife was commented upon *'I would rather choose to freebirth than go back to the NHS.'* (41)

Frequently, the unacceptability of NHS maternity care was as a result of a previous traumatic perinatal experience *'I will not register with the NHS as I felt coerced into tests I did not consent to at the beginning of my last pregnancy.'* (74)

Women were clear that they were not choosing to forego having healthcare professionals at their birth by choice. Many women were at pains to assert the difference between a situation in which a woman chose to freebirth because she felt it was the best choice, and the situation these women found themselves in, where they would prefer to have an Independent Midwife present, but no longer had that choice. *'I would birth unassisted, it won't be a freebirth as in my situation I believe it's safer to have my IM with me therefore I'm being backed into a corner.'* (73)

The responses were unanimous in feeling that the NMC, and/or the NHS, rather than Independent Midwives, were responsible for the removal of choice in birth: *'The NMC has now left me to face birth alone and possibly to risk my life and that of my baby. Give me back my freedom and my safety.'* (30)

Many women expressed concern for their safety in childbirth as a result of the decisions made: *'The NMC has removed all possible safe options.'* (46)

Respondents were also concerned that the NMC decisions had had a financial impact on currently expectant parents, and that the NMC had not taken appropriate steps in considering this in the timing of its decisions. A high number of parents who responded were in the *'horrible position of having to settle the financial situation with our independent midwife whose undisputed expert services we have paid for, but which she is now forbidden to provide.'* (19)

In the NMC document for parents,[2] the suggestion is made that affected expectant parents could seek care from *'an alternative independent provider.'*

This suggestion was not well received by some parents, who expressed *'I am more than halfway through my pregnancy – to go elsewhere will incur significant additional cost.'* (38).

The responses to this survey indicate that overall, the NMC decision was felt by respondents to have a wholly negative effect on parents, in relation to health, birth choices, perceptions of safety, and finances.

Impact on birth workers

A number of responses also discussed the impact on birth workers. The Independent Midwives who commented displayed considerable distress at the idea that women needed them, and they were not able to attend them. *'I am an IM who now cannot support the families that have chosen me.'* (78)

Independent Midwives were concerned about the effect of the decisions upon their clients, and felt a continuing responsibility to them *'I have clients too upset to be able to engage so am answering on their behalf.'* (93)

The decisions have had an immediate financial impact on Independent Midwives, *'It's the loss of my livelihood as*

an IMUK midwife. I'm a single, unsupported parent studying at Masters level.' (22)

The inability to work had also had an effect on the health of some of the Independent Midwives who responded to the survey *'I've become ill as a result of the NMC's decision.'* (22)

Several respondents also expressed concern about the impact of the decisions upon other birthworkers. This concern linked back to concerns that more women might be forced into a situation where they unwillingly choose to give birth unattended. This situation was seen as potentially difficult for doulas in particular; *'I am a doula who is preparing at the last minute to attend unwanted unassisted births.'* (62)

'I do not want to see doulas being forced into a position of being the only support for a woman who has fear of midwives.' (77)

NHS Midwives who responded to the survey also expressed the immediate impact that the decision had had on them, as practicing midwives. There was a sense that their future choices were being limited *'my job as a non IM will be at risk in the future.'* (9)

Some NHS Midwives also felt that the decisions by the NMC had caused them to lose faith in their regulatory body *'I am a midwife working in the NHS and I feel that the NMC actions are a direct blow to the autonomy of the midwifery profession as a whole.'* (12)

One midwife, working in the NHS, expressed such upset at the decision that *'I am seriously considering leaving the profession.'* (7)

Lack of clarity over the decisions made

Many respondents expressed confusion over the decisions that had been made. In particular, respondents found the statements issued by the NMC in relation to its role in determining the appropriateness of indemnity insurance contradictory.

'The NMC's professional indemnity agreement states that the midwife and the indemnity provider are in the best position to determine what level of cover is appropriate. The same indemnity agreement clearly states that the NMC is unable to advise about the level of cover needed.' (71)

Others also found the statements issued by the NMC as to the specific issue with IMUK's indemnity insurance confusing.

'the lack of detail provided by the NMC on why the current indemnity isn't adequate is simply not acceptable. My rights are being removed without adequate explanation'. (67)

There was a general sense from parents that the NMC had a duty to provide explanations to them directly about the decisions made, and that the NMC had not fulfilled this role. One parent respondent summarised the NMC statements as: *'Your insurance is inadequate but we cannot tell you what we would consider adequate.'* (125)

Respondents also expressed anger at the numerical representation of the issue by the NMC in its statement (2017a).

'the NMC dismiss the significance of their decision saying only 80 midwives out of 41,000 are affected. This misleading and disingenuous use of statistics is clearly intended to imply that over 41,000 midwives have sought and secured insurance themselves when in fact most of those 41,000 are covered by the NHS.' (38)

Parents expressed the view that they were the people most affected by the decision, rather than the Independent Midwives.

'The use of the word 'only' is particularly offensive in this context.' (38)

There was also a lack of clarity over how the decision was implemented. Parents were concerned that no consideration appeared to have been given by the NMC to delaying the decision.

'They could easily have given a notice period that ensured current clients were not affected by their decision to suddenly rule IMUK's indemnity cover as inadequate'. (38)

Parents asked for clarity from the NMC about their conflation of safety, and indemnity insurance, stating: *'The IMs are no less 'safe' than they were six weeks, months or years ago'.* (146)

Overall, the decisions taken by the NMC were confusing and contradictory for those who were affected by them.

Conclusions

Parents employ Independent Midwives for a variety of reasons, but predominant reasons given in this research include women who feel they need care which is greater than the NHS can provide, and women who have had a previous traumatic perinatal experience. These women are at greater risk of experiencing childbirth-related post traumatic stress disorder (PTSD).[7] The lack of a proactive provision of alternative care by the NMC or the NHS for these women has caused distress. It is possible that direct communication between women affected and the NMC could assist in this situation.

Independent Midwifery services are highly valued by those parents who have chosen to employ them. The decision taken by the NMC has had an immediate impact on those parents who have booked an Independent Midwife. The impact has included parents feeling their emotional health has been negatively impacted. Some women have decided to give birth by non-medically indicated caesarean section, and others have chosen to give birth unattended. None of these decisions are seen by parents as their preferred choice. Other women have chosen to have a home birth with NHS Midwives, but have found that this option is not necessarily open to them either.

There is a great deal of anger and distress experienced by parents who have employed Independent Midwives in the past, currently, or who would wish to do so in the future. These negative feelings are directed towards the NMC, who parents in this research identified as responsible for the current situation. There is also confusion amongst these parents about the difference between the NMC and the NHS. This poses a further difficulty for women who had employed Independent

Midwives, who now may need to access NHS Maternity Services. It could be helpful to those women for there to be greater clarity about the role of the NMC, and its relationship to the NHS.

Confusion also exists over some elements of the decisions made by the NMC. This confusion was expressed by parents and midwives (both Independent and employed by the NHS) in this research. Further clarification of the NMC decisions would be beneficial in resolving this.

This research shows that considerable distress and confusion has been caused by the current situation, particularly to expectant parents. It seems likely that the distress in not being able to access Independent Midwifery is likely to continue, unless the situation is resolved. For women who are currently pregnant, any resolution cannot come soon enough.

'I will never get this opportunity back. And it has all been taken away from me over something that I do not believe was a problem in the first place.' (80)

Mari Greenfield

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Reproductive justice

Jo Murphy-Lawless raises awareness of the situation for women in Ireland

In a wide-ranging article by social policy analysts on women's reproductive needs in all their dimensions, Zakiya Luna and Kristen Luker have put forward this definition of reproductive justice, taken from an action group in the United States, Asian Communities for Reproductive Justice:

'the complete physical, mental, spiritual, political, economic, and social well-being of women and girls [that] will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives'[1]

If all women, regardless of class, body shape, mental health status, ethnicity, and citizenship, immigration status (just to mention some of the ways whereby pregnant women suffer discrimination), were to have such scope over their needs in relation to pregnancy and birth, we would see a true revolution in maternal wellbeing and in social justice. That revolution would centre above all on an impeccable quality of care, attention, and responsiveness given to women within our maternity services as a matter of course.

although only 2% give birth at home, 10% of women said they would prefer a home birth

In Ireland, at the end of 2016 we have reason to think about this definition with considerable sadness and dismay, and not a little determination to throw ourselves back in to the struggle to give it substance. The last week in October this year saw the publication of the Economic and Social Research institiute, (ESRI) report on the current national rate of caesareans, and then 28 October, was the fourth anniversary of the death of Savita Halappanavar.

Lessons learned?

I want to turn first to Savita Halappananvar's tragic and completely avoidable death in 2012, see AIMS Journal Vol:25 No:2 2013, p14-15. If her inevitable miscarriage had been dealt with appropriately, on the Sunday when she was admitted to Galway University Hospital Savita would have lived despite her ordeal. Blood tests which already showed a raised blood cell count should have been appropriately reported back on and followed through with a termination which was her request. The blood tests never found their way back to the ward and her request for a termination was met with a stony-faced response about the cruel Eighth Amendment to the Irish constitution, which gives equal right to life of the unborn fetus. This amendment, still not overturned despite numerous actions within Irish courts and within the European Court of Human Rights, has insinuated its way into women's maternity care straight across the board and is enshrined in the national consent policy of the Health Services Executive (HSE) which has responsibility for the running of the Irish health services.

Of the official reports which followed Savita's death, the most important was that published by HIQA, the national Health Information and Quality Authority which discussed the thirteen occasions where staff failed to act to prevent Savita's dying and said in starkest possible terms that Irish maternity services were failing to provide uniform care of the best possible quality and that a national review was urgently meeded.[2]

More rhetoric, no substance, no change

That review process finally began in 2015 and the National Maternity Strategy which was the outcome of the review committee was published in 2016.[3] The strategy, entitled 'Creating a Better Future Together', is a major disappointment. Stamped all over it is the mark of the struggle between the midwives who fought for a clear evidence base on which to finally develop Irish maternity services appropriately, including the expansion of midwifery-led units around the country (there are still only in existence, the original pilot midwifery-led schemes established in 2005 in Cavan General Hospital and in Our Lady of Lourdes Hospital Drogheda) and Irish obstetricians. The latter will not let go of their power base and continue to be fixated with their entirely inadequate understanding of the term 'risk' and their professional control to set and define the parameters of what 'risk' might constitute.

There are two key statements which expose this thinking in the Strategy's introductory comments:

... that this new 'service' is a 'maternity service that facilitates choice, yet has all the necessary safety assurance'.[3]

Yet again the implication and the drift are that women may make 'choices' but that their choices need to be 'safe' with the decision-making on safety being in the hands of the clinicians, not the woman. This is a million miles removed from the ethos of the Albany, for just one sterling example, where the woman was the primary decision-maker in partnership with her midwife.[4]

The second longer comment is, if anything, a more disquieting use of rhetoric:

'At the centre of this Strategy is the mother. We have therefore avoided, as far as possible, profession-centric terms such as "consultant led" and "midwifery led", as they incorrectly place an emphasis on the profession.'[3]

This neatly dumps overboard a decade and more of consistently outstanding international research on the central importance of the midwife-mother relationship and its connection to best possible physical, psychological and social outcomes for a new mother and her baby.

The strategy continues to valorise the clinically ascribed risk status of women within the narrowest possible parameters:

A woman's risk status will be determined by clinicians led by obstetric 'guidelines'.

Women whose pregnancies are deemed 'normal' will still require 'permission' to give birth in an alongside midwifery-led unit.

Women who are deemed 'medium' or 'high risk' will have no additional latitude in where they give birth than now: it will be in an obstetric consultant-led unit.

As the commentator Jacky Jones wrote, after waiting 60 years for a new maternity strategy, we have got one which continues to see women's bodies as 'defective and dysfunctional' and where the Eighth Amendment absolutely limits women's decision-making autonomy.[5]

Since the report's launch on 5 January 2016, and despite a spate of probing questions in the Dáil by the Independent Right 4 Change socialist TD Deputy Clare Daly, there is no indication when this strategy will actually begin to be implemented in any concrete way. All we have gathered is that a mere three million euro budget has been set aside for its implementation.

Safe? How safe?

The three million budget will not even begin to cover the desperate problems created by shortfalls in staffing which themselves follow on decades of neglect of the maternity services exacerbated by the economic collapse of 2008-2010. A recent parliamentary question submitted by Deputy Daly emerged with the information that this understaffing of midwives alone amounts to a 17 percent shortfall or 35 fulltime equivalent midwives in the Coombe Women and Infants University Hospital and 42 in the Rotunda Hospital.[6] These two hospitals are handling over 8,000 births each calendar year.

The lack of basic safety is glaringly obvious in these figures as are the pressures on staff and may account for the ESRI conference on increasing rates of caesareans to 30 percent nationally in the most recent year available, 2014.[7] While recently presented research calls attention to the rising age of first-time mothers and suggests that increasing complexity leads to more caesareans, the inability to staff labour wards to proper levels certainly plays a part as the ESRI summarises: *'However, funding and staffing levels in maternity services has not kept pace with either the number of births or the risk profile.'*[7]

In the meanwhile we have had two high-profile maternal deaths in 2016[8] and two more babies' deaths during May in the already troubled Cavan General Hospital.[9]

Getting to reproductive justice

The Picking Up the Threads exhibition, drawing attention to the women who have died with our quilt (contributed to substantially by AIMS members) and our documentary, has been touring the country and drawing attention to the need for automatic inquests for maternal deaths. We are also drawing attention to the broader and very impacted problems with the maternity services: if we summarise these as understaffing, poor quality evidence, and poor professional support, we must also add that these services continue a tradition of state-backed patriarchy in Ireland which has consistently disadvantaged women's voices, needs and lives.

So the other good news is that more recently qualified midwives are finding their voices and have been active in setting up two new groups, Midwives for Choice in Ireland and the Irish Midwives Association.

Tiny though these three efforts are measured against the all the work there is to do, we have at least a firm understanding of what reproductive justice comprises and how badly we need it in Ireland.

Jo Murphy-Lawless

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Lay perspectives

Charlotte Williamson looks at the value of out-of-system knowledge

Lay means not trained or qualified in whatever profession is being considered – the law, medicine, the church.[1] Professionals learn valuable skills during training but they also lose some of lay society's everyday ethical values and behavioural norms, substituting professional ones.[2] Health professionals' perspectives, the stances from which they look at and interpret things, may come to deviate so far from lay people's perspectives that 'hospital scandals' result.[3]

In a multicultural society, lay people hold in common basic views of what is fitting or unfitting in patient care.[4] Tensions between professional and lay values and norms can impact negatively on patients' lives. We increasingly understand that lay perspectives are necessary for ensuring that professionals' treatment and care accord with lay society's values.

Exactly what those lay perspectives are has never been clarified but they are to do with the basic value of humaneness, in other words 'as befitting a human'.[1] In every day parlance, it means causing no avoidable harm or distress to any sentient being. Patient care is inhumane if it causes avoidable harm or distress to patients or is harsh or restrictive without therapeutic justification. By virtue of being lay, people are able to identify practices and policies they feel are oppressive or unkind when they read or hear about them or experience them as patients but they do not always use that ability. They may be diffident or feel deference towards professionals (or managers) or adopt their values and align themselves emotionally with them or accept constraints on what lay people should do.[5,6] Difficulties and confusions abound. Nevertheless, lay people can legitimately draw on whatever sources of knowledge they can find to inform their judgements and to give them the evidence and arguments they need to identify and oppose inhumane care. Here I put these sources of knowledge into three categories, starting with what all lay people know already, then moving on to the additional or specialised knowledge they need to identify inhumane care more widely. The sources overlap and reinforce each other; using them can give lay people confidence and authority.

General lay knowledge

Lay people can often see things that seem invisible to professionals and managers.[7] 'Wilful blindness' is a common way of not seeing other people's pain.[8] Examples from hospitals include windowless labour rooms in which women may spend many hours; frosted glass windows in a mother and baby unit in a psychiatric hospital, preventing mothers from soothing themselves and their babies by showing them the view outside; extractor fans from nearby buildings droning non-stop into orthopaedic wards where patients are in pain (personal observations); the smell of urine and faeces from piles of dirty linen and clothes; call bells inaccessible or switched off and nurses abrupt with patients or absent altogether in geriatric wards.[9] To identify instances of obvious inhumane care like these, lay people only need a capacity to feel disturbed by deviations from ordinary norms and everyday standards and the courage to say so.

Semi-specialised lay knowledge

Lay people sometimes see or hear something that surprises or disquiets them but do not know whether valid reasons of safety or therapy justify it: maternity care is associated with unjustified practices, as AIMS members know. Taking flowers to patients in hospital has long been a custom in the UK, but many hospitals now ban them even in general and elderly care wards. That denies patients pleasure, deprives them of symbols of love and support from relatives and friends and removes from nurses a reminder that, in the outside world, patients are valued people. Flowers are banned because nurses believe that the water in flower vases contains harmful infectious bacteria: there is no microbiological evidence for this belief.[10] Similarly, staff tend to undervalue the support friends and relatives give to patients by visiting.

Specialised lay knowledge starts from unease

Specialised lay knowledge

Specialised lay knowledge starts from unease over clinical policies and practices that may be distressing or harming patients, examples include certain drugs' side effects, episiotomies and approaches to the third stage of labour. Setting lay values and norms against complex clinical matters apparently justified for clinical reasons requires thorough investigation. Drawing on and evaluating evidence from clinical research, as well as from accounts and surveys of patients' clinical experiences and professionals' discussions of controversial issues, is often necessary before making a judgement. Patient groups, real or virtual, are the repository for this specialised lay knowledge and knowledge from one patient group can sometimes be transferred to other categories of patients. With experience, lay people can build up expertise and an ability to judge the humaneness or inhumaneness of specific clinical policies and practices over a wide range of patient care.[11]

The medical profession now accepts that high standards come from marrying the perspectives of professionals and of patients.[12] In this context the word 'patient' applies to people in active clinical relationships at the

time of the research or enquiry. Ideally, standards should be formulated by professionals and knowledgeable lay people (often former or recurrent patients in the speciality) working collaboratively as equals.[13] Collaborative standards are more likely to meet the interests, clinical values and ethical sensibilities of both professionals and patients than standards produced by either alone. (Like professionals, lay people and patient groups can have blind spots and biases.) Thus collaborative standards are likely to be humane. Making normal birth a reality, in which AIMS took part, shows what can be done.[14] Even one knowledgeable lay person can sometimes change the assumptions and practices of a group of professionals but the composition of collaborative groups should be checked and tokenism challenged.

Conclusion

Lay people can draw on various kinds of knowledge to argue against policies and practices that inflict unjustifiable restrictions and hardships on patients. Most professionals want to give humane care. Sometimes they need lay help in discerning what that is. Lay people *'who do not doubt our good intentions, but are prepared to tell us things others will not'* sums up, in one doctor's words,[15] how to work effectively and humanely to make patient care befitting for those who give and those who receive it.

Charlotte Williamson

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ENCA 2017

25th annual meeting of the European Network of Childbirth Associations

Twenty-two representatives from eleven European countries met for the 25th annual meeting of the European Network of Childbirth Associations in Cascais, Portugal. The first and third days focused on ENCA's activities and organisation.

To aid better communication within the group a Facebook page and a google list, for members to exchange ideas and information, has been created. The ENCA page on the web is being updated. www.enca.info

It was clear from the meeting that all the countries suffer from over-medicalised care to a lesser or greater degree. As in the UK, many birth centres have been closed down. In Germany, a woman can choose her antenatal care from a doctor or midwife, but some doctors were requiring women to sign a form which would ensure that they could only receive care from that particular doctor, protests to the government successfully outlawed that practice. Many countries highlighted the difficulties in obtaining and promoting midwifery care, the lack of freestanding midwifery units, and the inadequacy of postnatal care appeared to be universal.

14–21 May 2018 has been designated the International Week for Respecting Childbirth and it was decided that the ENCA slogan for this will be *'Less interference. More Care'*. Each country is encouraged to organise events and demonstrations around this and promotional material will be publically available on the ENCA website.

The Portuguese group, Associação Gravidez e Parto, www.associacaogravidezeparto.pt organised a very successful conference on the second day and invited Professor Cecily Begley to present the findings of the OptiBIRTH study and the AIMS Chair, Beverley Beech, presented a paper on the history of birth culture in the UK. A copy is available on request from chair@aims.org.uk.

The next ENCA meeting will be held on the 27-29th April 2018 in Sanski Most, Bosnia and Herzegovina.

Beverley Lawrence Beech

Celebrating continuity

Rhetoric into reality, policy into practice
London – 13 April 2016

AIMS, together with Neighbourhood Midwives, Positive Birth Movement, Sandwell and West Birmingham NHS Trust – home of Serenity and Halcyon Birth Centres, and supported by the Royal College of Midwives, held a very successful conference, bringing together woman and midwives to progress the concept of continuity of carer – one of the key recommendations of the National Maternity Review.

The event included a range of workshops on the issues that would ensure the efficacy of continuity of care; one of these was an inquiry into the role of commissioning. Participants were encouraged to imagine good commissioning that would enable them to deliver continuity, then asked them to imagine what they would do if they were a commissioner and offered them the opportunity to share one piece of advice with a commissioner.

This is a short summary of the report of the feedback prepared by the partners in the event and Georgina Craig from the ELC programme: Experience Led Care, a social enterprise organisation which came into existence to investigate how health and care systems could design services that would improve peoples' lives by finding out what matters to the users and providers of the services.

The feedback itself came from over 50 frontline teams and senior midwifery leaders. They suggested that good commissioning would be relational, that is from commissioners who are engaged, committed and approachable; who seek to work in partnership to improve care with mutual respect and high trust with a positive mindset; who invest in well designed engagement and involvement processes to involve midwives, GPs, MSLCs with lots of user involvement; closing feedback loops and working with a 'wellness model', valuing different outcomes and nurturing innovation.

In answer to the question of how to nudge relationship-centered care that creates continuity, participants felt that continuity of commissioner was important too. Too much moving on meant that commissioners neither knew, nor understood enough about the maternity services. Commissioners could shadow midwives as part of their work, be open to change and listen more. They should be evidence based (they could read the National Maternity Review). They should be transparent with the budget; make the money follow the woman; give additional tariff to providers who can provide 85% of midwifery care from the same midwife; measure health gain far more broadly with longer term measures of satisfaction, breast feeding and family health, and monitor staff recruitment and retention, and sickness rates.

Perhaps the most important message participants sent was that commissioning must be a partnership, one that also involves strategic clinical networks. Participants stressed that they want the same things as commissioners, that is a high quality safe service, meeting the needs of the community they serve, *'... predicated on commissioners understanding the lives of those providing care and the families they serve'*. They felt that two-way dialogue is key to great commissioning. They wanted commissioners to allow long-term outcomes for women and families to influence decisions on funding and saving on costs and to really consider what outcome measures are set by asking whether or not they will make a difference.

AIMS would like to see this report taken very seriously and used to inform commissioning in England.

Jo Dagustun

AIMS organised a second successful conference in Leeds on 8th April 2017 – details in the next journal.

25th annual meeting of ENCA
© ENCA 2017

Rural midwifery

Implementing the Maternity Review in Rural Areas
Better Births – Shropshire and Beyond. 12 February 2017

The conference organisers succeeded in getting some of the movers and shakers in maternity together in a very nice conference centre in Shrewsbury, for what turned out to be an encouraging and upbeat day.

Baroness Julia Cumberlege chaired the day capably with energy and enthusiasm, as you might expect; I was much pleased with her commitment to continuity of carer which she described as 'a passion' and emphasised repeatedly. She referred to the work of the National Perinatal Epidemiology Unit NPEU showing that 24% of premature births could be prevented by continuity of carer, and quoted Soo Downe: *'if it was a drug you'd have to give it'*.

Cathy Warwick set out 'our vision' of community hubs as one-stop shops with multiple facilities, including ultrasound, alongside centralised specialist care; Tracey Cooper, consultant midwife from Lanarkshire described 'our experience' of organising the services around the women and including antenatal care, dieticians, physiotherapy and much more at hubs, including an obstetric clinic once a week. Simon Wright, CEO Shrewsbury and Telford Hospital Trust (SaTH), introduced a slightly jarring note by focusing on the government's targets of cutting the stillbirth rate by interventions during pregnancy,[1] but also talked of efforts to increase births in MLUs.

Kathryn Gutteridge spoke of her work in setting up MLUs in the Birmingham area, where there had been a failing unit with high levels of intervention and low levels of recruitment. She started by listening carefully to experiences of service-users and learned lessons from hospices about their patient and family-centred approach, estimated that 30% of women need to give birth in hospital, the rest, as she has shown, can give birth outside with excellent outcomes, achieving the highest normal birth rate in the UK. She reminded us of the recent survey from Women's Institute (WI) and NCT showing that 88% of women have not met their midwife before the birth. Adam Gornall, Clinical Director of SaTH, set out sustainable services in Shropshire talking of the need to encourage more use of the midwifery led units (MLU).

Women's voices were heard too in presentations from service users, then lunch with 'speed dating' giving a good opportunity to meet and have a conversation with the speakers and other participants.

Cate Langley, Head of Midwifery in Powys, in a completely midwife-led service in a massive rural county with no obstetric unit, and 1200 births a year, told us how to deliver community based maternity services where the service staffs women not buildings, and Gill Walton, Director of Midwifery in Portsmouth gave us lessons from Portsmouth, where she has developed an app, 'My Birthplace' to support women's choice of place of birth.

Childbirth activists have had difficulty mapping midwife-led units in the UK as there is considerable change and no central register so it was very useful to see some preliminary results from Denis Walsh, Associate Professor in Nottingham, who described the ongoing research into mapping and utilisation of midwifery units in England.[2] A key finding is that there has been a significant increase of births in MLUs over the last 6 years following the Birthplace study: he suggests that a conservative estimate of the proportion of women who could birth in MLUs, based on numbers booking midwife-led care in early pregnancy reduced by subsequent transfer to obstetric-led care, should be at least 30%.

Of course utilisation of MLUs depends on their provision

Of course utilization of MLUs depends on their provision. Denis showed the large variation between trusts, some with no MLUs at all, but some with many. The closure of obstetric units with an increase in alongside provision but little overall increase in freestanding midwifery units (FMU) must mean many women travelling potentially avoidable distances in labour, however there has been a welcome drop in the number of trusts with no midwifery units at all.

There was agreement on the need to increase midwife-led care and much commitment to doing so, but the take home message for me was definitely the widespread acceptance of the importance of continuity of carer as well. This seems to me to be in stark contrast to the message in the minds of policy makers until recently (for example Midwifery 2000), which was that every woman needs a team and, at most, continuity of care. For me this is a very welcome and positive shift.

Gill Boden

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The Albany analysis

Sarah Davies summarises the long-awaited analysis of the Albany Midwifery Practice data

Midwifery continuity of carer in an area of high socio-economic disadvantage in London: A retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997–2009). Midwifery 48 (2017) p1-10

by Caroline Homer, Nicky Leap, Nadine Edwards, Jane Sandall.

Background

This paper is an important read for anyone who wishes to learn more about the huge benefits of continuity of midwifery carer. Understanding a little of the background to the paper will also give an insight into the politics of autonomous midwifery in the NHS.

The Albany Midwifery Practice (AMP) (1997-2009) was a unique and ground-breaking practice; it was the first midwifery practice in the UK to negotiate a contract between an NHS trust and self-employed midwives. The AMP model provided midwifery continuity so that each woman was able to get to know and trust one or two named midwives who then looked after her during pregnancy, labour, birth and postnatally. During its first few years, the model was rigorously evaluated and found to have excellent outcomes.[1] The AMP explicitly aimed to reduce inequalities and promote long term health gain through the provision of NHS community based midwifery care to women in an area with high levels of social deprivation, with the aim of replication elsewhere.[2] It became an exemplar for midwifery continuity models nationally and internationally.

As well as evaluations showing excellent outcomes,[1] qualitative studies described less measurable but equally important benefits, such as women growing in confidence as a result of their care.[3,4] Nadine Edwards, who interviewed women cared for by the AMP wrote: *'together the midwives and women developed a positive birth culture that increased confidence, self esteem, knowledge and skills in both women and midwives'*.[5]

However, in 2009 the AMP was closed by the host Trust, King's College Hospital Foundation Trust, (KCHFT) with no prior consultation with women and without proper provision in place to replace the service. Justifying its decision to close the Practice, King's cited safety grounds.[6] A statement on its website claimed that the Albany rate of referrals to the neonatal unit for serious Hypoxic Ischaemic Encephalopathy (which they described as brain damage caused by a lack of oxygen to the brain around or at the time of birth) was much higher than for women cared for by other King's midwifery practices, or by hospital midwives. It stated that *'although Albany looked after 4% of our mothers, 42% of all the poor outcomes associated with serious HIE involved infants in their care'*.

The statistics upon which King's were basing this extremely serious allegation were questioned by various authors.[5,7,8] They were based upon a specially selected time period of 31 months and one day; and according to one author[9] were 'riddled with methodological flaws and (…) scientifically invalid through gross selection bias'. Meanwhile, the decision by King's left mothers without their midwives, the midwives bereft and a cloud over the name of the Albany. As Denis Walsh, Associate Professor of Midwifery at Nottingham University wrote: *'The repercussions of the Albany Midwifery Practice Group losing their contract with King's (were) felt not just across the UK but internationally'*.[7]

The paper

The outcomes of the 2568 women cared for by the AMP from April 1997 to September 2009 have been retrospectively analysed by a team of researchers, led by Professor Caroline Homer from the University of Technology Sydney, Australia. Their findings totally vindicate the Albany Midwifery Practice and provide further evidence of the superiority of continuity models of midwifery carer over other models. The AMP outcomes are striking, especially given that 57% of the women looked after by the Practice were from Black, Asian and Minority Ethnic Communities and a third of the women were single. These women and their babies have been frequently shown to have poorer outcomes when cared for within usual maternity services models. The following is a discussion of some of the key findings of the paper, but it should be read in its entirety: www.sciencedirect.com/science/article/pii/S0266613817301511

Findings and discussion

Continuity

The researchers found that over the 12½ years, 95.5% of AMP women were cared for in labour by either their primary or secondary midwife. 87.1% of women had their primary midwife at their birth.

Home birth

Home birth rates were the highest ever described in any UK setting. 28% of women booked for home at the initial visit; this increased to 38% at the 36 week visit with 43.5% of women ultimately giving birth at home. These statistics demonstrate the recognition by the midwives that decision about place of birth is not a one-off choice, but a process.[10] The AMP home birth rate may be contrasted with the UK's current home birth rate of 2.35%.[11] It now seems clear that continuity of midwifery carer is the model that must be implemented if women are to have meaningful choice regarding place of birth as recommended by numerous UK policy documents.

Induction

6.5% women had an induction – this compares with a current national induction rate of 27.1% in 2015–16.

Use of analgesia

Although there are no national records for comparison, use of analgesia was low – 9.9% of women used epidural analgesia, 1.2% pethidine and 15.4% Entonox.

Transfer to hospital for women planning a home birth

Overall, 15.1% of AMP women transferred to hospital during labour with rates of 12.4% for primiparous, and 5.5% for multiparous women. As the authors note, this contrasts strongly with data from the Birthplace In England study[12] which described transfer rates of 45% for primigravidae and 12% for multigravidae.

Mode of birth

79.8% of women had a spontaneous vaginal birth. The current rate in England is 60%. The overall caesarean section rate for women cared for by the AMP was 16% as compared with a current rate in England of 27.1%. There was a low incidence (4.2%) of instrumental birth (forceps/ventouse) which is a third of the current rate in England of 12.9%. The authors suggest this may be linked to the low use (9.9%) of epidural.[13] All AMP women were supported by known midwives, which increases the likelihood of spontaneous vaginal birth.[14] As noted by the authors, this finding underlines the value of midwifery continuity of carer to help women cope with labour pain.

Third stage

Of the women who had a vaginal birth, 78% had a physiological third stage. UK national rates are not available for comparison but this means that a large percentage of babies benefited from delayed cord clamping.[15]

Neonatal outcomes

There were 2585 babies, 21 sets of twins and one set of triplets.

The preterm birth rate was 5.1%, with 4.5% babies low birth weight (below 2500g). This was lower than the national average – 5.1% compared with the UK rate of 7-7.5% from 2006-2010. This finding is in keeping with high quality evidence that midwifery continuity of care reduces the rate of preterm birth.[1]

6.2% of babies were admitted to neonatal unit for more than two days; the most frequent reasons for admission were preterm or low birth weight.

Breastfeeding

91.5% commenced breastfeeding at birth, while 74.3% were exclusively breastfeeding at 28 days. These figures compare very favourably with UK rates from the Millennium Cohort study which found that 70% of mothers initiated breastfeeding and 49.3% were breastfeeding at one month.[16] As the authors note, this difference is hugely important in terms of the well documented public health benefits of breastfeeding.

Perinatal mortality

The perinatal mortality rate (PMR) rate for babies born with the AMP was lower than the rates for the UK over a similar period. AMP rates varied over the time period from 1.8 – 7.7 per 1000 total births compared with the UK rate during the same period of 7.5-8.5.[17] These figures are especially important given that the AMP was situated in an area of high ethnic diversity and social deprivation where outcomes would be expected to be poorer.

Overall this study vindicates the Albany Midwifery Practice and demonstrates outstanding outcomes for the 12½ years of its existence. It has now been unequivocally demonstrated that the AMP provided important health and psycho-social benefits for mothers and babies. The study lends even more weight to arguments for providing this model of care for all women.

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Every reason

Michelle Quashie tells us why women, midwives and everyone has reason to be concerned

For the past few weeks I've had this grey cloud hanging over my head. It stops me from returning to sleep when I wake in the night to feed my baby. When I do eventually get to sleep I wake up hoping that it was just a nightmare but then the realisation returns....

My mind is haunted with the knowledge that some pregnant women have had their chosen midwife taken away from them, a midwife who they know and trust. I hear from women that they are experiencing feelings of fear, vulnerability, helplessness, solitude, all adding to their feelings of anxiety. Feelings I can relate to. I worry for these women and the impact these feelings are having on the future of their growing babies….

It has only been a matter of weeks since I had experienced a form of care that I had never experienced at any of my previous three births. It was a form of care that met my needs physically, emotionally, fully respected my choices and ensured I was safe whilst I birthed my baby. This new-found care was provided to me by independent midwife Kay Hardie. It was a revelation, a gold standard form of care that has my full support and approval. The type of care that I would only ever expect and seek for my daughter, my nieces, my loved ones, my friends and for all women….

I am pleased to see that many are finding the actions of the NMC concerning. If you have a daughter, a niece, a wife or care about women and society as a whole, then you too should be concerned about the NMC's latest decisions. One day a woman who is close to you may find themselves pregnant with limited choices regarding her maternity care and birth, possibly limited or no midwifery support, during a monumental time of her life.

This is a time when a woman leaves her footprint on the world and time when a mother is born. Birth has the ability to shape a woman for life and will effect who she is as a mother and a member of society as a whole.

Michelle Quashie

UN Population Award 2016

Congratulations are due to the Polish 'Childbirth with Dignity Foundation' whose representatives, Ania Zdral and Joanna Pietrusiewicz travelled to New York to receive this prestigious award from the United Nations Secretary General. The award was in recognition of their campaigns and advocacy work over the last twenty years to inform and empower and campaign about the treatment of women in Polish hospitals.

The Foundation created the web portal www.gdzierodzic.info (where to give birth info), which helps pregnant women to choose the best obstetric ward or hospital (there's the search engine of all 404 obstetric wards and hospitals in Poland) and find answers to their questions about pregnancy, labour and maternity care (many articles, new outcomes and statistics). Because of the portal some obstetric units are changing, doctors, midwives and decision makers read the parents' comments about them and compared that with other hospitals.

The Foundation was, along with AIMS, among the founding members of the European Network of Childbirth Associations. ENCA was founded in 1993 by the Society for Childbirth Education (GfG) and held its first annual conference in Frankfurt, Germany. ENCA's purpose is to gather together representatives of lay organisations from as many European countries as possible to exchange ideas and information and support those who are trying to change maternity care for the better.

photo, from left to right, Jan Eliasson, former Deputy Secretary-general of The United Nations, Ania Zdral, Coordinator of Training and Conference in Childbirth with Dignity Foundation, Dr Babatunde Osotimehin Executive Director and Under-Secretary-General of the United Nations.

The Polish members were very excited when Beverley Beech showed them a copy of Sheila Kitzinger's book 'The Good Hospital Guide', which came about as a result of a past Secretary Ann Taylor suggesting that, like the Good

photo, from left to right, Joanna Pietrusiewicz, president of Childbirth with Dignity Foundation, Agata Duda, Płonka, First Secretary at Permanent Representation of Poland to the UN, Ania Zdral.

Beer Guide, we ought to have a Good Hospitals Guide. AIMS had no money to work on it, but Sheila asked if AIMS would be happy for her to work on this idea. The committee enthusiastically agreed. The Polish women, however, were concerned that they could not challenge medical interventions, and came up with the brilliant idea of a questionnaire that would indicate how well the women were treated in the hospitals and awarded hearts to those with the best outcomes. Over 8,000 women from all over Poland responded and as the years have passed the Foundation has challenged obstetric practices and empowered the women to demand better care. The United Nations' recognition of their work is well deserved.

Ania Zdral

An open letter to the NMC

From Birthplace Matters

We are writing to convey our despair at the decision by the NMC to shut down and persecute the profession of Independent Midwifery….

Since we started our Birthplace Matters campaign in response to the erosion of women's choices in Norfolk, we have received hundreds of birth stories from women from all over the UK and beyond. We have also had many ongoing conversations with midwives, birth rights campaigners, doulas and other birth workers about women's choices and rights and the different models of care available to them.

Sadly, we have received a great many stories of poor care within the NHS setting... stories of neglect, women treated like cattle, coercion and bullying, and lack of continuity. Please feel free to go and read for yourselves the difference it made being at home compared with being in the NHS setting at www.birthplacematters.org.uk/.

In contrast, we are yet to hear a single complaint about the care a woman received from an Independent Midwife. Independent Midwives take their responsibilities to women extremely seriously – their livelihood, reputation and future job prospects are at stake. An Independent Midwife is acutely aware that she has no one to hide behind and cannot blame poor budgets or staff shortages if the woman she serves receives poor care.

One of our own team, Jeanette, will be eternally grateful that she was able to have an Independent Midwife support her during her last pregnancy and birth, rather than being forced into a hospital she has never felt safe in. Being relaxed and at home with her husband and other children around her was all she wanted – like so many women who prefer a more peaceful and undisturbed beginning to her child's life.

Clearly, the NHS is getting some things right, and some women are very happy with the care they receive from their NHS Midwife. We do not dispute this. Some women absolutely prefer the clinical setting and some need to be there for medical reasons which we do not deny. Many do sterling work under difficult circumstances. We are in awe of so many NHS midwives who are champions of good practice, in spite of budget pressures and other restrictions.

However, given the current situation where home birth services all over the UK are being 'restricted' the decision by the NMC isn't one simply about choice of carer, but choice of birthplace. Stripping away one, leaves the other exposed too.

We ask, no urge you to honour the fact that women themselves should decide who they feel is most suitable to deliver their child. Trust them to interview and do the appropriate research and soul searching on something so very important. To take away this choice is to infantilise women and take a step backwards in women's history. This is a feminist issue and a human rights issue.

At Birthplace Matters we stand shoulder to shoulder with Independent Midwives and value their unique qualities, their unique position to care 1:1 for women with the utmost dedication, and question whether the NMC is putting more women in harm's way than any Independent Midwife ever has.

Sincerely and with heavy hearts,

Paula, Jeanette and Anna
Birthplace Matters Team
February 2017

www.birthplacematters.org.uk/#docs

Reviews

Why The Politics of Breastfeeding Matter

By Gabrielle Palmer
Pinter and Martin, November 2016
ISBN 978-1-78066-525-2
also available as an e-book.

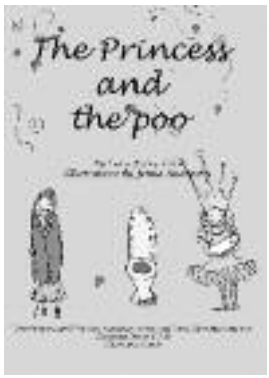
Like many AIMS members, I suspect, I first read Gabrielle Palmer's groundbreaking book, The Politics of Breastfeeding, in 1988 and it changed the way I thought about the world. Picking up the new book, 'Why the Politics of Breastfeeding Matter', I didn't expect a similar effect but despite nearly three decades of living with her original message, her argument had lost none of its power and again I found it transforming my thinking.

Breastfeeding is vital for the health and well being of our global society in so many ways and becoming more and more important in a world besieged by humanitarian and environmental crises. Mass migration now affects the lives of 60 million people including five million infants who are particularly vulnerable to malnutrition and infection: mothers coming from Syria into Europe have already had their breastfeeding sabotaged causing appalling problems for aid workers. Gabrielle also discusses antibiotic resistance and climate change; greenhouse gas emissions attributed to milk powder are significantly higher because of extra processing so for every kilo of milk powder four kilos of greenhouse gases are emitted. Having been an HIV and Infant Feeding Officer for UNICEF and co-directing the Institute of Child Health in London in the 1990s she is well qualified to comment on legislation surrounding infant feeding, for example she contrasts the situation in India with that in China: in China the market for artificial milks for babies and infants grew by 90 per cent in the four years to 2012, whereas in India it grew by only 13 per cent because the Indian government has actually implemented the International Code of Marketing of Breastmilk Substitutes rather than simply signing up to it. The result has been childhood obesity in China. Thirty years ago the market in China had not opened up to infant 'formula', now it has, resulting in manufacturing riches which some might consider to be beyond the dreams of wildest avarice.

The story is not one of helpful manufacturers who produce a breast milk substitute for the tiny number of women who cannot or choose not to feed their babies: it is a story of the triumph of neoliberal capitalism that has persuaded women that they can't successfully nourish their babies, causing 'commerciogenic malnutrition'. George Monbiot, (Guardian, 14 November), talks of human beings as being essentially both highly social and highly unselfish, and thus potentially able to avoid global catastrophe, but successful breastfeeding may have been a crucial part of the development of social beings. Gabrielle exposes the process whereby women have been subjected to gross and overwhelming commercial pressures that inhibit their choices and wishes: she explains how misinformation and inept care crush their confidence and innate skills.' All over the world there are breast milk famines, they are not caused by nature but by a loss of entitlement'. Gabrielle calls breastfeeding, 'the great equaliser', giving a baby born into poverty the chance to be as intelligent and healthy as one born into wealth. This book is a call to arms to protect nothing less than the future of the human race.

Gill Boden

The Princess and the Poo



by Lara Fairy
Available from AIMS this summer

This story was lovely and though short and simple it held a useful and good lesson. I enjoyed the illustrations they contributed well to the story. I think that the word 'abundantly' is a good word but if little children were to read it they might not understand it but that is my only fault. I think many people would love this book. It is a magical story, excellent lesson and great topic.

A flawless and amazing story

Tilly Weston (aged 14)

Girls need to know how about poo – especially perfect princesses *'For if you know how to poo… you know how to have babies.'*

This book tells a fairy story and so with humour and a light touch teaches a lesson about babies and poo. It is not a biology lesson, but a lesson in life, an empowering lesson in life.

'The knowledge contained, In each little body, Knows all the moves, For birthing a baby!'

Every woman needs to be conditioned and empowered to know this and:

'There's no describing the power, That comes from within, As you deal with your pain, And face up to your fears'

Girls need to read this book to learn about poo and babies and the power of womanhood. Mothers and Grannies should read this to know how to be a crone and how to support their daughter and daughter-in-laws.

Finally, this book makes a hilarious one act play, when acted out at a conference.

A book for your bookshelf and possibly your toilet.

Ruth Weston

How you can help AIMS

AIMS became a Charity in 2014. It still has no paid staff – our committee and volunteers give their time freely. All monies raised go towards providing women with support and information.

If you are not already a member, you could join

As a Member, your benefits include four AIMS Journals a year and 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.

Visit www.aims.org.uk

Transforming Maternity Care

The Maternity Transformation Stakeholder Council (MTSC), chaired by Baroness Cumberlege, met on 22 March to review what progress has been made in bringing about the Government's Better Births National Maternity Review's vision for improving maternity care in England over the next five years. It has a vision of safer, more personalised, kinder, professional and more family friendly care centred around the needs and decisions of the mother and her baby.

The MTSC is responsible to the National Maternity Transformation Programme Board whose programme for change was formally launched in July 2016. This was followed by a series of workshops in England designed to establish what care should look like locally and empower women and clinicians to develop a forum for discussion (Maternity Voices), and encourage Early Adopter sites to improve local services and outcomes.

To enable this change seven Maternity Pioneer sites have been set up and two of them, Merseyside and Cheshire, are developing plans for women to have Personal Maternity Care Budgets, a tool which will allow the system to ensure that the funding of maternity services will follow the choices that the woman makes and that she will be fully informed of what is available. It does not mean that the women will be given money. See www.england.nhs.uk/blog/personal-maternity-care-budgets-a-new-way-forward/

NHS organisations and local councils in 44 geographical areas are developing shared proposals to improve health care. To see what is happening in your area go to: www.england.nhs.uk/stps/view-stps/

The government has recognised that fit and healthy women are safer giving birth in their own homes or in small free-standing midwifery units and Baroness Cumberlege has been travelling the country encouraging changes that will enable midwives to provide continuity of carer and more community based care, properly supported by obstetrics, paediatrics, and other related services. There is enormous potential for change, the infrastructure is being developed to enable care that is properly women centred and now is the time to find out what the plans are in your area, join your local Maternity Services Liaison Committee (now renamed Maternity Voices in some areas) and make sure your views are known.
www.chimat.org.uk/resource/view.aspx?QN=MSLC_ABOUT

Maternity care can change for the better and now is the time to do it and be involved in making it happen.

Better Births: Report of the National Maternity Review:

www.england.nhs.uk/ourwork/futurenhs/mat-review

Pioneer sites: www.england.nhs.uk/ourwork/futurenhs/mat-transformation/mat-pioneers/

Rapid Resolution and Redress Scheme (RRR)

Better Births recommended that the Department of Health should consider introducing a RRR scheme for severe avoidable birth injuries to enable staff to learn from an adverse event and compensate 'eligible' families without recourse to litigation – currently cases take, on average, over eleven years to settle.

The NHS Litigation Authority in 2015/16 spent £1.5 billion on clinical negligence claims, of which 34% related to maternity.

The Department of Health has issued a consultation document setting out its proposed plans for the Rapid Resolution and Redress scheme. If a fairer scheme to help seriously damaged babies is to be developed it is vital for AIMS' members to comment. The deadline is the 26 May 2017.
www.gov.uk/government/consultations/rapid-resolution-and-redress-scheme-for-severe-birth-injury