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The Sound of Violence

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Contents

Editorial

The label of 'high risk': the promise of gentle and attentive care, or a first violence in pregnancy?

by Alex Smith

In 2011, Vicki Williams asked in the AIMS journal editorial, "is this label of 'high risk pregnancy' doing women any favours, or is it...creating damaging additional stress for childbearing women and those who care for them?".[1] Eleven years on, with escalating rates of medicalised births and birth trauma, it has become an even more urgent question. Does this label directly or indirectly harm people, and if so, can this be considered as an example of obstetric violence?

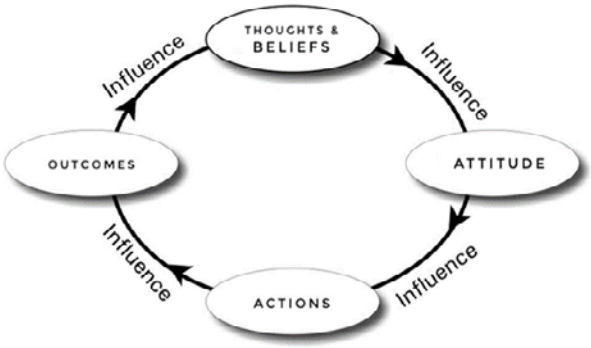
It would be wonderful to imagine that women who really do have a higher chance of problems arising during their pregnancy or labour receive particularly gentle and attentive care. Midwife-led care, combined with good inter-professional communication and continuity of carer, improves outcomes,[2] almost certainly because this allows for relationships of trust to develop through which, as deemed essential in the 2020 interim Ockenden report,[3] women and their families are listened to and respected. But all too often, the very things that may have made a positive difference to people labelled as 'high-risk' are denied, and thus, the label becomes a self-fulfilling prophecy,[4] a prediction that causes itself to become true.

It may seem strange that two small words, words intended to safeguard, could cause harm. This is how they might:

The emotional resonance of the words: The term 'high risk' suggests that danger is ever present. The words alone are enough to fill the labelled person with a constant sense of anxiety, uncertainty and powerlessness. Those feelings, even when very low-key, trigger a rise in the level of the stress hormone cortisol, leaving the person on high alert. At the same time, in a see-saw effect, the hormones that support physiological functioning and well-being are lowered, diverting energy from non-essential functioning and holding it in readiness for coping with the potential emergency. In one (not pregnancy-related) study looking at over 33,000 adults, those who were aware that they had hypertension reported elevated levels of psychological distress compared with those individuals who had hypertension but were unaware of this.[5] While there is a natural rise in cortisol as pregnancy advances, this extra feeling of being 'at risk' tips the balance with unfavourable implications for both mother and baby. [6],[7]. Chronic anxiety in pregnancy can increase the chance of hypertension, pre-eclampsia and premature birth;[8] conversely, pregnancy may even become extended, with the body holding onto the baby until the situation feels safer.[9] In labour, if the mother feels 'at risk', her body

may slow or stall labour to give her time to find a place of safety before the baby is born.[10] Not only is this internalised anxiety upsetting and unpleasant for the mother; there is also growing evidence that even milder forms of maternal stress or anxiety during pregnancy affect the fetus causing possible long-term consequences for infant and child development.[11]

Believing the words: In addition to the effect on hormone levels, the belief that a label of 'high risk' means we are in increased danger informs our attitudes and subsequently, our actions.



circular flow chart – thoughts and beliefs, attitude, actions and outcomes[12]

When people with the label of 'high risk' approach the AIMS helpline asking for information about their options, we usually suggest that they ask the labeller (the midwife or doctor) to quantify their chance of the risk manifesting when compared with a person labelled as 'low risk'. It is usually much smaller than suggested by the label.

> Think of two bags of sweets. One (the 'low risk' bag A) contains 999 green sweets and 1 red sweet, the other (the 'high risk' bag B) contains 998 green sweets and 2 red sweets. It is accurate to say that the chance of selecting a red sweet from bag B is double that of bag A – the risk has risen by 100% – and yet the actual chance of picking a red sweet from bag B is very low indeed, and little different from the chance of picking one from bag A. Of course, all other things being equal, if you definitely want to avoid the risk of a red sweet, bag A is the one to choose, but things aren't equal. If you know that the bags are handled differently and many more green sweets in bag A will get cracked or crushed compared to the number in bag B, then this may sway your beliefs, attitudes and actions.

Let's think of this in terms of two women of 40, Rose and Mary, both considering a home or midwife-led unit birth. Rose is told that these options are not advised as she is at 'high risk' of stillbirth at her age. That sounds alarming. She believes her midwife (BELIEF), doesn't feel there is any point in expecting a normal birth (ATTITUDE), and books into the consultant unit (ACTION), immediately doubling her chance of major interventions[13] [14] (OUTCOMES). No one has told her about the risks associated with hospital birth and so she assumes that the complex birth she experiences is a result of her age. Thank goodness she was in hospital.

Mary is also told that these options are not advised as she is at 'high risk' of stillbirth at her age. That sounds alarming but she can't quite believe it (BELIEF). Mary has a questioning attitude. She knows that life is not without risk, but she is healthier than many younger women – the word 'high' doesn't ring true (ATTITUDE). She researches the numbers (ACTION) and finds that in 2019 the perinatal death rate for babies of mothers over 40 was about 6.5 in every 1000 births, compared with about 5.2 per 1000 births for those of mothers aged 35 to 39, so that's an additional 1.3 per 1000 (0.13%). These are figures for the total population and take no account of the fact that the risk for an individual mother is likely to be affected by things like health, lifestyle factors and socio-economic status. Not all people aged over 40 are the same. She also finds that only about 8% of these deaths occur during labour. This means that there is roughly a 0.52 in 1000 chance of her baby dying during the birth compared with 0.42 in 1000 for a younger friend who has been told she is 'low risk'. Mary empathises with her friend Rose's decision to have her baby in hospital, but she personally aspires to a birth with minimal intervention and so, on balance, she opts for a homebirth knowing that this is likely to reduce the overall chance of experiencing birth trauma – of being cracked or crushed. That (OUTCOME) matters to her too. Rose's belief that 'high risk' actually means bag B is loaded with the dangerous red sweets, changes the actions taken in a way that increases the chance of a traumatic experience of birth – and the label becomes a self-fulfilling prophecy.

Treating the label: The label of 'high risk' also affects the actions taken by the midwife or doctor and is another way that it reinforces the self-fulfilling prophecy. Many doctors and midwives simply believe the label and act accordingly. When asked to quantify the actual risk, and especially the actual risk for a given individual, they will often be stumped.

They may not know that it is often very low. Their attitude is likely to be to stick with the protocol as, working within a culture of litigation, this feels safer to them. When women challenge the protocol, the talk about risk will often crank up in a desperate bid to gain the woman's compliance, and their fear becomes palpable. This is poignantly described by Helen Ward Leese in her personal account of birth. When maternal 'consent' is gained by saying to the mother, 'Do as we say or your baby is in danger' it is not consent, it is a hostage situation.

Pointing the bone: Considering the harm caused by being labelled 'high-risk' put me in mind of the ultimate example of this, the (almost but not quite extinct) Aboriginal practice of Kurdaitcha or pointing the bone.[15] This is a practice whereby an elder or elders from the group sentence someone to death simply by uttering a few words and by pointing a special carved bone in the direction of the victim. The condemned, then free to go but believing the power of the curse with every fibre of their body, dies within days or weeks. It is the deeply embedded cultural belief, in the face of the curse, that changes the person's physiological functioning and behaviour in a way that ensures it comes true. In Australia 'to point the bone' has come to mean: to predict someone's or something's ruin, downfall, or failure, or to cast blame or aspersions on someone.[16] This is exactly what happens when our cultural elders (midwives and doctors that people believe) tell a woman that she is at high-risk of bad things happening because she is too fat or too old or has not gone into labour yet.

So, my plea to midwives, doctors and policy-makers who wish to 'do no harm':

- Abandon the use of the word risk all together, and especially the label of high-risk. If necessary, talk instead about there appearing to be 'a slightly higher chance'.
- Be ready with the numbers to quantify any slightly higher chance of an undesired outcome when compared to someone without the issue of concern, for example you might say, 'the chance of this happening for someone of your age is about 2 in 1000 compared with 1 in 1000 for a younger person, but you are very healthy and so the difference for you may be even smaller.' Be clear whether there is evidence that a proposed course of action actually lowers that chance.
- Use your natural compassion and empathy (as well as respecting your legal duty) in offering all options without undue pressure or coercion to accept one in particular. Respect and support the pregnant person's decision. Consent has not been lawfully gained unless this has happened.
- Develop self-awareness of your own fear and of your use of 'shroud-waving'[17] to gain compliance. When you notice this happening, reflect on it with your supervisor.
- When the pregnant person has a complexity of factors that may increase the chance of an undesired outcome, prioritise continuity of carer, listen extra well, keep all options open, and respect and support her decisions. Safety for everyone lies in the genuine relationship of trust and respect that you build together.

The theme of this issue of the AIMS journal is obstetric violence. This is the term used today to describe what happens to people, during their experience of maternity care, that leaves them feeling traumatised – when what happened was avoidable.

We open with an article by Gemma McKenzie who explains the term in greater detail. In particular she shows how much of what women experience as violence is so deeply embedded within the accepted structure of care, that midwives and doctors simply cannot see it at the time – and yet it leaves its scars nevertheless. This is movingly illustrated by Helen Ward Leese's personal account. It makes for a chilling read but one that could usefully be part of the training of anyone charged with the care of a woman in labour. And moving to much earlier in the conditioning of our cultural attitudes, Beth Whitehead addresses 'body-shaming' and the way that this impacts the experience of pregnancy and birth, putting forward a very strong challenge to the use of BMI measurements in decision-making.

Obstetric violence and the law is discussed by legal experts Olivia Verity and Dr Camilla Pickles and midwifery lecturer Leigh Ham write about human rights in maternity

care. Echoing Gemma's reference to the BBC series, 'This is Going to Hurt', Heather Spain uses mention of the programme to launch into a passionate analysis of the harms done by the way that the media portrays birth and in particular by the way that the violence is normalised. Kelly Sawyer addresses one such 'normality' – the routine or even mandatory vaginal examination, that many women feel they have no choice but to accept. Kelly describes how her NHS Trust is running the Respectful Vaginal Examinations Project to improve practice and educate pregnant people about their rights; while activist Mara Ricoy tells the AIMS campaigns team about her inspiring international movement to tackle obstetric violence: The Roses Revolution.

The idea of normalised violence within maternity care is not a new one. Midwifery student Antonita Kirubanathan reflects on Frédérick Leboyer's 1974 still-revolutionary book *Birth Without Violence*, with his emphasis on the baby's experience. UK Resuscitation Council Newborn Life Support Instructor, Joanne Foster, talks about newborn life support, and how today this reflects a stronger and gentler understanding of the newborn's transition to life outside of the womb. The themed articles for this issue also include a very hopeful account, from Julia Adams and Pat Ballantyne, of the evidence for Emotional Freedom Technique 'tapping' (EFT) as a fast, gentle and successful treatment for those people who have been left feeling traumatised by their maternity care experience.

Moving on from the themed content, we have three book reviews: Anne Glover looks at Sallyanne Beresford's interesting and informative book Labour of Love, aimed at birth partners; Keren Williams reviews Laura Godfrey-Isaacs and Samantha McGowan's interactive book Maternal Journal: A creative guide to journaling through pregnancy, birth and beyond; and Sue Boughton reviews Penny Simpkin's The Birth Partner and concludes that it is a book justifiably on its 5th edition.

Following the recent Ockenden Report, Cyril Chantler – deputy chair of NHS–England's Maternity Transformation Programme's Stakeholder Council – offers his immediate reflections highlighting the broader context of ongoing maternity transformation in England. Continuing to push for continuity of carer, AIMS Volunteer Georgia Clancy reports on researchers at King's College London who have been exploring the implementation of continuity since the Better Births report. In one article, The AIMS Campaigns Team give us an insight into their priorities for 2022-2023; in another they summarise why continuity of carer is so important and how team members have been working with others to support its implementation.; and in a third they introduce their new series of position papers explaining why they have produced them and how they hope they will be of use. Last but not least, The AIMS Campaigns Team let us know what they have been writing, reading, viewing and doing in their vital work.

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Article

Obstetric Violence – What is it?

by Gemma McKenzie

It feels as if violence against women is everywhere. Whenever I turn on my TV, I feel bombarded with the many and varied ways in which women and their bodies are abused and violated. Whether it appears in a news broadcast, on a Netflix crime docuseries or in the form of comedy, I often find myself shuddering at the cruelties experienced by women in our society.

One recent show depicting violence against women has caught my attention: The BBC's *This is Going to Hurt*. It is based on a true story about a former obstetrician, Adam Kay, and the traumas he experienced whilst working for the NHS in the early noughties. In one scene a labouring woman is racist towards a member of staff; as a form of punishment, Adam unnecessarily cuts through the woman's tattoo during caesarean surgery and seemingly with intention, sutures her in a way that the tattoo image becomes distorted. As a result, one of his midwifery colleagues, Tracey, reports him to the General Medical Council. During a confrontation between Adam and Tracey, she states:

> *You assaulted your patient. That's what it is if you cut someone's tattoo.*
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She lists the various unethical acts Adam has carried out and continues:

> *It's pride. It's dishonesty. It's arrogance and it's entitlement. You think that you are the cleverest person in the room. And that makes you dangerous.*

Although the term is not used in the show, Tracey is effectively calling Adam out for acts of obstetric violence. Regardless of his disgust at the woman's racist attitude, Adam – an obstetrician – physically assaults someone who trusts him and who he is meant to be caring for. He abuses the power dynamics and takes advantage of the pregnant woman's vulnerability. Irrespective of the woman's views, he has no right to physically assault her. This is a particular form of cruelty and another insidious example of violence against women.

The point of this anecdote and short article is to explore the term obstetric violence and to highlight that this type of abuse does not have to be as overt as what is seen in *This is Going to Hurt*. In fact, obstetric violence is often not as obvious as the scene in this show. Rather, it is typically more complex than this and frequently harder to pinpoint a specific person as a perpetrator.

What is Obstetric Violence?

'Obstetric violence' is a term that is gaining traction in both the UK and abroad. As alluded to above, it refers to instances when pregnant women or people have been subjected to abusive encounters with health care professionals, most typically during birth. However, the types of behaviour that could be considered obstetric violence remain unclear. There is no set list of acts, or even a settled definition. Throughout South America, for example, there are laws prohibiting this type of violence, yet each country has formulated its own description of what it is.

To add further confusion, obstetric violence is not a term used by everyone who is concerned with the phenomenon. For example, the World Health Organisation (WHO) employs the phrase "disrespect and abuse during facility-based childbirth." Other terms writers have used include 'mistreatment' and sometimes people have employed the more general umbrella phrase 'birth trauma.'

One of the clearest – although still not perfect – definition comes from WHO.[1] It prohibits:

> …outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilisation), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay. (p.1)

The United Nations Special Rapporteur [2] has also written a report on obstetric violence. It summarised a range of abuses, including the overuse of episiotomies (cutting of the perineum i.e. skin between the anus and the vulva) and caesarean sections, application of non-evidenced based procedures such as the Kristeller manoeuvre (pressing on the abdomen during childbirth), symphysiotomy (surgical widening of the pelvis during childbirth) and forced abortions and sterilisations (pp.7-12).

The type of abuse these organisations describe is overt. They reflect what we might typically understand as violence – acts which create direct harm. These are similar to the tattoo example in *This is Going to Hurt*; the health carer physically or verbally abuses the person in their care.

Yet the 'violence' in obstetric violence does not only include wilful, overt and direct cruelty. It does not solely mean that staff must want to hurt pregnant women and people vindictively and intentionally. Obstetric violence also includes structural violence that is normalised within maternity services. In some cases, it can even be carried out unintentionally, leaving the health carer oblivious to the harm they have caused.

Normalised, structural and unintentional obstetric violence

I recently watched a Panorama documentary entitled A Cow's Life: The True Cost of Milk. It explored the treatment of dairy cows in the UK. There was a scene in which a hoist was used to lift up a "stricken" cow by its hips. As the farm worker used the equipment, the cow was raised completely into the air, its face and front hoofs dragging across the concrete floor. It was dragged this way until the farm worker was satisfied that it had been moved to an appropriate place.

For me, this undercover footage was disturbing. An academic and a lawyer on the documentary were clearly appalled by the incident. Yet what was interesting, is that a farm vet who was also interviewed appeared nonplussed. He described it as "fairly common practice". In his view, the animal needed to be moved and even though he conceded there was "potential for damage," this was short term pain for the benefit of being moved to a "nicer" area.

This is a good example of a professional who has become desensitised to abuse. So frequently does he see these incidents, that they no longer strike him as problematic. Such scenes have become a normal part of his everyday role, whilst outsiders, unused to such acts, feel dismayed and shocked. In essence, the violence has become normalised and the professional no longer sees the abuse attached to his or her act. This is exactly what is meant when people suggest midwives and obstetricians may carry out acts of obstetric violence and yet not understand that their behaviour is problematic.

In essence, the violence has become normalised and the professional no longer sees the abuse attached to his or her act.

Health carers may also not recognise obstetric violence if it is structural in nature. Sometimes, in these cases, a midwife or doctor may not be directly responsible for the abuse. Take for example the expectation that pregnant women and people birth on their backs. Research shows that this can make birthing more difficult. [3] Of course, there is plenty of good practice within the NHS where health carers will actively encourage a person in labour to move around and find a comfortable position. However, if a hospital room contains a bed at its centre and no alternative space for adopting different positions, a pregnant woman or person is left with little choice but to give birth on that bed. Whilst a person could theoretically kneel on the mattress to birth, the emphasis of a bed in the room certainly privileges – or even promotes – the idea of laying down or reclining during birth. The lay out of the room can therefore channel people into adopting positions that make their labours and their births more difficult. The additional pain and birthing difficulties become the violence. The room layout is the structural problem and the frequency at which people birth on their backs in such circumstances is what has normalised this abusive situation.

A further example of structural, normalised and unintentional obstetric violence is the requirement for a person in labour to be at a certain level of cervical dilation before they are either admitted to hospital or can be moved to the delivery suite. The typical way of determining how dilated a person's cervix is, is by a midwife carrying out a vaginal examination. This is an intimate procedure that a pregnant woman or person may wish to decline, as is their right; but equally they might feel compelled to undergo it so that they can satisfy the requirements of the maternity ward. Being channelled into submitting to an invasive vaginal examination for this reason does not constitute informed consent and is therefore unethical. In essence, in this situation vaginal examinations have been normalised and midwives and doctors become complicit in acts of obstetric violence – even when they believe they are providing appropriate care.

Challenging obstetric violence

It is often difficult for pregnant women and people to challenge obstetric violence. Not everyone subjected to the acts described above will immediately recognise their experiences as a form of abuse. For example, some people may wrongly believe they have to endure all medical interventions proposed by their health carers and that they are not allowed to say 'no' or 'stop'. In other cases, people may not have the confidence, ability or even opportunity to challenge a midwife or doctor. They may feel afraid or confused as to what they have experienced, unsure as to whether they are overreacting or have misunderstood what was happening. This may be compounded by the fact that most people will only give birth a small number of times. Typically, therefore, they will not have much experience of the maternity system. Consequently, some of the best people to challenge obstetric violence and to advocate for pregnant women and people are healthcare professionals.

The role of health carers in challenging obstetric violence

There is a book available online by the midwife Sarah Stone who practised in rural Georgian Somerset. It was written in 1737 and is entitled A Complete Practice of Midwifery. At

the time, midwifery was not an official profession. Instead, childbirth was very much an informal female event in which women gave birth at home surrounded and supported by other women. During this era however, men began to get involved in childbirth. Stone witnessed the rise of men–midwives whom she argued overused medical instruments in ways that could be damaging to both mothers and babies. In one passage she noted that this overuse had resulted in "infants being born alive with their Brains working out of their Heads" (xiii).

The point of this is to highlight that there is a long history of health carers calling out the abuse of pregnant women and their babies. In eighteenth-century England, a woman like Sarah Stone would not have enjoyed many rights. Yet she used her small platform to challenge abusive practices she witnessed in her own work environment. It must not have been easy to do so, and likely Stone was taking considerable risk when she published her opinions.

As Tracey discovered in *This is Going to Hurt,* it is always difficult to call out any form of unprofessional behaviour, especially of colleagues. However, obstetric violence will continue to poison the maternity system unless midwives and doctors practice ethically, actively resist structural forms of obstetric violence and challenge any bad practice they witness. It is hugely problematic if health carers do not understand how abusive practices can become normalised. Short of being subjected to a medical negligence claim, this awareness can only materialise if it is pointed out – and professional colleagues and peers are the obvious people to do this.

Concluding thoughts

I wanted to hate *This is Going to Hurt*. But the truth is that I didn't. Yes, the show provided more examples of violence against women to a viewing audience that are no doubt saturated by scenes of abuse. However, it also highlighted what AIMS has been campaigning about for 60 years – namely, that there need to be improvements in the maternity services. Obstetric violence will thrive when abusers go unchecked. It will perpetuate when structures channel midwives and doctors into becoming complicit in the abuse. Importantly, health carers have been challenging abusive practices for centuries and the requirement for them to continue to do so remains as pressing as ever.

Author Bio: Gemma McKenzie is currently completing her PhD at King's College London. Her research explores the experiences of women who freebirth in the UK. You can find out more about the study at www.gemmamckenzie.co.uk and follow her on @Childbirth_UK

Information for pregnant women and people

It is a sad indictment of NHS maternity services if pregnant women and people need to prepare ways to try to avoid being subjected to obstetric violence. However, the reality is that whilst there are excellent levels of NHS care in Trusts throughout the UK, obstetric violence does exist. One way to pursue a respectful birth is for pregnant women and people to empower themselves with knowledge of their rights. AIMS has various publications that can help with this, and these are listed here:

AIMS Guide to Giving Birth to Your Baby
AIMS Guide to Resolution After Birth
Making Decisions About Your Care
AIMS Position Paper on Obstetric Violence
AIMS Position Paper on Decision Making in Maternity

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Article

Human rights in UK maternity services: moving from observation to action

by Leigh Ham

Human rights in maternity care is not a new concept. The Code (Nursing and Midwifery Council, 2018) states that the dignity, respect and human rights of all individuals should be upheld and, therefore, the human rights of those in our care should be central to everything that we do. [1] However, the growing body of evidence regarding the disrespect and abuse experienced during pregnancy and childbirth makes it an issue of global concern that demands acknowledgement, (World Health Organization (WHO), 2015).[2] It has been found that women worldwide, especially in areas of economic deprivation and developing countries, are being neglected, discriminated against, humiliated and exposed to both verbal and physical abuse. [3]

Human rights are also being violated closer to home, in developed countries such as the United Kingdom, United States and Australia. It can be argued that the abuse is more subtle and nuanced here, with women reporting coercion, lack of autonomy, being intimidated, and obstetric violence. [4],[5] In the United Kingdom, with its social preference towards institutionalised birth, women may find themselves within a stretched healthcare system, navigating medical paternalism that demands they 'act' in a certain way in order to conform to what is expected from 'a good mother'.[6] The result of this is that many may not even be aware that their rights are being violated. Unfortunately, society and culture often reinforces this. An example of this is seen in the representations of birth in the media, where women's rights, including their right to give full, informed consent without coercion, are largely ignored, thus compounding the problem. [7][8]

My personal experience as a midwife and midwifery lecturer suggests that human rights in childbirth are not consistently upheld or discussed. I have witnessed numerous and wide ranging breaches and failings in my fourteen years as a qualified midwife. As a midwifery lecturer, I have listened to the accounts of student midwives' experiences during clinical placement where it was felt that human rights have been overlooked. In my teaching role, I have been afforded the opportunity to take a step back from clinical practice and truly reflect on my experiences, views and knowledge about this subject. Whilst it is a painful truth, I must acknowledge that there may have been instances where I have not fully considered the human rights of those within my care, even if I did not realise this at the time. I have always viewed myself as a 'good' midwife who is competent, kind and empowers others but, out of the clinical setting, I can reflect on being part of a culture where rights are sometimes neglected. AIMS' Position Paper on Obstetric Violence[9] brings this issue to the fore by acknowledging that many clinical staff may not be aware that their ingrained culture and day to day practices may be causing harm. They also recognise that staff need ongoing education, awareness and support, to take responsibility for and reflect on their practice, and to learn from past mistakes.

My experiences and understanding of this important subject have motivated me to focus on this topic as a postgraduate student. My research, a constructivist grounded theory study, will examine midwives' understanding of human rights in childbirth in different settings. My objectives are to explore midwives' perspective on their own role in regard to human rights, whether they believe human rights are respected in childbirth and how the environment in which they work promotes or obstructs their ability to uphold human rights. I believe that the reasons for mistreatment, much like midwives' understanding of human rights, are varied and complex. Understanding how midwives may balance the professional dissonance between the values and philosophy

of the profession, and the factors which lead them to fail to challenge a lack of respect of fundamental human rights and dignity, is crucial if these issues are to be addressed. Phase one of my research is complete, with the completion of an online survey by midwives across the UK and Ireland; themes from this data will be used to inform semi-structured interviews. I believe that this research has the potential to contribute to midwifery knowledge and positively impact future care and services. Using my grounded theory, I hope to design and deliver an educational programme that will challenge and inform maternity staff. I also hope that it will influence midwifery education by helping to inform teaching around human rights issues and providing a context for students to understand their future colleagues' understanding and implementation of human rights.

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Author Bio: Leigh Ham is a Midwifery Lecturer at Swansea University who is undertaking her own postgraduate research into midwives' understanding of human rights in childbirth.

END NOTES

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Article

Newborn resuscitation without violence

by Joanne Foster - a UK Resuscitation Council Newborn Life Support Instructor

Being approached to write an article on newborn resuscitation without violence has offered me the opportunity for some quiet contemplation and reflection, both as a mother and midwife. Firstly, my experiences of my own children's births are rejoiceful. I met both my babies when the midwife placed them skin to skin into my arms as they transitioned to extrauterine life [1]. My own mother's experience of my birth was very different; this occurred immediately post Peel Report.[2] The report recommended 100% hospital births on the basis of safety, removing the choice of place of birth for women. It wasn't until Tew challenged the recommendations from this report [3]that it was concluded that the recommendations were not based on any robust evidence.

As such, my birth was planned at the local hospital. My father worked night duty, so my mother stayed with my grandparents and my auntie at the family home when he was on shift. I was the second child and, in true second time fashion, didn't give my family much time to prepare for my arrival. In the early hours of the morning my mother started with her first labour pains. My grandfather and auntie took the perilous walk on icy footpaths to call the ambulance from the local phone box. My mother arrived at the hospital at the end of the night shift to an even more frosty reception by the midwife in charge. The student midwife was summoned to attend to my mother with the prerequisite shave and enema [4] as was the practice at the time. My mother explained she didn't need the enema as her own body had purged, as is nature's way. The student, fearful of the reprisals, gave my mother an enema anyway. Moments later as my mother sat on the toilet with enema fluids running from her, she could feel my head descending. This prompted the swift return of the senior midwife who catapulted my mother onto the birthing bed just in time for my arrival. Both my mother and I were rather stunned and as such there was some delay in my response, no crying – not surprising given I was almost born into the toilet. My mother's first memory of my arrival was watching the midwife slapping my buttocks hard to elicit what my mother describes as my full-blown bawling. Unfortunately, my mother's experience is not an isolated case, many newborns have faced a similar if not more extreme arrival into the world, and in 1974 Leboyer offered a perceptive insight into the potential feelings of a newborn baby.[5]

My mother's first memory of my arrival was watching the midwife slapping my buttocks hard to elicit what my mother describes as my full-blown bawling.

As a midwife, I can without a doubt state that the first breath taken by a newborn touches all those who are privileged to be in attendance. But what if the baby doesn't breathe and needs support? Midwives are usually the professional making the initial assessment; this responsibility remains one of the most daunting aspects of our roles.[6] Dr Hey and Professor Kenneth Cross's 1980s research into birth asphyxia[7] and temperature control forms an intrinsic part of our current approach to care. They acknowledged the need for supportive literature to help healthcare professionals develop their newborn resuscitation practices. The Resuscitation Council UK set up a working group chaired by the late Dr Sam Richmond who developed the first three NLS (newborn life support) manuals. Sam was also Chair of the NLS international courses and The European Resuscitation Council.[8] Professor Jonathan Wyllie is our current Vice-President, and Joe Fawke our Chair, and we are now on the fifth edition of the NLS manual.[9] The Resuscitation Council UK guidelines are adapted from

the European Resuscitation Council guidelines and have been developed using a process accredited by the National Institute for Health and Care Excellence to reflect the needs of the National Health Service.

I have been fortunate to practice with some exceptional healthcare professionals and trained early in my career as an NLS Instructor. My confidence in NLS grew along with my ability to advocate for women and their newborns regarding their birth choices. Evidence based NLS guidelines are now a mandatory aspect of our training, also openly available for anyone to access on the website.[10] NLS training remains one of the most rewarding aspects of my role as a midwifery educator and I would like to think I have made a difference for those who have been in receipt of that knowledge – professional and parent.

The NLS training course is run largely by nurses, doctors and midwives who are trained as NLS Instructors, often running the full day course in their own time.[11] It is recommended that those regularly attending births undertake the course every four years, with local annual training in between. Over the 50 years since my own birth there has been a shift in the approach to newborn resuscitation, with a more contemporary focus on supporting the transition to extrauterine life. The language we use has been strengthened with the term resuscitation now being used loosely in favour of the more accurate references to assisted transition at birth.[12] It is accepted that some newborns will need additional support at this time and, as such, the safest resources, including escalation to appropriately trained healthcare professionals and specialist service provision, should be available.

Reassuringly, 85% of babies who are born at or close to their due date will initiate spontaneous breathing within 10-30 seconds of birth.In addition, another 10% will respond through drying or gentle stimulation.

Reassuringly, 85% of babies who are born at or close to their due date will initiate spontaneous breathing within 10-30 seconds of birth.[13] In addition, another 10% will respond through drying or gentle stimulation.[9] Madar *et al* indicate that approximately 5% will require the support of a healthcare professional breathing for the baby;[12] 1% requiring significant resuscitation with chest compressions[13] and medication. [10],[14] Interestingly Mann et al conclude that although there are many areas of good evidence-based practice with hospital-based resuscitation, there is a marked variation in management requiring a continuation of training and guideline review. [15]

Speaking to parents before their births about their expectations is essential, and although it is not possible to predict the need to resuscitate a newborn, there should be a discussion to identify any potential concerns. NLS training includes assessing breathing, muscle tone (being whether the baby seems floppy), heart rate, and the colour of skin and of the mucous membranes to assess how well oxygenated the newborn is.[16] Current NLS guidelines include recommendations regarding umbilical cord clamping. Research into delaying cord clamping has largely focused on preterm newborns,[17] however, babies who are born on or around their due date should have cord clamping delayed for at least 60 seconds, ideally until they are breathing.[9] When this is not possible, milking the cord [18] should be considered, although this practice is not recommended for babies who are born less than 28 weeks.[9] When delaying cord clamping is not possible, in that the newborn needs to be transferred to appropriate equipment to be resuscitated, NLS guidance recommends that the umbilical cord is clamped and cut.[9] Interestingly, some maternity care settings are taking essential steps to fund bedside resuscitation equipment, so the cord can remain intact if resuscitation is required. This should be the drive for all maternity settings to ensure there is equitable, evidenced based service provision and care for all newborns.

Keeping the newborn warm is also imperative; their small size alongside being born wet means they are prone to cooling. It is important to ask the mother if she wishes to have the baby placed directly onto her skin at birth. During the initial assessment, the newborn should be quickly but carefully dried, with wet towels being removed and replaced with warmed, dry ones to cover the newborn and mother. Connolly (2010)[19] explains that some heat loss is inevitable and results in the newborn using unnecessary

glucose and oxygen. However, being skin to skin with the mother is thought to stabilise the cardio-respiratory system [20], increase glucose levels and support thermoregulation [21], [22]. Once the newborn has initiated spontaneous respiration, continued skin to skin contact helps to maintain this physiological stability and support a successful first breastfeed. If further assistance is required, the newborn should be placed under radiant heat to prevent further heat loss;[9] ideally using a bedside resuscitaire.[23]

Some maternity units advocate the routine use of a hat to prevent heat loss through evaporation, however, there is no robust evidence base to support this during skin to skin contact with a healthy newborn; it should be the choice of the parents.

Midwives are present at every type of birth, from complex, emergency childbirth to those in low technology birthing environments; this affords us a unique opportunity to develop a broad range of experience, which in turn strengthens confidence and understanding in making our assessment to determine how we support those newborns in our care.

At times, I have observed professionals being too hasty in intervening with normal transition to extrauterine life. This can leave parents feeling anxious and less than satisfied with how they meet their newborn, and Leboyer also calls into question the feelings of the newborn.[5] This haste can unfortunately be down to a lack of confidence and understanding in making the initial assessment.[6] However, newborn resuscitation is an emergency and as such healthcare professionals carry the responsibility for ensuring the newborn is safe. Midwives are present at every type of birth, from complex, emergency childbirth to those in low technology birthing environments; this affords us a unique opportunity to develop a broad range of experience, which in turn strengthens confidence and understanding in making our assessment to determine how we support those newborns in our care. In my experience, babies who are born in quiet, calm environments such as a birthing pool with low lighting, are much quieter at birth. A Cochrane review of water immersion during labour and birth concluded that this is not associated with any difference in newborn outcomes.[24] Experience, knowledge and understanding of fetal adaptation to extrauterine life in these circumstances is vital in either supporting transition or initiating resuscitation.

The clear recall of my mother and myself looking back to our birth experiences is testament to the fact that parents never forget the arrival of their babies. Most newborns spontaneously transition to extrauterine life unaided, but for those who need support with this transition or resuscitation, health care professionals in every birth setting should be appropriately trained and should take responsibility for keeping up-to-date with the latest guidelines. Leboyer also reminds us about the feelings of the newborn, who may remember their birth experience. I can honestly say I don't remember my own birth, however maybe that is why I am so passionate about newborn transition and resuscitation being delivered with compassion and respect for both mother and baby.

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Author Bio: Jo graduated as a Registered General Nurse in 1994 and then completed a BSc in Midwifery in 1999. Jo practised in a range of clinical midwifery roles and her passion for intrapartum care ultimately led her to practice in a leadership role as a Labour Suite Coordinator. Jo's Masters research was in Preceptorship and she is currently an Assistant Professor and Module Convenor for both undergraduate and postgraduate courses at the University of Nottingham. Jo trained as a UK Resuscitation Council Newborn Life Support Instructor in 2011 and remains an active instructor.

Jo Foster RGN RM BSc MSc PGCHE NMC Midwife Teacher FHEA
Assistant Professor in Midwifery, University of Nottingham
Email: ntzjmf@exmail.nottingham.ac.uk

END NOTES

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[4] Editor's note: A shave and enema refers to the former practice of removing the woman in labour's pubic hair and then giving her an emema.
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[11] Editor's note: AIMS applauds the passion and dedication reflected in this, but at the same time, wonders why this generosity is necessary.

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[13] Editor's note: Chest compressions refer to a resuscitation procedure given if the baby's heartbeat is very weak or absent at birth. The midwife or doctor applies repeated finger pressure compressions to the baby's chest.

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[16] Editor's note: This is often referred to as the APGAR test after Dr Virginia Apgar who developed it in 1952.

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[18] Editor's note: Umbilical cord milking is a procedure in which the umbilical cord is grasped, and blood in the cord is pushed two to four times towards the newborn, usually within 20 seconds.

[19] Connolly G. Resuscitation of the Newborn, in Boxwell, G. (Ed.). (2010). Neonatal Intensive Care Nursing (2nd ed.). Routledge. Chapter 4, pages 65-86 – https://www.taylorfrancis.com/books/edit/10.4324/9780203857076/neonatal-intensive-care-nursing-glenys-boxwell.

[20] Editor's note: The cardio-respiratory system refers to the working of the baby's heart and lungs.

[21] Editor's note: Thermoregulation is a mechanism by which we maintain body temperature

[22] Moore ER, Bergman N, Anderson GC, Medley N. Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database Syst Rev. 2016 https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003519.pub4/full.

[23] Editor's note: A resuscitaire is a workstation that includes everything that might be needed to resuscitate a baby. A bedside resuscitaire can be moved to the mother's bedside enabling resuscitation to take place without the need to clamp and cut the baby's cord.

[24] Cluett E.R., Burns E. and Cuthbert A. (2009) Immersion in water in labour and birth (Review). Cochrane Database of Systematic Reviews Issue. John Wiley & Sons.

Article

Guilty

by Helen Ward Leese

Helen with baby Amara

A theme I've noticed since giving birth myself, and surrounding myself with other mothers, is 'guilt'. So many births (including my own) don't go to plan, and there are so many contributing factors in this – but what do so many new mums feel?
Guilt.

I am now 9 months postpartum, my daughter is thriving, but I haven't yet managed to move on from how my birthing experience played out.

To step back and contextualise; I knew what type of birth I wanted and I didn't get it.

Not even close.

I had had a low risk pregnancy, and for all intents and purposes, there was no reason why I shouldn't have a low risk labour. I had arranged to give birth at a local NHS birthing centre, and although I absolutely recognise that labour can go down many paths; I had not, in any way, anticipated what actually did happen.

I had for many years been warned about 'the system' over-medicalising birth (treating us like we are an unwell patient, as opposed to a person doing the most natural thing on the planet), and I took NCT and hypnobirthing classes to make sure I was as informed as possible, enabling me to make the best decisions for myself and my baby. I was prepared for all eventualities (or so I thought) and I felt truly calm and collected when I thought about going into labour.

I loved the idea that the birthing centre was midwife-led, that they encourage you to listen to your instincts, that you can give birth in a birthing pool (should you choose to), and you might even say I was 'looking forward' to the experience!

When my waters broke, in bed at 3.00am, I calmly woke my husband and told him I was in labour. I spent the first 12 hours of my labour in my home. Just me, my husband, and bump.

Were the contractions agony? Absolutely. I won't pretend it didn't hurt. But did I feel calm, in control, prepared, ready? – Yes.

My husband rubbed my back, kept me hydrated and helped me with my breathing exercises. My labour progressed exactly as expected and my contractions became more and more frequent.

Once it was time to head to the birthing centre, my husband called to let them know we were on the way (having also informed them when I went into labour 12 hours before).

"Oh sorry, we are understaffed so the birthing centre has closed. She'll have to give birth in the hospital next door."

I tried to stay calm. It wasn't my plan, but I knew the worst thing for myself and my baby was for me to panic.

We headed to the labour ward at the hospital, and that's where everything changed.

There was no room for me, bright lights, loud noises, no doctor available to see me, no midwives free to help, nowhere for me to go.

We sat in a corridor whilst my contractions got worse, with my husband asking if there was somewhere we could go to give birth. Eventually we were put into a holding room; "Just stay in here for a while until we can find somewhere for you to go."

My contractions slowed.

I had learnt what this meant and I knew that my rising panic (and the hormones that said panic releases) was going to halt the labour process. I was in agony, but I could feel she had stopped coming down.

I worked on my breathing, but I could already feel myself losing control of my birth, and I was worried.

Eventually they found us a room. Doctors and nurses immediately put me onto my back, with my legs in stirrups, to examine me internally. I told them "I don't mind being examined now, but if we can keep them to a minimum that would be good, and I really don't want to push lying on my back." I was told that they'll 'need' to examine me multiple times throughout the push process to check on the baby, and a heart monitor was quickly strapped around my stomach.

To cut a long (33 hour labour) story short – I was stuck in that room, fighting to have some control, for over 10 hours.

I was continuously flipped onto my back by medical staff, examined internally during contractions, told I couldn't push whilst kneeling on all fours or standing ("we won't be able to check her heart in those positions and that's dangerous") and I felt truly violated.

My husband said firmly to the staff "she can't push on her back, why can't she push kneeling up, if that's what feels right?"

He was told that it was dangerous for his child if they couldn't hear her heart. What parent can argue with that? Of course, our daughter comes first. Of course, we will believe what we're told by the supposed experts.

And so of course – I complied.

Eventually, a surgeon came in and said I'd been in labour for 'too long' and that myself and my baby were 'getting tired' and she offered me a caesarean section. I refused.

(Of course I recognise this can be the right thing for some women. But it wasn't for me.)

The surgeon then explained to me that the safest thing for my baby was for her to pull her out with forceps. She said that the baby seemed 'a bit stuck' and it was best to cut into me (an episiotomy) and to pull my daughter out.

I conceded.

I was 30 hours into labour. I felt powerless. I felt defeated. I felt like I had let my baby down. And if I'm being blunt – I just wanted her out.

The forceps delivery was relatively quick. I had an epidural (having had no pain relief for the duration of labour so far) and they pulled her out. Even after she came out, I remained feeling out of control. They took her off to the other side of the room and I said "please give her to me!"

Eventually I held her on my chest and I sobbed.

I instantly loved her more than anything I had ever loved, but I couldn't help but feel overwhelmed with guilt.

This wasn't how it was supposed to happen.

I won't bore you with my current postpartum issues, but unfortunately my forcep delivery has done some serious damage. In addition to initial problems following the birth (including haemorrhaging and needing multiple blood transfusions), I had some long lasting damage to my internal organs that I am still receiving treatment for.

My daughter is happy and well, and I couldn't be more grateful for that.

Everyone tells you 'Well, at least your baby is healthy.' She is. I'm so lucky. And I wish that was enough to dissolve my feelings of pain and trauma, and of being violated… but it isn't.

At the moment those feelings are something I am still tackling every day.

So why is 'guilt' my primary emotion?

Well, I consented.

That's what I keep going over and over in my head.

I should have said no. I should have refused forceps. Maybe I should have had a home birth. I should have refused having so many examinations during labour.

I can't pretend I didn't say 'okay' to the 10th, 11th, 12th internal examination during my contractions. Because I did.

I struggle with the fact that I 'let things happen' in the way that they did.

But what I am now (after many months) able to recognise too; is that if you tell a vulnerable woman who's in agony, who's attempting to birth her baby safely, who's trying to navigate her labour in a completely unnatural birthing environment with doctors shouting at her, that she 'needs to do something for her baby' – she's going to do it.

And do you know what's shocking? – it turns out there was no actual risk to my baby. Or to me. Her heartbeat was fine. My body was fine. All of my birthing medical notes say it. And the use of forceps was 'precautionary.' Had my labour slowed down? – of course it had! Nature knows what it's doing, and it didn't think I was safe (I was giving birth in a busy corridor for goodness sake!).

But my baby was fine, and so was I.

What I needed was support in breathing right, support in pushing in the positions that felt right instinctively, support in staying calm.

What did I receive instead? They pulled her out as though that was my only option.

I want to be clear that I love the NHS. I LOVE that in theory we have a system that provides care for anyone who needs it. But I also see that severe underfunding (and thus, understaffing) is leaving us with an 'in and out' system for labour. Get the mother in, deliver the baby as swiftly as possible, discharge them and 'onto the next.'

(And of course, a system devised many years ago by men, for birthing women, is a factor too).

As it stands – I don't think we're getting it right. And recently meeting so many other mothers in similar positions has confirmed that.

For me, 9 months into my postpartum journey, I am still not healed. Mentally or physically. Despite being previously fit and healthy and having a low risk pregnancy, I am still suffering with a plethora of medical problems.

I also don't know if I could ever go through with having another child.

I recently received some trauma support from one of the team at AIMS, and the first thing she said after I sat sobbing, telling her about how I had failed in labour, how I had made stupid decisions that have left me with permanent damage, how guilty I feel about bringing my wonderful daughter into a panicked, stressful environment…

"I'm so sorry that happened to you. It's not your fault."

Author Bio: Following an accomplished career as a vocalist/performer (Helen Hart), Helen is about to return after maternity leave to being Head of Client Services with a company serving large charities. She's the oldest of 8 siblings in a blended family and was born at home.

Article

Birth Without Violence: a reflection

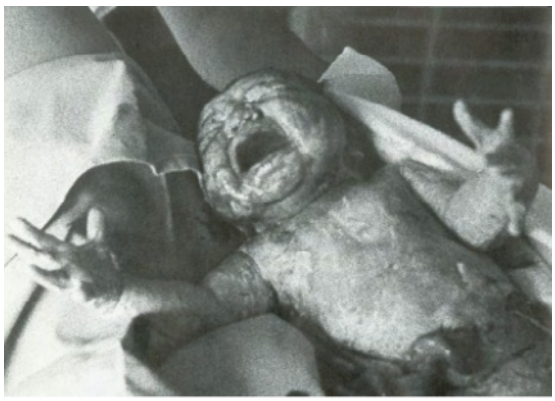
by Antonita Kirubanathan

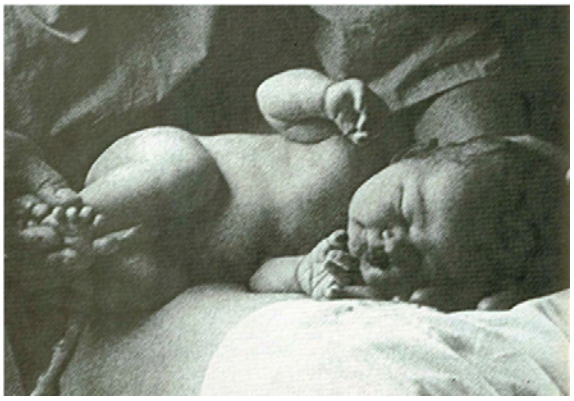
As a second–year midwifery student, the care we give is aimed at ensuring the birthing person has a positive birthing experience. Yet how much thought goes into a positive experience for the baby? Is this ever considered?? Frédérick Leboyer did consider the baby's experience in his book 'Birth without Violence' (1974); an interesting read that makes one question one's own thoughts and presumptions, possibly for the first time.

Leboyer's message was a profound one, a call for normality to be returned to midwifery practice, and to aid in the gentle physiological transition of the baby. Midwife means 'with woman', but who is with the baby? Who is advocating for this small person to have a memorable and pleasant birth experience? Why is it so easy for some of us to understand that animals can have feelings and preferences, yet think that a newborn baby cannot possibly have?

Midwives can often detect the differences in certain noises women make during labour, ears pricking up when they hear noises that have been made during first stage transition to noises present during second stage. Similarly, women can often differentiate between the cry of their own baby amongst the cries of several babies. Is there then a difference between a baby crying in terror and pain, and a baby crying to begin a transition to extrauterine life? Leboyer argues that the birth experience for the newborn, when highly medicalised, causes stress and ultimately terrorises the baby.

Leboyer invited us to consider the experience of the baby using beautiful prose and illustrating this with photographs that need no words.





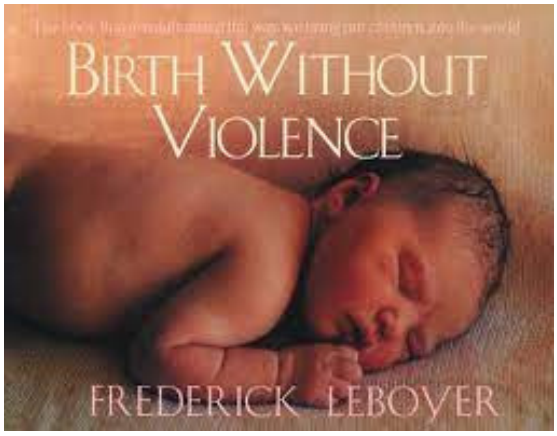
Images from: Leboyer, Frédérick. Birth Without Violence / Frederick Leboyer. New York: Knopf, 1976.

The book was written at a time where there was a shift in mindset from home being the typical place of birth to the hospital being the safest place for birth to occur. Highly medicalised births became the norm, with bright lights, enemas, regular episiotomies, immediate cord cutting, and newborn checks happening soon after birth. These aspects of midwifery practice were often unevidenced and are now considered 'bad practice'.

A stark difference to the practice we see today – or is it? Do we still use routine practices where there isn't sufficient evidence? The answer is yes and these actions will one day be considered as the 'bad practice' of our current time. Of course, it would be wrong to say that practices have remained static from when the book was written, however, it is not wrong or insensitive to say that there are a multitude of things that need to be addressed for midwifery to be what it was intended to be – the protection of women and babies from an experience of birth that leaves them either traumatised or feeling violated.

An emphasis is now placed on making birth an experience to be enjoyed and cherished, an experience to remember. Women are told they can make informed choices and are invited to make intricate birth plans. Sadly, and despite the rhetoric of choice, birth trauma is on the increase and is an experience to remember but for all the wrong reasons. Granted, there are times when medical assistance is unavoidable, and in those moments we rejoice for the life-saving procedures, but even then – especially then – there are a number of actions that can be undertaken as practitioners to make the situation more bearable and the care we give more compassionate for the mother and for her baby.

Leboyer, as a male obstetrician, wrote this book in a time when he might have been ridiculed for even having the thoughts he expressed. However, nothing can be achieved without going against the status quo. As such Leboyer was way ahead of his time, questioning non-evidence-based practice, making his book relevant for us still today.



Leboyer, Frédérick. Birth Without Violence.
ISBN 10: 0892815450
ISBN 13: 9780892815456
Publisher: Inner Traditions Bear and Company, 1995

Obstetric Violence: Where is the Law?

by Olivia Verity and Dr Camilla Pickles

Law is a powerful tool that shapes relationships, defines boundaries, and regulates interactions within our social structure. Importantly, as a society, we turn to law for legal remedies when we are wronged and our rights are violated. In this way, 'law and its language can be a critical frontier for feminist change'.[1] However, the power of law to do this important work is undermined when it fails to recognise specific harms, such as obstetric violence and its gender-based injuries. In what follows, we offer some reflections on law's failings in the context of obstetric violence, and encourage continued complaint and discussion to keep this form of violence visible. Consciousness-raising is vital, not only for empowering victim-survivors of obstetric violence by validating their experiences,[2] but also to ensure that the shortcomings of our legal system do not go unrecognised and, consequently, unremedied.

Obstetric violence is a form of gender-based violence, and, at its core, concerns the violation of women's integrity (physical and psychological) during the provision of maternity care,[3] with childbirth being a particularly vulnerable time for violence and abuse. It is rooted in women's gender inequality, as a product of a broader discriminatory failure to value and respect women, which makes it possible for healthcare institutions to violate them during pregnancy and birth. This is why obstetric violence is also a form of structural violence, with violent maternity care practices being systematically legitimated and normalised, such that women and society are often prevented from recognising violent birthing experiences for what they are – violence. The World Health Organization recognises that violence and abuse in childbirth is a violation of fundamental human rights, which causes profound and long-lasting harmful consequences for women and their families.[4] It is for this reason that we need the law to take a stand on obstetric violence as a specific form of gender-based violence.

Outside the United Kingdom, there is certainly an appreciation for the important role of law in this context. For instance, since 2007, several Latin American countries have included obstetric violence in laws dedicated to tackling gender-based violence, with some countries criminalising specific manifestations of obstetric violence.

> The passage of these laws is a good start, as they empower women and families to claim their rights to health care without discrimination.[5]

The importance of these laws is painstakingly clear in light of a recent case brought before the Committee on the Elimination of Discrimination against Women, *SFM v Spain*. In 2018, the Committee heard its first obstetric violence complaint against Spain, where the complainant had been subjected to numerous interventions without her informed consent, including several vaginal examinations and an episiotomy.[6] The complainant in this case was forced to approach the Committee for redress because she was unable to secure access to justice through the Spanish legal system. Here, the Committee recognised obstetric violence as a form of gender-based violence and confirmed that States are under an obligation, under international human rights law, to ensure access to remedies for violations of women's reproductive health rights during childbirth. Indeed, the United Nations Special Rapporteur on Violence Against Women published a report on obstetric violence and mistreatment, highlighting:

> 'States have an obligation to respect, protect and fulfil women's human rights, including the right to [the] highest standard attainable of physical and mental health during reproductive services and childbirth, free from mistreatment and gender-based violence, and to adopt appropriate laws and policies to combat and prevent such violence, to prosecute perpetrators and to provide reparations and compensation to victims'.[7]

The obligations highlighted by the UN Special Rapporteur reflect the position in the Convention on the Elimination of All Forms of Discrimination Against Women, an international human rights treaty of which the UK is a signatory. This means that the UK has formally committed itself to take measures to tackle violence against women. So, where do we stand in the United Kingdom? Unfortunately, the law is in a sorry state for victim-survivors of obstetric violence.

At present, no distinct provisions against obstetric violence exist in the UK legal system. This means that, in order to seek redress, victim-survivors must rely on pre-existing legal actions. Whilst avenues are technically available under civil law (such as the torts of negligence and battery) and criminal law (such as criminal battery, and other Non-fatal Offences Against the Person),[8] these actions are not designed to address obstetric violence as a specific form of gender-based violence. Consequently, reliance on these avenues exacerbates the difficulties victim-survivors may encounter when attempting to seek redress, and their lived experiences may be distorted as they are 'filter[ed] through a mesh of legal relevances'[9] specific to the relevant criminal or civil law action being brought. Notably, even if a victim-survivor is successful, redress against the harms and wrongs suffered will not necessarily follow if the objectives of the action do not align with her individual justice needs. For example, the primary mode of redress under civil law is the granting of compensation. However, monetary compensation may not provide meaningful redress for some victim-survivors of obstetric violence. For those who do seek compensation to meet their justice needs, meaningful redress nevertheless remains illusory, as courts are notorious for failing to recognise and compensate satisfactorily for 'gender-specific' harms.[10] Furthermore, reliance on these laws decontextualises obstetric violence as a form of gender-based and structural violence, instead, suggesting they are individual issues between women or birthing people and their healthcare providers.[11] Whilst this may not impact the outcome of a given case, it fails to ground the issue as part of women's human rights struggles, obscures the underlying causes of this violence, and sustains the lack of understanding surrounding the specific nature of obstetric violence and its consequences for victim-survivors.

For a long time, feminist lawyers have highlighted the law's failure to reflect women's experiences and its limitations in the context of gender-based harm. They have also stressed, however, the need to engage with law, 'because law is an important and unavoidable site of political struggle'.[12] In order to meaningfully provide redress and ultimately, to prevent obstetric violence, the law must be able to account for the complexity of the phenomenon, and it must speak to women's and birthing people's lived experiences. Given that our current legal frameworks struggle to accommodate for and fail to redress gendered experiences of violence and gender-based harms, the adoption of an obstetric violence framework in UK law is the only way to ensure this is achieved.

In conclusion, it is vital that victim-survivors are enabled to recognise their degrading and dehumanising experiences during labour and childbirth as obstetric violence. It is equally important, however, that they are able to seek meaningful redress through the law. Whilst actions may be available in some instances in UK law, they are ill-equipped to deal with this specific form of violence. This forces victim-survivors to rely on these actions despite their fundamental incapacity to reflect the nature of the issue and of the specific harms suffered. Additionally, it sends a harmful message about the validity of their experiences, their suffering, and fails to communicate the intolerability of violating women's bodies in the maternity care context with the fervour it warrants. However, through the sharing of lived experiences and collective condemnation of this violence, we generate empathic concern and demand attention to the issue, and with it, responsivity from the law. It certainly has a role to play.

Author Bios:

Olivia Verity is a MJur Candidate at Durham Law School. She is a co-editor of Durham CELLS Obstetric Violence Blog, and is currently researching unauthorised vaginal

examinations as obstetric violence.

Dr Camilla Pickles is an Assistant Professor of Biolaw at Durham Law School, Durham University. Her research is focused on women's rights during pregnancy and childbirth, with a particular focus on obstetric violence.

END NOTES

[1] Stephanie Palmer, 'Feminism and the Promise of Human Rights: Possibilities and Paradoxes' in Susan James and Stephanie Palmer (eds) *Visible Women: Essays on Feminist Legal Theory and Political Philosophy* (Hart 2002) 115.

[2] Leslie Bender, 'A Lawyer's Primer on Feminist Theory and Tort' (1988) Journal of Legal Education 9.

[3] Camilla Pickles and Jonathan Herring (eds), *Childbirth, Vulnerability and Law: Exploring Issue of Violence and Control* (Routledge 2019) 151.

[4]World Health Organization, 'The prevention and elimination of disrespect and abuse during facility-based childbirth' (2015) https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf

[5] CR Williams, C Jerez, K Klein, M Correa, JM Belizán, and G Cormick, 'Obstetric Violence: A Latin American Legal Response to Mistreatment During Childbirth' (2018) *BJOG: An International Journal of Obstetrics and Gynaecology* 1208.

[6] *SFM v Spain* CEDAW/C/75/D/138/2018.

[7] Dubravka Šimonović, *A Human Rights-Based Approach to Mistreatment and Violence against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence* (2019) A/74/137.

[8] Non-fatal Offences Against the Person Act 1861.

[9] Carol Smart, 'Law's Power, the Sexed Body, and Feminist Discourse' (1990) 17 *Journal of Law and Society* 205.

[10] Leslie Bender, 'An Overview of Feminist Torts Scholarship' (1993) 78 *Cornell Law Review* 585.

[11] Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability* (Hart 2020) 131.

[12] Joanne Conaghan, 'Gendered Harm and the Law of Tort: Remedying (Sexual) Harassment' (1996) *Oxford Journal of Legal Studies* 16 431.

Article

This Hurts: how the media portrays childbirth matters

by Heather Spain

My first reaction on discovering the BBC was releasing a series based on Adam Kay's non-fiction memoir, '*This is going to hurt*' was rage, closely followed by gut-wrenching sorrow. I read the memoir years ago - before I'd given birth much thought and with a robust sense of humour courtesy of several years in the British Army. I'd been told the memoir was hilarious, but was increasingly appalled by the author's misogyny, dehumanisation, and mockery of women. I was devastated by the hateful tales that rapaciously instrumentalised women's pain, suffering, anatomy, bodily fluids and attempts to exercise bodily autonomy, as cannon fodder for comedy and a source of yet more female shame. I remember my concern for the women who, during the most vulnerable and important moments of their lives, would have met unnecessary suffering at this man's hands and attitude. I remember being baffled and incredibly sad that no one seemed to see this was wrong and dangerous, and confused about how this book met with rave reviews and a place on best seller lists. I remember being convinced that, given the book's popularity and lack of public outcry, that this must just be the way birth is. Violent. Terrifying. At that time, I didn't have the words to name what I was reading but I now know this to be obstetric violence: the disrespectful and/or abusive treatment that violates the rights of women to respectful care and threatens their right to life, health, bodily integrity, and freedom from discrimination.

For these reasons, I was glad when the book faded from view, and then so angry that the BBC - arguably one of the country's most important cultural institutions – brought this troubling book back into the public's eye. The fact of a TV adaption signals the BBC's stamp of approval and affords its harmful narrative with legitimacy and credibility. The BBC celebrates an author who repeatedly compares himself to a celebrity or God as he appropriates women's power: he makes his disgust and revulsion at the women under his care absolutely clear, describing them as "crotchety as a pen of wet hens…grunting their way through their appointments"; he recalls the smell of a woman that made him imagine, "every bunch of flowers in the hospital suddenly wilted"; he asserts that, "there's no such thing as a non-traumatic vaginal delivery" and revels in female injury ("durex should take their cue from cigarette manufactures and show photos of postpartum perineums on their packaging – no woman could look at that and ever risk getting pregnant"); he doesn't believe in informed consent ("I've saved countless patient delays to effective treatment by not proffering a specials board of options… instead, I've offered my expert opinion; the patient's choice is whether or not to take it"); he is outraged that women have the audacity to complain about his care, even when he has damaged their bladder ("the patient almost certainly had no idea how sad and exhausting the process would be for me…maybe the patient was one of those joyless types who sues half the people she meets.") I could go on.

On the heels of my fury came grief. Grief that *yet again* women would be presented with powerful images of scary birth and the normalisation of obstetric violence. TV and film almost always depict birth as terrifying, agonising, and inherently dangerous; rarely are women treated with the respect and sensitive care that is their legal right. Even in the best of

circumstances, birth for entertainment's sake usually looks like this: a woman birthing on her back, legs in stirrups, screaming in agony, screaming at their partner, begging for drugs to take the pain away, "supported" by health care professionals that patronise, joke or generally refuse to listen. Then, more often than not, the birth becomes life-threatening.

True to form, *This is Going to Hurt*, opens with a highly dramatised medical emergency and from then on the alarms, screaming and panic never really stop. The events in the show range from the uncommon e.g. a cord prolapse[1], severe pre-eclampsia[2], to the downright rare perimortem caesarean section[3],and the equally rare symphysiotomy - cutting through a woman's pubic bone to manage shoulder dystocia. This really matters. People are left to decide for themselves whether these depictions are fictional or real, common or uncommon. Undoubtedly, this steady flow of identical (mis)information - that birth is dangerous, women's bodies are dysfunctional and unable to birth their baby without medical intervention – creates a collective belief that birth is something to be feared and never goes smoothly. It portrays healthcare professionals as the heroes and the attitude is "never you mind the obstetric violence - that is just part and parcel of the birth experience". This isn't the case. How I long for us to see the whole spectrum of birth experiences: the calm and uneventful homebirth; the woman roaring with power; the beautiful, peaceful Midwife Led Unit waterbirth; the woman reaching down to catch the baby herself; the respectful women-centred elective caesarean; a woman with an epidural facilitated to move around should she so wish; the calm management of things not going to plan that doesn't require abandoning the woman's dignity and bodily autonomy. But gratuitous violence against women sells, and women represented with the power they deserve – highly capable, warrior goddesses bringing new life into this world – sadly wouldn't be nearly so entertaining or, perhaps, even palatable.

Like the book, the TV series seems to have been well received by mainstream media, praised for its realism, an important tale of a broken, chronically under-resourced NHS, revealing the immense pressure that exhausts and crushes staff. Personally, I think the series plays to an appetite for violence against women – whether through the BBC's laziness (at best) or intentionally and with a patriarchal agenda (at worst). Let's say, and hope, that I'm wrong and it really was the BBC's intention to shine a spotlight on buckling maternity services. Well really, they could have done a much better, nuanced and intelligent job. Firstly, this is largely a story of medical services that exist to serve women, but where are the women? The women in *This is Going to Hurt* are little more than bleeding slabs of meat; dehumanised body parts; theatrical props and a backdrop to a story of poor, exhausted obstetricians. When they are permitted to speak the women are depressing parodies: thick, malingerers, racists, crazy hippies. But these traumatic experiences are happening to real women and I'm certain they don't find it a laughing matter. Since personally being subjected to obstetric violence, which included non-consensual surgery and being held captive on the maternity ward, I have encountered countless women with their own harrowing tales of largely avoidable, brutal, demeaning and ultimately illegal experiences; experiences that have left them with physical and emotional trauma that will haunt them for the rest of their lives. Does the BBC realise the disservice it does to these women when it serves up this trauma as comedy on a weekday evening, without so much as a trigger warning that the show contains anything more than "discriminatory language?"

Fine, I accept this is a story of an acting registrar and will be dominated by that perspective, but that does not excuse the harmful reduction of women. This could have been a real opportunity to demonstrate the important and inextricable link between the working conditions of health care professionals and the experience of birth – why aren't we shown the impact this violent, poor treatment has on women? In one particularly troubling scene Dr Kay fails to adequately supervise a junior doctor's first forceps delivery - he's too busy on the phone organising a stag do (whilst in hearing of the mother) - and the woman suffers from a fourth-degree tear. We're asked to pity Dr Kay who now must add unnecessary time in surgery to his workload but there is no mention of the impact on the woman. There is no mention of the physical and emotional trauma that is likely to impact on the woman's quality of life for decades to come, echoing through her family and community. The mind-blowing negligence also goes unremarked upon. Nor does the show think to give any sense of choice, of options discussed, of informed consent, let alone to curiously probe

whether being in second stage labour for an hour should be grounds enough for a forceps delivery.

Indeed, the behaviour that goes unremarked upon is perhaps the most troubling aspect of the series, asking us to accept that this terrible, if not illegal behaviour is normal and acceptable. Take an ongoing induction where instead of discussing options, Dr Kay commands that they, "wang the dose up on the drip and if that doesn't work… [mimes slicing through her stomach]". Then there's the conversations that happen over the operating table, as if the woman and her partner aren't on the other side of a flimsy paper barrier listening to every single word: "so you know the routine. See one, f**k one up, teach one"; calling a newborn a "thieving little f**ker"; joking, "oh sh*t, I think you've left some scissors inside her'' and she "smells like a two-day old kebab." There are the disrespectful jokes to patients: when Dr Kay announces, "I've got some bad news", he waits for a panicked pause and then tells her she's misspelled a word on her crossword puzzle. Or the consultant who jokes about a caesarean for triplets: "I mean we've got three goes so by the time the last one's out we'll be great at it, won't we?" There's the mockery of a person-centred language workshop without any questioning of the archaic language used in childbirth, such as 'I delivered the baby', 'incompetent cervix', 'failure to progress', 'poor maternal effort.' There is the repeated use of premature cord clamping. The series ends with a baby born in the hospital car park who, for some unexplained reason, has their cord tied with a shoelace and immediately cut with an ice-scraper.

With the casual treatment of each traumatic encounter, the trivialisation of obstetric violence and so much bad behaviour hidden in the background, it's hard to believe that there isn't a less than scrupulous agenda at play. And just in case viewers weren't paying attention, the series hammers home that message in its handling of the single instance of a physiological birth that almost occurs without medical intervention: a woman intent on a water birth and, I imagine by no coincidence - given how the BBC must have known it would be perceived by the general-public - eating her placenta. We're not shown any of the glory or magic of a straightforward birth, but we are shown the seemingly inevitable emergency ending of a retained placenta (apparently 3 minutes after birth…) and the woman 'hilariously' eating blood clots, mistaking them for her placenta and vomiting everywhere. It's hard to believe that the BBC didn't know exactly what it was doing here, telling us that only a certain 'type' of ridiculous woman wants a waterbirth, but don't worry they'll soon learn their lesson: no matter how much they fight it, their female body is just as weak and dysfunctional as any other woman, and they too will need a (male) doctor to rescue them.

This attitude is certainly evident in the memoir that gleefully recounts how a woman's "nine-page birth plan, in full colour and laminated", has "gone right up the f**k . Hypnotherapy has given way to gas and air has given way to an epidural and is now headed to surgery due to failure to progress" and asserting that "two centuries of obstetricians have found no way of predicting the course of a labour, but a certain denomination of floaty-dressed mother seems to think she can manage it easily." This mocking attitude, the chilling triumph in a birth not going to plan (which can't have been helped by the environment created by an obstetrician who believed it "doomed from the start") seeks to strip women of their power and autonomy, to shrink them back to a manageable size and discipline them back into the weak and passive box where they surely belong. For Adam Kay nothing less than a brutal birth will do; he is annoyed when a consultant performs a woman-centred caesarean with dimmed lights, classical music, the baby slowly emerging, dismissing it as a gimmick that the woman 'laps up'.

If the BBC truly intends this to be a call to action, then why aren't we shown what good care looks like? There could have been such a powerful juxtaposition between the care women *should* be receiving – compassionate, emotionally intelligent, woman-centred – and the inhumane treatment delivered by Dr Kay. This would have made it explicitly clear that the actions of Dr Kay and others in the show are wrong and this is not just the way childbirth goes. This is important for those who may not realise another way is possible. For the most part childbirth can and should be joyous, empowering and beautiful. Yes, hard and painful and bloody perhaps, *but also* wondrous. That isn't to gloss over the fact that sometimes things go wrong. But, perhaps, we could have been shown how an appropriate environment and proper support reduces the likelihood of things going wrong in the first place, and what it means to support a woman through an emergency with respect and compassion.

It wouldn't have taken much, the inclusion of an additional character, an additional thread running through the series. This care does exist. And just as this series does birthing women a disservice, so too it wrongs the thousands of committed, hard-working, compassionate health care professionals that want women to succeed and who go above and beyond to support women to have the best birth possible. It's hard not to wonder what agenda hides this care from sight, hard not to believe that this isn't yet another instance of women (the largely female midwife workforce) being side-lined and silenced.

We do, however, need a call to action. Our midwifery and birth services are undisputedly in an appalling condition. The Ockenden review, the scale and size of which is unprecedented in NHS history, has shown that our maternity services are failing mothers and babies at the most important times of their lives, with shocking levels of care leading to devastating consequences. Women and babies are avoidably dying [4], [5]. In the 21st century, in a high-income country, just under half of all maternity services in England have been rated unsafe by the Care Quality Commission: 80 out of 193 units have been deemed either "inadequate" or "requires improvement". *This is Going to Hurt* got it right when it showed a broken, demoralised and exhausted workforce. Midwives are leaving in droves. The March with Midwives campaign[6] makes it clear why: a toxic working environment, largely the result of underfunding; Midwife Led Units and homebirth services suspended across the country, supposedly temporarily, but I suspect this is part of a slow erosion of women's choice and care options.

Perhaps then, *This is Going to Hurt*, does well to spark a debate on these important issues? No. What it does is normalise obstetric violence and reinforce a birthing culture and system that demands women's unquestioning cooperation and powerlessness. It strengthens the narrative that birth must be a highly medicalised conveyer belt; that women do not have options and should follow the prescribed model like good little girls; that traumatic birth is commonplace and, therefore, to be expected and accepted. It is this attitude, this refusal to respect and listen to women, that is harming and killing mothers and babies.

You can see a similar attitude in press reporting on the Ockenden report. It seems many journalists either haven't read the report or have actively chosen to ignore the key findings of unsafe staffing levels, the failure to listen to women and their families, weak leadership and governance and an environment that makes it extremely difficult to raise and learn from concerns. Instead, they focus on 'normal births' as being the root of all problems, not only missing the importance of other significant failings but also failing to make the important differentiation between a heavily interfered with vaginal birth (with each intervention increasing the chances that another will be required) and an uninterrupted, well supported physiological birth. We see the media largely filter out any positive birth story, or the need for tangible government-led change, preferring instead the narrative of faulty female bodies and laying the blame on supposedly ideologically obsessed (female) midwives, NCT practitioners and doulas - usually the women most actively working in support of good and safe birth, *regardless* of what form that might take. Is it because these lazy, sensationalist stories make good press or are there more sinister forces of politics, money and power at play? After all it's easier to blame a 'normal birth ideology' than ensure our maternity services are properly resourced.

This is not an unimportant or niche issue. Every single one of us experiences birth in one or many forms. Birth really matters - from the sheer humanity of ensuring this momentous moment in a woman's life is respected and honoured and that we all enter this world as peacefully and respectfully as possible, to the utilitarian fact that bad births have knock on effects for the mother, child and family that have untold costs that ripple far into the future. It is time for a more honest dialogue and to widen the lens around birth. Above all, it is time to actively give voice to and genuinely listen to women. How devastating then that *This is Going to Hurt*, missed an important opportunity to drive change and instead perpetuated harm against women. Come on BBC, you could have done so much better. Should you have wanted to.

Author Bio: Heather is a mother of one, soon to be two, and a fledgling birth activist - drawn to the cause by a beautiful and empowering homebirth, followed by traumatic encounters with the medical services. Heather is a diplomat recently returned from Afghanistan and currently lives in South Wales, where she enjoys spending lots of time outside with her son, partner and two Labradors.

END NOTES

[1] A cord prolapse shown in the opening of the series is uncommon, occurring in between 1 in 200 and 1 in 1000 births. RCOG

[2] Around 1 in 200 women (0.5%) develop severe pre-eclampsia in pregnancy. RCOG. www.rcog.org.uk/for-the-public/browse-all-patient-information-leaflets/pre-eclampsia-patient-information-page

[3] A perimortem caesarean is a caesarean section performed during or near the time of the mother's death.

[4] MBRRACE-UK (2021) Saving Lives, Improving Mothers' Care Lay Summary 2021 - https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_Lay_Summary_v10.pdf

[5] UK Parliament (2021) 'Blame culture' in maternity safety failures prevents lessons being learnt, says Committee

https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/156351/blame-culture-in-maternity-safety-failures-prevents-lessons-being-learnt-says-committee/

[6] www.aims.org.uk/journal/item/march-midwives-reflection

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Article

Emotional Freedom Techniques for Obstetric Violence

By Julia Adams with Pat Ballantyne

As I was planning this article, I read some research from the website 'Pregnant then Screwed'.[1] It painted a grim picture of birth trauma endured by thousands of women during the pandemic. The Covid pandemic was an exceptional circumstance, and traumatic for many in numerous ways. It is known that around 30,000 women every year are diagnosed with Post Traumatic Stress Disorder (PTSD) as a direct and indirect result of their experience of being pregnant and giving birth within the UK maternity care systems.[2] Treatment, as usual, often takes a long time due to long waiting lists. The standard treatment for PTSD – various talking therapies – appear to be ineffective for some people. As I now complete this article, the Ockendon report is in the news, with the business of giving birth in the UK under scrutiny as never before. Both women and the midwifery profession are in need of much more support to deal with the trauma associated with childbirth and family life in general. The need for another safe and effective treatment for traumatic issues has never been greater. Thankfully, it exists and it is called Emotional Freedom Techniques (EFT), also known as "Tapping" (not to be confused with Emotionally Focused Therapy). EFT techniques are very effective in the hands of qualified professionals [3], [4], [10] yet interestingly, also when used as a self-help technique.[11]

Childbirth for many women involves serious and often persistent traumatisation. It is not just the threat of birth trauma that is worrying for many; one in three women worldwide also experience sexual violence.[5] The long-term effects of a history of sexual violence, can be a contributing factor to women being very sensitive during the perinatal period. It has implications for maternity care with many women experiencing an invasion of their boundaries, if indeed, they attend their appointments at all. Apart from the devastating impact on their physical health, they may suffer long term psychological consequences.[6]

For many women their experience of giving birth stays with them, haunting them and impacting not only their quality of life but also that of their loved ones. Few women would wish their trauma on anyone, let alone their own children, yet the latest studies show that trauma is heritable. Recent research shows that if your parents or their parents experienced trauma then it is possible that somewhere in the DNA, transmission of the imprint of that trauma has passed to their descendants.[7]

Childbirth is a natural process, yet it is not without inherent risks – hence the move towards hospital and medicalised interventions. We also know the impact of feelings of anxiety and being overwhelmed on expectant mothers. Most women would far prefer natural surroundings, natural treatments and to avoid the drugs wherever possible, but to have them available if needed. An over medicalised environment can be disempowering at the very time when a woman wants to feel in control and respected by those around her. Feeling in control and feeling respected is extremely important to outcomes for mother, baby and the wider family. When a woman's boundaries

have been violated (her perception is key here, and not the doctor's) attaining a sense of one's own self determinism is an essential part of recovery.

With EFT, it is not necessary to actually verbalise the issue at first. Indeed, silent tapping with a professional, while focusing on feelings about the issue, will reduce the intensity to a level where the trauma can be more readily engaged with, always using a minimum of words.

Why is EFT good for Obstetric violence and birth trauma?

EFT is becoming well known as a treatment for trauma and can be particularly effective when the trauma can be identified, as in the case of birth trauma. With EFT the more specific one can be, the more effective the results, but so many people are so traumatised they cannot even begin the process by using words. With mainstream talking therapies, however skilled and experienced the clinician or psychotherapist, the very act of talking about the trauma still forces people to relive it and 'go there'. With EFT, it is not necessary to actually verbalise the issue at first. Indeed, silent tapping with a professional, while focusing on feelings about the issue, will reduce the intensity to a level where the trauma can be more readily engaged with, always using a minimum of words.

Because EFT includes the use of acupoints,[8] the body's own healing processes are being engaged, so the healing is done with the client rather than to them. With EFT the client is in control of the pace and depth of the work at all times. The client is an active partner in their own healing. Many of our clients tell us that the very gentleness of the EFT process, when compared to other treatment methods they have tried, is the main reason they see their sessions through to completion. Below are anecdotes of how rapid and effective use of EFT can be with women with birth trauma.

A client last year approached me to treat her with EFT for trauma. This client was a psychologist and first-time mother. She was aware that the experience of her own birth experience would have a significant impact on her impending experience of childbirth. She was also aware of the conditions in hospitals and the acute shortage of qualified staff. This did not help her relax into what is the natural process of childbirth. Using EFT, we managed to neutralise the negative experience of her (forceps) delivery rapidly and gently.[9] She went on to have a positive experience, and her son is happy and healthy.

In another anecdote from EFT International's archives 'Carol' was a 32-year old first time mother who presented for therapy two weeks after giving birth. She was traumatised by her birth experience and felt she was unable to bond with her new baby. Carol's mother, who had been present at the birth, accompanied her to her sessions. Her mother agreed that the experience was horrendous, for both her daughter and for her looking on at what happened. At her first session, Carol was shaky, anxious and worried about her inability to bond with her baby. Both Carol and her mother were taught the EFT 'Basic Recipe' at this first session, using Carol's physical symptoms to start, followed by them both addressing the various aspects of the birth experience. Carol's Mum tapped along with Carol and her therapist. At her next session, again accompanied by her mother, Carol was able to easily describe her birth experience with no intensity whatsoever. Her mother, who had 'borrowed benefits' throughout Carol's EFT experience, also agreed that she was able to describe that it had, indeed, been a difficult birth, however, now, she was unaffected emotionally by the experience.

EFT is valuable in that it is a skill that can be easily taught and used to manage one's own feelings in stressful situations or in between sessions with a professional. With EFT Tapping, women can achieve a sense of calm by themselves, in alien circumstances – which will help both them and their child.

Apart from the usual counselling and psychotherapy approaches, there are two main treatments currently offered to UK sufferers of childbirth trauma – Trauma-focused Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR). EFT, or 'Tapping' is now a third option recently recognised by

PTSD (UK) as a safe and effective treatment. If someone has PTSD they naturally seek the safest and most effective treatment and if at all possible it should also be gentle. EFT ticks all those boxes, in fact it has shown to be highly effective because of its very gentleness.[4], [10]

In our experience clients given a choice have actually preferred it. The UK's quality assurance body The National Institute for Clinical Excellence (NICE) is aware of EFT's effectiveness in relation to trauma and has called for more research into more diverse populations. Research is ongoing, with over 150 published studies including Randomised Controlled Trials (RCTs) and Meta Analyses showing that it is effective, often when other interventions have failed, and the effects are durable.[4] [10]

So what is EFT (Tapping)?

EFT combines the ancient system of Meridians, energy lines in and around the body that were identified by Traditional Chinese Medicine, with more recent models for understanding the psychology and neurobiology of Trauma. [11] Tapping on specifically identified points on their body, an individual is able to reprocess 'stuck' trauma.

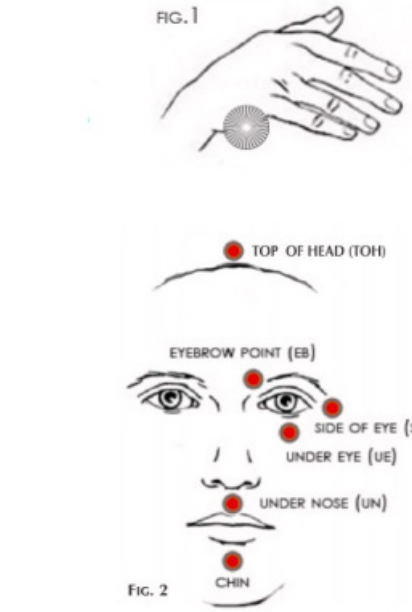
The Benefits

- Fewer sessions are needed for the client to no longer meet the diagnostic criteria for PTSD.[12]
- The elements of EFT treatment itself make it both gentle and effective. Research found no adverse effects from EFT interventions and showed that it can be used both on a self-help basis and as a primary evidence-based treatment for PTSD.[11]
- After successful discharge, people will have learned valuable coping and stress management skills they can take into their future, not just for their own benefit but for that of their families and friends.

EFT has been described as emotional acupuncture without needles. Indeed, it uses similar points to acupuncture on the face and upper body. Firm pressure is applied by fingers on certain 'Meridian Points'. When tapping on these points a thought, memory, feeling, or a physical symptom associated with a traumatic experience, is brought to mind..

At first, some practitioners like to tap silently with the client, others prefer to listen to the client describing what is going on for them. Some practitioners tap on their clients, others will tap along with their clients, demonstrating where the clients should tap. While tapping, the client is encouraged to repeat a 'reminder' phrase out loud, which helps them stay focussed on the issue being worked on. Depending on what they are told, the practitioner will follow 'what comes up' for the client in the session. Each round of tapping takes less than a minute. The information the client receives from their body during their session is essential to the processing of the 'stuck' trauma. The information coming from the client tells the practitioner where the session needs to go – with the client's permission of course! The information the client supplies may seem irrelevant to an outsider; however, if this is what the client's subconscious is providing, the EFT practitioner is trained to follow it as far as the client will allow. The client is able to access subconscious memories, sensations and feelings that help direct the practitioner to address the event being resolved.

Map of the tapping points



Can I tap by myself at home?

EFT Tapping can indeed be done alone. It can be wonderfully empowering to be able to achieve a sense of calm for oneself, to begin to damp down that hyperarousal and get some rest. There are many apps, YouTube videos, and 'Tap along' videos available to follow and whilst getting used to the process. Tapping can be used to manage one's feelings 'in the moment', to help achieve a sense of calm prior to performing a relaxation process (including going to sleep), for managing one's anxiety about an upcoming event, or simply to take the edge off one's feelings after a tough day. It should be said, however, that this activity should really fall into the category of self-care. For EFT to treat trauma effectively, it is best to work with an experienced practitioner with training specific to trauma, with tapping on oneself used in between sessions. By all means take your time to select someone you feel is a good fit for you and who has a lot of experience working with trauma.

For more information on EFT go to PTSD UK page here [13] and here is a link to a list of accredited EFT professionally qualified practitioners.[14]

Author Bios:

Julia Adams – Julia found the EFT was the only thing that worked to help her cope with her son was an infant. Now qualified in EFT Julia, Julia draws on her deep understanding of the subtle nuances of language, when tapping with clients. This proves very useful when unearthing hidden patterns and core beliefs. Julia believes in gently holding space for women while they overcome their traumas. Julia believes that gently 'holding space' for women while they tap to overcome their traumas provides the best context for women to rediscover their uniquely feminine power to live and heal.

Pat Ballantyne – Pat was awarded her BPsych in Australia, where she also learned EFT in 1999 In 2003 she returned to the UK and has used EFT professionally ever since. Pat also works with the NHS and is chair of the EFTi research team, whose mission is for EFT to be accepted as a mainstream therapy.

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[2] Maternal Mental Health Alliance (2021) https://maternalmentalhealthalliance.org/news/birth-trauma-ptsd-awareness-survey

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[9] Described in more detail here: https://eftinternational.org/eft-for-pregnancy-and-birth

[10] EFT INternational (2022) EFT Tapping is Supported by a Large and Growing Body of Scientific Research

https://eftinternational.org/discover-eft-tapping/eft-science-research

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[13] ptsdUK - EFT 'tapping' for PTSD. https://www.ptsduk.org/eft-tapping-for-ptsd

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Article

The Ritual of Body Shaming

by Beth Whitehead

"Your baby is so diddy, mine is a chunk." "Look at you, you are so small." "Your baby is really tall, just like his dad." These were comments made by others that I encountered as a new mum. All of them made me feel uncomfortable but I had been guilty of making similar ones about physical appearance myself. What made these comments socially acceptable is the colloquial exchanges we make, reflecting our culture, habits and biases based on sex.

Is bigger really better?

The deep-seated belief that bigger babies are better probably originated from times when food was scarce and bigger babies were believed to have more likelihood of survival. With better hygiene and food being widely available and varied, the size of the baby is no longer a key determinant of survival. Yet the cultural belief continues as a tradition and habit. At what age, as a child grows up, does being 'big' turn from being a favourable characteristic to an unfavourable one? It is ridiculous, isn't it?!

Men and women come in different shapes and sizes and yet it is women's shapes that are referred to as apple, pear, hourglass or triangle. Men's bodies are not classified or scrutinised to the same extent or as commonly as women's bodies. Whilst not totally off the hook, far more than women, men are let be. Despite being of different shapes and sizes, our body parts are all fitted to function integrally, working together, for our body.

The BMI smoke screen

As women, our bodies start being judged from a young age and become more targeted as we go through puberty. The size of our breasts, our body shape, weight, height, even our hair colour, style and skin colour are all under scrutiny. We are being compared to others and often to some invisible person or standard that does more to hinder our confidence than anything else. This kind of superficial judgement based on one's sex and biological characteristics sets impossible expectations that make girls feel anxious about how they fit in with others, obsessed about appearance and shamed about differences. None of these exterior characteristics has anything to do with one's ability to breathe, think, feel, speak, study, write, run, swim… the list goes on.

What does this have to do with pregnancy, birth and maternity services? During pregnancy and birth, our bodies are judged incessantly by healthcare staff and other people. Maternity practices are a reflection and integration of the culture of shaming women's bodies. I've lost count of how often women have told me that their obstetricians or midwives said they should birth in the hospital a certain way with such and such interventions because their BMI (Body Mass Index) was too high or too low. Their bumps were measuring too big or too small based on fundal height (unreliable because measurements depend on position of the baby and healthcare practitioners' techniques or their consistency). These non-evidence-based measurements are routinely used to shame pregnant women's bodies, undermine women's birthing decisions, and to justify interventions and medicalisation.

BMI is a number calculated by your weight in kilograms divided by the square of your height in metres.[1] We come in different shapes and sizes with 'fat vs muscle' composition and family variations. Some of us are taller, some shorter, some wider, some thinner, some have denser heavier bones, some are more muscly, some have more fatty bits, some

1 Wikipedia. Body mass index: https://en.wikipedia.org/wiki/Body_mass_index

have bigger breasts, some have smaller ones, some have flatter tummies, some have more fat around them, some have thicker arms, some have thinner ones, some have longer legs, some have shorter ones... and so on. These physical attributes affect the BMI calculation but none of them has anything to do with one's ability to birth. Yet BMI is often used to limit women's options on birth place, how they are 'allowed' to birth,[2] access to a birthing pool, and freedom of movement in labour - all of which have a significant impact on outcomes mentally, physically and emotionally.[3] Women are often pushed into having caesarean sections, major abdominal surgery, by medical staff citing BMI. Women, people, are not just stacks of muscles, fat and bones. When medical staff use BMI to determine how we are treated it is not just dehumanising but violent. Coercing, fear-mongering or forcing women into unnecessary treatments (interventions) and surgeries are acts of violence. When this happens to women in obstetric settings, it is obstetric violence.[4] To understand how this form of violence against women gets to embed via BMI in the medical system, we need to examine our cultural environment and science storytelling.

BMI demystified

How can fiction become fact? Narratives around BMI and risk seem believable because, as women, we are taught to look for deficiencies in our bodies and that our physicality is somehow responsible for failures. This is effective in distracting us from what we know has a profound effect on whether or not physiological birth happens such as how women are treated or supported during the births as well as the environment.

You can be an excellent runner but if people around you keep telling you that you will fail and stop you every hour to check your pulse, lie you down or kick you in the ankle, it will dent your confidence, slow you down, if not injure you, too. Can you see how the obstacles you are expected to overcome when birthing have little to do with your physicality?[5] BMI is a way to objectify women, reducing us to a number to be dealt with systematically. Scientific narrative makes subjective observations sound neutral by removing reference to the subject so it seems objective, like facts. That is why it is difficult to distinguish between facts and cultural bias as the latter is implicit in the narrative. BMI also sounds scientific and complex even though it is not evidence-based.

BMI narratives become more convincing when the person saying it is wearing a uniform or white coat in a health institution. Everything seems more believable when it comes out of the mouth of medical staff in uniform because we have been conditioned from a young age to trust them. We stop questioning the validity of what they say and the existence of bias and cultural insertions.

High BMI is not the same as obesity.[6] BMI says nothing about a person's lifestyle, state of health, what you eat, how much exercise you do, your family history, your shape; but it is integrated in health assessments, begging some important questions.[7]

You can see on online calculators[8] that BMI is just a number, a ratio, jargon that makes healthcare staff sound more knowledgeable, specialist and convincing. We need to take it upon ourselves to call them out, to break the smoke screen. Next time, when medical staff mention BMI, ask them what their understanding of it is and whether different shapes and sizes can affect the calculation. It will be good education and awareness raising for all.

What to do to change culture?

The healthcare system and its workers are in positions of power with more resources and systemic support than the individual clients. They need to take responsibility for health policy, scrutinising the BMI measurement and its integration. Individualised care has to be a priority to ensure women's autonomy and human rights are respected in their interactions with maternity services.

There are some things we can do ourselves to change culture:

- Stop making comments about other people's bodies, particularly pregnant women's bodies.
- If you find you or your child on the receiving end of unhealthy and unfair comments about physique, say, "We're all different and unique."
- Call out family members who criticise how you and your children look or make comparisons between them.
- When medical staff make comments or recommendations based on BMI, your body shape or size or other physical features, ask them to provide

unbiased research evidence to support them. You can then check them and evaluate whether they are relevant to you to make your own decisions.

Remember, just because something seems plausible does not mean it is true or appropriate for the individual. You know your body, family history and personal values the best. BMI is a popular measurement being integrated into medical treatments and recommendations. We must challenge the validity of this lazy science and push for more humane individualised care for not just maternity services but the general national healthcare system.

Beth is a writer on maternity and women's rights matters. She lives in Southeast England with her husband and children.

Recommended Reading

The Politics of Women's Biology by Ruth Hubbard, 1990

END NOTES

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"... there is a general consensus that obesity is associated with poor outcomes for women and babies and the solution is to reduce BMI. However, this raises further questions: is obesity the direct cause of poor outcomes? Is obesity a symptom of some other heath related disorder that is the causal factor of obesity? Is the treatment of obese women the cause of poor outcomes (increased stress/shaming, surveillance, intervention)?"

[8] NHS (2018) BMI healthy weight calculator. www.nhs.uk/live-well/healthy-weight/bmi-calculator

Interview with

Mara Ricoy: Campaigning against obstetric violence

Interview by Jo Dagustun

In this interview, we hear from Mara who - based on her knowledge of variations in maternity experiences between the UK and Spain[1] –created an international movement to raise awareness of, and ultimately seek to eradicate, the problem that is obstetric violence. Mara called the movement The Roses Revolution. In this interview, Mara reflects on the campaign's progress and the barriers that remain.

Thank you for agreeing to be interviewed by AIMS, Mara. To start, can you tell us more about what drives your interest in maternity service improvement, and how you got started?

Thank you for giving me this space. When I was pregnant with my first child 20 years ago in London, I used to talk to other Spanish women like me, online, and realised the disparity in the care between the two countries. I had a great birth experience and I couldn't understand that this was a matter of chance, luck or location.

You describe yourself as matri-activist. What do you mean by that?

It was a way of trying to shorten my introductions and explanations, but it didn't work. I need to explain the word now. I consider myself an activist for the rights of women over our reproductive bodies throughout our lives,

irrespectively of becoming mothers or not (menstruation, miscarriage, abortion, birth, breastfeeding, menopause, etc.) But also an activist to promote and recover our matriarchal culture and science.

Please tell us about the international initiative you created, The Roses Revolution.

The movement started 10 years ago as a reaction to the The Spanish Society of Gynaecology and Obstretrics publishing comic strips on their public website in which they laughed at women during labour, and at their sexual health and other issues. I was quite popular on social media talking about birth and the Spanish women were, quite rightly so, outraged - so was I. There were so many stories of obstetric violence coming out, the general feeling was of adding insult to injury. So I suggested writing those stories and taking them to maternity hospitals. I have learned - thanks to my admired Sheila Kitzinger and working for a birth crisis helpline - of the power of writing our stories to help with trauma. And we adopted the image of a rose, as it has such powerful symbolic meanings for people. The day I chose when we repeated the first action was the 25th of November as it is the day against violence towards women.[2] The movement grew so much that someone told me in Austria they used the day to retrain midwives, and it has been mentioned as part of an exhibition about birth.

You've been working in this area for over 10 years. What progress have you seen over that period, and how optimistic are you for the potential for future progress?

I have to say, little, and difficult to know; it is almost like some positives in one direction and negatives in others. For example, 10 years ago most of the attacks I received were because I used the term 'obstetric violence' - nowadays the term is more commonly used, but I feel that we are still more worried about debating it than solving it, more concern about descriptions and definitions than the actual suffering and the behaviours.

What do you think is the biggest challenge faced by those working to eliminate obstetric violence today?

The lack of understanding of obstetric violence as a misogynistic crime. Not realising that this is a women's issue, for being women. And diluting our fight with neologisms from gender ideology[3] that, rather than bring inclusivity, spread confusion and further invisibility of the oppression of women.

AIMS celebrated its 60th birthday in 2020. Looking forward, how do you think AIMS might best focus our limited resources, to help ensure improved maternity services for all?

Understanding how women, in all circumstances, give birth in the UK and in the world, refrain from falling into the trap of accidentally placing responsibility on women. I find birth a fascinating topic, but women have a right to turn up completely uninformed, no antenatal classes, not speaking the language, and to still be treated as the ones making the decisions in birth. So perhaps our activism should start at that level and engage with the women who don't know what AIMS is.

Visit this website to find out more about **The Roses Revolution** movement: *https://jesusaricoy.wixsite.com/rosesrevolution*

Watch this video to see Mara speak about her work at the Forth Valley Feminists Women's Festival (March 2022): *www.youtube.com/watch?v=R9L5mFSiQ44*

END NOTES

[1] Editor's note: Mara first wrote for AIMS in 2012: www.aims.org.uk/journal/item/spanish-rights

[2]United Nations - International Day for the Elimination of Violence against Women, 25 November www.un.org/en/observances/ending-violence-against-women-day

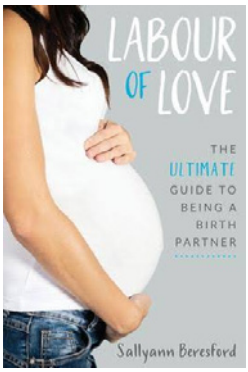
[3] Editor's note: A neologism is a new word, usage or expression (Collins English Dictionary). The author appears to be suggesting that language around current debates on gender can dim the focus on women's issues in this case.

Book review

Labour of Love: The Ultimate Guide to Being a Birth Partner

by Sallyann Beresford

ISBN: 978 1 8382295 0 4
Dandelion Books (2020)
316 pages
RRP: £14.99



Reviewed for AIMS by Anne Glover

This is a very informative, easy to read book, bursting with chapters of interesting detail. It is one of those books that you want to devour quickly, but also savour slowly so you don't miss anything. It focuses on the role of the birth partner and, as a doula, I absolutely loved reading it, as it felt like a revision and reassurance of what I do. In fact I could read it all over again as I enjoyed it so much.

Sallyann Beresford has been a doula for over 20 years and her experience and knowledge shine throughout this book. The book came about as she noticed that those clients who attended antenatal sessions with specific classes addressing the role of the birth partner, were more satisfied with their birthing experience. The author clearly defines a birth partner as anyone supporting someone during pregnancy, labour and birth, including a spouse, relative, friend, doula or midwife.

This book promises to give you all you need to know about the physiological needs of a labouring woman, and it really does that. The more you read and proceed through the book, the more your knowledge about birth options, plans and the birthing process grows. The material equips you with the confidence to go into the birthing space knowing what to expect and what to do. The content of the book also covers important aspects such as the process of hormones, comfort measures and pain relief, and finishes up with preparations for the postnatal period. Beresford has included dollops of personal birth experiences throughout the book, which bring a sense of reality to the content.

Even though all the content is aimed at birth partners, there is one specific chapter on the birth partner. In this chapter, the author introduces the PROTECTS acronym to ensure the birth partner remembers their role. It is an invaluable tool to have for labour, and can also be used during the postnatal period too. I will certainly be using it in my practice from now on! As a doula I also enjoyed reading the chapter on the safety word, which is a word or phrase previously chosen by the birthing person to indicate that they want to change their plan. This is something I often chat to my clients about and now I have a lovely reference for them in this book.

Beresford uses a straightforward style of writing to make the content accessible to most people. The consistent layout is appealing to the eye, with beautiful sketches of dandelions throughout, and diagrams, drawings and simple sketches to give clarity and understanding. The content is thoughtfully laid out to be interesting and eye-catching, with areas of shaded text scattered intermittently, which are easy to find but also make you want to read more, e.g. 'It is not a woman's job to explain why she doesn't want to consent!' (page 252). Each chapter begins with an inspiring positive quote, and there are 'Important to know' sections throughout. Beresford also puts a quick recap at the end of each chapter, which can be used as a revision tool or simply as a reference. The book is bulging with tips and handy titbits of information to help birth partners understand their role and how to be actively involved in the birthing process, if their partner wants them to.

As an AIMS volunteer, I was delighted to see the many references to AIMS website and publications throughout the book, and also to see AIMS listed as a resource: 'Support for women's rights in childbirth'.

When you purchase the book, you also receive a free download [1] with links to the websites, research studies and articles that relate to information in the book. There are also free resources to print and take to the birth, such as a birth partner's checklist.

I would argue that this book is not only for birth partners as described earlier, but for anyone and everyone interested in birth!

[1] www.birthability.co.uk/links-and-resources/

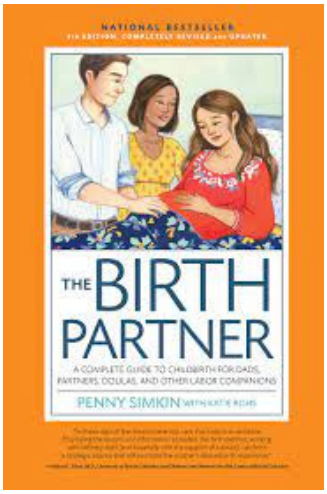
Book review

The Birth Partner

by Penny Simkin with Katie Rohs

Illustrations by Susie So, Gayle Isabelle Ford and Dolly Sundstrom

ISBN: 978-1558329102
Harvard Common Press; Fifth Edition, 2018
440 pages
RRP: £12.95



Reviewed for AIMS by Sue Boughton

There are not many birth preparation books that are written specifically for birth partners and out of those that are, many try to be funny and are not very helpful. This book was first published in 1989 and is now in its 5th edition, completely revised and updated. The Birth Partner has been a favourite go to for doulas, birth partners and other birth supporters for over 25 years!

Penny Simpkin has specialised in childbirth education and birth support since 1968, she is the author of several books, videos and teaching materials. Penny is also the co-founder of DONA [Doulas of North America], now known as DONA International.[1] After studying people's long-term memories of their birth experiences, Penny realised that one of the most important aspects of their care that affected their memories of birth was how well they were looked after. If their care had been kind and respectful, regardless of whether their labour had been long or complicated, the mothers experienced a positive, often empowering birth. This book was written to inform birth partners, to give them confidence in the labour process, knowledge of various aspects of maternity care, and understanding of the pros and cons of medical interventions and medications frequently used during labour and birth.

The Birth Partner is a wonderfully comprehensive guide to everything you need to know to be able to offer calm and effective support as a birth partner, from late pregnancy, during labour and after the birth. The more knowledge people have, the more confidence they will have to trust their instincts and to ask appropriate questions, and the more courage they will have to decline what they do not want or do not feel is necessary.

Penny's straightforward advice and information is clearly presented in easy to follow sections. She covers everything from practical questions such as "what to take to a hospital birth" and "what you need for a home birth", to explaining the basic physiology of labour and birth and how to help the process, for example: what positions and movements can be helpful during labour and why; and various comfort measures such as massage, breathing, and the use of water. She also explains the common problems that can occur during labour and gives impartial information on medical interventions and labour medication. There are handy checklists included through the book, these are printed on coloured paper making them easy to find. There are also many useful illustrations to help explain the practical aspects of labour support. Altogether this makes it one of the best guides to labour support I've read.

[1]DONA International: www.dona.org

Author Bio: Sue Boughton is a birth and postnatal doula, massage practitioner, and an AIMS volunteer.

Article

Respectful Vaginal Examinations Project – Co-Production in Action

by Kelly Sawyer

The Respectful Vaginal Examinations project is an ongoing quality improvement project at Maidstone and Tunbridge Wells (MTW) NHS Trust. The project aims to improve practice to reduce the amount of unnecessary and unwanted vaginal examinations (VEs) being performed in labour, make sure those that are necessary are being performed in a dignified and compassionate way, and educate women and pregnant people about their rights and their choices around VEs in labour.

The project is being completely co-produced between midwives at MTW and members of the Maternity Voices Partnership (MVP), led by MVP chair Nina Rickman and Deputy Consultant Midwife Kelly Sawyer. Co-production between clinicians and service users ensures that all problems, and the required solutions for those problems, are understood and worked upon from both service user and clinician's viewpoints. Utilising the expertise and knowledge of service user reps also encourages the voices of marginalised and vulnerable groups to be heard, ensuring we are focusing on the topics that matter to all. Nina has done a lot of work mapping out the demographics of our catchment area to target those voices and ensure their views are incorporated into the project.

What are the issues?

Vaginal examinations have become a common intervention during labour. The examination has a variety of important uses, including diagnosing a cord prolapse (a rare emergency when the umbilical cord is being born before the baby), deciding on the best method to start an induction of labour, and checking the position of the baby during labour. VEs are also often carried out routinely to diagnose the start of the first and second stages of labour, and to assess how labour is progressing. The World Health Organisation (WHO) [1] recommends that if a birthing person is low-risk, VEs should be offered at least every 4 hours to assess progress and rule out 'labour dystocia'- the abnormal slowing or stopping of labour that can increase the likelihood of trauma to the birthing person and baby.[2]

Critics of the VE claim that modern-day maternity care has become too 'cervix-centric' and the VE is relied upon so heavily because it is the only way to quantify labour in numerical terms, not because of its accuracy.[3] A Cochrane review in 2013 concluded that there is no evidence that routine VEs in labour improve outcomes, with the authors displaying concern at how widespread the use of routine VEs have become without a solid evidence base to back it up.[4] This Cochrane review was updated this year; despite there being nine years between reviews, the authors still came to the same conclusion.[5] Evidence from around the world has emerged suggesting that the VE can actually cause harm rather than prevent it. Two recent large-scale studies by Gluck et al. (2020a[6]; 2020b[7]) found that having five or more VEs increases the chance of experiencing a raised temperature (which may be a sign of infection) during labour, and can also increase the risk of a serious (third- or fourth-degree) tear.

In addition, numerous studies have suggested that the experience of the VE for the birthing person is often a damaging one, with some reporting feeling pain and embarrassment during a VE.[8],[9] Worryingly, several studies have found that some women and birthing people felt coerced or intimidated into having VEs without giving their full informed consent.[10], [11],[12],[13],[14]

Very little is known about the lived experiences of healthcare professionals and how they approach the VE within their clinical practices; Mary Stewart carried out a study in England in 2005 to understand how midwives negotiate the tensions that exist around the VE. She found that midwives often remove all language that can sexualise the procedure or cause embarrassment to either party - both during pregnancy and labour.[15] Not discussing the implications of a VE thoroughly can result in the creation of an unequal power balance between practitioner and birthing person, increasing that person's risk of being coerced into a procedure they do not want or need because they do not understand it.[16]

What is happening locally?

At the beginning of the project, I audited 55 sets of labour and birth notes, ensuring the sample contained a mixture of births from those having their first babies and those who have had babies before; both spontaneous and induced labours; and labours that took place in both midwifery-led and obstetric-led settings. The findings mirrored those found in the wider research - that VEs were taking place during labour more than twice as frequently than the 4-hour intervals recommended by the WHO[17],[18],[19],[20]. The audit also found that on average, each person in labour had 6 VEs performed by 4 different practitioners, also indicating that continuity between clinicians was not being achieved, increasing each birthing person and baby's risk of developing an infection.

In order to understand it from the birthing person's perspective, Nina Rickman and fellow service user representative, Nadia Higson, developed a survey which was released on the Trust and MVP social media pages. The survey received a staggering 150 responses within 24 hours- the biggest hit-rate the MVP or MTW have seen from a patient experience survey, seemingly indicating how passionately women and birthing people feel about the topic. The findings were mixed- although many reported that they were given excellent, compassionate care, many were left feeling otherwise. Only 17% of respondents knew about the alternatives to a VE, including their right to decline, and 54% felt that they didn't have a choice whether to have a VE or not. This raises issues around how informed the consent given for a VE truly is within maternity care, and how well practitioners discuss the risks, benefits and alternatives of a VE in comparison with other interventions.

Objectives of the Respectful VE Project

The Respectful Vaginal Examinations project aims to break down these communication barriers and encourage midwives and obstetricians to become comfortable discussing VEs during pregnancy and labour. Information will be created for women and birthing people in a variety of formats, including incorporating the discussion into parent education classes, to help increase the accessibility of that information. Posters will be displayed in clinical areas reminding women and birthing people of their rights to receive more detailed information about the VE, as well as their right to decline a VE at any point in labour. Work is also ongoing to develop a training package for staff, encouraging them to critically analyse their practice, make improvements to their care, advocate for women and birthing people and support informed decision-making. Training will also include increasing midwives' confidence in alternative, holistic methods of assessing progress in labour, so that they can feel less afraid of caring for those birthing people who choose to decline routine VEs.

We really hope that the work we are doing within the project will go on to improve the experiences of women and birthing people at MTW. We are aware that the issues we face are not isolated to our Trust - the over-reliance on VEs is a common problem across the globe, but we feel proud to be one of the first Trusts in the UK to address the issue head-on. Co-production has so far proved to be an invaluable component of the project, and we wholeheartedly believe that working on the project together will only make it stronger and more likely to succeed in improving the outcomes and experiences of everyone who uses our services.

Author Bio: Kelly Sawyer is the Deputy Consultant Midwife at Maidstone and Tunbridge Wells NHS Trust. She has a particular interest in promoting physiological labour & birth in high- and low-risk labours and advocating for choice and personalisation in maternity care. Her interest in VE practice started during her time working as a caseloading home birth midwife in South London, and she is about to embark on her first research project further exploring VE practices in the UK.

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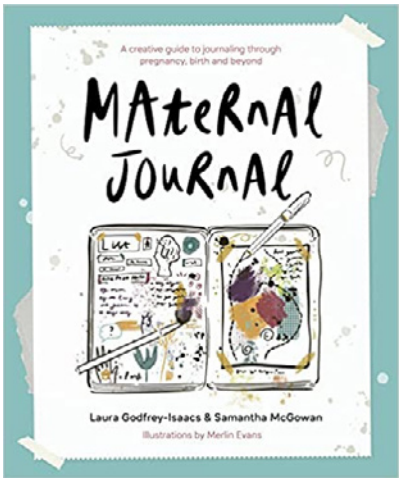
Book review

Maternal Journal: A creative guide to journaling through pregnancy, birth and beyond

by Laura Godfrey-Isaacs and Samantha McGowan

Illustrations by Merlin Evans

ISBN 978178066-745-4
Pinter and Martin (2021)
224 pages
RRP: £16.99



Reviewed for AIMS by Keren Williams

I always thought the term 'journaling' was an arty word for 'keeping a diary'. But after reading the newly published *Maternal Journal*, I realised it's whatever you want it to be – poems, lists, painting, sketching, mark-making, collage; the journal offers more than 80 creative ideas to help express thoughts and emotions. What I loved though, is how accessible it is. As a non-artistic person I easily feel intimidated by the pressure to produce something worthy but anybody can access these ideas.

Maternal Journal was produced as part of a project, funded by King's College, London, to improve maternal mental wellbeing, after research showed that 1 in 4 pregnant women are affected by mental health problems. Many women find that doing something creative on a regular basis can boost self-esteem, reduce feelings of loneliness and isolation, lower levels of stress and anxiety and help defeat depression. So 'journaling' is an ideal intervention – it requires very few materials and doesn't have to be time consuming.

Each 'task' in the book is clearly explained by individual artists, poets and writers and full of inspiring examples and illustrations. The directions lead you step by step and even have prompts to help you over the hump of writer's block or feeling stuck for artistic ideas. It starts with a simple 'list poem' – all you need is a pen and some paper and not much time. Ideal for a new mother but also a highly effective way to engage with your thoughts and suppressed feelings. Poet, Holly McNish, urges you to write 'uncensored' responses to open questions which help you access the deeper recesses of your mind.

Other suggestions are more colourful, such as Laura Godfrey-Isaacs' 'automatic drawing' session. The idea is to make art, drawing from your subconscious. Laura helps you tap into meaningful memories, thoughts or feelings and transform these into colourful representations; a swirl of lines or shapes, layered with collage or decorative washes or patterns – whatever takes your fancy. She encourages this to be abstract – a free-form response that liberates you from the need to be precise or skilful, rather than a faithful representation.

A more playful option that I loved was Machine Me, by Pia Jaime. She suggests making a collage of magazine images to create a mother machine – a sort of robot that performs all the tasks expected of a mother - cleaner/lover/gardener/therapist, etc,. You will end up with something that looks like a human Swiss Army knife, with a part for every demand. The image left me feeling simultaneously proud and exhausted, which is fairly accurate I suppose.

There are more targeted activities to help address specific problems, such as 'pain drawings', where you're encouraged to create an image of your pain; give it shape and colour and externalise the experience.

As well as being accessible for individuals to use, this book includes some really good resources for anyone wishing to set up a maternal mental wellbeing journaling group. And despite the project's origin in supporting maternal mental wellbeing, I really think that this book could be used by anybody because the concept is so broad and applicable to any stage of life. I love the quotations from inspiring writers, including Sylvia Plath. Susan Sontag sums up the value of journaling perfectly: 'In the journal, I do not just express myself more openly than I could to any person; I create myself.'

Reviewer Keren Williams is a midwife and mother of 22 year old twins.

AIMS Campaigns Team

Update - Continuity of Carer Implementation: always seeking to move forward

In this update, the AIMS Campaigns Team explains how we have been working with others this year to support the implementation of Continuity of Carer. AIMS looks forward to a time when we no longer talk much about a continuity of carer model of care, because this will be the standard model of care offered to all women and families. We take the opportunity here to summarise why this is so important for us.

AIMS has been campaigning for 'continuity of carer' for many years now, but since the beginning of 2022, we have been working with other charities and service user advocates [1] to bring focus to this most important of maternity services improvement topics. AIMS believes that the focused care of 'a midwife for me and my baby' is an essential foundation for truly safe, personalised and equitable maternity care. This midwife is the 'key account holder' for each of us seeking to access and navigate what can sometimes feel like extremely complex modern maternity services.

As our pregnancy, birth and postnatal journey unfolds, it is in the context of our relationship with this midwife that our decisions about the care we wish to receive will be best informed and best made. This highly-trained midwife, with an excellent ability to signpost us to the information we need, should have the autonomy to work in a way that recognises our individuality and all that we bring, with the full support of a multi-professional team and wider organisation. You can see what this model of care looks like from a service-user perspective here. This, for AIMS, is the crux - the foundation of each of the maternity transformation programmes underway across the UK, in England, Scotland, Wales and Northern Ireland. It is only by offering someone to walk alongside us, for our whole journey, that a safe service can be truly received, based on the best possible understanding of us and our needs.

AIMS recognises that this transformation is not a light undertaking. It requires a commitment to radical

organisational change, and a significant shift in the way, for example, some midwives understand their role and professional identity. But we insist on full spectrum continuity of carer as our transformation goal.

So for AIMS, it's not the why, it's the how. That's what we need to focus on now. That's what we're willing to help with. Wherever we can be of assistance, we relish the opportunity to be involved in conversations aimed at supporting this implementation journey - however hard that journey may be.

It has therefore been a privilege to be able to spend some structured time with others in the lay maternity improvement community this year, at a regular series of meetings, to share our perspectives and understandings on this key issue. This in itself provides a great opportunity for learning. For example, we shared our understanding that this policy - that we all support - is far from being implemented, six years on from the publication of Better Births, and that our role in this implementation programme might be crucial. We discussed how there remain key barriers to implementation, barriers that we can and need to better understand and - ideally - help to tackle together. We discussed how the good evidence for this model of care could be better communicated.

We have made a good start as a newly formed informal group, already having liaised deeply with the policy implementation team at NHS-England, with academic researchers, with senior midwives, and with the Royal College of Midwives. We have begun to engage with MSLCs (Maternity Services Liaison Committees) and MVPs (Maternity Voices Partnerships). We have recognised the need to build links to key decision-makers across the UK, as each nation goes forward with a slightly different implementation plan. We are already well linked in to England's Maternity Transformation Programme (MTP), as some of us in the group - including AIMS - sit on the MTP's Stakeholder Council.

From a service-user perspective, AIMS has been carefully observing and providing critical appraisal of the maternity services for over 60 years, and - in solidarity with those providing the services - we continue to do so, seeking to understand and inform discussions about necessary improvements. AIMS is heartened that we are joined in our call for the careful implementation of the Continuity of Carer model of care by so many other service-user led maternity service improvement organisations.

As the implementation proceeds, there will doubtless be rocky moments along the way. We trust that this new network will offer support as we seek together to understand and resolve such moments. As with maternity care, our maternity service improvement work is made all the more secure with ongoing trusting relationships in place.

The AIMS Campaigns Team thank Mary Newburn, long-time birth activist, for stepping forward to convene this group, in close collaboration with AIMS Volunteer and Campaigns Team facilitator Jo Dagustun.

[1] This is a recently convened group of charities which support the implementation of midwifery continuity of care and carer (MCoC) in England - the only such umbrella grouping in the UK taking this as their primary focus of attention. The group comprises representatives of: AIMS, Best Beginnings, Birthrights, First 1001 Days/Parent-Infant Network, Mummy's Day Out, NCT, Pregnancy and Babies Charities Network, Sands, St Thomas' Hospital MVP (parent), The Motherhood Group, Tommy's, White Ribbon Alliance, and service users, and is convened by Mary Newburn, who wrote a piece on Better Births implementation for AIMS in 2018: www.aims.org.uk/journal/item/the-chance-of-better-births.

Research Update

Continuing to Push for Midwifery Continuity of Carer

by Georgia Clancy, AIMS Volunteer

The push for midwifery continuity of care(r) has been a long one. First put into policy via Changing Childbirth in 1993,[1] 29 years later we're still figuring out how to make continuity a reality for all women in a way that works for providers too. In 2016, the Better Births policy offered a renewed commitment to continuity of carer:

to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.[2]

There is already considerable evidence to support the use of continuity of carer, with benefits such as fewer interventions and a higher chance of spontaneous vaginal birth for women,[3] as well as improving confidence, job satisfaction and workforce retention for midwives.[4][5] Recently researchers at King's College London (lead by Professor Jane Sandall who is also Head of Midwifery Research for NHS England) have been exploring the implementation of continuity since Better Births and trying to identify where further research is still needed. Back in February this year, the team at King's College London held an online update event on their work so far, highlighting three projects:[6]

The POPPIE trial [7] focussed on women who were likely to give birth prematurely receiving continuity from a specialist team of midwives. Despite the team coming up against many of the structural challenges usually associated with implementing MCoC (midwifery continuity of carer), 97% of women who took part in the POPPIE trial said that they would want a similar experience again, highlighting the benefits of personalised care and building a relationship with known midwives.[8] The POPPIE midwives who delivered care also reported the positive impact on autonomy, job satisfaction and support. Of course the midwives who volunteer to take part in a continuity of carer trial, may already favour this way of working and not all midwives may feel the same way. The Midwives' perspectives of continuity based working in the UK: A cross-sectional survey[9] found that whilst a third of midwives were willing to work in caseloading and/or team continuity models, barriers to providing this included concerns about changing shift patterns/place of work, night shifts, work-life balance, and the need for different skill sets in different workplace settings. Indeed, in my own research I heard midwives raise concerns about safety if providing continuity required them to work across birthplace settings, as well as the impact on work-life balance.[10] Overall, the POPPIE trial was found to be a feasible model for providing MCoC to a high-risk group.

Project 20 [11] was focussed on improving birth outcomes and experiences for women with social risk factors such as low socioeconomic status, black and minority ethnicity, homelessness, victims of abuse, and more. To do this, two models of maternity care for these women were evaluated: a community model in which women were cared for by a team and a hospital model where women had one named midwife.[8], [12] One point highlighted by this team was that continuity is not a 'magic pill' for poor health and social outcomes which require long-term multi-sectoral intervention. That said, the models of care explored here did seem to help as support from known midwives led to

increased disclosure of risk factors, reduced anxiety and improved safety (as midwives knew women's medical and social history). These factors seemed to be enhanced in the community model and indeed one member of the team, Victoria Cochrane, highlighted the importance of midwives actually being in the community – in community and children's centres – not just GP surgeries and hospitals.

Finally, we heard from the Lambeth Early Action Partnership (LEAP)[13] who were testing a community-based caseload MCoC model for women in areas of social disadvantage and ethnic diversity to try and reduce birth inequalities as part of the wider services LEAP offers to local families and children.[14] The study found that the preterm birth rate for women in caseload midwifery was less than half that of women in standard midwifery care (5.1% vs 11.2%) and the number of caesareans was also significantly reduced (24.3% vs 38%). It also showcased the value of local, community-based services that support women and families way beyond the usual six-eight week postnatal period.[15]

Overall it was a fascinating event put on by the team at King's College London which reinforced the benefits of MCoC and showed that there are ways of making continuity of carer the standard model for all women regardless of race, ethnicity, risk-category or postcode. Now that implementation of continuity of carer has begun in England, it will be interesting to see how these studies feed into those plans, and how the implementation will undoubtedly highlight areas where further research is needed.

Author Bio: Georgia Clancy is a research fellow at the University of Warwick. Her research explores women's childbirth preferences, decisions and outcomes in light of NHS England's Better Births policy. Georgia is also a member of the AIMS Campaigns Team.

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AIMS Campaigns Team

Our key priorities for 2022/23

The AIMS mission statement calls for us to "campaign for a system which truly meets the needs of all." More recently, the AIMS Campaigns Team has expanded on this, noting that, "We campaign for improvements in the maternity services based on a principle of proportionate universalism, to ensure that we have both high-quality services for all and services that are equitable and address inequity." In this piece, we explain what this means in practice, by offering readers an update on our key priorities for 2022/23.

AIMS is just one player in a complex and dynamic UK maternity service improvement community, but we believe we play a unique campaigning role within this community through:

- Making a strong and persistent case for change on key maternity service improvement issues
- Providing ongoing critical scrutiny, tracking developments in policy and practice, and holding government and the maternity services to account
- Responding frequently and robustly to consultations and policy documents
- Engaging others and raising awareness of issues via a range of campaigning outputs

Over the last year, we have developed a number of action-oriented Position Papers on key issues in the maternity services. We hope these will support campaigning by both our own Volunteers and other birth activists. We consider all of these topics - and others - to be important, but for the coming year we plan to focus our efforts on the following five aspects. We believe that progress in these areas would go far to address a number of our other concerns:

- Our call for physiology-informed maternity services.
- Our ongoing call for relational care for all (Continuity of Carer). We will continue to lobby for full, transparent monitoring of progress towards the targets included in the national maternity improvement plans of the four nations of the UK, and for the development of a vision for the next steps for delivering this model of care.
- Our ongoing support for, and scrutiny of, the Maternity Transformation Programme for England, including the implementation of the Better Births recommendations. Our ambition is to build a Volunteers base which would enable us to provide similar scrutiny of the corresponding programmes in Scotland, Wales and Northern Ireland.
- Our support for initiatives to deliver equity in the maternity services, including addressing racial inequalities {link to position paper once published}. We will also continue to support the efforts of other organisations who are campaigning specifically on this topic.
- Our work to address maternity service issues needing urgent attention in the context of the Covid 19 pandemic.

We look forward to working across each of these priority areas, alongside a wide range of colleagues across the maternity service improvement community.

We are particularly keen to recruit new Volunteers from Scotland, Wales and Northern Ireland to help us in this task.

As you may be aware, the AIMS Campaigns Team relies on Volunteers to carry out its work. If you would like to collaborate with us, are looking for further information about our work, or would like to join our team, please email campaigns@aims.org.uk.

Campaigns Steering Group

An Introduction to AIMS Position Papers – Birth Activist Update

For the latest in our occasional series of Birth Activist Briefings, AIMS is pleased to introduce a new series of AIMS position papers. In this briefing, we provide some background to these, explaining why we have produced them and how we hope they will be of use to you.

Over the years, AIMS has developed a reputation for taking a position on a wide range of maternity service improvement related issues. By developing a set of position papers, we aim to provide clear, accessible, and up-to-date statements of these positions, what AIMS believes needs to change on a particular issue, the evidence around the issue, what campaigning AIMS is doing, and what others can do to help bring about change.

What is an AIMS position paper?

Each position paper is clearly focused on an area that AIMS has identified as one in which maternity service improvement is necessary, and seeks to explain why. The papers are written by AIMS Volunteers, are fully referenced and provide concise information on the particular topic. They are available on the AIMS website in a PDF format and therefore accessible to anyone interested in maternity services improvement. They are action-orientated so the reader (you!) can determine what needs to be done. Conveniently there are links to other AIMS material of relevance to the topic.

These position papers are intended to provide our own Volunteers with guidance to draw on when they represent AIMS in their public-facing activities, and to enable AIMS to communicate our views to policy makers and other stakeholders in a way that ultimately contributes to an improvement in the maternity services. We hope that they will also be of value for other campaigning organisations and individual birth activists to use in their own local or national campaigning.

The first batch of position papers are currently available on the AIMS website and there will be more to follow:

- Physiology-informed Maternity Services
- Decision Making in Maternity
- Continuity of Care
- Obstetric Violence
- Choice of Birthplace
- Freebirth
- Racial Inequalities

Let's introduce the AIMS Position Paper on Obstetric Violence as an example:

The first section sets out AIMS position on obstetric violence. We call for the issue to be recognised and addressed nationally and at the local level. We explain why AIMS believes that many maternity service users are experiencing violations of their human rights. We note that AIMS supports the human rights of service users, including the absolute right to bodily autonomy. The position paper gives a summary of what obstetric violence is, and sets out why AIMS believes such experiences, and the physical and psychological injuries they cause, come to be normalised. The last couple of sections explain what AIMS is doing to raise awareness of the issue and how you can get involved to help to stamp it out. All factual information is referenced and there are links to optional reading as necessary.

How you can use it in your birth activist work

- Share it to raise awareness of the issue.
- Promote it to others who might want to use it to inform their own work, such as MVP (Maternity Voices Partnership) members or other individual birth activists.
- Share the birth information pages with maternity service users.
- If you have experienced obstetric violence, please consider making a complaint to your Trust/Board and/or the relevant professional body.
- If you are concerned about the behaviour of staff and/or Trust/Board policies and guidelines that may be causing cases of obstetric violence, please write to your Maternity Voices Partnership/Maternity Services Liaison Committee and/or your Trust/Board.

We hope you find our position papers helpful. If you have any comments on the content of any position papers, or suggestions for other topics that you would like AIMS to consider, please email campaigns@aims.org.uk and please consider joining AIMS to support our campaigning initiatives.

Article

Placing the Ockenden Report in context

by Cyril Chantler

The Ockenden report details harrowing accounts of avoidable human distress in a service dedicated to caring, kindness and the relief of suffering. It contains many recommendations for improvement. It is, however, sadly not the first such report - there have been others in the recent past such as Morecambe Bay, and there are others already in preparation for Kent and Nottingham. Thus the Ockenden report does need to be considered in the light of these other reports, begging the question as to why these awful events keep happening and whether we can reduce the number of times things go wrong and the number of places where this occurs. Ockenden does note that regulation does not seem to have been the answer.

There are multiple contexts to be considered and not only for the report itself but also the media's reporting of it and the Government's response. This requires reflection. One context is the overall safety of maternity services in England. As was noted by Donna Ockenden and the Chief Nurse and Medical Officer of NHS England in a letter to the Times, England is one of the safest countries in the world in which to give birth.[1]2 Not only that, but the stillbirth rate has fallen by 25% over the last 10 years, equivalent to 753 fewer stillbirths than there would have been in 2020 if the rate had remained at the 2010 level. The equivalent figures for neonatal deaths are a reduction of 36% or 412 fewer deaths. The media's response to the Ockenden report did not seem, at least to me, to recognise this context, which cannot have improved the morale of the many staff who have worked mightily to improve services over this period.

Another context to be considered is the other reports and recommendations for improvement that have been produced over this period. Amongst these is the National Maternity Review commissioned by NHS, and its recommendations in its report, Better Births, published in 2016. Over the last 6 years the Maternity Transformation Board (MTB) and our Stakeholder Council, which itself represents a large number of charitable and voluntary organisations that are working hard to improve services for women and families, have striven to get these recommendations into the service to produce more personal and safer care. Much has improved but there is more that must be done and Ockenden helpfully emphasises this. We know that it is vital to learn from mistakes and it was at our instigation that the government extended the remit of the Health Service Investigation Branch to include maternity, so that a consistent, no blame process involving the family and the staff is now available across the country. We have consistently argued that we need an administrative process, not one based on litigation, to support the families and to enable learning for the clinical teams when things go wrong, as has happened in Sweden. The Health and Social Care Select Committee now supports the introduction of such a system. It is interesting to reflect on what the doctor who oversees the system in Sweden said, when interviewed by the Health Select Committee. In his view, the main reason why the system works is the improvement in the culture that has occurred since their new system was introduced. As Ockenden emphasises, it is this culture that we all agree needs to be addressed. Personally I hope the Department of Health will reconsider their opposition to the administrative

2Editor's note - This is true except that, when compared only with other European countries, there is still room for improvement. https://www.statista.com/statistics/1240400/maternal-mortality-rates-worldwide-by-country/

system that we recommend at least for maternity, though not necessarily at this stage for the NHS as a whole. There are 28 recommendations in Better Births and the Maternity Transformation Board has put many of these into practice. One that has not yet happened, in spite of much effort and money, is a digital maternity care plan and record 'owned' by the mother but connected to all who are caring for her through the pregnancy, delivery and beyond. The Ockenden report recommends that it should be done!

In conclusion, there is much from which we can learn in the Ockenden report as indeed there has been from the other reports over the years. The emphasis on workforce issues is especially important. There is, however, a risk that if we don't consider the report within its wider context we may cease to sustain initiatives that are improving services whilst we adopt the new changes that are necessary. As we all recognise, it is urgent that we support the staff up and down the country who are working in such difficult circumstances at this time.

Author Bio: Professor Sir Cyril Chantler, whose early career focussed on kidney problems in children and who subsequently worked very broadly in healthcare leadership roles, was a member of the National Maternity Review team established in 2015 and chaired by Baroness Julia Cumberlege. That Review resulted in the Better Births report, which continues to underpin the work of the ongoing Maternity Transformation Programme in England. Julia and Cyril continue to support the implementation of the Maternity Transformation Programme in their respective roles as Chair and Vice Chair of the Maternity Transformation Programme's Stakeholder Council.

AIMS Campaigns Team Comment

Following the publication of the final Ockenden Report on March 30, 2022, AIMS published two commentary documents.[2], [3].

The AIMS Campaigns Team is now pleased to publish here these reflections from Cyril Chantler. We agree entirely with his suggestion that the Ockenden Report - and indeed the reports from East Kent and Nottingham currently underway - must be placed in the context of the ongoing Maternity Transformation Programme.

As members of the Stakeholder Council, the AIMS Campaigns Team commits to supporting that call and Journal readers might also be interested to read our statement prepared for the extraordinary meeting of the Stakeholder Council on April 8 2022.

END NOTES

[1] Editor's note - This is true except that, when compared only with other European countries, there is still room for improvement. www.statista.com/statistics/1240400/maternal-mortality-rates-worldwide-by-country/

[2] AIMS (2022) Ockenden 2022: if we want to see real change, then transparency and accountability is key. www.aims.org.uk/campaigning/item/ockenden-2022-if-we-want-to-see-real-change-then-transparency-and-accountability-is-key-says-aims

[3] AIMS (2022) AIMS Campaigns Team comment on the Ockenden Report and next steps. www.aims.org.uk/campaigning/item/aims-campaigns-team-comment-on-the-ockenden-report-and-next-steps

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AIMS Campaigns Team

What has the AIMS Campaigns Team been up to this quarter?

Written outputs:

Campaigns Team responses to the Ockenden Report Ockenden 2022: if we want to see real change, then transparency and accountability is key, says AIMS and AIMS Campaigns Team comment on the Ockenden Report and next steps

We have sent a letter to Sajid Javid, Secretary of State for Health and Social Care, re. Continuity of Carer in light of Ockenden Report.

Article by Jo Dagustun in Midwifery Matters, March 2022 Campaigning for physiology-informed maternity services: where shall we start?

Publication of another AIMS Position Paper Racial Inequalities in Maternity Services

Conferences and meetings attended

Jo Dagustun attended online sessions organised by the Midwifery and Maternity Festival team, including the
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weekly Maternity & Midwifery Hour. These sessions are recorded and available online.

- Jo Dagustun attended regular meetings of:
- NHS England's Maternity Transformation Programme Stakeholder Council
- the Royal College of Midwives re:Birth Project Oversight Group
- the MBRRACE-UK 3rd sector stakeholder group
- the group convened by Mary Newburn on Continuity of Carer
- Nadia Higson attended the NMPA's (National Maternity and Perinatal Audit) Clinical Reference Group meeting
- Jo Dagustun and Georgia Clancy attended a research seminar hosted by ARC-SL sharing recent findings about the benefits of Continuity of Carer models of midwifery care. This session was recorded and is available online.
- We met twice with representatives of the Royal College of Midwives, including as part of the Newburn Group, to discuss the implementation of Continuity of Carer.
- We met twice with representatives of NHS-E to discuss a range of maternity service improvement issues.
- On International Women's Day on the 8th of March, Jo attended CAHN (Caribbean and African Health Network) and The Independent events.
- Monthly meetings with a working group on one Zine Project on consent and obstetric violence. Watch this space!

What else we have been reading:

Government sets clear ambition to close gender health gap - (www.gov.uk)

Findings from the Care Quality Commission's annual survey of maternity services across England www.cqc.org.uk/publications/surveys/maternity-survey-2021

Maternity Transformation Programme regular bulletins - you can sign up here.

The Chief Midwifery Officer's email bulletins for NHS England. This one is from January/February and includes a link if you'd like to subscribe.

News that a new Chief Nursing Officer for Northern Ireland has been appointed from March 2022 www.health-ni.gov.uk/news/maria-mcilgorm-appointed-chief-nursing-officer-northern-ireland

The NMPA audit Obstetric interventions and pregnancy outcomes during the COVID-19 pandemic in England: A nationwide cohort study - (plos.org)

A paper exploring the use of sexed language in maternity care: Frontiers | Effective Communication About Pregnancy, Birth, Lactation, Breastfeeding and Newborn Care: The Importance of Sexed Language | Global Women's Health - (frontiersin.org). The purpose of this paper is "to increase understanding of why and how language regarding pregnancy, birth, lactation, breastfeeding, and newborn care is being desexed and to empower readers to consider the implications of these changes in their own contexts."

NICE quality standard on Fetal Alcohol Spectrum Disorder issued on 16 March 2022.

NIHR Evidence - Care and decision-making in pregnancy Maternity and Midwifery - Humanising childbirth in the aftermath of the final Ockenden report

What we have been watching:

Parallel Mothers - a new film touching on birth and early motherhood, from acclaimed director Pedro Almodóvar

The BBC series This Is Going to Hurt, based on the book by Adam Kay

BBC Two - Yorkshire Midwives on Call

Thanks to all the AIMS campaigns Volunteers who have made this work possible. We are very keen to expand our campaigns team work, so please do get in touch with campaigns@aims.org.uk if you'd like to help!

AIMS

There for your mother

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Helpline

helpline@aims.org.uk

0300 365 0663