AIMS JOURNAL

AIMS at 60

Making a difference past and future

Volume 32, Number 3

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Association for Improvements in the Maternity Services

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Contents

Editorial
Looking back to move forward 4
By Debbie Chippington Derrick, AIMS Trustee

Articles
AIMS during the 1960s 7
by Dorothy Brassington, AIMS Trustee and Treasurer

AIMS during the 1970s 10
by Shane Ridley, AIMS Trustee

AIMS during the 1980s 16
by Verina Henchy, AIMS Trustee

AIMS during the 1990s 18
by Nadia Higson, AIMS Trustee

AIMS during the 2000s 20
by Emma Ashworth, AIMS Trustee

AIMS during the 2010s 24
by Virginia Hatton, AIMS Trustee

Running maternity services during the coronavirus pandemic: keep calm and don't forget the woman! 28
By Natalie Carter, Consultant Midwife,

Interview
An Interview with Baroness Julia Cumberlege 32
by Rachel Boldero

Research in Focus
Researchers leading surveillance of how Covid 19 is affecting pregnant women and babies 35
By AIMS Campaign Team

Campaign Update
What has AIMS been doing? 36

Article
#Fivexmore: Addressing the Maternal Mortality Disparities for Black Women in the UK 38
By Tinuke Awe & Clotilde Rebecca Abe

Birth Activist Briefing
Introducing England's new Regional Chief Midwives 40

Book Review
A Social History of Maternity and Childbirth: 41
By Tania McIntosh

Editorial

Looking back to move forward

By Debbie Chippington Derrick, AIMS Trustee

I am honoured to be writing the editorial for the AIMS 60th Anniversary Journal. When AIMS was founded in 1960, the NHS was only 12 years old. AIMS' history is closely intertwined with the changes we have seen in the NHS over that period of time. The early AIMS Newsletters and later the AIMS Journals provide a window into the experiences and concerns of those using and working in the maternity services over those six decades.

We, the current AIMS Volunteers, stand on the shoulders of those who have gone before us, benefitting from the understanding that has been developed over the decades, passing what we do from generation to generation. So it is an appropriate time to celebrate AIMS Volunteers, those who have gone before as well as our current Volunteers, and to look forward to welcoming new Volunteers who are our future. AIMS is, and always has been, its Volunteers.

It is important that we not only celebrate the AIMS names that you will have heard over the years, but also the unsung heroes who have kept the AIMS ship afloat, those who have carried out management and admin roles, that have allowed others to be able to provide information and support, or campaign. One example of behind the scenes work was the scanning of all our early Newsletters and Journals. These had been carefully saved, and then scanned by Volunteers, meaning that we have nearly all our AIMS Newsletters and Journals to draw on for this Journal. This enabled us to look back, and share some of that content with you. We still have an ambition that at some point we will be able to share all that content on the website.

In the early years, AIMS started publishing a quarterly Newsletter which was sent to members, and these quickly started to develop to include articles, book reviews and other pieces that you would expect to see in an AIMS Journal today. The first edition that was published bearing the title 'AIMS Journal' was in Spring 1982, and at the beginning of 1989 the first Journal bearing a Volume number was published. Volume 1 No 1 was titled "Death of Choice" and focused on the demise of GP units.

So, now to the delights of what we have for you in this Journal. My fellow Trustees have each spent time reading the Newsletters or Journals from one of the decades. I am very grateful to them for their insightful reviews of these, highlighting how things have changed, or not, since they were written. I have really enjoyed reading about what they found interesting from each decade and I hope that you will too.

Dorothy Brassington, our AIMS Treasurer, writes about the Newsletters from AIMS' first decade and highlights an interesting list of what AIMS recommends which starts with more midwives! Shane Ridley takes us through the Newsletters of the 70s. She reports on how AIMS started that decade by carrying out a large survey reaching 2600 people, no mean feat when these all had to be sent and returned by post, and the results put together on paper. She concludes with a quote from an AIMS member asking 'Have we in AIMS got our priorities, right?' a question which we do try to make sure we keep asking ourselves, and one that we would love to hear your thoughts about.

Verina Henchy looks at the Newsletters and Journals of the 1980s focusing on the issue of Ultrasound about which the same questions are still being asked today.

The articles of the 60s, 70s and 80s have not been made available online before, but some of that content is now available now on the following pages www.aims.org.uk/general/1960, www.aims.org.uk/general/1970 and www.aims.org.uk/general/1980, including those which Dorothy, Shane and Verina talk about. So please, when you have finished reading this Journal, do have a browse.

Nadia Higson takes us through the 90s with warnings about overuse of drugs such as oxytocin, rising caesarean rates, difficulty getting support with VBAC and access to waterbirth; which as she says all sound a bit familiar, but she manages to find good news too, news that we need to hold onto to continue moving forward with the work we do.

Emma Ashworth follows the waterbirth issues into 2000s, she then discusses what AIMS was saying about how women and midwives were being traumatised by our maternity services. She also looks to where we are going in the work we do, and I would like to repeat her words "Knowledge is power, and sharing knowledge is sharing power". This has been the strength of AIMS right from the start and is crucial for our way forward.

Virginia Hatton looks at the last decade focusing on three key issues. The first of these is the issue of the privatisation of the NHS with the Health and Social care act of 2012, and the impact on Maternity Services. She then looks at what AIMS has been saying and doing on the issues of equality, diversity and inclusivity in terms of gender, and finally at the issue of racial equality and the clear health inequalities which have now been made so apparent.

We are very pleased to also be able to include an interview with Baroness Julia Cumberlege who chaired both the Changing Childbirth report and the latest English Maternity Review leading to the Better Birth report. She congratulates AIMS on achieving 60 years, and commenting that "AIMS have kept up the momentum, understood the changing world and how they can contribute" and that she hopes we will keep up the momentum to try to achieve the 28 recommendations of Better Birth. She also talks about the midwife's skill at the birth of her first baby, with a GP in attendance, the normal medical back up for midwives at the time should there be problems during the labour or birth.

The book review in this Journal is of Tania McIntosh's book 'A Social History of Maternity and Childbirth: Key themes in maternity care'. The book looks at maternity care from 1902 to 2002, and includes an exploration of the role of AIMS in promoting improvements in the maternity system.

We have a full Campaign section in this Journal. In the second 'What has the AIMS Campaigns team been doing?' we update you on the activities of the last three months. We bring you the first 'Birth Activist Briefing' which introduces the Regional Chief Midwives from NHS-England. We hope to make this a regular feature, providing information about maternity services which we think Birth Activists will find useful. We will particularly focus on changes that are happening and will be making suggestions about action that can be taken. Please do have a look and consider taking up the suggestions and letting the campaign team know how you get on. We also comment on the preliminary report from the UKOSS surveillance study on COVID-19 in pregnancy.

We are very pleased to have Tinuke Awe and Clotilde Rebecca Abe introduce the Five X More campaign. They tell us how they came to found the campaign, what the issues are and what they want to see happen to start to address the health inequalities for black women having babies in the UK; and how you can help to support their work.

Natalie Carter, Consultant Midwife at Chelsea and Westminster NHS Foundation Trust, talks about how they have managed their midwifery service since March 2020 despite restrictions due to Covid-19. As the AIMS comment says at the end of the article, we had reached out because we heard that they were not following many other NHS Trusts in shutting down services that women were telling AIMS were more, not less, crucial, for them during the pandemic. The campaign team would be very interested to hear from women who have received care from Chelsea and Westminster NHS Foundation Trust since March 2020 , and how well they feel that their needs have been met.

I would like to finish by coming back to the importance of AIMS' Volunteers, Members and Supporters. AIMS is what we all bring as individuals choosing to be involved in different ways. We do appreciate those who share AIMS

Editorial contd.

information and we do have a mailing list which can be signed up tocan be signed up to here. However, without our Members we would not be able to continue financially and without our Volunteers we could not put together the Journal, publish books provide birth information pages, run the helpline or campaign.

Whilst working through the content for this Journal I found a piece in the 1990 Journal which said that membership was being increased to £1E8 per year, and was struck by the fact that is has only gone up £7 in 30 years (it would be just over £41 if we had raised it in line with inflation). We have felt for a while that we don't want to increase the finance burden on our current Members, but instead reach out to a larger group to help us continue.

For our sixtieth we have been asking YOU to raise £60 pounds and/or to recruit six new AIMS Members. If everyone who read this editorial was able to do one of those things YOU would have put AIMS in a very good position to be here for the generations of the next 60 years.

So please, if you are not a member then please do consider joining us and if you are, consider who else you know that should be and talk to them about what membership of the AIMS Charity supports. If you would be interested in taking part in the challenge to raise £60 for the 60th, there is more information on our fundraising page.

And if you have some time to offer to AIMS as a Volunteer, then please do considering joining our growing team. Over the last few years we have developed ways of working which have enabled more people to get involved, many doing small occasional tasks that only require an hour or two infrequently, others get involved in ways that require a regular commitment, with a smaller number whose lives have come to revolve around AIMS. Currently we have about 50 active Volunteers keeping AIMS moving forward. For more information about getting involved, from supporting us with specific tasks occasionally, being involved with the management of our work or becoming a Trustee, please see our vacancies page.

Also to celebrate AIMS 60th we have been asking for your stories about what AIMS has meant for you. We want to collect 60 short stories which we can share in the Journal, on our webpage, on social media and at our 60th birthday event (which has been postponed until June 2021 due to coronavirus). We would love you to share your stories of what AIMS has done for you, your family or friends. Please send us your story (maximum 250 words) and a photo if possible to campaigns@aims.org.uk. We have a few we can share with you here.

I don't think that those who banded together following Sonia (Sally) Willington's letter in appeared in a national newpaper, nine months after she wrote it, realised quite what revolutionaries they were and quite how they were at the forefront of consumer organisations driving change. AIMS has continued for 60 years as a Volunteer run organisation – led by volunteers, managed by volunteers, and the work on the whole is carried out by volunteers. This is a challenge for us as Volunteers balancing work, family and volunteering, but one that is hugely rewarding, too. I was asked years ago whether what I did was a hobby, after a moment or two thought my response was 'no, it is an obsession'. I find it very difficult to turn away from the plight of others trying to 'navigate the system as it exists' but would really like to think we can get to a point where we have 'a system which truly meets the needs of all'.

So, please share the Journal and other AIMS information, recruit new AIMS members and Volunteers, and light your candles.

Article

AIMS during the 1960s

by Dorothy Brassington,
AIMS Trustee and Treasurer

It has been fascinating to read the early newsletters and discover exactly what AIMS was set up to deal with. I have been shocked by the many reports of the appalling state of many hospitals: usually cramped, often filthy and once a ceiling actually fell down on a ward full of mothers, babies and visitors. The emotional treatment of mothers and babies was even worse. Most hospitals would not allow husbands to be with their wives during labour, when this was permitted he was ejected at the end of first stage. There was a chronic shortage of midwives, which only got worse during the decade as the birth rate climbed, so many mothers were left alone during labour, reporting that this was the hardest aspect of the birth. The vocabulary seems archaic now: fathers were always husbands, mothers were often homemakers; they went into confinement. And I never worked out exactly what the "space suit" and Frilene machines were, except that they were early attempts at pain relief of some kind.

I cannot resist a few random quotes. It was generally accepted as fact within AIMS that Cornwall had no incubators and that premature babies were dying as a result of this lack. The energetic Newcastle AIMS regional group raise money to buy one, but in 1963 Newsletter 8 reported:

"the South West Regional Board said that after all there was an incubator at Redruth Hospital but that it was out of sight in a cupboard because the Consultant does not believe in their use. Newcastle Group have sent £50 to War on Want"

And, although from very early on AIMS representatives were asked to meet with the Ministry of Health, many hospital boards were very unwilling to listen to AIMS, let alone learn. From Newsletter 5 in 1961

> *".. met with some members of St Mary's Hospital (Portsmouth) Management Committee … and the Management Committee, while acknowledging that the Unit was very understaffed and that the physical conditions there were poor, stated that they were not responsible for the mothers' emotional state, and considerate treatment could only be expected by private patients, Tempers became very heated and no good came of the meeting."*

I was impressed by the dedication and ambition of the early members – not satisfied with working for the reform of the maternity services, they also joined with other organisations to campaign for cervical cancer screening. In particular I was awed by the energy and accomplishments of Mrs Willington, who set AIMS up and guided it for many years. I look at her list of AIMS' recommendations for the maternity services and am amazed both by how far we have come and how far we still have to go. So I will conclude with her own words, from Newsletter 4 in 1961.

"Human Relations in Obstetrics" comes as a kind of first birthday card to A.I.M.S. This report by the Minister of Health's Standing Maternity and Midwifery Advisory Committee says:-

> *"The Committee received a general complaint that many hospitals had too little regard for the personal dignity and emotional condition of women during pregnancy. Most, but not all, of this evidence was given by women's organisations, much of it from mothers who had had experience of delivery in hospital.*

Correspondence and articles in the medical papers, newspapers and women's journals have shown that criticisms are sufficiently widespread to merit serious attention. While it probably is true that the mothers who are satisfied with the treatment they received say little, the extreme interest shown in ——'s inaugural lecture at the opening of the new professional unit at Charing Cross Hospital has emphasised that there is room for improvement in the way in which some mothers are treated during childbirth both at home and in hospital.

It goes on to list type of complaint, cause of complaints and suggests methods of overcoming some of these complaints. Mr. Enoch Powell, the Minister of Health, emphasised that he was aware that much excellent and devoted work in midwifery went unpublished, but he sent the report to hospitals asking for their proposals to remedy the situation to be sent to him by July 31st.

Write to your Hospital Management Committee and offer them your help and ideas for improving the maternity services. Do it now. (Not next August!)

The Observer *said:- "It is up to women to see that their local hospitals pay attention to the report." It is! It is also up to midwives to demand better working conditions.*

The Times *for April 5th said:-*

"The conclusion of the Standing Maternity and Midwifery Advisory Committee that there is room for improvement in the way in which some mothers are treated during childbirth at home and in hospital will strike many mothers as mild. Their report comes after, some little time after, a remarkable outburst of complaints which found a valuable catalyst in the assertion made last year by Professor — — that the existing hospital system "often fails miserably in its care of the patients' emotions". The joys, hopes, and wonder that the arrival of new life should bring are spoiled, he observed, and splintered into loneliness, indignity, and despair, and there is nothing in the report to suggest that he was exaggerating. The committee did not say – perhaps they do not know – how widespread the dissatisfaction is or how reasonable, but they are sufficiently impressed to set out some sensible ways of overcoming or avoiding it. At the core of the problem is the chronic inadequacy of the physical conditions and the shortage of midwives. But also there has been little serious study of patients' emotional responses to pregnancy and labour. There is no conceivable defence for a situation in which, for example, patients apparently can be so frightened to ring a bell that they delivery their babies unaided. No doubt it is a nuisance to harassed doctors, midwives and attendants that patients should no longer be satisfied with squalid premises or content to be treated as the passive burden of an intensive conveyor belt system, but it is a healthy symptom of an educated and affluent democracy that they are not, and a corresponding change of attitude among hospital staff is called for. An important obstacle here is the dead hand of hospital routine. Waking wards unnecessarily early, for example, is one of the items in the traditional pattern of an inpatient's day which were critically discussed in a report published last week by the Central Health Services Council. Changing it will require both zeal and perseverance, and it is doubtful whether occasional committee reports or ministerial memoranda alone will accomplish it. It is sobering to reflect that more than two years ago the Cranbrook committee drew attention to a general complaint that many hospitals had too little regard for the personal dignity and emotional condition of women during pregnancy. In fact, the report published today adds little that is new to the state of public knowledge, and it will be a matter of some concern to see whether it will add much that is new to the treatment of women before and after their confinement. Which prompted a letter to the Times *which said*

'.... it is recommended that the mother be 'received and treated kindly'.

Could there be a more searing comment upon a state of affairs that probably exists in many hospitals ?"

On the day this report came out I was talking to a branch meeting of the Royal College of Midwives at Canterbury. (I was therefore unable to appear on B.B.C. Television's programme 'Tonight' even though a car was offered to rush me back to London). Here I was told that the midwives are tired of feeling that they must apologise to the patients for bed shortages and lack of space, and to would-be trainee midwives for the dilapidation of the building. The ante-natal clinic is so inadequate that strong complaints about it from the mothers would be welcomed so that it could be drawn to the notice of the general public. This is a "happy" maternity unit. Friendliness and freedom are positively encouraged. The mothers are satisfied but the staff are not. They are "up to strength" but they are irked because the number of mothers (720 births last year with only 27 beds) is too great. They are

not able to give as much care and attention to each mother as they would like. If an emergency is brought in another mother must be sent home in order to make room. The staff feel that they cannot protest (although I wish that they would). It is this type of pressure of work and frustration at being prevented from giving of their best which drives more midwives away from the profession than the activities of A.I.M.S. ever will. Joy in their work can be marred by adverse conditions of work, which in some cases leads to shortness of temper and bad feeling.

If midwives are to have improved working conditions, more pay and better administration, where is the extra money to pay for these things to come from ? Write and ask your M.P. this question.

Ante natal clinics should not have to be conducted in a small room containing a dentists chair and a screen with a bed pan behind it for supplying urine samples, in dirty, draughty drill halls. Or in places where mothers must wait for hours on hard benches to be seen by doctors in a hurry, without privacy, modesty or civility. The low standard of cleanliness in some hospitals must be experienced to be believed. A mother should not be made to feel that all humanity has deserted her in her hours of need because a midwife is expected to care for too many mothers at once.

As long as these things exist in some places we should not be complacent about our Welfare State. The midwives have never had it so bad. The Matron of a large London Hospital fears a return to the "times of Sarah Gamp" if something is not quickly done to solve the problem of the shortage of midwives. At the same time she thinks that accounts of poor maternity care should be publicised rather than officially hushed up.

A.I.M.S. recommends:-

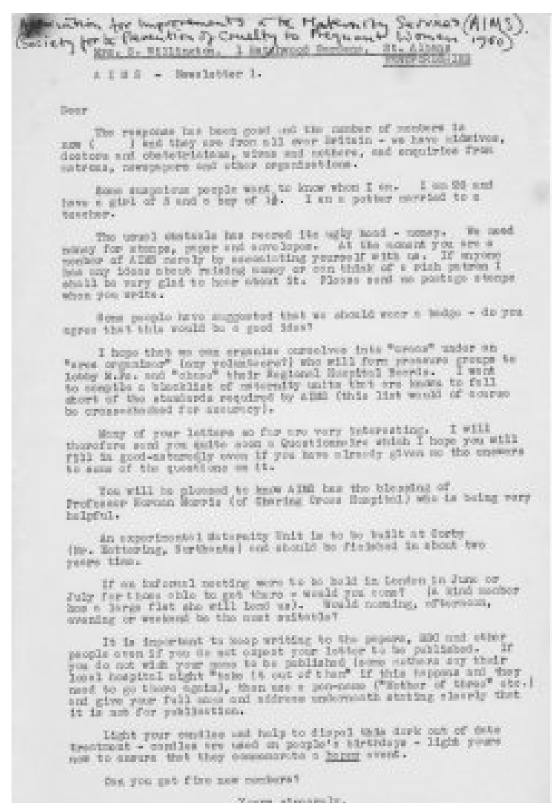
1. A prestige campaign to get more midwives and good working conditions, time off, more pay, an attractive uniform, prestige posters about their work.
2. The building of ideal Maternity Units.
3. An inspectoral system for all hospitals.
4. The appointment of a sensible person to the post of co-ordinator of all maternity services in each region.
5. Further research into analgesia.
6. Training of male S.R.N. as midwives.
7. More "obstetrical doctors" both in hospitals and amongst G.Ps.
8. Voluntary help:- "Mothers' friends"

a) Sitters-in with mothers in labour when a husband is unable to be there

b) Helpers-out at home confinements (caring for small children, helping when the Home Help Service is inadequate or not available.).

c) Helpers-out in a mother's home if she has to go to hospital, and after her return from hospital.

d) Midwives-helps at home births – i.e. the "third person in the house" in case of emergencies – if no one else is available.



Association for Improvements in the Maternity Services (AIMS). (Society for the Prevention of Cruelty to Pregnant Women 1960)

Mrs. S. Willington, 1 [illegible] Gardens, St. Albans

A I M S - Newsletter 1.

Dear

The response has been good and the number of members is now ([illegible]) and they are from all over Britain - we have midwives, doctors and obstetricians, wives and mothers, and enquiries from matrons, newspapers and other organisations.

Some suspicious people want to know who I am. I am 28 and have a girl of 3 and a boy of 1½. I am a mother married to a teacher.

The usual obstacle has reared its ugly head - money. We need money for stamps, paper and envelopes. At the moment you are a member of AIMS merely by associating yourself with us. If anyone has any ideas about raising money or can think of a rich patron I should be very glad to hear about it. Please send me postage stamps when you write.

Some people have suggested that we should wear a badge - do you agree that this would be a good idea?

I hope that we can organise ourselves into "areas" under an "area organiser" (any volunteers?) who will form pressure groups to lobby M.Ps. and "chase" their Regional Hospital Boards. I want to compile a blacklist of maternity units that are known to fall short of the standards required by AIMS (this list would of course be cross-checked for accuracy).

Many of your letters so far are very interesting. I will therefore send you quite soon a Questionnaire which I hope you will fill in good-naturedly even if you have already given me the answers to some of the questions on it.

You will be pleased to know AIMS has the blessing of Professor Norman Morris (of Charing Cross Hospital) who is being very helpful.

An experimental Maternity Unit is to be built at Corby (Nr. Kettering, Northants) and should be finished in about two years time.

If an informal meeting were to be held in London in June or July for those able to get there - would you come? (A kind member has a large flat she will lend us). Would morning, afternoon, evening or weekend be the most suitable?

It is important to keep writing to the papers, BBC and other people even if you do not expect your letter to be published. If you do not wish your name to be published (some mothers say their local hospital might "take it out of them" if this happens and they need to go there again), then use a pen-name ("Mother of three" etc.) and give your full name and address underneath stating clearly that it is not for publication.

Light your candles and help to dispel this dark out of date treatment - candles are used on people's birthdays - light yours now to ensure that they commemorate a happy event.

Can you get five new members?

Yours sincerely,

Newsletter No 4, 1961

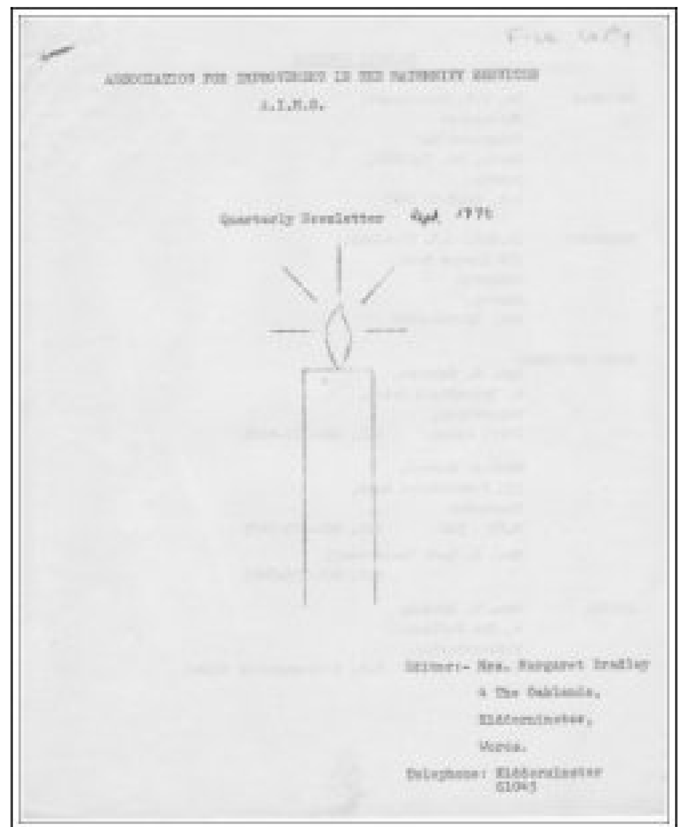
To view the newsletters mentioned in this article and that we have in our 1960 collection see:

The 1960 Newsletters

Article

AIMS during the 1970s

by Shane Ridley AIMS Trustee



A.I.M.S.

Quarterly Newsletter

AIMS

Association for Improvements in the Maternity Services Quarterly Newsletter

I decided to read through the 1970s, starting with the Quarterly Newsletter for September 1970 which was typed by Mrs M Bradley of Kidderminster. Dr P M Fox-Russell was Chairman, Lt Col W J Fletcher the Treasurer, and two press officers Mrs S Suthers and Mrs J Leyden. Mrs J Lowe was the Secretary.

In this year, they managed to achieve a national questionnaire sent out to 2,600 people after publicity given in the Guardian, the Times and the Telegraph. Enquiries for the results came from Good Housekeeping, Pulse (a GP's magazine) and a Scottish journalist. Completed forms were returned from all over the world – all relating to births in the UK. Mrs Suthers was the recipient of all the returned surveys, spending many hours with some of the group and her husband, opening and sorting the responses. This was all achieved by post – no easy internet then! The stamps were all saved and sent to Oxfam.

The editorial explains that there is a new Government but with fewer women MPs – interestingly it doesn't mention the party but hopes for new ideas (it was the Conservatives under Edward Heath).

Editorial.

A.I.M.S. seems to be heading for an exciting time. The national questionnaire is going ahead, with a hugh response, and it seems that the boom we have worked for and waited for may finally be on the way. Be prepared, by reading as widely as possible. Get your own ideas sorted out, in time to welcome new members.

There is a new Government, and new ideas. Look at the new ideas squarely, and consider the effect on your local maternity services. If I had paid for my hospital 'keep' when my first child was born, I might have complained about the food, as well as the treatment. As it was I swallowed the Spam and Mash a la NHS, without a word.

There are now even fewer women M.P.s, let's hope that the gentlemen use a bit of imagination when they organise our health service.

....

At this time, AIMS was trying to set up new groups around the country, such as Bury, Bedford, Birmingham, Manchester and London. Lots more members were gained because of the questionnaire. At this point they had 100 paid up members and £31 in the bank! As we often do now, they used Friends Meeting Houses for their central meetings which appear to be very formal, but also the Oxford and Cambridge University Club on Pall Mall.

They seemed to have a good relationship with the Guardian newspaper and comment on an article about mother-care in hospital for young child patients. Another comment:

> *"……AIMS should educate couples to want to be together at a birth, and to ask. Flat refusals seem rare, it is more often the case of patients and their relatives being afraid to ask. Progressive hospitals have got around to inviting relatives to help, but other hospitals may be more willing than we think. What we need are posters to put up in antenatal clinics. 'Why not ask Sister to arrange for your husband to be present when your child is born – you only have to ask.'"*

The local members visited Hope Hospital in Salford known locally as the Salford Hilton. They were very impressed with several initiatives, including a toilet in the Enema Room, encouraging husbands to attend both the hospital and the birth, antenatal ward chairs having arms and postnatal ones with no arms to help mothers feed their babies. There was a GP unit and the wards were either 2, 4 or 6 bedded with some single rooms. *"Everything had been thought of, and members wished that all mothers and all staffs could have facilities like these."*

Comment: enemas were such a routine intervention at the time there were often dedicated rooms where it could be done.

There is a letter and response to a consultation by the Department of Health and Social Security on the future structure of the Maternity Services.

It looks as though they used the results of the questionnaire to supply the answers. It is a little difficult to decipher as we don't know the questions, but some of the comments resonate today:

> *"We would continue to urge the recruitment of midwives as we believe that the shortage of midwives is still the cause of women being left alone in labour and generally not receiving the care and attention they require. A few overworked midwives can but perpetuate poor human relations."*

Article contd.

They talk about the possibility of maternity aid – a person who would help at home. At this time, AIMS had an active Voluntary Sitters Scheme. The response was asking for these maternity aid workers to be paid – even suggesting a state lottery to help pay for it.

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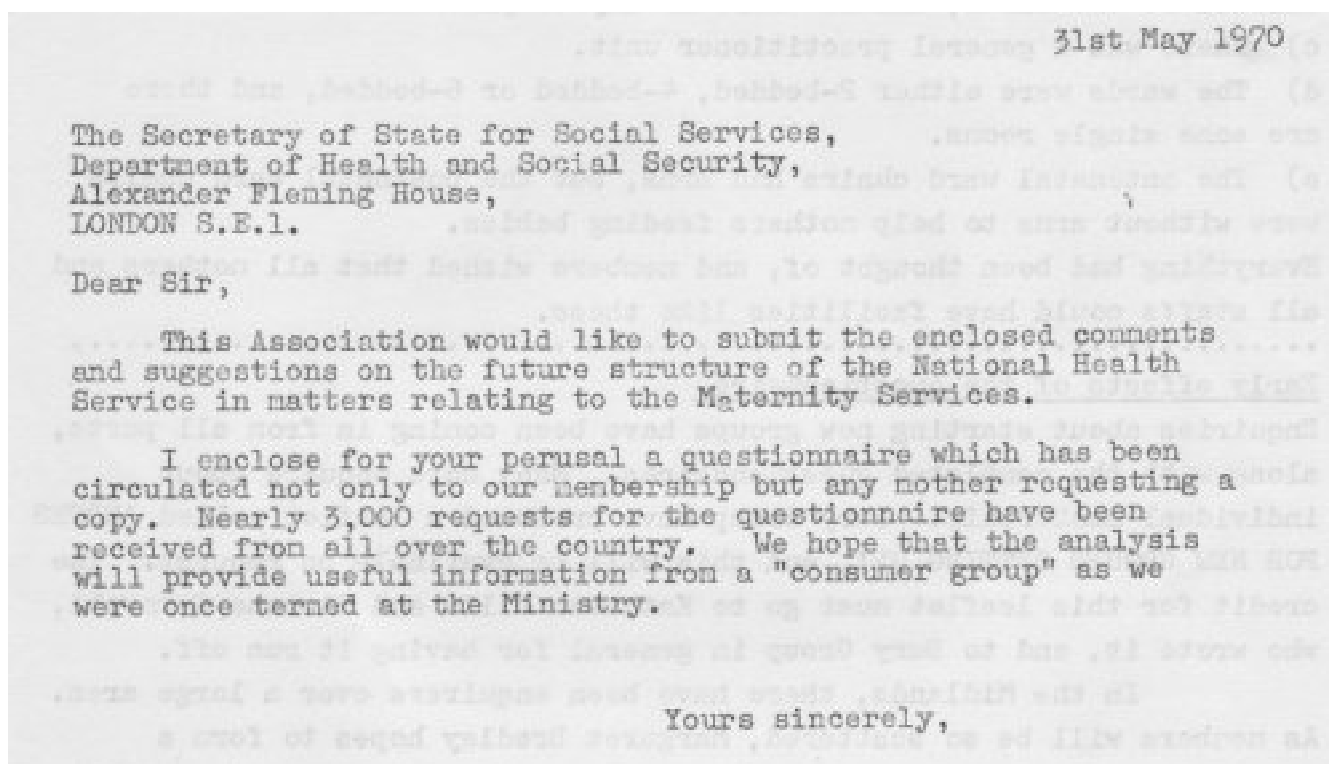


31st May 1970

The Secretary of State for Social Services,
Department of Health and Social Security,
Alexander Fleming House,
LONDON S.E.1.

Dear Sir,

This Association would like to submit the enclosed comments and suggestions on the future structure of the National Health Service in matters relating to the Maternity Services.

I enclose for your perusal a questionnaire which has been circulated not only to our membership but any mother requesting a copy. Nearly 3,000 requests for the questionnaire have been received from all over the country. We hope that the analysis will provide useful information from a "consumer group" as we were once termed at the Ministry.

Yours sincerely,

A quote from an article which had been printed in the Guardian also highlights the "sweet and sour" of charities – *"Volunteers are cheap, which is one good reason for the Government to have latched on to them to help bale out the welfare services."*

Comment: Sadly, this is still so often the case.

Skipping through the 1970s (there is a lot to read) I noticed the following snippets:

- AIMS articles appeared in other magazines such as Mother
- 21 members at the AGM on 26th April 1975 – they still had groups around the country
- Family Planning became free on 1st July 1975
- Quote from procedure from the North West, "although not illegal for a midwife to accept a patient for home confinement, such an arrangement is no longer satisfactory, and any midwife who took such action might well find herself in the position of having a case of malpractice to answer"
- Quote from a hospital in London June 1975. 'When Marie was seven days old my husband had been visiting and at 8.30pm Marie starting yelling. I let her yell for 15 minutes, then I decided that everything I did wasn't going to settle her down so I started feeding her. I'd just got my baby settled on the breast when Sister ----- came in and saw me feeding, so she just walked up and pulled Marie off the breast and tossed her back in the cot. When Marie was six days old I made

my first attempt to bath her, and the sister kept coming in and said "Haven't you finished yet? I could have bathed two babies in this time"

- Beverley Lawrence Beech became Chair of AIMS in April 1977, a post she held until 2017

Jumping to Winter of 1979

A Conference was held to discuss a document from The Children's Committee – Reduction of Peri-natal Mortality and Morbidity. Miss Margaret Bain, a midwife, gave a 'stimulating talk' including speaking about Continuity of Care – 'midwives needed to be known locally by the young mothers…. thus being able to provide continuity of care'. She felt that many women felt abandoned in the post-natal period but early discharge was a good thing – the mother could then be visited by the midwife in her own home and have continuity of care.

Dr Anne Oakley presented a paper on 'The Consumer View', amongst her comments she asked what women wanted? They want to be treated as intelligent human beings, not as individuals on an assembly line; they noted the depersonalisation and long waiting times at clinics and the reluctance of the professionals to give information and the unnecessary intervention. She also noted the reluctance of women to complain but as she very pithily put it 'it is unwise to tell the garage attendant that you don't like the way he talks to you when you are waiting for him to start your car'!

A very interesting article on Special Care Baby Units (SCBU) – Benefit or Hazard?

Special Care Baby Units - Benefit or Hazard?

The more technology becomes available the more we tend to use it. In obstetrics we have seen the use of induction wax and wane as the fashion changed, and it turned out not to be the answer to peri-natal mortality as was first thought. The same with the enthusiasm for foetal monitoring (a recent article suggests that a scalp electrode, measuring the p.h. of foetal scalp blood may not reflect at all the p.h. in the rest of the baby's blood. ('Lancet' Nov. 3 1979).

Is the same happening with special care baby units? A recent publication by Martin Richards et al - Clinics in Developmental medicine No.68 'Separation and Special Care Baby Units', suggests that it is.

It seems that because the technology was available, obstetricians and paediatricians were taking some babies into the SCBU routinely, such as twins, breech presentation, forceps and caesareans, rather than train midwives, nurses and doctors to watch carefully 'at risk' babies in the ordinary post-natal ward without taking the babies away from their mothers. Research was beginning to show that it could be detrimental to the parent/child relationship with possible lasting effects. About one such study they say "Infection was thought to be a reason not to let parents handle very small babies but even this has shown not to be the case…. in fact babies may acquire immunity in the form of mothers' bacterial flora and of course through breast milk".

An article called 'What do they really want?' discusses the father's role in parenthood from a rather strident sounding NCT Antenatal teacher, who obviously wasn't keen on fathers being involved saying that '*we seem to be seeing a swing from the Victorian patriarch to the involved father in society.*' She really is interested in what they want to know and how they should be accommodated in ante-natal classes. She's worried about '*these extreme men who try to take over the labour and deny their partner the emotional growth which can so often accompany pregnancy and birth*'.

Comment: She probably had a point and I particularly love the fact she can 'sound off' in the AIMS Journal!!

The Journal includes a review of the joint AIMS/ARM/NCT meeting called the Monday Group, held at NCT HQ, arranged by Lady Micklethwaite. Professor Murray Enkin and his wife Eleanor from Canada, on secondment to the NPEU (National Peri-natal Epidemiology Unit) in Oxford were invited to speak. They said that they believed that childbirth is a natural event and intervention should be kept to a minimum, as experienced at the McMaster University in Hamilton, Ontario where

they encouraged walking around the grounds, and beds big enough for mother and father and children! Siblings were invited to meet the new baby as soon as possible. As for third stage they report he smiled and very deliberately put his hands in his pockets and when asked "How long do you sit like that?" replied, "As long as there is no bleeding".
The NE London group invited Professor Peter Huntingford at Mile End Hospital to speak to explain about Flying Squad provision for home confinements. He explained that it was falling into 'natural disuse' as the number of home births reduced and midwives had lost their confidence because of some isolated incidences of maternal death. The Professor liked "to support women to have their baby in the way they want, providing that they are well informed and aware of the risks". During his time in London he reduced induction from 40% to 7% and episiotomy from 90% to 25%! No shaves or enemas for his mothers!! Despite the paternal language, he was very despondent about his fellow consultants whom he said were answerable to no-one – he felt that pain relief drugs have 'allowed doctors to drive the uterus like a machine and turn birth into a mechanical process'. He felt there were 'many ominous sexist overtones in the way obstetric practice has developed'. At his hospital, they did hypnotherapy classes for those who wished or needed this kind of help. 'For some, hypnosis gives them the self-reliance and self-achievement which can enrich the birth experience.' There was mention again of continuity of care in the ante-natal period – with women colour-coded to ensure they saw the same doctor each time.

I noticed that under the title Research, it was reported that 'T*he King's Fund Centre is compiling a list of surveys and research related in any way to the health care needs and difficulties of ethnic minority groups in Britain*'. The appeal wanted anything – small or large projects, informal surveys run by 'people working in the field' as well as formal research studies. Although I couldn't find whether anything came of this in terms of a report, my search did lead me to a King's Fund podcast called Covid-19, racism and the roots of health inequality. A reminder, perhaps, for AIMS to establish a link with The King's Fund (it is an independent charitable organisation working to ensure '*the best possible health and care is available to all'* based in London).

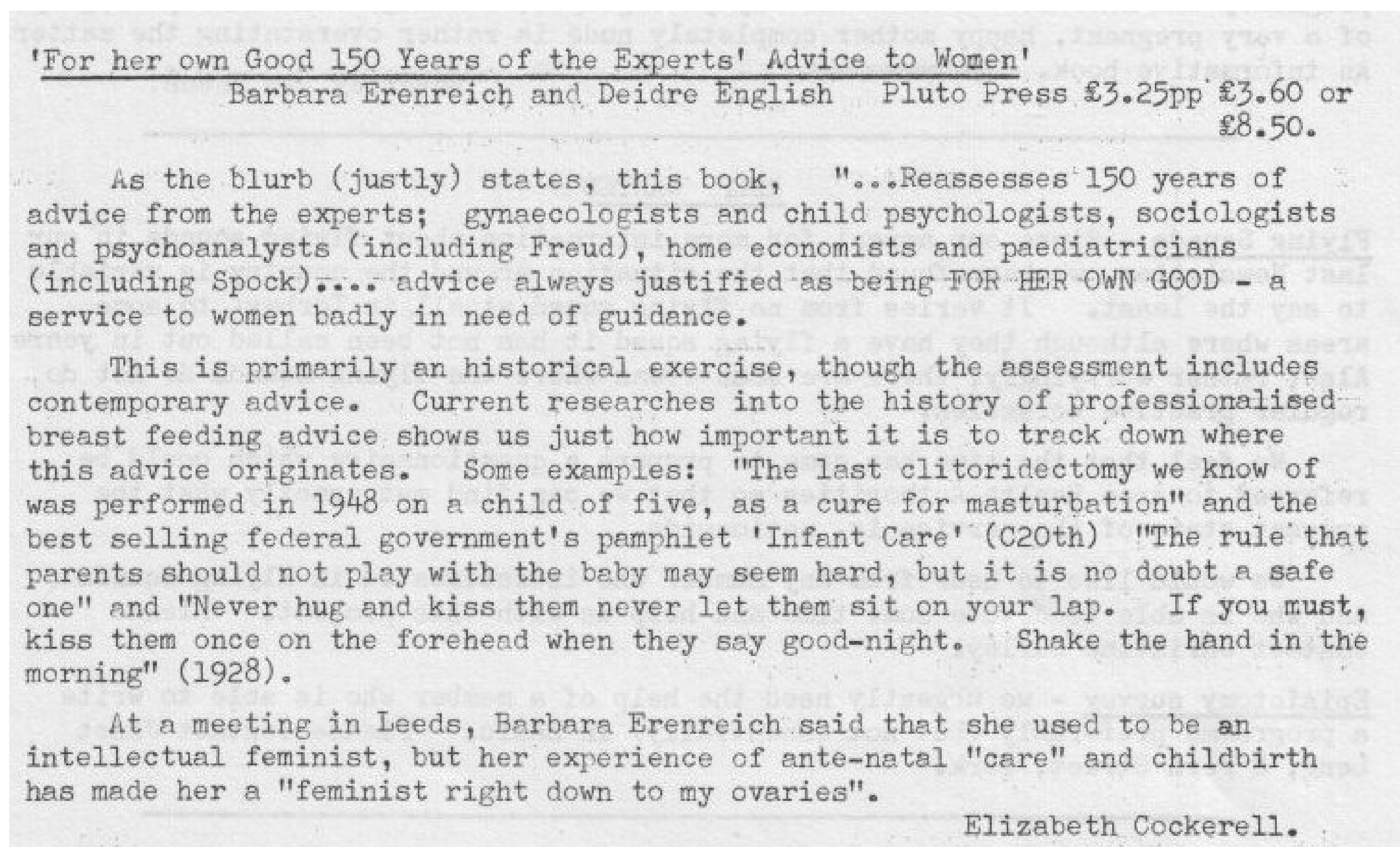
AIMS/ARMS/NCT MEETING

At the last, and arguably, the best meeting of this group Professor Murray Enkin and his wife Eleanor were invited to speak. They showed a series of beautiful slides, taken by Eleanor, showing the experiences of childbirth for parents having their babies at McMaster University, Hamilton, Ontario. Professor Enkin believes that childbirth is a natural event and, wherever possible, intervention is kept to an absolute minimum. During their labours the women are encourage to walk around the grounds of the hospital, although Professor Enkin did point out that no woman would be more than two minutes walk away from the labour suite. The delivery rooms are brightly furnished and have the appearance of a rather nice bedroom rather than a delivery suite. The beds are large enough to accommodate the mother the father and any children. Indeed, the siblings are invited to see their new baby as soon as possible.

Because Professor Enkin believes in using drugs and intervention only when absolutely necessary the forceps delivery rates and caesarian section rates are very low. There were many questions between slides and he was asked "How do you manage the third stage?" He smiled, and very deliberately put his hands in his pockets. "How long do you sit like that?" "As long as there is no bleeding".

It was clear from the slides that Professor Enkin's unit has managed to achieve the goal of many hospitals - that of providing the facilities and yet having the atmosphere of a home birth. Hopefully, his message will not be lost on those units that are so enthusiastic about "managed labour". Professor Enkin is furthering his interest in human relations in obstetrics this year while attached to the National Peri-natal Epidemiology Unit in Oxford.

There's a great book review of 'For her own good – 150 Years of the Experts' Advice to Women' by Barbara Ehrenreich (it's still available on-line). The book gives a historical assessment of that advice – '*The last clitoridectomy we know of was performed in 1948 on a child of five as a cure from masturbation*'; "*The rule that parents should not play with the baby may seem hard, but it is no doubt a safe one*" and "*Never hug and kiss them, never let them sit on your lap. If you must kiss them on the forehead when they say good-night. Shake the hand in the morning*" (1928).



'For her own Good 150 Years of the Experts' Advice to Women'
Barbara Erenreich and Deidre English Pluto Press £3.25pp £3.60 or £8.50.

As the blurb (justly) states, this book, "...Reassesses 150 years of advice from the experts; gynaecologists and child psychologists, sociologists and psychoanalysts (including Freud), home economists and paediatricians (including Spock).... advice always justified as being FOR HER OWN GOOD - a service to women badly in need of guidance.

This is primarily an historical exercise, though the assessment includes contemporary advice. Current researches into the history of professionalised breast feeding advice shows us just how important it is to track down where this advice originates. Some examples: "The last clitoridectomy we know of was performed in 1948 on a child of five, as a cure for masturbation" and the best selling federal government's pamphlet 'Infant Care' (C20th) "The rule that parents should not play with the baby may seem hard, but it is no doubt a safe one" and "Never hug and kiss them never let them sit on your lap. If you must, kiss them once on the forehead when they say good-night. Shake the hand in the morning" (1928).

At a meeting in Leeds, Barbara Erenreich said that she used to be an intellectual feminist, but her experience of ante-natal "care" and childbirth has made her a "feminist right down to my ovaries".

Elizabeth Cockerell.

A member of AIMS from the NE London Group wrote in Members Viewpoint - Have we in AIMS got our priorities, right?

"The overall feeling, I get from the newsletter is that one cannot have a satisfactory birth experience if one doesn't have a home confinement. As the vast majority of women do not have this type of experience and many do not want it, I think to a great extent AIMS has lost sight of its function. That function, as I see it in simple terms, is to try and bring pressure to improve for the majority of women, the standards of maternity services in order to obtain a higher level of personal, emotional and medical care.

"The place where more women are confined and the most dissatisfaction is felt, is in the hospital set-up. Surely it is self-evident that we should concentrate on this area to gain most headway with our aim for improvements in the maternity services.

"Please let us strike more balance in our interest in the services and perhaps give home confinement issue a bit of rest, or at least keep it low key, or limit ourselves to reporting factual details of PROPERLY CONDUCTED RESEARCH.

"This should enable us to concentrate on getting stuck into improving things in a real sense where we are needed most."

I enjoyed this task of some historical reading for the 60th Anniversary of AIMS. Sadly, many of the topics are still relevant today and still not solved. The most fascinating aspect to my read is that I found there is always an expert on hand to expound the latest theory. Maybe what we can all learn is that the passage of time shows us that different views have always prevailed but the one thing that is constant is that the person who is pregnant must have the final say for their body and their baby.

AIMS Newsletters 1970s

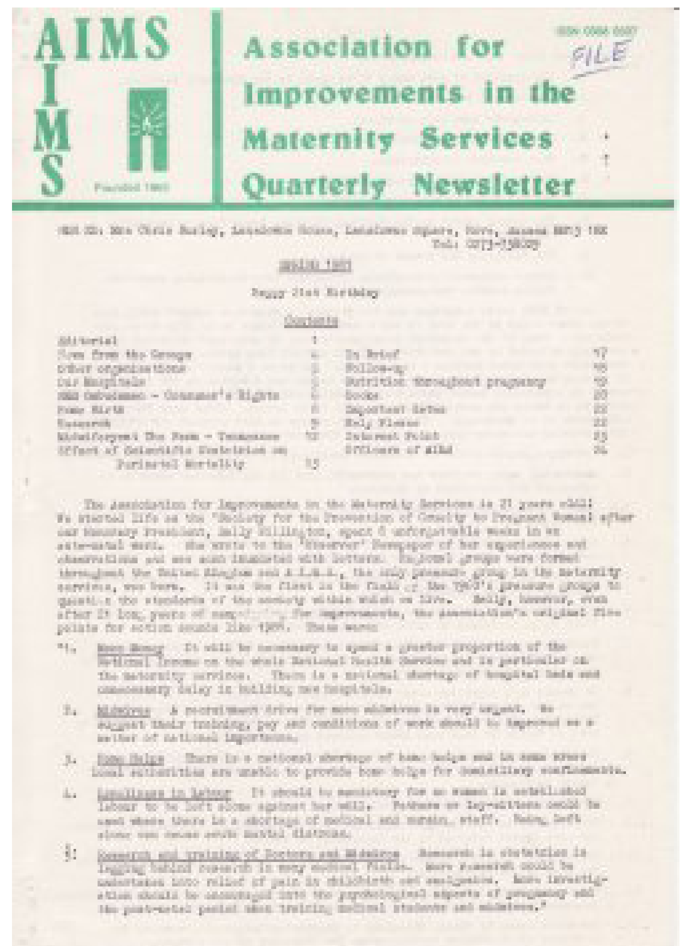
Article

AIMS during the 1980s

by Verina Henchy, AIMS Trustee

I was delighted to hear that the theme for this Journal is to look back over a 60 year history of maternity services, seen through the eyes of our service users and journal contributors. My eldest child was born in 1981 and it was particularly interesting for me to look at this year to see if the AIMS Journal of this time was reflective of my own experience of birthing in the early 80s.

Looking at the quarterly Newsletter for Spring 1981, the first thing that I notice is that AIMS is the same age as me! As AIMS was celebrating its 21st birthday, I was heavily pregnant with my first born, feeling pretty unprepared for motherhood and with very little thought for the birthing process to be honest! Are young people more prepared today I wonder? There is certainly much more media coverage of birth these days but the mainstream images frequently portray birth as something to be feared, something to be medically managed, something that creates a certain amount of panic and alarm! In the year 2020, images of positive birth and a narrative that supports empowerment and fulfilment can at least be found if you want to go looking for it and there are literally dozens of books on the market to help you to prepare for a positive birthing experience. How does this varied diet of information influence us I wonder and was my own somewhat restricted diet a bonus or a disadvantage? Sadly, I didn't know about AIMS in those days but I did attend NCT classes which made me "a bit of a hippy" in the eyes of many at that time! I personally believe that knowledge is power and that access to information about birth and our maternity systems is important. I think that my own experiences would have been quite different if I had entered the 'birth room' with the knowledge that I hold now.


AIMS

Association for Improvements in the Maternity Services Quarterly Newsletter

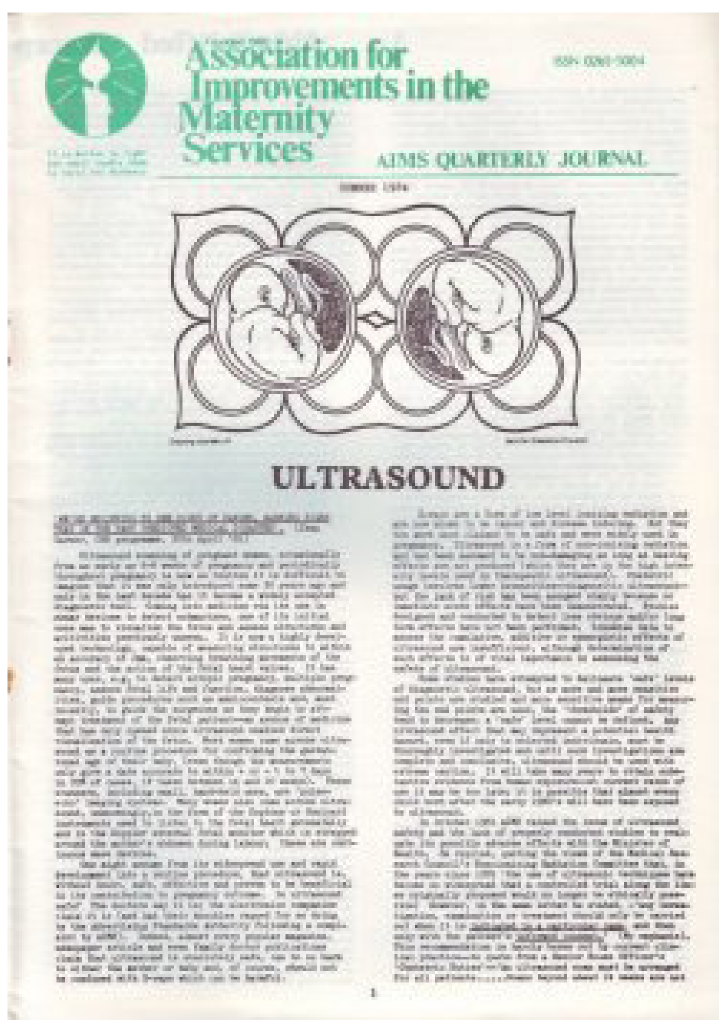
Founded 1960

The main headline that caught my eye in the Summer 1981 Journal was "**Ultrasound: Watching Babies Grow**".

When I was pregnant in 1981, one scan was routinely offered to all pregnant women and people and my understanding at the time was that it was simply offered to "count the number of babies"! A friend had recently birthed twins which had come as a complete surprise to her. Watching

her struggle up the street with her double pram with three relatively young siblings in tow, I was relieved to at least eliminate the risk of surprise twins and do not remember having any other benefits (or risks) mentioned.

The 1981 Journal article, it was reported that, "ultrasound scanning is rapidly becoming the norm, including repeated scans to closely follow a baby's growth. Debates about the merits of this trend are beginning to surface, both because of the possible hazards and for its social implications - the necessary centralisation of ante-natal services in high-technology centres, and the effect on people's attitude to the normality of pregnancy and birth".


Association for Improvements in the Maternity Services

AIMS QUARTERLY JOURNAL

ULTRASOUND

The journal reported a series of letters in the Guardian (May 1981) that had raised the issue of safety of ultrasound for an unborn baby. Jean Robinson of the Patients Association had raised concerns that ultrasound might damage a baby's central nervous system and this had been strongly refuted by Peter Scanlon (paediatrician).

Jean Robinson noted various reports of harmful effects of ultrasound exposure and directed readers to a report by an FDA researcher into ultrasound effects (Birth and the Family Journal, Summer 1980). She quoted FDA warnings about ultrasound safety and suggested that, "women should not be told that ultrasound is unequivocally safe, and that its use should be reserved for cases where essential diagnostic information cannot be gained by other means".

The Journal article discussed some of the merits of ultrasound as claimed by physicians and explored specific and general risks to women, concluding that, 'One is led to questions about the social management of pregnancy and childbirth'.

> *A midwife's skilful hands can feel a baby's position, and can monitor a baby's growth, week by week. An attuned ear with a simple metal trumpet can hear a baby's heartbeat. A mother can bond to her unborn baby by tuning in to its movements and rhythms; by recognising the validity of her own sensations. These are the skills and potentials that are not to be taken lightly, and that need not be sacrificed for the lure of still more sophisticated technology.*

My second child was born in 1984 and interestingly, the front page of the Summer 1984 Journal was also an article on Ultrasound. The headline on the front page read, Ultrasound 'We're Beginning to see the signs of Danger, warning signs that in the past predicted medical disaster', (Jean Garner, CNN Programme, 30th April 1982).

Beverley Ann Beech wrote in this journal:

> *The Association is most concerned that routine ultrasound is being carried out on large numbers of women; that no records are kept of the levels and occasions of these exposures; and that no long-term studies of the possible effects of ultrasound are being carried out...There is no evidence to support the claim that ultrasound is safe and the evidence that it may cause ill effects is still inadequate.*

This lengthy (3 page) article set out the arguments and concerns in true AIMS fashion, citing dozens of articles and scientific papers along with details of the considerable amount of correspondence that had been generated as part of the AIMS campaign for safety in maternity care.

35 years later, In July 2016, Dr Sarah Buckley revisited these questions in her article, Ultrasound Scans in Pregnancy

– Your Questions Answered! (sarahbuckley.com/ultrasound-scans-in-pregnancy-your-questions-answered)
In answer to the question “Is Ultrasound Safe”, Sarah tells us that the short answer to this question is, “we don’t know.”

“We do not currently have any high-quality scientific studies that compare the development of children who were exposed and unexposed to modern high-powered ultrasound scans in the womb”.

Our work at AIMS is the same as it was 4 decades ago. AIMS supports all maternity service users to navigate the system as it exists, and campaigns for a system which truly meets the needs of all. Our advice to maternity service users with regard to scans is that they have the right to decide what medical procedures they will and won’t accept, and that should include declining some or all ultrasound scans. We refer women to www.aims.org.uk/information/item/making-decisions and to the Birthrights factsheet www.birthrights.org.uk/factsheets/consenting-to-treatment both of which explain about the principle of ‘informed consent’. This makes it clear that pregnant and birthing women and people must not be put under ‘undue influence’ to persuade them to accept something against their wishes, and gives several examples of undue influence including “threats to withdraw care”.

To conclude, I find myself once more reflecting on my own pregnancy and birthing experience in 1981 and I ask myself the same questions? Was AIMS reflecting issues that were of concern to me at that time? The answer is most certainly yes as it would seem that the surge in surveillance with the help of technology was rising in the 80s and AIMS was raising questions about the safety of this trend at the time. Was my own lack of knowledge about the risks and benefits of interventions a disadvantage? I’m not sure if I can answer that question. Whilst I am much more conscious of the debates 40 years on and I’m much more conscious of our rights when it comes to decision making, it would seem that there remains a lack of evidence in so many areas, scans being just one of the many ‘unknowns’ which makes decision making extremely hard even when you have access to the existing body of knowledge.

The 1980 Newsletters and Journals

Article

AIMS during the 1990s

by Nadia Higson, AIMS Trustee

I chose to revisit the Journals from the 1990s because it was the decade in which I gave birth to my sons, and also the decade in which I joined AIMS, and so I was reading many of these issues as they came out.

At times it has been dispiriting to read about concerns which were current then and remain familiar issues today as discussed below, but there are things that have changed for the better too.

The decade opened with Doris Haire bringing us an “American Warning” (1990, Volume 2, No 1). She talked about the backlash from *“a growing number of American women who feel that their obstetricians misled them into a false sense of security regarding the obstetric drugs and procedures offered them”* as a result of *“general reluctance to call attention to the adverse effects of the drugs which have long been a part of their armament”* including pethidine, the local anaesthetics used in epidurals, and oxytocin drips. We now have the NICE guideline on Intrapartum care for healthy women and babies (www.nice.org.uk/guidance/cg190) making recommendations to *“Assess the woman’s knowledge of strategies for coping with pain and provide balanced information to find out which available approaches are acceptable to her”*, to give information about the side effects of drugs and to *“support her in her choice”*. However, as calls to the AIMS Helpline regularly show, this *“reluctance to call attention to the adverse effects”* is still apparent amongst many obstetricians in the UK today. Only last year, Linn Shepherd was writing in the AIMS Journal (2019, Volume 31, No 4) to warn that *“currently no-one is*

informing women that when synthetic oxytocin is recommended, it is likely to be prescribed and administered in unlicensed dilutions and increments, with regular disregard for the benefits and safety measures built into the licensed instructions".

AIMS
QUARTERLY
JOURNAL
Association for Improvements in the Maternity Services
Vol. 2 No. 1 1990 £2

AMERICAN WARNING

"One of every four women in the United States has her baby surgically removed"

"....There is no drug that has been proven safe for the unborn child...."

One thing that doesn't seem to have changed is concern over the rising caesarean rate – but back in 1990 Nancy Stewart reviewed a report from the Maternity Alliance revealing that *"In 1982 the caesarean rate was 10.5% of all births, but by 1985 it had reached 11.6%"* (Volume 2 No 2 1990). The latest statistics for England and Wales from NHS Digital (digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2018-19) showed that it had reached 29%!

Back in 1990 vaginal birth after caesarean (VBAC) was still viewed by doctors and midwives as a risky process. It was commonly described as a 'trial of scar' and those 'attempting' it were routinely starved and put on an intravenous drip in case they needed a caesarean, as Yvonne Williams found when she decided on this option for her second birth (1990, Volume 2, No 2). Now the NHS website states that *"Most women who have had a caesarean section can safely have a vaginal delivery for their next baby"* - although doctors and midwives are frequently wary of VBACs taking place outside an obstetric unit or without continuous monitoring 'just in case'.

In the 1990s, waterbirth was still regarded as a novel practice, and was meeting resistance from many in the medical establishment – one of them warning that "If we become mesmerised by the eccentricities proposed by these aquatic fanatics, we undermine social and technological advances and run the risk of turning the clock back decades" (1995, Volume 7, No 1). Even when labouring in water was considered 'acceptable' people were usually expected to get out in order to birth. AIMS scored a success when in 1995, at the request of Beverley Beech, the UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting - forerunner of the NMC) issued a statement recognising that "*waterbirth is preferred by some women as their chosen method of delivery of their baby. Waterbirth should, therefore, be viewed as an alternative method of care and management in labour and as one which must, therefore fall within the duty of care and normal sphere of practice as a midwife".*

AIMS JOURNAL
ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES

Where's the Good News?

The last two AIMS Journals have dealt with a very serious topic - the destruction of midwifery both locally and on a world-wide scale. It was therefore interesting to monitor comments from some midwives at the recent *Midwifery Today* conference about the journal. At the one extreme some stopped by our table to ask *'what can we do to help?'*. At the other, were those who remarked *'why would I want to read about that - it's too depressing!'* It seems the schism in midwifery is as large as ever.

Lately at AIMS we have had to remind ourselves to celebrate the little victories. The good news at AIMS is when an individual mother calls and says "thank you - you helped me get the birth I wanted."

VISIT AIMS ON THE WEB AT WWW.AIMS.ORG.UK

Although birth-pools were becoming more widely available in hospitals through the 1990s, it didn't always mean that they were being used. In the middle of the decade ("Waterbirth: False hopes, False promises", p17, 1996, Volume 8 No 3), Jean Robinson reported on findings from a survey by the National Perinatal Epidemiology Unit showing that *"nearly half the hospitals that have pools virtually never use them."*

Although we know that access to waterbirths is still patchy, and often limited to so-called 'low risk' women and birthing people, at least it is now viewed as a mainstream choice and the NICE guideline on Intrapartum care for healthy women and babies recommends *"Offer the woman the opportunity to labour in water for pain relief."*

For all those with an interest in supporting physiological birth and the individual's right to choose, the big story of the 1990s was the publication first of the Winterton Report on Maternity Services in 1992, and then the Cumberlege Report "Changing Childbirth" in 1993. (1993, Volume 5, No 3). The recommendations gladdened our hearts, for example:

- services should be woman-centred, accessible to all and geared to individual needs
- they should provide appropriate, locally based antenatal care, known carers, a relaxed and private environment for birth and the moments after birth, and accessible help in the weeks after birth
- women should have the right to book with a midwife or GP, change their booking or plans for the birth at any stage during pregnancy, choose different forms of care and be respected by professionals.

Wonderful! So why did we need Baroness Cumberlege to lead another National Maternity Services review leading to the Better Births report in 2016?

To be fair, some of the recommendations of Changing Childbirth were implemented, but others fell by the wayside. For example, in 1994 Sandar Warshall ("Moving forward on Cumberlege", p18, 1994, Volume 6, No 2) reported on an RSM (Royal Society of Medicine) Forum which celebrated three innovative models of midwifery care: a midwife-led unit in Bournemouth with a 96% 'normal birth rate', a case-loading scheme at Queen Charlotte's providing one-to-one care including to those labelled 'high risk', and the South East (London) Midwifery Group Practice, which was to become the inspirational - and much-lamented - Albany Practice. Over the years, further midwife-led units have opened, but some have closed, and access to them is frequently limited to those who fit within narrow guidelines. Innovative schemes offering continuity of carers, such as Neighbourhood Midwives and One-to-One have secured NHS contracts and then been unable to survive. The struggle continues.

Will the Better Births recommendations fare any better than those of Changing Childbirth? This time, the recommendations have been formally adopted into the NHS long-term improvement plan and a national Maternity Transformation Programme put in place to implement them. You can be sure AIMS will be watching, contributing our views and continuing to campaign for genuinely 'better births' in the future.

To end on a positive note, towards the end of the decade the Journal's editorial asked ***"Where's the good news?"*** (1999, Volume 11, No 3) and concluded that *"The good news at AIMS is when an individual mother calls and says, "Thank you – you helped me get the birth I wanted."* As an AIMS Helpline volunteer, I can confirm that that's as true now as it was thirty years ago. Whatever the national picture may be *"It is [still] better to light a single candle than to curse the darkness."*

Article

AIMS during the 2000s

by Emma Ashworth, AIMS Trustee

When asked to review a decade of AIMS Journal articles for the 60th Anniversary edition, I chose the decade of the 2000s for two reasons. Firstly, my oldest child was born in 2004 and secondly it was during this time that I started my work as a birth campaigner. I was fascinated to see how things have changed over the past twenty years.

Plus ça change, plus c'est la même chose

The more it changes, the more it's the same thing. The phrase may be a cliché, but clichés exist because they represent the truth. There are few phrases to describe my thoughts better, as I read through the historical record of those years, than 'plus ça change'.

I first noticed an article in Volume 12, number 2, which noted the position of the Royal College of Obstetricians and Gynaecologists (RCOG) on Waterbirth. The article was entitled, "Clinical Guidelines on Waterbirth are Pretty Wet" which gave me a rue smile, as twenty years later I am currently in an ongoing discussion with RCOG about their implementation of 'pretty wet' guidelines on the use of water for women during the Covid-19 pandemic. My current arguments were that RCOG's guidance is not evidence based, which they have conceded but continue to recommend against the use of water anyway. The article from twenty years ago had similar complaints.

The article states, *"These Guidelines were produced under the direction of the 'Scientific Advisory Committee'. Very impressive, until one discovers that the members of this Committee have little or no experience of helping women give birth in water. But why let a little matter of ignorance inhibit one from pontificating on a subject of which they have no knowledge or experience."* (AIMS Journal, p7-8 Volume 12, Number 2, Summer 2000, Beech)

This state of affairs exactly reflects the position that RCOG are taking right now, where their waterbirth guidelines related to an epidemiological issue had no epidemiologists involved in their creation.

This state of affairs exactly reflects the position that RCOG are taking right now, where their waterbirth guidelines related to an epidemiological issue had no epidemiologists involved in their creation.

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AIMS JOURNAL

ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES

Waterbirth – Time to Move Forward

AIMS Chair **Beverley Beech** believes that it's time we started taking labour and birth in water more seriously.

It was not uncommon for women to be told: "There are no other midwives qualified to attend a woman in water, so if 'Jane' is not on duty you will not be allowed to use the pool"

ANOTHER ENFORCED CAESAREAN – SEE PAGE 22

Access to water

As the article about the 1990s explains, AIMS was arguing then that waterbirth should be offered as part of standard care, to those women who wanted it and persuaded the UKCC to publish a statement to that effect. Yet at the beginning of the new millennium women were still being denied waterbirths – but only at the last minute. The AIMS Journal Volume 12 number 2 publishes the story of a woman referred to as 'DV' who was promised access to the birth pool, only to have it denied when she went into labour, despite her best efforts to negotiate it. She writes, *"When I was first asked to write about my birthing experience I had no idea how traumatic that would prove to be…"*

DV goes on to say how she had planned with her midwives to use the birth pool at her local hospital, but when she arrived in labour nobody had any record of this, and doctors told her that she wasn't allowed to use it. She asked the doctors *"..whose responsibility it was to make such a decision. I wanted to know if ultimately the decision was mine to make."* and they left the room to seek further advice. These doctors seem to have been totally unaware that this was DV's decision, as to deny her access to her chosen form of pain relief is an infringement of her human rights.

In 2004, when my first son was born, I experienced exactly the same situation. I was promised that if I transferred in from my planned home birth I would have access to the pool, and even as the home birth midwife attempted to persuade me to transfer in, she continued with that promise. Of course, as soon as I was safely delivered to the hospital, the request was denied.

There is no doubt that this is still happening in the year 2020. It is not unusual to hear stories of people who reach the hospital only to be denied their waterbirth. However, things have changed. Waterbirth has become more common. It is a very common way for women and people to have their babies at home and in midwife led units, and the pool rooms at many hospitals are often busier than twenty years ago. For this we can be thankful, but we do need to keep up the pressure. AIMS has published a number of useful articles to support women and people regardless of their body size who want to access water in hospital (here), and those who wish to use water as pain relief during an induced labour (here).

Waterbirth has become more common. It is a very common way for women and people to have their babies at home and in midwife led units, and the pool rooms at many hospitals are often busier than twenty years ago.

Traumatised women, traumatised midwives

The first two articles of this series that I read were in direct contrast to one another. AIMS noted in 2007 how women are not the only ones who are impacted by the effects of a traumatic birth. In the first Journal of the decade, Laura Kaplin Shanley shares the incredible stories of the births of her four children – two boys, then two girls – all birthed at home without a midwife or doctor in attendance. By the time her fourth baby was born she felt a strong urge to be completely alone and she writes about how she laboured quietly and without alerting her husband until she felt that the baby was coming. At this point she moved into the bathroom – her husband, still unaware that she was in labour – thought she was running herself a bath – and birthed little Michelle into her arms. She called her husband in and *"his eyes widened as he saw Michelle sitting on my lap".*

Laura's story contrasts horribly with Jasmine le Marquand's story. Soon after arriving in hospital she conceded to continuous monitoring, having tried to negotiate intermittent monitoring. *"From the moment the monitoring started I felt trapped", she describes. She was bullied into having her waters broken and tried to escape to the toilet "in order to hide". When her waters were broken, she, "lay on the bed and, in my opinion, she raped me. Over and over again she speared me with a stick. The pain was so bad I thought I would pass out. I cried out but I don't think they heard me. The pain went into my skull and back. I was sure the baby had been killed and was frozen with pain and fear."*

The rest of Jasmine's story continues in the same horrific vein. She used Entonox in order to get away from the midwives and doctors, at least in her head. She describes her legs being forced into stirrups, taken out again and put back up multiple times, and then left there as multiple staff members walked in and out as her vulva and anus were on display to them all, and, now with an epidural, she had no

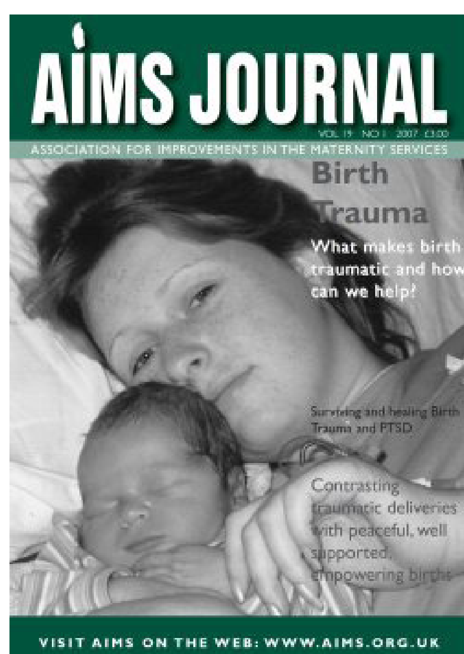
ability at all to attempt to regain her dignity. A registrar said, ***"You wanted a home birth, now you can see why you didn't get one"***. She worried that the angle that her legs were being put in would leave her paralysed. She remembers saying to herself over and over again, "my poor baby".

Jasmine's experience is one which happens every day in the UK 20 years later. But why?

Back in 2007, Professor Mavis Kirkham wrote in the AIMS Journal about Midwifery Trauma. In the AIMS Journal Volume 19, Issue 1, she discussed the value of positive relationships and the harm of poor ones, how being valued by clients and by colleagues was the key to happy midwives, and happy midwives are more likely to provide nurturing care.

Mavis points out, ***"We tend to treat others as we ourselves are treated. How can midwives cherish and support women as individuals if they themselves are pressed to conform, experience little support and fear bullying as an ever present possibility? Midwives' experience and fear of bullying creates risk for women in their care."***

Twelve years later, in 2019, Mari Greenfield and I edited an AIMS Journal on the topic of birth trauma, and we published a piece by Jenny Patterson which explored the relationship between traumatised midwives and traumatised women in more detail, as more research has now been done. Despite the fact that we're two decades later, and more data has been accumulated showing how essential it is that midwives are cared for by their employers and colleagues, even now in 2020 midwives are burning out and leaving the NHS in droves. Staff shortages, already in crisis, became even more acute as Covid-19 hit, and so the need for nurturing of all midwifery staff has become even more essential, and even more lacking.



Professor Mavis Kirkham wrote ... about Midwifery Trauma in the AIMS Journal Volume 19, Issue 1, she discussed the value of positive relationships and the harm of poor ones, how being valued by clients and by colleagues was the key to happy midwives, and happy midwives are more likely to provide nurturing care.

Moving forward with positivity

It is too easy to become despondent when reading the ways that things have not changed since the 2000s. Yet there is room for cautious positivity, if not sitting on our laurels. Social media, not yet central to most people's lives in 2000 is now one of our main ways to connect with people like ourselves. This means that pregnant women and people can now meet others online who are pregnant and planning their births. Through social media, AIMS and other birth campaigning organisations have been able to reach far more people, and awareness of birth rights is dramatically higher than it was twenty years ago.

Stories of people successfully negotiating with their maternity providers abound on pregnancy groups. Maternity Voices Partnerships (MVPS), may still have flaws but their ability to easily communicate with others increases their reach and influence. Knowledge really is power. And while charities like AIMS can't reach everyone, we are reaching so many more people than we could back then, and we, and other organisations like us, are supporting pregnant women and families to achieve the births they want in far greater numbers than ever before.

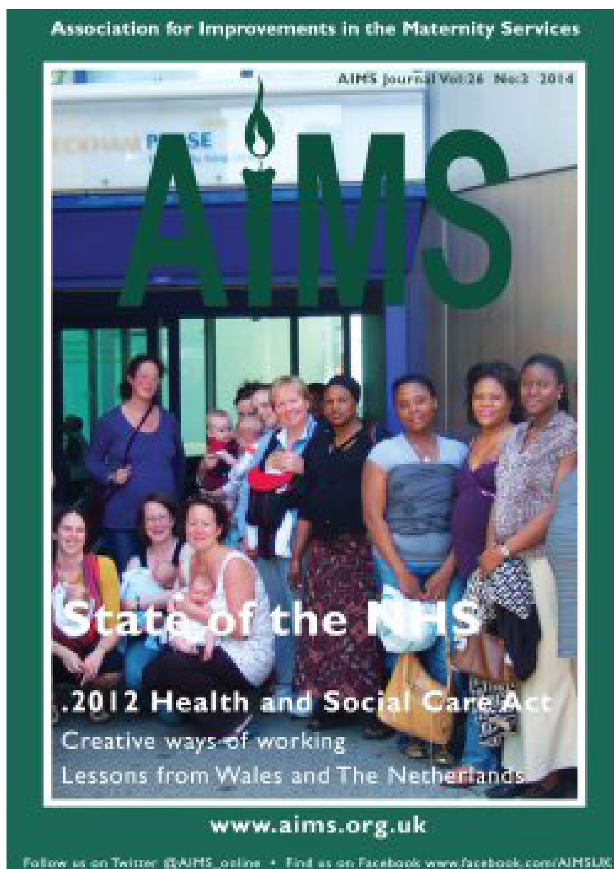
While I might have opened with '*plus ça change*', in fact I close by contradicting myself. While much is still the same, and many of the same challenges still exist, while we still need to continue to fight the good fight and families still need us more than ever, we have ways and means to do this which were little more than science fiction in 2000. Knowledge is power, and sharing knowledge is sharing power. Let's keep sharing the AIMS Journal – now online – and let's keep sharing the knowledge.

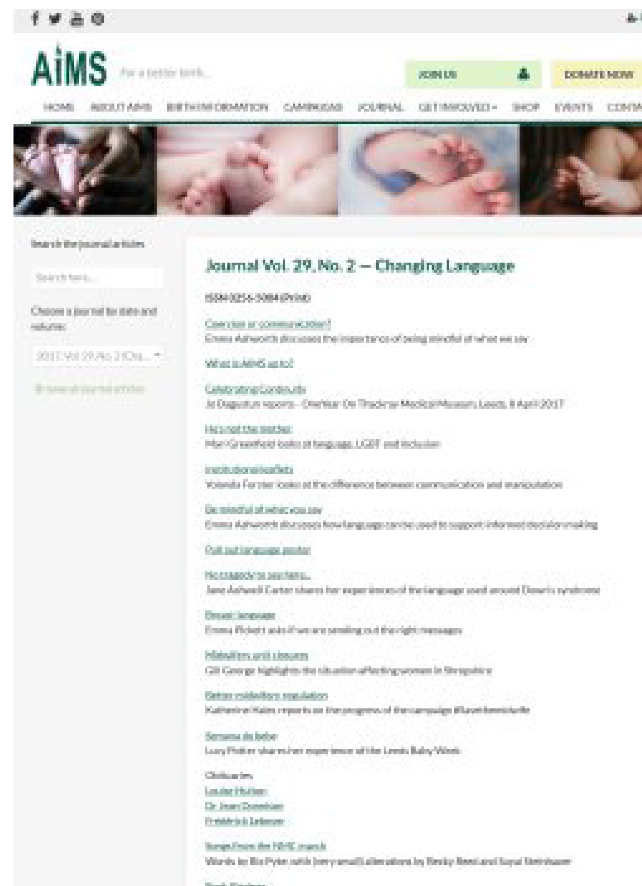
Article

AIMS during the 2010s

by Virginia Hatton, AIMS Trustee

The 2010s is the decade in which my two children were born and when I became a member of AIMS. Maternity care in the UK, and AIMS, have both gone through significant transitions in this decade. The AIMS Journal is now published online as an open access resource available to all. The Journal has featured discussions on the many opportunities that we as AIMS members have had in improving maternity services in this decade including the Better Births Report (2016), the national agenda to offer Continuity of Carer, the change from Maternity Services Liaison Committees (MSLCs) to Maternity Voices Partnerships (MVPs) and the challenges faced by independent midwives regarding insurance cover. However, there are articles on three topics that I feel best represent the current landscape of maternity care and why we need to improve it, and the changes that AIMS itself is undergoing in order to be a charity that supports '*all maternity service users to navigate the system as it exists, and campaign for a system which truly meets the needs of all*'[1]. I would encourage all readers of the AIMS Journal to read (or reread) these articles and reflect on their significance in your own birth work or lives, and most importantly to then take action.





Anything but Simple, by Jo Murphy-Lawless, 2014

When the Health and Social Care Act of 2012 was passed, some birth activists saw this as the end of effective national campaigning, as now there was no one accountable at the national level for national targets such as increasing the number of midwives. Other birth activists were more optimistic, seeing the advantages for local campaigning, for example getting a Continuity of Carer scheme running in one local area could be more achievable than guaranteeing Continuity of Carer nationally for all women. Jo Murphy-Lawless' article on the impact of the Health and Social Care Act foreshadowed the challenges faced by One to One Midwives and Neighbourhood Midwives. Both of these names will be familiar to women who sought Continuity of Carer in the 2010s, and to midwives who wanted to offer this type of women-centred care. Unfortunately, the process of contracting to Clinical Commissioning Groups (CCGs) did not allow these models of care to be sustainable. Another example of outstanding care for women highlighted in this article was the Halcyon Birth Centre, which is also now closed. The coronavirus pandemic has demonstrated the consequences of underfunding and fragmentation that are results of privatisation, and this in many ways mirrors the impact of privatisation on maternity services[2]. I would encourage all AIMS members to seek to understand the continuing impact of privatisation of health and social care in their local area[3].

I found the following quotes from Jo Murphy-Lawless' article useful for thinking about what AIMS' role is amidst this change to our health care system, and what our role will be as campaigners in the future:

> *"We believe that there is incontrovertible evidence that midwives do not wish to work as they are having to do at present. We also strongly believe that the English public, and the people of Northern Ireland, Scotland and Wales wish to have an NHS that is truly public, publicly accountable, freed from the vice-like grip of market profit-taking as if it were a commodity like mobile telephones or computers. We need a social, holistic, approach throughout the NHS and certainly in maternity care."*

> *"Independent Midwives and some of the new midwifery initiatives are providing the kind of maternity care that AIMS and other organisations have long campaigned for, but only a tiny minority of women can afford or have access to these, and only a tiny number of women will freebirth – another option about which women ask AIMS. AIMS' position has been to support a woman's plans, and that all women have the right to good maternity care and to be supported in their decisions about where, how and with whom to give birth irrespective of their economic situation. Thus, it has always responded to the growing tensions in maternity services by focusing first and foremost on the woman seeking support and has been endeavouring to work with the tensions forced upon us."*

> *"Any activism will necessarily need to continue to challenge vigorously the increasing and debilitating focus on risk and fear which is driving the centralisation of birth into large obstetric units, the medicalisation of birth, and the 'expert' culture where women's decisions are overridden, all of which plays into the now wholesale privatisation of the NHS."*

He's Not the Mother, by Mari Greenfield, 2017

The second article I would urge all AIMS readers to be familiar with was the first AIMS article to address the challenges faced by trans men who give birth. This article (linked above), and a following one, Birth Beyond the Binary by AJ Silver (2019), challenged AIMS as an organisation to be inclusive and supportive of all maternity service users. The changes to the language in AIMS books, including the term 'birthing women and people' and the first AIMS Equality, Diversity and Inclusivity Statement4 have their roots in the discussions that came out of these articles. These discussions were not easy ones, and the quotes below highlight why this was a challenge within AIMS, as well as the better practices that AIMS is trying to implement itself within the charity to be inclusive.

In 'He's Not the Mother', Mari Greenfield says:

> *"MacDonald (2015)5,urges those involved in maternity care not to choose between celebrating women, and ensuring we include all pregnant people. He advocates being 'generous with our ink' and ensuring we include everyone. In the context of LGBT inclusive language, we could add the suggestion to those involved in maternity care to be 'generous with our questions' – starting with a generous approach to questioning our own assumptions."*

Article contd.

In 'Birth Beyond the Binary', AJ Silver says:

> *"Pleas for inclusion are often met with the objection that it is erasing the overwhelming majority of those who birth, the mothers, the women. This thought process needs some examining here.*
>
> *The example I always fall back on is that ramps on public buildings take nothing away from the able bodied people that want to access them, but it makes it possible for disabled persons to access them. Cis-heteronormativity will not disappear overnight because we include language, tick boxes and space in our hearts and minds to accept that not all who birth are women or mothers."*

Diverse, Not Defective, by Beth Whitehead, 2019

The last article that I would like to draw attention to from the 2010s was written in response to the MBRRACE report (2018)[6], which highlighted that black women were five times and Asian women twice as likely as white women to die in pregnancy and childbirth in the UK. Campaigning against privatisation of the health services (as mentioned above in 'Anything But Simple') is out of AIMS' remit as a small maternity services charity. However, maternal mortality is something which we as a charity and individual activists must be shouting about. There can be no 'improvement' more vital in the maternity services than preventing women's deaths. Black Lives Matter has highlighted the everyday acts of racism prevalent throughout all aspects of our lives, and why it is more important than ever for this to be a central focus of all of those working to improve the maternity services.

Beth Whitehead is quick to point out that more obstetric intervention may not be the way to prevent these unnecessary deaths:

> *"BAME (ed: Black, Asian and Minority Ethnic) women can be subjected to more interventions because of the institutional criteria and protocols limiting their choice of place of birth. They are often subjected to birthing in the obstetric units, interventions and cascading effects because their bodies are different to the Western 'norm' and so considered to be less able and defective. If more interventions actually lead to improved safety, you would expect mortality rates to be lower for BAMEs as they are more subjected to protocol interventions and yet the [MBRRACE] report shows that this is not the case. Something is not adding up."*

The article also outlines how we need to question our own assumptions, understand and challenge institutional racism and see how continuity of carer is a positive solution:

> *"When discussing the poorer maternity outcomes for BAME women, I notice people often fall back on the stereotypical narratives of vulnerability due to lack of language skills and low socioeconomic status. However, these assumptions are outdated. Most British-born BAME women speak English as a first language and many who are immigrants to the UK speak English even in their countries of origin. The MBRRACE report table 2.9 outlined that out of all the women who died, 96% spoke English and 63% were actually born in the UK. Just look around your workplace, commuter trains, hospitals, cafes and restaurants, there are BAME women working everywhere in a range of professions and are of various socioeconomic status. What is going on?*
>
> *A woman's chance of survival, how she is treated in pregnancy and childbirth and her autonomy should not be determined by the colour of the skin she was born with or the ethnic community she came from. It's time for healthcare providers to see past the colour of someone's skin and acknowledge the effects of structural inequality in the healthcare system, their attitude and practices. We are unique individuals deserving of personalised, respectful and safe [health]care.*
>
> *Most importantly, we need to stop racist narratives about women's bodies; stop presenting 'white, British women' as the default to which we should all be compared …, the average [from] which we are considered to deviate and start talking about diversity. After all, diversity is what helps humanity survive and thrive.*
>
> *Continuity of Carer, a relationship-based model, will help to mitigate [legal risks] because client knowledge and a relationship with the pregnant woman will minimise mistakes and improve birth experience. It will also give BAME women a better chance of being listened to, treated with respect and provided with individualised care. Safer for everyone involved. No brainer really."*

Conclusion

Growing up in America and reading Birth as an American Rite of Passage[7] as a student, countries where midwifery care was still the default such as the United Kingdom were held up as a beacon of best practice to strive for. In my almost a decade of being involved in the UK maternity services, both as a mother and as a birth activist, I have felt disheartened by the increasingly 'American' models of privatised health care and a 'medical' model of maternity care rather than a holistic, 'midwifery' model that we see in the UK today.

However, to match this, in this decade there has been an increase in lay support by doulas, the creation of new birth activist organisations, such as Birthrights, a focus on maternity care by long established groups such as the Women's Institute[8], and individual birth activists raising awareness and creating tangible change through campaigns on social media. There have also been causes to celebrate such as the European Court of Human Rights ruling of Ternovszky v Hungary in 2011[9]. All of these organisations and voices have added strength to the campaign work that AIMS has already been pushing for decades.

This campaign work, as AIMS member Caroline Mayers aptly puts it, is "to address the intricate and complex aspects of maternity care and evolving human (his)stories, whilst shouting from the rooftops about inequality in maternity care and the unnecessary devastation that takes place every day"[10]. We need to recognise the long-term effects of this on families and their care-givers. AIMS continues to be a national leader bringing individuals, parents, health care professionals and birth activists together, and together we will continue to create lasting change.

The COVID-19 crisis has demonstrated how the NHS maternity system can adapt rapidly to new ways of working. I hope that this strength and resilience can be applied to change other ways of working which AIMS and others continue to campaign for: to offer Continuity of Carer to more families and to offer care that is based on a personal relationship between the care giver and birth giver.

References:

1 AIMS mission statement, agreed in 2017

2 Allyson Pollock, 'Spending cuts and privatisation have left us without a functioning social care system', www.newstatesman.com/2020/07/where-did-uk-go-wrong-coronavirus

3 For further reading on this subject: Allyson Pollock, *The End of the NHS* (2020) Verso Books and Youssef El-Gingihy, *How to Dismantle the NHS in 10 Easy Steps* (second edition): *The blueprint that the government does not want you to see* (2018) Zero Books

4 www.aims.org.uk/general/aims-equality-diversity-and-inclusivity-statement

5 MacDonald T (2015) 'Transphobia in the midwifery community' *Huffington Post,* 15th September 2015

6 Saving Lives, Improving Mothers' Care. Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16, *MBRRACE 2018*

7 David-Floyd, R. (2004, 2nd edition) *Birth as an American Rite of Passage* - University of California Press; 2nd edition

8 www.thewi.org.uk/__data/assets/pdf_file/0006/49857/support-overdue-final-15-may-2013.pdf

9 www.birthrights.org.uk/factsheets/human-rights-in-maternity-care/#:~:text=The%20European%20Court%20of%20Human,v%20Czech%20Republic%20(2016)).

10 Quoted from email exchange with AIMS member Caroline Mayers

Article

Running maternity services during the coronavirus pandemic: keep calm and don't forget the woman!

By Natalie Carter, Consultant Midwife, Chelsea and Westminster NHS Foundation Trust

Hello, my name is Natalie. I am immensely proud to work in a service that maintained most services for women giving birth during the COVID-19 pandemic. I would like to share with you how we did it, the challenges of doing it, and the recovery from it!

It begins and continues with leadership, with a Director of Midwifery who puts the woman at the centre of every decision, asking the difficult questions that examine every possibility before saying either we can't or we can or we just need to do it differently! Long before COVID-19 the mission for the provision of high-quality maternity care at this Trust has included continuity, choice, equality, and respect for the birthing rights of women. I believe it is fundamentally this drive and belief in what is possible and expected within our service and in those that provide it that enables us to say we can, and we will.

Sitting alongside this leadership is an enormous team effort. Before lockdown took effect a daily morning COVID-19 call was established between the cross-site key stakeholders from midwifery, obstetrics, gynaecology, anaesthetics, and included one of the co-chairs from the Maternity Voices Partnership (MVP) once a week. This was and still is a group of around 25 people, which enabled the service to be immediately responsive to the pace of change as these are the key decision makers. One of the first challenges was creating the identified 'spaces' where separate pathways would exist to keep those with COVID and those without apart. On both hospital sites the alongside birth centres were discussed as the areas that could become COVID positive zones and they have remained a potential space for this in the escalation plan if there was an increased need for capacity but we have not needed to use these spaces so far. It would have been easy to see this space as ideal due to its contained nature, but we made a strong argument for enabling women with straightforward pregnancies to access a space that would facilitate birth with the best chance of keeping intervention rates low and as such prompt discharge home from the hospital setting, especially given we may face a situation with reduced anaesthetic support for epidurals for pain relief in women unaffected by COVID.

At all times we tried to keep in mind helping women be in the hospital for as short a time as possible minimizing their exposure risk while also still respecting their choices.

It also didn't make sense for our obstetric and anaesthetic colleagues to have to cover a greater area of oversight with the existing obstetric areas and then the birth centre space as a positive COVID area as well. Far safer and easier for staff to locate the COVID positive zones as close to the obstetric labour ward as possible, including temporary theatres. Temporary partitions and doors enabled areas to be closed off but accessible to staff and alternative entrances used for women to keep pathways separate. Fortunately, we did not reach a position where capacity was breached within these spaces and we did not have to escalate into the birth centre areas and effectively close them as midwifery-led areas. They remained open for the duration, only experiencing a small drop in numbers of births which can be explained by the increase in home births.

The community workforce were incredible at supporting each other, covering on-call gaps, working additional hours, and positively embracing every new woman who suddenly wanted to birth at home, including several who had complexities where guidelines recommended the birth took place in hospital.

Another significant challenge was the continued provision of a safe home birth service. Firstly, from a staffing point of view where we did encounter gaps due to sickness and midwives shielding. The community workforce were incredible at supporting each other, covering on-call gaps, working additional hours, and positively embracing every new woman who suddenly wanted to birth at home, including several who had complexities where guidelines recommended the birth took place in hospital. Staff who were part time and able to increase their hours did, many cancelled annual leave, and pausing all mandatory training and study leave helped maintain staffing levels. The senior midwifery on-call team found themselves covering as second midwives which helped support women with more complex needs who were choosing to birth at home. We were also able to ask our local independent midwifery colleagues for help and support during this time because of the existing relationship we have built with them over the last few years. These independent midwives have a bank contract with us which enables them to provide midwifery care to their clients in the midwifery-led areas at our hospital sites.

The second challenge around the home birth service was the announcement from the London Ambulance Service (LAS) that they could no longer guarantee safe response times. This was met head on by our Director of Midwifery in terms of finding a solution. Again, reminding ourselves that supporting women to remain out of the hospital was perhaps one of the most important safety considerations underpinned the importance of finding this solution. Speaking with our colleagues in the LAS and neighbouring ambulance services led us to contract a private ambulance and a crew to be available for both our community sites for several months, 24 hours a day 7 days a week. The local private transport provider (HATS) is experienced in providing health service related travel and a Standard Operating Procedure (SOP) was developed with all parties to support the use of this service. The LAS remained the first call for category 1 transfers with the HATS ambulance responding if LAS were unable and for all other category transfers. The HATS service was required three times during the contract period with them. This was a fantastic experience of collaboration to ensure the safety of women and valuing the importance of this service provision. Support for this also came from the Trust Chief Nurse and executive team in terms of sign-off for the cost of this contract.

Pressure also came to stop the provision of water births. The consultant midwife network across the country was extremely valuable for sharing everyone's thoughts, research, and conversations regarding this. There was a surprising difference of opinion amongst our microbiology consultants about the potential risks of infection to babies and staff through water, indicative I think of the amount we did not and still do not know about this virus. A mantra our Director of Midwifery kept repeating to us was 'Is this proportionate?'. It was helpful to keep us steady throughout all the adrenalin, stress, and fear. Was our

response proportionate to what we knew, did not know and in relation to different groups of women: those who were unwell or suspected of being unwell, or those who to the best of our knowledge were well and not affected. For the latter we did not stop access to water as we did not have any evidence that this would cause a greater transmission risk.

We did however ensure our staff had full provision of PPE to alleviate any concern they had about the possibility of a greater risk, should she be carrying the virus unbeknownst to us. We also created guidance that if the pool water became contaminated with faeces, the woman be asked to exit, shower and the water replaced, or she consider getting out to birth in order to reduce any risk to her baby or the staff giving care.

> Although partners were restricted, at no time were they unable to be present once a woman was in established labour. This was defined not on the basis of a vaginal examination, but by the labour she was experiencing and the support she needed.

Although partners were restricted, at no time were they unable to be present once a woman was in established labour. This was defined not on the basis of a vaginal examination, but by the labour she was experiencing and the support she needed. Under no circumstances were women to be alone during labour and agreements for an additional second person in labour due to exceptional circumstances were made on occasion for women with significant physical or mental health concerns. We got innovative with certain services where it was safe, to enable women to be at home with their partners as much as possible. For example, we extended outpatient induction with the mechanical balloon to include the majority of women undergoing induction which meant they could spend the first part of induction at home with their partner while partners were restricted from the ward areas. Women then waited at home until the labour ward was ready to accept them for an ARM, which is when the membranes are broken to release the waters.

We have always had a good working relationship with our MVP and none more so than during this time. Our co-chairs on the MVP have been invaluable in supporting us to communicate with women. They have hosted us on social media for live weekly Facebook Q&As, helped us create the messaging for regular updates and leaflets to explain changes to services. They have spent hours posting photos of staff in their PPE to provide reassurance to women prior to coming into the hospital sites and managing daily message queries from women. We also had a lot of fun getting a videographer to come and help us put our antenatal education online. This now includes a variety of videos for women to engage with, as well as weekly Zoom Q&As with our amazing antenatal education and infant feeding teams.

The Maternity Transformation Programme, which has Continuity of Carer as one of the main quality improvements, was put on hold during the pandemic. Up until that point we had achieved 30% of women booked onto a Continuity of Carer pathway. We have caseload teams caring for specific groups of women such as those with straightforward pregnancies, a home birth team, caseload for women with previous gestational diabetes and teams located in geographical areas of high deprivation. We have also created hybrid teams that provide shift-based continuity rather than on-call continuity. To date these teams are working as part of the birth centres and the obstetric medicine service. All these teams were sustained throughout the pandemic and we are predominantly sustaining our current continuity achievements. Where some teams have had staff needing to shield there has been a small drop in numbers of women able to be booked but this should shortly resolve itself. The target of 51% of women booked onto continuity teams by March 2021 is likely to be put back to a later date once the programme resumes. However, we have continued to plan the next stage of our implementation and intend to maintain momentum wherever possible.

While the staff have been amazing, it is important to note that maintaining these services has not come without a degree of stress and concern for staff. Reassurance and good communication have been important but have not always been as good as we would intend, with the pace at which guidance and decisions were made. WhatsApp and Facebook groups helped but of course this can also lead to work infiltrating home life. And with the lack of any recent annual

leave having been taken, this 'recovery' period now is really important to process and take stock of what we achieved but also what we have all experienced and how it has made us feel. The Trust has provided well-being support throughout this time and continues to do so, and the incredible donations from local business have been overwhelming and very gratefully received. Staff are being encouraged to take annual leave now for rest and recuperation while we slowly reintroduce things like mandatory training, albeit in a 'new normal' format.

While the staff have been amazing, it is important to note that maintaining these services has not come without a degree of stress and concern for staff. Reassurance and good communication have been important but have not always been as good as we would intend, with the pace at which guidance and decisions were made.

Women have of course experienced restrictions, ones which we would never have thought we would have to make. For example, partners have not always been able to attend care in some situations such as scans and appointments. We are part way through reinstating visiting and thankfully partners are now attending scans. We are proud to have maintained the majority of services that support women to give birth to their babies in the way that they have chosen and dreamed of, while also balancing the protection and needs of our staff and all women and their babies.

AIMS comment

We reached out to the midwives at Chelsea and Westminster NHS Foundation Trust when we heard that they were not following many other NHS Trusts in shutting down services that women were telling AIMS were more, not less, crucial, for them during the pandemic. We would be very interested to hear from women who have received care from Chelsea and Westminster NHS Foundation Trust since March 2020, and how well they feel their needs have been met.

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An Interview with Baroness Julia Cumberlege

by Rachel Boldero

For this issue, as we mark the 60th anniversary of AIMS, the AIMS Campaigns team were keen to invite Baroness Julia Cumberlege to introduce herself to our readers. For more than half of the time that AIMS has been in existence, Julia has been at the forefront of policy work on community, health and maternity service improvement. Julia remains on the Maternity Transformation Programme board and plays a key role in ensuring stakeholder voices are heard as the implementation programme proceeds. Most recently, Julia also led the review into medicines and medical devices safety[1], and we will be reporting on the key messages from this review in our next issue, as it links to our work to seek improvements to the maternity services.

We invited Julia to tell us about what drives her interest in maternity policy, to share her reflections on her long-term involvement in this policy area, and to reflect on AIMS' role in campaigning for maternity service.

1. Thank you for making the time and agreeing to be interviewed by AIMS. To start, can you tell us about your passion for maternity services and women's health, and how this journey began?

It began when I gave birth to three sons. Two of those (the first two) I had at home, and the third in hospital. The difference between giving birth at home and hospital was so great. It was right that I had the third in hospital as I needed to be induced, but the difference in the care was significant.

At home I was in my territory, and that made such a difference. Indeed, with my first baby, I was 18 at the time, it was a very difficult birth and my midwife taught me how she being really skilled and confident can manage a difficult labour.

The professional partner at the time was my GP –- he was very anxious because I was the daughter of his medical partner in the practice! During the birth, my husband took him to the kitchen and they shared a bottle of whiskey while the birth was taking place and overall I had a wonderful experience.

I am a farmer's wife (my husband is now retired) so I got very involved with sheep and lambs and whilst of course this is very different from the birth of a human baby, there is this miracle of new birth and whether it is animals or humans, it is amazing to see.

2. You've been pivotal in two important maternity services reports, (Changing Childbirth 1993 and Better Births 2016)- How do you feel about the impact Changing Childbirth made?

Well I have talked to a lot of people since that report and they said it began to put women much more at the centre of care, and it did change some attitudes. We tried to introduce Continuity of Carer and unfortunately that withered.
It was interesting with Changing Childbirth – I was a Minister in her Majesty's government at the time so this was administered from the top. I learnt with Better Births years

later that you have to drive things from the bottom up as much as top down. You have to make people in the service want to do it, and you have to ensure what they are doing is what women want.

I think the great difference between the two reports was that with Changing Childbirth I was only a Minister for a relatively short period of time and then a new government came in with different priorities, and maternity wasn't one of them. With Better Births I was not a Minister and was appointed by Simon Stevens to lead the review of maternity services; NHS England were amazing because they gave us 8 years to implement and they gave us the people and resources to achieve this.

Now COVID has obviously intervened, some of the progress we were making has stood still or even gone back a bit and we now only have another 5 months to try to reinvigorate what we (and many maternity units) were trying to achieve.

3. There is a degree of overlap between some of the key points and recommendations in Changing Childbirth and Better Births, what do you see as the challenges and barriers as to why it has taken some time for particular initiatives to really embed into maternity services?

Well I think it is true of any major change – when I was Chair of the Brighton Health Authority (1986) I was asked to review Community Nursing and one of the 14 recommendations we made in neighbourhood nursing was that Nurses should be able to prescribe. I picked that up because I had been out with the Midwives and realised they could prescribe pethidine yet Nurses could prescribe nothing. We recommended that Community Nurses should be allowed to prescribe. It took 20 years for that to happen. It does take time to achieve your vision and what you want to see happen. You have to be persistent, determined and you have to inspire people who are giving the service in the community, the wards, labour wards, postnatally and throughout maternity services. You have to inspire them to want to do it. It is no good trying to introduce something nobody wants to do.

The other difference between the two reports is the wish of the women and the growth of women being more confident in knowing what they want, and on occasion insisting on what they want- that has been a major change in those 20 years.

4. Better Births put a lot of emphasis on Continuity of Care, why do you feel this is important?

Because it is safer. Because we only managed to get Jeremy Hunt (when he was Secretary of State for Health) to back this when he saw the results and research that had been carried out that evidenced it was safer. Of course, safety and making health services safer has been his great purpose in health. It does not necessarily depend on more interventions and more testing if you can provide the sort of services that Neighbourhood Midwives provided, and you can see what women want. We felt it was right with Changing Childbirth and then with Better Births we had the evidence. A lot more research had taken place and the results were obvious- the evidence showed this provided safer services. Equally important is that this is what women want.

5. Since you were Junior Health Minister in the House of Lords, what are the biggest changes you have observed in maternity services?

I think it has been the establishment of Local Maternity Systems (LMSs)[2]. Where they work well, these can make a real difference to the local services that are provided. These weren't in existence until the NHS started to get them established. They are important as they attain the data and should then be looking at this very carefully to see how they can do better, and how other people/services may be doing better, and what they can put into practice in order to achieve the best. It is holding up a mirror on what is going on in different areas, in the different LMSs.

The second thing is community hubs[3]. These are equally important. We have 28 recommendations and wanted all of them implemented. We have much more information now, as to what women want. One of the difficulties with COVID has been that where we were collecting data, this has not been possible during COVID so we are lacking up to date information. Also of course, some of the services

have had to be very differently organised and provided in order to accommodate the virus, so some of that information is going to be a bit skewed.

6. How do you think you have been able to make a difference to the maternity services - and ultimately the experiences of maternity service users - in the role that you have played?

I think what I have tried to do is put out a consistent message. I have tried to meet as many Midwives and women receiving services as I possibly could. You learn so much when you go and visit people. They tell you things you would never find on a piece of paper. In one area we met women who were very upset with what was happening to their service (closure of Freestanding Maternity Units), and you pick up the anger, energy, the determination to fight, when face to face. The thing is with maternity services- it is always changing. I get very upset when women's choices are reduced. I think they should have the four choices we mention in the report- Home birth, Freestanding Maternity units/Midwife led units, Alongside Midwifery Units and also Obstetric Units. Women should have these four choices, and I think that is really important. The beginning of life is the most precious thing, that many women achieve and they are very conscious of how they give birth. The way they are treated during this time really makes a difference to the bonding with their baby and the longer term of the child into adulthood.

That leads to one of my worries about neonatal care- some babies at the moment [during the Covid19 pandemic] don't have contact with a human face, only someone with a mask and there is the current great difficulty assuring parents they will get access to their babies and will be able to hold them. You cannot dismiss what has been going on since the world began in terms of bonding and ensuring that the future for your newborn is going to be a good one. It starts at the beginning. I do not underestimate the tremendous difficulty that units are currently going through where they are keeping everyone safe. I understand this. Some units have really gone out to ensure access is available 24/7 through technology or other means. Often it is reassurance that women want.

7. What particularly excites you about what is happening in maternity services currently?

When I see women being given real choices. When I see really high quality care that is given unstintingly to the women who need it, the commitment, dedication and even the love that midwives provide. A huge challenge now is how we address the health inequalities that have become so evident within the data we collect about maternity outcomes, especially those that relate to race and ethnicity. But I am sure that there will be an increasingly effective focus on that, now that we have the data.

8. How far will we have achieved the objectives of Maternity Transformation programme within the timescale of the NHS long term plan?

I think we will have gone a long way. It is very good that the long term plan is written in a way that incorporates all that we wanted in Better Births. It is not a full stop; it is a going forward view. It is right that we were given the time and now it has been taken forward in a wider context. This has been hugely encouraging.

9. AIMS is celebrating its 60th birthday this year. We believe we have contributed to improvement in Maternity Services and the Better Births agenda. How might Birth activists and AIMS in particular, help to progress the Better Births agenda?

First of all I would like to congratulate AIMS on achieving 60 years. There are an awful lot of Organisations (voluntary and not) who don't survive that long. AIMS have kept up the momentum, understood the changing world and how they can contribute- AIMS has been outstanding in this field. I hope AIMS will keep momentum in achieving what you can against the 28 recommended improvements.

The other area I want to reference is Maternity Voices Partnerships (MVPs). We had Maternity Services Liaison Committees previously and some were very effective (and some less so), but out of that has grown the MVPs and what I want to ensure is much more co-production between users of these services and charities like AIMS, which will ensure that women's voices are really heard and acted upon. There is still a bit of a way to go on that.

1 www.immdsreview.org.uk

2 Local Maternity Systems (LMSs) Better Births recommendation (6.1) said that "Providers and commissioners should come together in local maternity systems covering populations of 500,000 to 1.5 million, with shared standards and protocols agreed by all.

3 The community hub concept, as described in the Better Births report, represents a recommendation to radically transform the way that maternity services are organised, to shift away from the current bias of a hospital-based services. Better Births stated that 'the NHS needs to organise its services around women and families. Community hubs should be identified to help every woman access the services she needs, with obstetric units providing care if she needs more specialised services. Hubs, hospitals and other services will need to work together to wrap the care around each woman' (4.28). Thus 'the concept of a community hub is that it is a local centre where women can access various elements of their maternity care' (4.29). www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

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Research in Focus

Researchers leading surveillance of how Covid 19 is affecting pregnant women and babies across

By AIMS Campaign Team

AIMS is pleased to see that a programme of data surveillance ave been put in place by researchers, as part of the UK Obstetric Surveillance System (UKOSS), to understand the effects of COVID-19 on pregnant women and their infants[1].

UKOSS is perhaps one of the 'crown jewels' of the UK maternity system enabling research on rare conditions in pregnancy and childbirth across the whole of the UK, with excellent levels of reporting. UKOSS research is not just 'research for research's sake' - instead they focus on issues that are of concern for maternity care. As a joint initiative of the National Perinatal Epidemiology Unit (NPEU) at the University of Oxford and the Royal College of Obstetricians and Gynaecologists, they were able to launch this programme of surveillance very quickly and effectively.

We were very pleased to hear that we were not going to have to wait until the period of surveillance comes to an end (in March 2021) before the researchers shared their findings. Rather, the research team, led by the NPEU's Professor Marian Knight, is keen to report emerging findings, to ensure that the data is used in a way which is likely to improve outcomes (for example, by driving changes in professional guidelines) as soon as possible.

To this end, the study team published their initial findings in the BMJ[2] in May and offered three main conclusions:

1. Most pregnant women admitted to hospital with SARS-CoV-2 infection were in the late second or third trimester, supporting guidance for continued social distancing measures in later pregnancy.
2. Most had good outcomes, and transmission of SARS-CoV-2 to infants was uncommon.
3. The high proportion of women from black or minority ethnic groups admitted with infection needs urgent investigation and explanation.

The AIMS Campaign Steering group was particularly struck by one rapid response to the BMJ article. The response was written by Cassandra Yuill, a Medical Anthropologist who specialises in maternal health. She points out that, "the authors and the BMJ editors left out any reference to systematic racism and inequality in their discussion of infection disparities among minorities". She states that the article suggests a "racialised view of biology that not only lacks a good evidence base but is also incredibly harmful". AIMS shares these concerns and hopes that they will be addressed when further data and analysis is published. We are expecting a further publication in September 2020.

References:

1 COVID-19 in Pregnancy, NPEU - www.npeu.ox.ac.uk/ukoss/current-surveillance/covid-19-in-pregnancy

2 Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study - www.bmj.com/content/369/bmj.m2107
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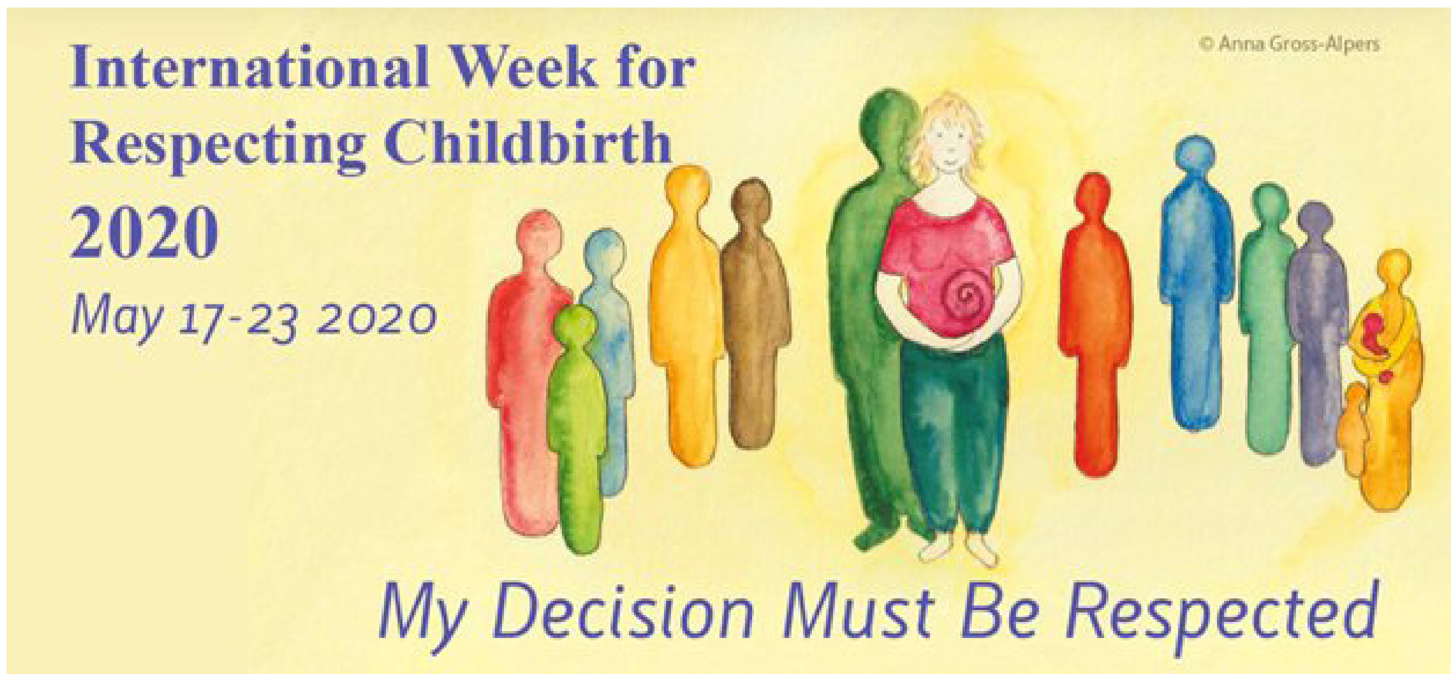
Campaign Update

What has AIMS been doing?

- We have continued to review and update the AIMS Birth Information page 'Coronavirus and your maternity care'[1] in line with latest guidance from the NHS and the Royal Colleges. We posted about new guidance lifting some of the restrictions on birth partners and having supporters at antenatal appointments in Northern Ireland, Scotland and England. Full details of the current guidance for each of the four nations are on the webpage.
- AIMS Volunteers Emma Ashworth and Verina Henchy have been in correspondence with RCOG about their guidance on waterbirth. We are pleased to see that thanks to these challenges that the latest version of the guidance now makes it clear that those who have no symptoms of COVID-19 and either do not have a test result or test negative for COVID-19 should be able to use a birth-pool. RCOG have also said that "For women who are asymptomatic but test positive, the evidence is unclear and we have made this evident in our guidance" while they seek an opinion on the evidence from the national Infection Prevention and Control team. Interestingly, they have also changed their reason for advising against use of birth-pools for those with COVID-19 symptoms from the theoretical risk of infection (for which, as Emma and Verina have pointed out, there is no evidence) to saying that necessary monitoring of their oxygen levels etc. "is better provided on land". We will continue to ask them why this monitoring cannot be done in water.
- We wrote to the Royal College of Midwives to welcome their Clinical Briefing Sheet: 'freebirth' or 'unassisted childbirth' during the COVID-19 pandemic[2] but also to lodge a few concerns. You can read our letter here[3]
- We supported the European Network of Childbirth Associations social media campaign #MyDecisionMustBeRespected for the International Week for Respecting Childbirth[4]



- AIMS has welcomed the RCOG document "Restoration and Recovery: priorities for obstetrics and gynaecology"[5] and made a number of suggestions[6].
- We welcomed the publication of the report "First do no harm"[7] from the Independent Medicines and Medical Devices Safety Review, chaired by Baroness Cumberlege. We plan to publish a review of this important document soon.
- We read the NHS constitution's seven key principles[8] that "guide the NHS in all it does". It's well worth looking at what these say about respecting human rights, supporting disadvantaged groups and offering services "tailored to the needs and preferences of patients, their families and their carers." In the light of the difficulties that many people have faced in finding information about maternity services changes and the decision-making process being used during the pandemic, we were particularly struck by the statement "The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff."
- AIMS Vice Chair Nadia Higson spoke at the virtual 'Let's Talk Birth' Conference about how AIMS has been supporting choice in the pandemic. You can watch her presentation here.[9]
- We attended a stakeholder meeting organised by the National Perinatal Epidemiology Unit (NPEU), and followed up our concerns about report delays and data issues by writing to Jacqueline Dunkley-Bent (Chief Midwife Officer, England) and Matthew Jolly (National Clinical Director for the Maternity Review and Women's Health, NHS England).
- We wrote to Helen Vernon, NHS Resolution, welcoming the inclusion of #ContinuityofCarer in the latest annual Maternity Incentive Scheme
- We submitted evidence to two Health and Social Care Select Committee inquiries, the first regarding the delivery of core NHS and care services during the pandemic and beyond[10], and the second regarding the safety of the maternity services in England[11].

Previous Campaign Team Update. June 2020

References:

1 www.aims.org.uk/information/item/coronavirus

2 www.rcm.org.uk/media/3904/freebirth_draft_23-april-v5-002-mrd-1.pdf

3 www.aims.org.uk/campaigning/item/rcm-briefing-freebirth

4 enca.info/iwrc

5 www.rcog.org.uk/globalassets/documents/guidelines/2020-06-26-restoration-and-recovery---priorities-for-obstetrics-and-gynaecology.pdf

6 www.aims.org.uk/campaigning/item/rcog-restoration-and-recovery

7 www.immdsreview.org.uk/Report.html

8 www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#principles-that-guide-the-nhs

9 www.youtube.com/watch?v=Kei2oFytS6E

10 www.aims.org.uk/campaigning/item/health-and-social-care-select-committee

11 www.aims.org.uk/campaigning/item/safety-of-maternity-services-in-england

Article

#Fivexmore: Addressing the Maternal Mortality Disparities for Black Women in the UK

By Tinuke Awe & Clotilde Rebecca Abe

"I felt like I wasn't listened to". Why must Black women demand to be listened to in order to receive fair and equal treatment in maternity care? The colour of our skin shouldn't determine the level of care we receive.

Tinuke and Clotilde Rebecca started the Five X More campaign in an attempt to raise awareness of the shocking disparities in maternal outcomes for Black women as a response to the MBRRACE 2018 report[1] which highlighted that Black women in the UK are five times more likely to die in pregnancy and the six weeks after childbirth in comparison to a white woman.

It's important to note at this point that the UK has one of the lowest maternal mortality rates in the world and it's very safe to give birth in the UK, however there is a huge disparity in the rates and that is what this campaign seeks to address. These statistics are not new and in fact the problem has been going on for decades. In the early 90s we saw that Black women had a higher risk of dying during pregnancy and childbirth in the UK than white women. Fast forward to now and we can see that Black women only account for 4% of births yet are five times more likely to die than white women (MBRRACE 2018[1] and MBRACE 2019[2]).

Tinuke runs an on and offline social platform for Black mothers and found that a lot of women echo her own birth experience with her first pregnancy. Many Black women she speaks to have had terrible experiences when giving birth. They felt like they were not being listened to, their pain was not taken seriously, or they were not given pain medication on time as a result. This forced Tinuke to join forces with her friend Clotilde Rebecca, who runs Prosperitys, a social enterprise specifically designed to support Black and South Asian pregnant women, to create the #fivexmore campaign. They are two Black mothers who have had to take matters into their own hands after feeling like nothing was being done about this issue over the years; an issue which was clear in the confidential enquires as early as 2007 (CMACH 2007[3])

The #fivexmore campaign isn't designed to scare women, but rather empower them with knowledge and support them through five recommended steps. The steps are, speak up, find an advocate for you, seek a second opinion, trust your gut feelings and body and do your research. They also launched the #fivexmore selfie as a way to increase awareness and bring this matter to the forefront using the power of social media.

In March 2020 they launched a petition asking for the government to improve maternal mortality rates and health outcomes for Black women. The petition asked for specific research to be done into the statistics to find out what in particular Black women are dying from as well as recommendations to improve healthcare outcomes for Black women. The petition exceeded the 100,000 signatures needed to be considered for debate in parliament.

A response from the government was given on 26 June 2020 in which they committed to funding the necessary research into factors associated with the higher risk of maternal death for Black and South Asian women which is greatly welcomed. The response also recommended that the 'Continuity of Carer' model should be in place for 2024 as part of the long-term NHS plan for 'BAME' women and women from deprived areas. This part of the response is very disappointing for us as campaigners, as the petition asked for urgent action and recommendations for Black women specifically and the response was a very general one targeted at 'BAME' women. The use of the word BAME puts all women who are not white under the same category and fails to highlight the differences in outcomes within this group. The rates of death compared to white women are double for Asian women, triple for mixed race women and five times as many for Black women. Specific and immediate action is needed to address these disparities.

The #fivexmore campaign have also asked members of the public to continue showing their support by writing letters to their local MP's to urge the department of health to give a revised response that addresses the concerns of the original petition and to give a solution outside of the one suggested that will be in place for 2024.

We are so grateful to AIMS for giving us the opportunity to speak about the campaign because while the campaign is getting popular via social media and the petition has over 186,000 signatures, a lot of people still do not know that these disparities exist.

If you would like to support us, you can:

Sign the petition
Write letters to your local MP
Share your own #fivexmore selfie on social media
Find out more www.fivexmore.com
Continue to have discussions to raise awareness about this shocking disparity.

Tinuke Awe is the founder of Mums and Tea, holding fun events and meet-ups for mothers. She is mum to two children aged 2 and 3 months old. She works in HR and is currently on maternity leave.

Clotilde Rebecca Abe is the founder of Prosperity. Prosperity is a maternal wellbeing social enterprise which supports Black and South Asian pregnant women. She is mum to two boys aged 7 and 4 and she works full time in a South London hospital in the fetal medicine and day assessment unit. She's also the co-chair of Lambeth and St Thomas hospital MVP.

References

1 www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf

2 www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

3 www.publichealth.hscni.net/sites/default/files/Saving%20Mothers'%20Lives%202003-05%20.pdf

Birth Activist Briefing

Introducing England's new Regional Chief Midwives

In 2019, Jacqueline Dunkley-Bent was appointed England's first Chief Midwifery Officer1. AIMS has welcomed this appointment, as a demonstration of the importance of midwifery leadership at the national level. Based in NHS England

In 2019, Jacqueline Dunkley-Bent was appointed England's first Chief Midwifery Officer1. AIMS has welcomed this appointment, as a demonstration of the importance of midwifery leadership at the national level. Based in NHS England and NHS Improvement, alongside other national leaders including Ruth May (Chief Nursing Officer2) and Matthew Jolly (National Clinical Director for Maternity and Women's Health3), one of Jacqueline's initial objectives is to improve midwifery leadership across the country. This year, Jacqueline has been busy appointing a team of Regional Chief Midwives, and there is now a full team of seven in place covering the whole of England.

Already, there are signs that this new structure is making a positive difference. Earlier this year, AIMS was pleased to see the role of the Regional Chief Midwife recognised in NHS guidance about the local handling of the coronavirus pandemic4. AIMS looks forward to the further development of the role, as these regional midwifery leaders each work to bridge the gap between NHS England and local trusts, offering increased scope for two-way communications about key maternity service improvement issues. This should considerably strengthen the ability of NHS England to properly implement the Maternity Transformation Programme, based on the vision of Better Births5 (2016).

In particular, AIMS looks forward to this enhanced leadership structure significantly improving the implementation of the roll-out of the Continuity of Carer6 programme across the country. We would encourage the Regional Chief Midwives to report regularly on this programme. Their contribution should underpin a positive culture of implementation in which momentum is maintained and the quality of implementation ensured, within a framework of increased accountability and transparency.

With each of the Regional Chief Midwives working with a small number of Local Maternity Systems, AIMS is sure that these new post holders have an important opportunity to improve the functioning of our decentralised maternity service, offering much of the benefit of a coherent National Maternity Service, where best practice is shared, postcode lotteries are a thing of the past and no one is left behind. We wish each of the new Regional Chief Midwives well in their new role and look forward to hearing more details about what they will be doing and their achievements.

Region	Name
South East	Jenny Hughes
SouthWest	Helen Williams
London	Kate Brintworth
East of England	Wendy Matthews
Midlands	Janet Driver
North East	Claire Keegan
North West	Claire Mathews

Action for Birth Activists:

We encourage you to note who the Regional Chief Midwife is for your area. Then you might like to write to congratulate them on their appointment, express your hopes for what they will be able to achieve based on your own local insights, and share any concerns about midwifery provision in your area or about the impact of service changes during the pandemic. The AIMS Campaign group (campaigns@aims.org.uk) would be interested to hear about what you have asked and the response you receive.

1 www.england.nhs.uk/nursingmidwifery/chief-midwifery-officer

2 www.england.nhs.uk/author/ruth-may

3 www.england.nhs.uk/about/structure/ncd/#mat

4 Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic - www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0241-specialty-guide-intrapartum-maternity-care-9-april-2020.pdf

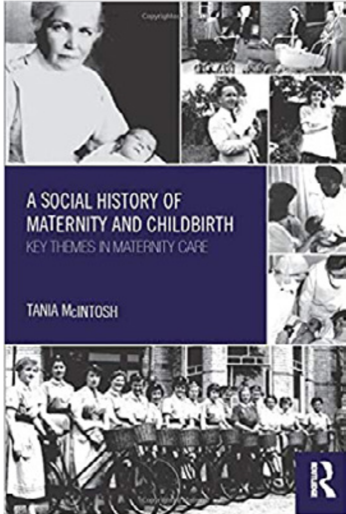
5 Better Births Basics #1: the Better Births vision, AIMS Journal 2018 Vol 30 No1- www.aims.org.uk/journal/item/better-births-vision

6 Campaign Update: Continuity of Carer and Better Births Implementation, AIMS Journal 2019 Vol 31 No4 - www.aims.org.uk/journal/item/coc-campaign-update

Book Review

A Social History of Maternity and Childbirth:
By Tania McIntosh

Published by Routledge
ISBN: 978-0-415561631
200 pages



This book was a joy to read; indeed, I would describe it as a little gem of a book. Slim, with only 150 pages of main text, it manages to incorporate discussion on over 100 years of maternity care in England. As someone who enjoys reading history books – especially when they relate to women's lives – I found it fascinating to delve into this history.

Tania McIntosh, who is both an historian and midwife, focuses in detail on the years 1902-2002, although there are passing references to earlier periods. She highlights the charged nature of the history surrounding maternity care. Although pregnancy and childbirth are private events, Tania notes how they are also events which have importance for wider society. Consequently, there has been a great deal of societal interest in where and how women should give birth, and who should attend them. In outlining the context of her book, she questions whose narrative has constructed our understanding of this period of history and explores what role the conflict between obstetrics and midwifery has played in our interpretation. Importantly, Tania highlights the lack of mothers' voices in the records, especially those from poorer backgrounds who left limited written documentation. Notably, there is also exploration of the role of AIMS in promoting improvements in the maternity system and a focus on our former AIMS president Jean Robinson.

One interesting section is the detailed discussion Tania provides on the role of the GP. This adds a unique dimension to our understanding of maternity care, which does not usually feature in typical discussions on the subject. Of most relevance is her exploration of a power struggle between obstetricians and GPs, with the latter being blamed for the high number of maternal deaths due to puerperal fever. Similarly, Tania notes how formally trained midwives lamented their 'untrained' peers, who were termed 'handywomen'. Some midwives accused handywomen of having no formal education, while handywomen accused midwives of learning everything from books and of having little knowledge or experience of birth (p.42). This interpretation is very different to the narrative that is often provided with regards to the development of the maternity system and which tends to argue that a male-dominated obstetric system overran the female-led midwifery style of care.

The chapter discussing birth between 1960 and 1980 and the way its management became increasingly scientific was of particular interest to me. Of relevance was the way Tania describes how the focus of care became the unborn baby as opposed to the health of the mother. This revolution in maternity care resulted in the use of 'technology' and 'machines' and heralded an era of the '"heroic" individual researcher', who created 'new technologies with little idea as to what benefits they might bring (and no research to back it up)' (p.102). This chapter explores the increased use of induction of labour, episiotomies and ultrasound, and may be of interest to people who wish to understand the origins of the medicalisation of childbirth in England.

Although this text is not a hard, dense book, it is the result of serious scholarship and therefore it reads somewhat 'academically'. However, the inclusion of the insights of ordinary women, midwives and doctors serves to elevate it from what could have been a heavy text on various laws, policies and mortality studies, to a digestible and readable book (albeit one that does require some concentration). Indeed, the quotes Tania has included are really illuminating. At times they include humour – for

example the way in which some women acknowledged their lack of understanding of birth (p.66) – and at other times there is sadness. There was a lot of signposting to other interesting sources, and having followed many of them, I would recommend Letters from Working Women (1915), which is accessible free of charge1. These letters from women regarding their birth complement the arguments Tania has made and serve as a fascinating insight into the era.

My only bugbear with this book was the continued use of the word 'delivery' instead of 'birth'. There is also the occasional slip into the phrase 'their women' in reference to the pregnant women midwives were supporting. An example reads "… midwives working on the district were not able to offer [gas and air] to their women until 1951" (p.96). Both of these terms are rather dated and 'un-PC', but, nevertheless, they do not detract too much from the quality of this excellent book.

In short, there are very few books of this quality and breadth on the English maternity system. For those interested in how we got to this point - a system which is overly medicalised, largely hospital based, and which often does not adequately support pregnant women and families, nor the midwives attending them - this book by Tania McIntosh provides a fascinating insight.

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If you would like us to review a particular book, or you would like a review you have written of a book considered for publication in the AIMS Journal, please contact bookreviews@aims.org.uk

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The AIMS Guide to

Induction of Labour

What happens when you have an induction of labour?

What are the reasons why you might be offered an induction?

What does the evidence show about the risks and benefits of having an induction?

What methods are commonly used?

Are there other options?

The AIMS Guide to Induction guides you through your rights and gives you suggestions of things to consider and questions you may want to ask your doctor or midwife, as well as ideas for how to prepare and encourage an induction to work.

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