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Everyone's an Individual (I'm not!)

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Editorial

Everyone's an individual (I'm not!)

by Emma Ashworth

We're all different, with different colour eyes that see
We're all the same, we all have a heart that beats
We're all different, with different hair colour and smiles
We're all the same, we all love to laugh and sometimes cry
Hold hands together and celebrate
We're all different and we're the same

(from *We're all different and we're all the same* by Jack Hartmann)

Pathways. Guidelines. Protocols. All these words are ways that the health services attempt to ensure that high quality, evidence based care is offered to everyone. If we work out what's best for most people we can treat everyone that way. But what if we don't fit into the picture of "most people"? Who are "most people" anyway? What is the average person? What if we're not the average person? WHO is the average person?

In one way or another, we're all diverse; we're all different. Even identical twins will have different needs and wants, different life experiences, different hopes and different ideas of risk. How does this fit into the picture of "what's the best treatment across a community"?

But if our bodies are not "the average" we are often treated as anomalies, as risk factors and as people who are, if not yet broken, who will be unless we comply. Cultural and social biases leach into healthcare – racism, fat phobia, homophobia, so many phobias. Starting with racism, this edition of the AIMS Journal considers how being a woman of colour giving birth in the UK can lead to a 5 times higher chance of death compared to a white woman. Gemma McKenzie digs deep into the MBRRACE data – analysing what we know and what we don't know – and debunks some of the common women-blaming theories which abound. Beth Whitehead speaks of her personal experience as a Southeast Asian woman navigating the UK's maternity system, with her ethnically normal body type being perceived as abnormal, and treated as such.

Women with obesity are likely to benefit greatly from access to water, as well as the types of facilities which are more often than not limited to Midwife Led Units (eg birth couches, birth chairs and slings which easily enable free movement). Yet they are very commonly denied these services, putting themselves and their babies at increased risk of problems. Is this evidence based? Amber Marshall's article explores the issues for us.

We've previously explored some of the challenges faced by LGBTQ+ people, but in this edition we have an insight into the ways that non-binary people might find pregnancy and birth particularly hard. AJ Silver, a non-binary person, sensitively addresses the challenges of language which is needed to support all of us, including the essential need to not erase women, as well as outlining some serious legal issues for people who do not identify as women, but who still give birth.

Our non-themed articles start with my report into the coercion we're seeing more and more from Child Services, where women are being forced into interventions that they don't want in order to attempt to protect themselves from being accused of child neglect or worse if they feel that the interventions they're being offered aren't right for them. The two cases I'm exploring mirror a shocking story from Spain with a woman's experience from the UK, both dragged into hospital from a home birth and forced into unwanted interventions. We must ensure that while looking across the pond to the likes of Alabama and Ohio, we don't forget to recognise that closer to home we have our own Gilead brewing away that must be stopped.

On a more positive note, we have an interview in this Journal with our much-loved Shane Ridley, long-time AIMS volunteer, without whom AIMS would simply not exist as it is now. Shane has always described herself as the "back-room girl" and few people outside of the volunteer team will know her name – but we all want to shout about her from the rooftops because she's amazing!

I'm grateful to Nikki Mather, birth and postnatal doula, for her fantastic article on what a postnatal doula actually is. Postnatal doulas offer so much to women and families as they become parents for the first time or the tenth – no matter how experienced a family is at welcoming a new

baby, an extra pair of experienced, non-judgemental hands to provide help and support is a real blessing.

We have a beautiful birth story from Jenna (not her real name), and to round off we have two book reviews arranged by our book editor Jo Dagustun.

We have had some amazing feedback about the AIMS Journal this month, which really makes the whole process feel exciting, and inspires all of us to keep going. We really would love to hear from you, what you like, what you don't like or disagree with. You can reach us on journal@aims.org.uk. And if the feedback you have is that you want us to keep going, maybe you might also consider donating to AIMS or becoming a member – we rely entirely on memberships and donations! Either way, thank you so much for reading, sharing articles and all of your contributions.

Until next time,
Emma Ashworth, AIMS Journal Editor

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Article

Diverse, not defective

The MBRRACE-UK Saving Lives, Improving Mothers' Care report – a BAME mother's perspective

by Beth Whitehead

The latest MBRRACE report[1] was released in November 2018. I found it very difficult to read as I couldn't help but think about the women and babies behind the numbers. One of the women who died was my friend. I almost became one of them myself after suffering severe post-traumatic stress disorder (PTSD) as a result of the abusive treatment I received during my second birth. I thought of the trauma, the grief, the children and families left behind, some may still be in search of explanations and answers, trying to come to terms with what happened.

The report highlighted that black women were five times and Asian women twice as likely as white women to die in pregnancy and childbirth. The startling differences in mortality rates by race sparked heated debate in the popular Matexp Facebook Group[2] (a forum for maternity services users and health care providers to share experiences) and on other social media platforms. There was a lot of debate on the existence of racism in the healthcare system. It was obviously a topic that people have been wanting to discuss and one that should not be dismissed. I am concerned about how the maternal mortality data can be misused to support the arguments that if Black, Asian, Minorities and Ethnic (BAME) women are at a higher risk as their birth outcomes are statistically worse than white British women, they should be subjected to more interventions. This is a self-fulfilling prophecy.

How many (BAME) people are there?

Hundreds? Thousands? Millions? Billions? Yes, there are BILLIONS of BAME people in the world. They in fact make up most of our planet's population, with hundreds of ethnic groups. Amongst BAME people there is vast diversity and mixes, different body and pelvic shapes3 and sizes in the various regions (consider different climate/geography, diet, bone density and body fat composition) and, of course, variation even within the same family. According to the 2011 census, there were over 8 million BAME people living in the UK. That is 13% of the total British population, or at least 1 in 8 people! For a country so diverse, why is there such substantial disparity in maternal mortality?
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The Curse of Stereotypes

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[1] 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?

I've spoken with a number of birth workers. The general observation has been that well educated and articulate BAME women are actually treated the worst when accessing maternity services because they challenge institutional protocols and do not fit the submissive stereotypes. Perhaps we are seen as unwelcome rivals to their authority, in a similar way to how Brexit has fed hatred for difference. In-groups versus out-groups. Insiders versus outsiders. Perhaps there are also remnants of colonialism. These women's birth choices – mine included – are thus limited; they are not listened to, nor treated with respect. This resonates with the birth stories from my circle of friends of Southeast Asian origin, all of whom speak perfect English, have university degrees and work in professional jobs.

... well educated and articulate BAME women are actually treated the worst when accessing maternity services because they challenge institutional protocols and do not fit the submissive stereotypes.

What is racism?

Racism isn't just about name-calling, though that still happens. Racism is the inability to see a person of a different race or ethnic origin to one's own in a position of power; believing they are less able, less intelligent, or to treat them as human beings less deserving of equal rights, dignity and respect. Experience and outcomes are worst for BAMEs across different socioeconomic statuses[4]. In other words, race/ethnicity itself is a risk factor for higher maternal mortality rates and worse maternity services experiences.

How does racism infiltrate the healthcare system?

One huge issue that BAME women often come across is the comparison of their bodies to the apparent "norm" i.e. the bodies of white Caucasian women. A recent comment seen on social media was, "Asian women are more prone to 3rd and 4th degree tears because their perineums are shorter". The assumption in this statement is that Asian women are being compared to white, western women. "More prone THAN white, western women" and "shorter perineums IN COMPARISON TO white, western women" was simply missing from the statement – it was just assumed to be understood in this way. The statement itself puts the "fault" for any increased number of tears in BAME women on their "imperfect" body compared to white women – rather than any outside influences such as, for instance, BAME women being classified as "high risk" due to their body types not falling within the Western norm, and their subsequent obstetric led interventions leading to more severe birth injuries. I will also note that no evidence was submitted to support this "shorter perineum" claim and in fact it appears to simply be a repeated assumption or a myth not based on reality[5,6].

There is something dangerous and psychologically damaging about measuring every woman to a theoretical statistical average white woman that rarely exists in real life.

The shaming narratives of NHS maternity services are built on women failing to measure up to this peculiar mannequin, rather than acknowledging its own systematic failure in understanding and caring for human variation. Many women and babies inevitably become casualties. Although this affects women of all ethnic backgrounds and skin colour, BAME women are affected disproportionately more than white, British born women as their bodies differ from what the western medical narratives perceive as the norm.

How many women know that BMI is not evidence-based? It's an arbitrary ratio of body fat, muscles and bone density to height ratio that really doesn't tell you anything about a person's health, body shape nor their ability to birth. Yet, it is often used to limit women's birth options. For instance, women who are themselves, or whose ancestors are from certain parts of Asia, where people have a smaller build compared to the average white British woman, are disproportionately affected. Their birth place options are often limited and they are more frequently subjected to close monitoring and interventions because of the fear of a "small baby" or "small pelvis". I noticed that gestational diabetes interventions (many of which are not based on strong evidence either, with inconsistencies between different trust's guidelines on diagnostic criteria[7]) are also used to limit options for them.

The narratives that feed cultural bias and the perceived supremacy of the white body are difficult to dispute when the medical/institutional protocols support it. We all go into pregnancy and birth with risk factors regardless of the colour of our skin. How physiological birth progresses and how women feel depend very much on how they are treated by birth attendants, how respectful their care is and the environment in which they give birth. When BAME women are seen as "high risk" solely due to their natural body type, treated differently and without kindness, risks and complications can be introduced by biases, interventions and healthcare providers' actions. Racism can go on undetected and unchallenged in the disguise of perceived body deficiency.

How can racism happen in practice in the maternity system?

My own experience of this issue was in my first pregnancy in 2014. I was assigned obstetrician-led "care" at a hospital in a diverse area of West London because my BMI was one point below the NHS cut-off. However, after some research I discovered that my BMI was considered a normal range when adjusted for people of Southeast Asian origin like me. My body is the average size in my hometown. I raised this with every obstetrician I met. I was asked to attend appointments with at least 5 different ones, who each asked me more or less the same questions in an appointment lasting just 5 to 10 minutes (after I had waited for at least an hour), without any further understanding or value added. I requested repeatedly to be transferred back to community midwife care, as I felt healthy and baby was growing, with strong kicks. I was also gaining weight.

It became very stressful because I was not listened to and had to take time off work to attend these extra appointments which had been scheduled at the start of my pregnancy. Rather than feeling productive or supportive, these appointments caused me a great deal of anxiety. Every time I tried to decline them I was referred to a more senior obstetrician instead of being respected for my informed decision. The way they coerced me into these interventions made me feel that I was not in control of what happened to me during my pregnancy. These medical staff exercising authority over me made me feel angry and undermined.

With a maths degree under my belt and the research I had done, I tried to reason with the obstetrician about the need to adjust my BMI score because of my ethnic origin. He needed to consider me as an individual, my ethnicity, my husband's and the size of our bodies.

He did not like to be challenged at all, so shouted at me with fury and threatened that if my baby failed to grow then he would cut it out from me. He also told me that I would not be allowed to use the birth centre.

Some health care providers are very determined in deciding what kind of birth women should have; it was exercising dominance. This obstetrician was black South African which highlights that not all racism is carried out by white people towards BAME people but frequently stems from cultural bias. I was 31 weeks pregnant. It became clear to me that what he wanted to do to me had nothing to do with what I was saying. It was a case of a power struggle which he was determined to win. My voice, knowledge and rights were not considered. I was not listened to nor respected. Institutional standardisation and protocols were used as a way to undermine my decision making, intellect and autonomy.

Out of panic, I went up to the front desk to request to see the obstetrician I had seen in my previous appointment, as he seemed more receptive to my reasoning for using the birth centre. Luckily he was available and made a note in my records to say it was okay. However, when I went into labour just before my due date, the hospital midwives at triage not only denied every request in my well thought out birth plan, including access to the birth centre, they also refused to listen to me and abused me intensely, psychologically and physically. They had no understanding of me as a person and were unwilling to provide care. They coerced me into unwanted vaginal examinations (VEs) and continuous monitoring (CTG), saying they were routine protocols that had to be carried out otherwise I would not be allowed to use the birth centre. Their violent actions, holding me hostage tied up by CTG belts under intense bright light in a shoebox size assessment room for 4 hours, not allowed to move sabotaged the physiological progression of my birth. I was treated equally cruelly at my second birth, in an NHS hospital in Berkshire, with access to the birth centre denied, coercion for VEs and pain relief withdrawn.

Did I think, if my skin was white, that I would have a better chance of being listened to and being respected? Absolutely. The constants in my two pregnancies and births were me and the NHS system. I have lived outside of my native country for so long and integrated so well in the UK that I had forgotten the colour of my skin and my body shape/size are different to Caucasians and that I had heard the medical establishment treats people differently because of their ethnic origin. Sadly, now I know this from experience. It happens. Too often in fact.

BAME 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 MBBRACE report shows that this is not the case. Something is not adding up. When women of colour are not being treated with kindness, staff being less patient and respectful with our bodies, for example by denying access to pain relief, not listening to us, complaining about us, rough handling us, ignoring our birthing decisions, not explaining procedures and not seeking informed consent, not accepting refusal, they make us feel unsupported. This could affect not just the physical outcome but how we feel. The trauma can have lasting effects. When healthcare providers fail to make us feel safe during our pregnancy and birth, even if we escape severe physical damage, our mental health may be badly affected for a long time afterwards.

...women of colour are not being treated with kindness, staff being less patient and respectful with our bodies...

I have seen various articles in the media labelling black and Asian women as loud and hysterical in labour[8]. The midwives I had made similar degrading comments. Complaints from these women and requests for pain relief are often dismissed because they are not being listened to or considered equally. Women should not need to be silent when having the most powerful experience of giving birth. The problem with such racial or racist myths is they reinforce racism. Racial stereotypes, particularly about women's bodies and ability to tolerant pain (their pain threshold) or prejudice can cause clinical bias and harm.

What can improve outcomes for BAME women?

The fragmented care model that most of us still experience, together with the lack of accountability for the actions of individual care providers, leaves women wide open to abuse. Racism and tribalism go on undetected. Poor working conditions, low pay and dismal job satisfaction mean that many maternity staff that remain in the system either do not

or cannot offer good care. Violence and violation are far too common. Under pressure, with an absence of relationship and client knowledge, they have little to go on but to follow protocols. A few minutes of flicking through a woman's notes is not enough. No wonder lots of mistakes are made within the maternity services. These mistakes often equate to injuries and even loss of lives for mums and babies.

Legal risks are often raised as concerns in discussions on improving maternity services.

Continuity of Carer, a relationship-based model, may... 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.

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.9 We are unique individuals deserving of personalised, respectful and safe heath care.

Breaking the habit of decision-making based on cultural bias requires education and conscious effort but it is essential for the provision of ethical and respectful care to improve safety and outcomes. 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 to, the average to which we are considered to deviate and start talking about diversity. After all, diversity is what helps humanity survive and thrive.

References

1 MBBRACE: *www.npeu.ox.ac.uk/mbrrace-uk/reports*

2 MatExp on Facebook: *www.facebook.com/groups/MatExp/*

3 Different pelvises: *www.sciencemag.org/news/2018/10/birth-canals-are-different-all-over-world-countering-long-held-evolutionary-theory*

4 Experiencing maternity care: the care received and perceptions of women from different ethnic groups: *https://doi.org/10.1186/1471-2393-13-19*

5 Racial/ethnic variations in perineal length and association with perineal lacerations: a prospective cohort study: *www.ncbi.nlm.nih.gov/pubmed/24749802*

6 Perineal length among Vietnamese women: *www.sciencedirect.com/science/article/pii/S1028455917301948*

7 AIMS book on Gestational Diabetes: *www.aims.org.uk/shop/item/gestational-diabetes*

8 I kept saying 'I'm in pain, this isn't a joke' – then everyone looked shocked when my daughter popped out: *https://inews.co.uk/opinion/comment/i-kept-saying-im-in-pain-this-isnt-a-joke-i-felt-completely-ignored-during-childbirth/*

9 Women's descriptions of childbirth trauma relating to care provider actions and interactions *https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-1197-0*

Further reading:

10 US Study on Racial Discrimination and Adverse Birth Outcomes: An Integrative Review *www.ncbi.nlm.nih.gov/pmc/articles/PMC5206968/*

11 Breeding Racism (research based on the countries the mothers were born in) *www.theguardian.com/society/joepublic/2008/jan/30/breedingracism*

Article

High BMI waterbirth – time for trusts to take the plunge?

by Amber Marshall

The Winterton Report[1] in 1992 recommended that all maternity services provide women with the option to labour and/or birth in water (in this article I'm going to use 'waterbirth' as a catch-all term for both), and by 2007 95% of maternity services in the UK had a birthing pool[2]. While there are no updates to these figures available, it is probably reasonable to assume that most trusts have at least one birth pool, with further options available through using home birthing pools.

Current NICE Guidance on intrapartum care for healthy women and babies[3] expressly recommends caregivers 'Offer the woman the opportunity to labour in water for pain relief', yet in many cases, despite the absence of other risk factors, anyone with a BMI over 40 (or in some Trusts, over 35) is automatically excluded from this option.

I take as an example, picked at random from a Google search; Salisbury NHS Trust's Clinical Management Guide to Underwater Labour & Birth[4] which states, as anticipated; 'Women with a BMI above 40 at booking will not be able to labour or deliver in water.'

Of course, what Salisbury NHS Trust means is that women with a BMI above 40 'will not be permitted to labour or deliver in water on their premises'. I, and many others with a BMI of 40+ can conclusively prove that we are perfectly able to do so, but we sadly often have to put up a fight with our caregivers (and in many instances insist on a home birth) in order to achieve a water birth.

The 2012 Cochrane Review on Pain Management in Labour[5] had this to say about the benefits of waterbirth:

- Warm water immersion during labour, including birth, for relaxation and pain relief, has a long history in lay and clinical care[6].
- The buoyancy of water enables a woman to move more easily than on land[7].
- Promotes the neuro-hormonal interactions of labour, alleviating pain, and potentially optimising the progress of labour.[8;9]
- May be associated with improved uterine perfusion, less painful contractions, and a shorter labour with fewer interventions[10; 11;12; 13; 14; 15].
- Reduces blood pressure due to vasodilatation of the peripheral vessels and redistribution of blood flow[16; 17].
- Potentially increased maternal satisfaction and sense of control [16; 17].
- The fetus may also benefit if it causes the mother to feel more relaxed, as this optimises placental perfusion, and release of endogenous opioids (endorphins and encephalins)[18].
- When the mother is not fearful, oxytocin release is optimised, stimulating effective contractions[18].
- The increase in maternal mobility may optimise fetal position by encouraging flexion [18].

If we compare the list of potential benefits with the maternal and fetal risks for labour and birth in women with a BMI ≥30 kg/m2 listed in the RCOG Management of Women with Obesity in Pregnancy Guidelines[19]:

1. Higher risk of anaesthesia-related complications[20]
2. Hypertension[21, 22]

3 Slower labour progress[23; 24; 25]

4 Shoulder dystocia (primary treatment of which is flexion of the mother)[26; 27]

5 Higher risk of post partum haemorrhage (PPH)[21; 27]

6 (Not mentioned in the RCOG guidance, but often cited as increasingly likely in women with obesity is an increased risk of instrumental birth[26], however subsequent studies have found the opposite to be true[28].)

We can see that there is a significant overlap in the two lists, except for PPH which seems unaffected by water immersion[29]. (Active management of third stage is the recommended course of action to reduce incidence of PPH in women with obesity by RCOG Guidance[19] which is compatible with waterbirth).

This overlap suggests that waterbirth could offer some very real benefits to women with obesity. Swann and Davies, in their article 'The role of the midwife in improving normal birth rates in obese women' in the British Journal of Midwifery, suggested that the advantages of using water in labour are equally, if not more applicable to obese women[30], and A Kerrigan et al's qualitative study of Clinician's management of obese pregnant women during labour[31] suggests that care givers agree:

> *"One of the difficulties that people with high BMIs have is difficulty in changing positions….and to have somebody like that buoyant in water takes all the pressure off their pelvis……"*

> *"I think we should be educating them about mobility and about being mobile"*

> *"That's the difficulty with water birth isn't it? Because they are the ideal sort of group to benefit….the weightlessness"*

So if clinicians are aware of this, why are women with a high BMI still routinely discouraged, and often actively prevented from having water births?

Returning to the example of Salisbury NHS Trust's Clinical Management Guide to Underwater Labour & Birth[4], no reasons for this arbitrary limit are given; a situation replicated across the UK, with many posts on pregnancy and parenting forums from frustrated women bearing witness to it. It is very difficult to find written justification, and since guidelines as these are the reference point for clinicians, it is unsurprising that refusal reasons given in consultations are often vague. Most seem to stem from[31]:

- Manual handling assumptions
- Emergency evacuation concerns
- Perceived difficulty with fetal monitoring

It feels somewhat disingenuous for hospital trusts to fall back on these excuses, as with minimal effort and planning, all can be overcome.

Aside from the automatic exclusion of anyone with a 40+ BMI, Salisbury NHS' Guide states "Women with a BMI of over 35 at booking should be informed that their suitability for labouring and or delivering in water will be individually assessed as to their ability to leave the pool"[4]. Surely this should be extended to all prospective pool users? Not everyone with a BMI of 35+ is immobile, and not everyone with a BMI of 34 or less is agile. To make assumptions on someone's abilities, and then through that decide their care pathway solely based on a mathematical function of their height and weight, is absurd.

A report by the Health & Safety Executive (HSE)32 details the manual handling risks to midwives associated with birthing pools; which are largely due to poor ergonomics prompting poor posture in the midwife attending or from the midwife actively supporting the mother on entry/exit. However, the report goes on to give examples of good pool design to mitigate against these risks, which are not exclusive to the care of those with high BMIs.

The HSE report also looks at emergency evacuation; "The two main methods reported for removing the mother from the pool in an emergency are a patient hoist (and sling) or a purpose designed lifting net... the hoist method was least preferred by midwives... however, for maternity units with limited numbers of midwives, the hoist method is preferred as a minimum of 4 staff would be required for the net method."

The emergency evacuation scenario is probably the most often cited reason for denial of access; specifically 'the

hoist isn't strong enough'. But using BMI in this example is fallacious when a 5'6" woman weighing 15st 5lbs (BMI 34) is allowed to use the pool, yet a 5' woman, weighing 13st 3lbs isn't (BMI 36). A hoist's safe working load is determined by weight, not BMI.

In any case, the RCOG Management of Women with Obesity in Pregnancy Guidelines recommends equipment is supplied with 'safe working loads up to 250kg'[19] (i.e. sufficient for someone of 6'6" with a BMI of 62) and 'lifting and lateral transfer equipment' is specifically listed. So if we're following the rest of the guidelines which have been published for nearly a decade, why aren't suitable hoists routinely available?

If emergency evacuation is needed with an inflatable pool, caregivers can open the valve on the centre ring. Normally home birth pools have three inflatable rings; deflating any one of these will very quickly reduce the height of the pool as the water replaces the space previously occupied by the air-filled ring, bringing the water level nearer the top and thereby enabling the woman to be evacuated more easily. The pool retains its shape and strength, however, somewhat like a quick-set paddling pool with only one inflatable ring at the rim. It is likely that the water will still be contained within the pool although a small amount may come over the top – but the water level being close to or near the top of the pool helps to support the woman's weight as she's lifted out. This is similar to the guidelines for solid pools in hospitals where it is normally advised to put MORE water into the pool, to provide buoyancy during the evacuation.

It is sometimes suggested that puncturing the pool with scissors or a knife would be a suitable emergency plan, however this should never be recommended. While it would have the desired effect of bringing the woman to the floor, the descent would be rapid; the woman's trajectory would be uncontrolled, potentially propelling her towards the blade used to puncture the pool; without suitable drainage there is a danger to all present from the possibility of the water coming into contact with electrical equipment; and a potential infection control risk from the spread of water and bodily fluids.

It is worth noting that any person, no matter their size, will be challenging to lift if they collapse completely (as anyone with an exhausted toddler knows!). It is therefore important to have an effective protocol in place for this scenario, irrespective of BMI/weight. Clinical management must also come into play here, by asking the woman if she would consider evacuating the pool if there are any concerns that might indicate collapse before the situation becomes an emergency. Indeed, this already seems to be the case, according to the HSE report; "*These methods are rarely used because most situations are clinically managed before it gets to an emergency evacuation state*."[32]

Lastly, the issue of fetal monitoring. Technology is always advancing, and with waterproof and increasingly wireless telemetry equipment available, this need not be a barrier to pool use, even where continuous fetal monitoring is indicated30. Surely, rather than exclude women on the basis of an unproven assumption that fetal monitoring will be problematic, a judgement can wait until it actually proves to be so after all available options have been explored? In such a circumstance, any labouring mother would undoubtedly be happy to exit the pool to enable different equipment to be used; getting into a birth pool is not an irreversible situation! There is some discussion in any case that the routine use of continuous fetal monitoring in high BMI pregnancies is neither advisable nor beneficial, and promotes an over-medicalised approach[31].

There is a paucity of good quality evidence on the safety and efficacy of waterbirth for any pregnancy; the 2009 Cochrane Review; Immersion in water during labour and birth[33] supports many of the earlier assertions of the benefits of immersion in water, but last year's Cochrane Review[34] of the same name by the same authors now seems more cautious, saying there isn't really great evidence for any of them, and advocating for more research.

This means it is important to remember when discussing and planning for labour in someone with a high BMI that there is no evidence that a waterbirth is unsafe, any more than there is evidence that it is more safe. There is simply no evidence to support either hypothesis. I hope this will be rectified by research in future, though I've been waiting for it for 10 years already.

In 2003 (the most recent data I could find), total health care costs were estimated to be £1698 for a spontaneous vaginal birth, £2262 for an instrumental vaginal delivery and £3200 for a caesarean section[35]. While financial concerns should never be a primary motivating factor for a

change in policy, in today's cash-strapped environment, it seems logical that any options which might promote optimal labours with fewer interventions, thereby reducing the risk of resultant complications, would both benefit women with obesity and reduce the burden on NHS resources, while increasing satisfaction. For me, this means rethinking policies on water birth in cases of high BMI urgently. We have everything to gain from doing so, particularly because the current policies force scores of high BMI women such as myself into having home births we don't necessarily want, against medical advice, purely to access a birth pool.

Amber Marshall, Founder of *BigBirthas.co.uk*

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Article

Birth Beyond the Binary

by AJ Silver

Before we start, we must be clear that this is not 'trauma top trumps'. It isn't who is the most at risk, or who is the most deserving of our time, effort and inclusion. Inclusion isn't pie, there is always enough to go around if we make the choice to be inclusive.

What is non binary?

Non binary is not always the lack of gender. It doesn't necessarily look like assigned-female-at-birth (AFAB) people who are wearing a suit from the men's section. It's more complicated than that. Non binary in general, although not always, is the absence of associating fully with the world's assumptions of your personality, likes and dislikes, abilities, strengths and weaknesses based on your assigned-at-birth gender. Assigned-at-birth gender refers to whether your genitals look like they are male or female, or perhaps not one or the other. It is also expected that our genital appearance will match our chromosomes, but this is not the case for many people.

Some non binary people will go by gender queer, demi gender, agender, bigender and more. Some will identify as trans. The most basic explanation of trans is that your assigned-at-birth gender doesn't fit who you are, who you present as. Other non binary people will identify as femme (feminine), others masc (masculine). The standing theme is that we do not fit into the world's cis-heteronormative expectations.

Non binary can be an AFAB person in dresses with long hair, it can be AMAB (assigned male at birth) people with a beard, suits and eyeliner. There is no one "look" or dress code. They may change their clothing style from day to day, or like me, they have found clothes that feel comfortable and they wear the same clothes day in day out to avoid dysphoria. Non binary people don't always present as androgynous people, although they might.

What is Dysphoria?

Dysphoria is when a person experiences distress or discomfort with the skin they are in, as this does not reflect their gender identity. This may be a non binary person wishing their chest or breasts were bigger or smaller, or a trans woman wanting to have a more "feminine" frame, walk or voice. These experiences vary dramatically from person to person. Not all trans and non binary people feel dysphoria at all, and many have no desire to change the body they were born in with surgery, hormones or anything else. Others feel that it is imperative to their life that they change their body's appearance. There is no wrong or right way to be trans or non binary. For many people, being referred to by the wrong pronouns can also be very upsetting and trigger dysphoria.

Something that triggers one person's dysphoria may not trigger another's. It's important to remember that gender euphoria also exists! "Follow the euphoria" can be a valid and safe way to explore gender expression in order to find an expression that fits, or more closely resembles your identity.

Some argue that gender roles in society have a lot of sway in a person's dysphoria and identification. In other words, boys can wear dresses, and like makeup and unicorns, and girls can be scientists, roll around in the mud and be physically stronger than boys. But by removing or dismantling the world's perceptions of femininity and masculinity will we remove dysphoria and remove the need for people to "change" or "transition" from one gender to

another? Unfortunately not. Being a "tom boy" or a "butch woman" doesn't mean you want to transition to being a boy or a man, want to have any surgeries or want to use male pronouns. Similarly, being a feminine boy, loving dollies and dressing up as princesses doesn't mean that all of these "girly girl boys" want to, or will grow up to be trans.

It is interesting to consider what the situation would be if in society we HAD equality. If every opportunity and availability that is afforded to AMAB persons were available and given to AFAB people (and vice versa) would we still have "tomboys" and "girly girls"? Would people still transition? Would non binary still be a "thing"? Maybe – but for the time being, like it or not, we live in a hugely gendered society that constantly insists we are pigeon holed into abilities, likes, dress, jobs, interests and personality traits based purely on our genitals.

Being non binary in the "maternity" system

There are very few studies of any queer people birthing, and there is no research into gender queer or trans peoples' birthing experiences that pre-dates 2013. The research that there is focuses more on lesbians experiencing pregnancy and the evidence does show that queer people may be at greater risk of perinatal mental health difficulties1.

However, there has been no follow up to these findings in the UK. Given that the percentage of lesbian couples registering birth has been rising by around 15-20% (these stats also do not include single parents2) year on year over the last decade, we can make an educated assumption that other queer people are also registering more babies year on year.

The birthing and parenting world is difficult for non binary people in a number of ways. The obvious and most prevalent are the ways the world constantly pushes us into boxes: Male or Female. Mum or Dad. Non binary people may choose to go by a different name, just as some grandparents are Nanny or Grandma, Pops or Granddad. Bubba seems to be fairly popular choice in the non binary world, as it's gender neutral, and super cute! The needs and wants of the non binary community aren't far removed from the wants and needs of the trans community who birth and feed their babies. AIMS has already covered a lot of this in their "He's not the mother" article3, but I will discuss some additional issues below.

Feedback from parents is encouraging health care providers and birth workers to move away from calling new parents "mum and dad." The fear is that it's dehumanising to anyone – straight, cis, trans, non binary people – to lose their identity as soon as they've brought a baby into the world, to stop being who they are and to simply be referred to by their relationship to their child. This is a fantastic example of how inclusive language doesn't just serve trans or non binary people – it can be viewed positively for everyone who births in society. It ensures recognition for the overwhelming majority, so let's take another half step to include even more people.

How can we be more inclusive in the Maternity system?

So, the first and arguably the easiest step is language. Can we be inclusive without language?

Misgendering someone is using the wrong pronouns (using the person's assigned at birth gender's pronouns: calling a trans woman he / him for example), or using their "dead name" (the name they were given at birth, if they have decided to no longer use it, rather than their chosen name, if they have one). The easiest way to explain how this feels, or what it does for the relationships that health care providers and service users are trying to forge, is that it destroys all confidence that the non binary person has in the person providing the care for them. If your health care provider kept getting your name or date of birth wrong, or calling you "Mr So and So" if you identify as a woman, would you feel confident that they understood you, your medical history or that they had prepared for the meeting?

The journal of adolescent health in 2018 published its findings that using a person's chosen name and pronouns may cut the risk of suicide by a massive 65%4. Given that the Stonewall research has uncovered that a staggering 89% of trans people have considered suicide, and that 27% have attempted suicide, using their chosen names and pronouns isn't just polite, it could be a matter of life and death.

Removing the word "Woman" is not an option.

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.

The wider LGBT+ community accepts and acknowledges that removing any and all references to women is in no one's interest. If we remove language that protects any person that births their baby we risk the principle of bodily autonomy being diluted. If we give equal rights to the non- birthing parent, we could risk giving the right to make decisions about our own bodies to other people such as fathers, known and unknown sperm donors and partners of the women and birthing people, rather than, as it should be, entirely the choice and decision of the pregnant woman or person. This needs further collective work, thought and time to ensure that no one is left out, no one's rights are diluted, and that we are all included in being able to access these basic human rights surrounding birth and pregnancy.

Issues that trans and non binary people experience around maternity care

One of the issues faced by Trans and non binary parents is their legal right to be known as the father (for trans men) and the mother (for trans women). The current law of the Human Fertilisation and Embryology Act 2008[5] states that whoever gives birth to the baby is legally the mother. However, if the birthing parent is a trans man he may want to be known as the baby's father. If the child is adopted by a lesbian couple, they can amend the birth certificate, and both be listed as parents (parent 1 and parent 2), and gay men can apply for a court order to then adopt their child. This leaves a hole for trans and non binary people who, in a legal document, are unable to be referred to as, or to be recognised for, their true relationship to the child. Even if the person birthing is legally male (have obtained a Gender Recognition Certificate, or GRC), they are currently recorded as being the mother.

There is currently an ongoing legal battle in the UK[6] for a trans man who birthed his baby to be listed as the father rather than the mother. The case could be a landmark victory for the LGBT+ community and open the doors for gender queer people to be recorded on official documents in accordance to their identities. If it is rejected by the court, the rights of LGBT+ persons, especially when it comes to gender and identity, will be rejected by officials once more. This is yet another blow to our freedom and rights to be who we are born to be.

The baby of a trans man has no legal protection to be breastfed in public. The Equality Act 2010[7] says that it is discrimination to treat a woman unfavourably because she is breastfeeding. Limiting the protection to just women, means trans men – who are legally men – are excluded from the protection that the Act offers. This therefore risks the baby's right to being given breastmilk, and, of course, risks the person breast or chest feeding that baby to be discriminated against.

Similarly, a trans man is not clearly protected by the Equality Act 2010 for aspects of the Act which only refer to women. A trans man therefore may have no protection, for example, against dismissal or unfair treatment based on pregnancy, nor rights regarding maternity pay, nor maternity leave. This situation has not yet been tested in court.

This goes some way to explain why many gender queer people will default to their assigned at birth gender, or remain closeted (or not "out") when birthing and parenting as there is often no other option for them. They are better protected as a woman, in a legal sense, despite the psychological distress that this may cause

There is no universal legal proof in the UK, or any document that a non-binary person can acquire to "prove" their gender, or lack thereof. Some countries (such as Canada, Portugal, and certain states in America) are emerging with a "third option" on driving licence, passports and birth certificates and so on, but the UK is lagging behind.

Documents have been issued in these countries as early as 2003 with an "X" or a "U" to indicate the bearer is neither "F" (female) or "M" (male)[8].

There are small leaps being made across the world for the right for people to be legally neither male nor female, however, we are often forgotten or erased in the battle for these small victories.

Having health care providers and birth workers that acknowledge our gender is an essential link in the chain to improving the outcomes for parents who do not fit into the world's cis-heteronormative expectations.

AJ Silver
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Article

MBRRACE and the disproportionate number of BAME deaths

Why is this happening and how can we tackle it?

by Gemma McKenzie

In November 2018 MBRRACE-UK[1] published a report on how many women had died in childbirth in the UK and Ireland between 2014 and 2016. It is a well-researched and important document that not only provides the statistics, but also short summaries on the circumstances in which some of these women died and recommendations for how maternity care can be improved. It is a harrowing read, not only because behind each statistic is a real woman and a motherless child, but also because there are patterns in the statistics that suggest endemic problems in our maternity system and wider society.
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What does the report say?

In the two-year period included in the study there were 2,301,628 pregnancies that resulted in birth (described as 'maternities' in the report). Out of that total, 225 women died from either direct or indirect causes of pregnancy or childbirth within the first year of their baby's life.

The two main direct causes are medical in nature. The first is thrombosis (blood clots in the circulatory system) and thromboembolism (a blood clot that becomes dislodged and clogs another vessel in e.g. the brain or lungs), and the second is haemorrhage. However, the third most frequent cause of maternal death is suicide. Between 2014 and 2016, sixteen women committed suicide within the first year of their baby's life. This appalling statistic raises serious questions not only about mental health services, but also about the support available for new mothers more generally in wider society.

The researchers also considered indirect causes of death and coincidental causes. Overwhelmingly, the main cause of indirect death was cardiac disease. Frighteningly, the main coincidental cause of death was cancer, of which 102 women died. The report notes that while some women with cancer received good care, there are still areas that need improvement. Women's cancer symptoms for example, were often mistakenly considered to be common pregnancy/lactation related issues, such as mastitis, meaning women did not always receive appropriate or timely care. A second issue highlighted in the report was that medical investigations that would be offered to non-pregnant people may have been withheld from pregnant women due to concerns about the unborn baby.

Equally disturbing is that, between 2014 and 2016, ten women were murdered in the first six weeks after giving birth, with a total of 14 murdered in their baby's first year of life. All of these women were murdered by their partners. Again, this indicates potential failings not only in the maternity system for women experiencing domestic abuse, but also systemic failings in wider society. Continuity of Carer may enable midwives to become better attuned to domestic abuse in a woman's life and may encourage women to confide in their health carers in order to seek support. However, this has only limited impact if women are not appropriately supported to escape abusive relationships and the criminal justice system does not adequately deal with offenders.

Women from Black and Minority Ethnic (BAME) communities

As already noted, one of the main findings of MBRRACE was that women from BAME communities were more likely than white women to die during birth or within the first year of their baby's life. In comparison to white women, black women were almost five times more likely to die from pregnancy and childbirth related causes, and Asian women were nearly twice as likely.

In comparison to white women, black women were almost five times more likely to die from pregnancy and childbirth related causes, and Asian women were nearly twice as likely.

Although AIMS welcomes the MBRRACE report, as an activist organisation campaigning for improvements in the maternity system, it is important that we understand why the rates of maternal death for BAME women are higher than those for white women. Until that is pinpointed it becomes difficult to actively challenge the problem and improve BAME women's outcomes. While MBRRACE is thorough and provides a lot of useful information, the report also raises many questions for which there are no adequate answers provided.

Racism

Statistics suggesting rates of maternal deaths are higher in BAME women than their white counterparts raise one important subject: Racism. People do not like talking about racism; it is the elephant in the room. It can make people – especially white people – very uncomfortable. No one likes to think of themselves as racist or acknowledge that they may be unconsciously benefiting from a racist system. It is easier to believe that racism is something overt and direct – name calling or violence – than to believe it is something that can be structurally ingrained into an institution, a system or a society.

But when we see statistics like those provided by MBRRACE we cannot deny that this looks like evidence of racism. The questions that immediately arise therefore are:

Who or what is responsible for this? Where is it coming from? And how do we tackle it?

What are the causes of death for BAME women? This is a crucial question if we are to understand exactly what is going on here. Unfortunately, MBRRACE does not provide us with enough information to adequately make links and to dig deep enough to root out the issues. This limitation means that we cannot pinpoint whether the problems lie within the maternity system, the society we live in – or both. Consequently, tackling the causes of disproportionate BAME deaths becomes a case of shadowboxing.

Responsibility

One argument that may be raised to explain the higher rates of BAME deaths is that there are physiological differences in BAME women's bodies that make their births more difficult or complicated. It is AIMS' position that this is extremely dangerous territory and it is not a view that we accept or advocate. This is explored further in this Journal by Beth Whitehead, in her article, "Diverse, not defective".

Although in the UK we use the term 'ethnic minority' to describe people who are not white, on a global level white people are in the minority. It therefore does not hold that there is some inherent physiological problem in BAME women's bodies that creates birthing complications. Further, to peddle the argument of physiological difference feeds the narrative that white bodies are the ideal and brown or black bodies are the defective version.

As highlighted in our article "Diverse, not defective", we know that there are examples of this presumption within the maternity system. This is something that we need to radically move away from. Acts, decisions, policies and guidelines that support the idea of racial hierarchies – even if these are unintentional and the person involved is acting with the best of intentions – need to be challenged and dismantled.

Even if after numerous robust scientific studies there could be proof that there was some pregnancy related problem that certain ethnic groups were prone to, this raises further questions. First, is that condition something which is caused or exacerbated by the way a person lives, for example, poor diet or stress? If so, we would then need to consider whether structural inequalities are playing a role in a particular ethnic group developing that condition. Second, even if a condition is found to be inherently physiological, we would have to ask whether BAME women were receiving appropriate and adequate care for that condition, and if not, why not?

Accessing antenatal care

The rates of BAME women who accessed antenatal care is not given in the report. Consequently, it cannot be presumed that BAME women were less likely to access this care and that this has contributed to their deaths. Even if the statistics were revealed and they showed that BAME women did not attend antenatal appointments, this is a potential oversimplification of what the reality may be.

While MBRRACE frequently critiques the services provided to all women and offers recommendations for improvement, the emphasis of the report is often on the characteristics of the women themselves. There is less emphasis on the characteristics of the social world around them, and the staff, department, hospital, prison or other environment in which they died. Examples of relevant information would be the staffing levels within the departments in which the deaths occurred, or the experience of the attending health care practitioners.

Returning to the idea that a disproportionate number of BAME women may not be attending antenatal care, the same problem becomes apparent. There is no exploration of whether antenatal care was accessible to women based on the distance from their home to the clinic, their access to transport or the support services in place. There is also no exploration of whether antenatal services were home delivered, or whether appointments could be made to see healthcare providers outside of 9– 5 working hours. A lack of this further exploration begins to shift blame away from the system and towards the women themselves. This is therefore an unfair presumption towards *all* of the women who died and does not adequately explain the higher rates of BAME deaths.

Looking behind the statistics

As already highlighted, MBRRACE provides detailed statistics on maternal deaths. But if we are to focus on the causes of BAME deaths in an attempt to tackle the disproportionate number, we begin to hit blind spots. This can be demonstrated by looking at some of the statistics.

Ethnicity	Number of women who died from direct causes of pregnancy and childbirth (out of 98	Number of women who died from indirect causes of pregnancy and childbirth (out of 127)	Total (out of 225)
White European	63 (= 64%)	83 (= 65%)	146 (= 65%)
Indian	3 (= 3%)	7 (= 6%)	10 (= 4%)
Pakistani	6 (= 6%)	8 (= 6%)	14 (= 6%) 1 (=1%
Bangladeshi	1 (=1%	2 (= 2%)	3 (= 1%)
Other Asian	4 (= 4%)	0 (= 0%)	4 (= 2%)
Black Caribbean	6 (= 6%)	2 (= 2%)	8 (= 4%)
Black African	6 (= 6%)	17 (= 13%)	23 (= 10%)
Others/Mixed	5 (= 5%)	6 (= 5%)	11 (= 5%)
Missing	4 (= 4%)	2 (= 2%	6 (= 3%)

Table 1: the ethnicity of the women who died

Women's region of birth	Number of women who died from direct causes of pregnancy and childbirth (out of 98)	Number of women who died from indirect causes of pregnancy and childbirth (out of 127)	Total (out of 225)
UK	59 (= 60%)	83 (= 65%)	142 (= 63%)
Eastern Europe	7 (= 7%)	2 (= 2%)	9 (= 4%)
Western Europe	1 (= 1%)	1 (= 1%)	2 (= 1%)
Asia	9 (= 9%)	9 (= 7%)	18 (= 8%)
Africa	4 (= 4%)	17 (= 13%)	21 (= 9%)
Australia and North America	0 (= 0%)	1 (= 0%)	1 (= 0%)
Central and South America and Caribbean	5 (= 5%)	1 (= 1%)	6 (= 3%)
Missing	13 (= 13%)	13 (= 10%)	26 (= 12%)

Table 2: Place of birth of the women who died

This data begins to paint a picture of the patterns and trends in BAME women's deaths. It is not possible to analyse all of the ethnic groups in this short article so just one group will be used to highlight the blind spots that become apparent. In Table 1 for example, the data tells us that 10% of all of the maternal deaths were of women who described their ethnicity as Black African. However, Black African people only make up just under 2% of the population of England and Wales.[3] The rates of maternal death are therefore much higher and totally disproportionate to what may be expected given the small percentage of Black African women living in this country.

We can also see that 21 out of the 23 Black African women who died were born in Africa. The report gives us a bit more detail on where some of these women came from. Seven were from Nigeria and three from Eritrea. However, we are not provided with information about the other eleven women. See Table 1 and Table 2 above.

Africa is a huge place - a whole continent – and each country has its own culture, language, ethnic groups and political and social history. Being born in a particular country only gives a snapshot of a person's connection to that place. A woman may have been born in Ghana but has spent her whole life until pregnancy living in London. In contrast, another woman may have only arrived in the UK from an African country a year before she gave birth. Her migrant status may also be relevant, for example if she was an asylum seeker. The point of this is that Black African women are not a homogenous group. In other words, they cannot all be bundled together and presumed to be the same. Doing so means that we cannot trace causes – simply knowing the rates of Black African women dying does not really explain very much at all.

On a similar note, all white people are grouped together even if they are recognised as a specific ethnic group in law, such as Gypsy and Travellers, who 20 years ago were believed to have "possibly the highest maternal death rate among all ethnic groups."[4] In 2012, the government considered Gypsies and Travellers to be "the most disadvantaged ethnic group in the UK" with a "shorter life expectancy than the rest of the population."[5] However, we cannot see them in the MBRRACE data. Perhaps this is because there were no maternal deaths in the Gypsy and Traveller community during this time. Or perhaps it is because they have been clumped together with white women or labelled 'other.' It is important that communities such as Gypsy and Travellers are not hidden within the datasets, or we may never be able to understand and dismantle structural inequalities or tackle racism.

Cross-referencing ethnic background with other factors
What MBRRACE also does not do is to cross reference how many BAME women died of which particular cause. Arguably this may be to maintain anonymity for the women and their families. However it becomes almost impossible to decipher whether the problems BAME women are facing lie within the maternity system, outside of it or in both. The exception to this is with regards to suicide. Data is provided that tells us that 86% of the women who committed suicide were white (61 women), 10% were 'black or other minority ethnic group' (7 women) and there was missing data on 4% (3 women). Unfortunately, a group entitled 'black or other minority ethnic group' again bundles a potentially wide range of women together. It does not provide enough information for us to even start to consider what role the infrastructure of the health service and/or society may be playing in the overall disproportionate number of BAME deaths.

is it the fabric of society that puts BAME women at higher risk when they enter the maternity system or is it something that is happening within the maternity system itself?

Similarly, the report tells us that women from the most deprived backgrounds were three times more likely to die than those from the wealthiest. But it does not provide details on which ethnic groups appeared more frequently in which socio-economic backgrounds. Just being from a particular ethnic group does not automatically signal someone's wealth, income or lifestyle. However, if there were more BAME deaths in the most deprived groups, it may be that the most influential factor in the disproportionate mortality rates does not lie within the maternity system, but in structural inequalities within our society. In other words, is it the fabric of society that puts BAME women at higher risk when they enter the maternity system or is it something that is happening within the maternity system itself?

As already mentioned, there is no information provided on ethnicity with regards to the various causes of death. The report tells us that 96% of the women who died could speak English, (although the level of proficiency is not given). What this suggests is that when in the maternity setting, an inability to communicate in English does not seem to be a factor in women's deaths. However, as we do not know which ethnic groups featured in each particular cause of death, we do not know whether other factors connected to a person's ethnicity played a role in the care that they received. For example, if BAME women were more likely to die from post-operative haemorrhage, this might mean that institutionalised racism is playing a role, i.e. BAME women are being left alone, or their concerns and pain are not being taken seriously. This is not something that we can conclude as we do not have the relevant information. The problem therefore is that we cannot trace the root of the problem and begin to tackle it.

A similar issue is with regards the standard of care provided to the women who died. Notably MBRRACE provides data on the number of cases in which care was good, and the number of cases in which improved care could have made a difference to the outcome. Frustratingly, even given the conclusions that were found in relation to the rates of BAME women's deaths, this is not broken down into ethnic groups. Consequently, we have no idea whether the women whose care could have been better, included a disproportionate number of BAME women.

Another gap in the data is the geographical spread of the deaths. Do BAME women have worse outcomes in various areas of the country? What about in particular NHS trusts? Are the deaths all in urban places, or are they in rural areas, or is there no pattern at all? Again, this type of information could have helped shed some light on what exactly is going on.

Conclusions – can we draw any?

It was never the MBRRACE researchers' aim to just focus on BAME deaths, which explains the lack of further investigation, but their report has uncovered an important problem. Given that the death rates for BAME women are shockingly high in comparison to white women, this is an issue that needs urgent attention. It is impossible to see those statistics and to not consider racism – in some form and somewhere, whether direct, structural or institutional – as playing a role in the poorer outcomes for BAME women. To think that this is all down to chance is unhelpful. And to think that this is all down to some fault of the women themselves is ignorant.

The MBRRACE team has the data that would put a better spotlight on what is happening to BAME women within the UK maternity system. AIMS would urge them to dig deeper into that data (e.g. coroners' reports, the birth place setting, medications and interventions used) so as to enable further causal connections to be made, and detailed conclusions to be drawn so that targeted action can be taken. One option would be to create a supplementary report that focuses specifically on the deaths of BAME women. This would enable organisations such as AIMS, those working in the maternity system and others in wider society to begin to tackle the root causes of what appears to be systemic inequality, disadvantage and racism.

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3. NOMIS Official Labour Market Statistics (2011) Country of birth by ethnic group by sex: 2011 Census. Available at: *https://www.nomisweb.co.uk/census/2011/DC2205EW/view/2092957703?rows=c_ethpuk11&cols=c_sex* [Accessed 6.6.19]
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Forced Inductions – the UK's shameful secret

by Emma Ashworth

In Spain

In April 2019, the Spanish Birth and Feminist world was rocked by the news that a Spanish woman had been taken forcibly from her home by Police, while in labour, in order to force her into hospital for an induction.

The history was that a woman I'll call Ana (not her real name but we have her full permission to share what happened to her) had planned a homebirth with an independent midwife who had been monitoring her carefully. She had reached 42 weeks gestation and had chosen to go to hospital for additional monitoring. During the monitoring, the hospital advised the woman that the baby's heart rate had a short period of reduced variability. Ana's midwife had informed her that this was not a concern or an indication for induction[1], however the doctor strongly recommended that she accept induction anyway. Ana wanted to consider this carefully, so she and her partner went for a walk to talk about it but when they came back to the hospital's midwifery station, it was closed, so they went home to decide their next steps.

Ana's labour started at home shortly after, but some hours later the police arrived wielding an arrest warrant and a court order which stated that she must be taken into hospital to have an induction. The couple complied with the arrest warrant once the police advised Ana that she could come with them without resisting, or otherwise she would be brought in by force.

However, when they arrived at the hospital they were left for over an hour before being attended by midwifery staff – undermining any argument that this was a dire emergency for the baby. They were then left again for many hours on the antenatal ward, mostly without any form of fetal monitoring although the small amount of monitoring that she did receive showed no signs of any issues.

Ana continued to labour and was eventually moved to the labour ward. As she was already in labour, augmentation was not inflicted upon her. However, ultimately she birthed her baby by caesarean, due to what the hospital called, "failure to progress". The baby is perfectly healthy.

This case breaches both Spanish and EU law. A woman has the right to choose her place of birth and to decline any interventions or care offered provided that she retains mental capacity to do so, and in this case, she did. The unborn baby has no rights in Spanish law, and it is not legal to override the woman's decisions – and yet they were.

Update in July 2019: Following the birth, a review of the hospital notes was undertaken by Ana's midwife, where it was found that there was no diagnosis of reduced variability in the first place…

And in the UK…

This terrifying case should lead us to reflect on the situation in the UK. Could this happen here? I'm sure that every midwife would immediately say no – never… but it does. It happens all the time.

Meryl (also not her real name - we have her full permission to use her story) contacted the AIMS helpline[2] when she was pregnant. Meryl's experience was that she found herself in the maelstrom of unnecessary Child Services intervention following an incorrect Child at Risk referral. False allegations were made about her after she made a complaint about the conduct of her midwife.

Meryl's complaint about her midwife was taken as a sign that her mental health must be poor. She was accused of "demanding" birth choices which were then denied to her, and it was then alleged that she was refusing antenatal and other health care (objectively untrue as a quick glance at her notes would have shown). The case was mishandled on multiple occasions including paperwork being lost or not sent, and poor communication between staff. For example, Meryl's obstetrician only found out about her baby being on the Register because Meryl advised them of this herself. Her legal birth choices were denied, and when she tried to deal with this she was accused of being aggressive, and this was added to the list of accusations against her. When she pointed out the power imbalance that she was stuck in, she was labelled as paranoid and unstable.

As a result of being branded non-compliant, her unborn baby was put on the Child Protection Register from birth under the category of neglect. This is because a baby cannot go on the register before birth as they have no rights, so Child Services were making the assumption that Meryl would neglect her child once born, solely on the basis of birth choices that they did not agree with. This will forever remain on their case files regardless of later resolution through the complaints process.

The nightmare of the Child Services system, under-resourced, understaffed, was now Meryl's path, just as she should have been preparing for the birth of her daughter. Child Services failed to follow their own guidelines, did not provide Meryl with the information that they were "charging" her with, and when she attended the child protection conference, she was not permitted to provide supportive evidence as, she was told, 'there wasn't time left'. However, professionals who barely knew her or the case, were given time to provide their evidence. It was within this secretive and hostile pseudo-court that the child protection order was made. It was then made clear to Meryl that if she did not comply with everything that the midwives and medics told her to do she would risk losing her baby after she was born. This area of law failed her, and criminal and civil law could only be applied after an assault happened – it could not stop it from happening in the first place.

Meryl continued to fight for her right to make decisions for herself about routine care, interventions and her place of birth, but in the end she was forced into hospital for a mandatory, unwanted induction due to the threat of her baby being removed if she did not comply. Child Services used the fact that she had been complaining about the way that she was being treated as evidence that she was 'non-compliant', 'paranoid' and 'a control freak'. Because she had been told that she was obliged to accept any intervention, midwives and doctors put their fingers into her vagina multiple times without obtaining her legal consent, even though she had expressed multiple times she did not want any of the interventions and therefore could not give consent. She was forced into 'consenting' on pain of losing her baby. This is not consent either in law or in any ethical sense.

Meryl's baby was born five horrific days after the induction started. At no point in her labour was the baby thought to be at risk. However, after the birth her baby developed an infection and had to be admitted to the Neonatal Intensive Care Unit (NICU). The chance of these types of infection occurring are known to be increased by excessive intervention. Meryl was not consulted about care in the NICU either, as a result of the Child Protection Order, and was even told to leave the unit when her baby needed feeding 'in case she became psychotic' from not sleeping.

It took three months for the Child Protection Order to be dropped and the NHS investigation found that there had been clinical negligence, but that they hadn't caused any harm. Meryl then complained to the Ombudsman who upheld her complaint and advised the Trust to change their policies and procedures, and retrain staff. They also ordered that the Trust must apologise to Meryl.

Nothing, however, changes the fact that Meryl, like Ana, was forced into hospital against her will, and had interventions inflicted upon her that she did not want, and they will live with the effects of this forever.

In both cases, women were subjected to being forced from their homes, into a place of birth that they did not want to birth their baby, and ended up with highly traumatic birth experiences which were completely avoidable. One woman also now has a permanent injury to her abdomen and uterus which may well not have happened if she'd been left in peace. In both cases medical staff and others considered that the unborn babies had more importance than the women –

which is, in Britain and Spain, legally untrue, and in fact in both cases the unborn babies were not at risk anyway.

The UK may feel that it is superior in terms of its human rights within maternity, but cases like this indicate that it is not. Meryl's handcuffs may have been made from words, with the threat of losing her baby, but they were as powerful, punishing, degrading and dehumanising as metal.

AIMS Comment

AIMS recognises that there are children who need the protection and support of Child Services. We also recognise that sometimes a baby will need to be put onto the Child Protection Register before birth in order to ensure that support is in place after the birth. However, AIMS is more and more frequently seeing unborn babies being put onto the Child Protection Register because their mothers' social workers inaccurately believe that some birth decisions mean that mothers are not caring sufficiently for their babies. In fact, it is those who create and give birth to their baby who have the most invested in the health of their child. It is also the case that only the person giving birth can make a decision about interventions, tests or anything else done to their body, whether they are pregnant or not. By using the threat of the baby being removed at birth if the woman does not comply with the demands of child services, this law is being effectively, and devastatingly, undermined. It also puts the woman and her child at significant risk of harm, as Child Services staff are not medically trained, and their demands that women comply with interventions that they do not fully understand can cause very severe physical and mental injuries.

References
1. AIMS' information sheet on monitoring your baby's heart rate in labour: www.aims.org.uk/information/item/monitoring-your-babys-heartbeat-in-labour
2. The AIMS helpline offers support and information by women for women. You can contact the helpline by phone on 0300 365 0663 or by email on helpline@aims.org.uk

Further reading
Spanish birth rights groups present the case to three human rights organisations: https://bit.ly/2MoIzdr

Interview

Interview with a birth campaigner: Shane Ridley, AIMS Trustee and Publications Secretary

When did you get involved in birth issues, and why?

Over 20 years ago when my son, Patrick, was a baby, I joined the Community Health Council in East Berkshire where I lived. I had worked in personnel in the health service for 20 years and when I left work to have a baby I wanted to remain connected to the health service. It was by chance that I became Chair of the MSLC (Maternity Services Liaison Committee) – just because I was a new mum with a young baby! I set about improving the lay representation on the committee from the one NCT person who was on it. One of the people I invited onto the committee was Beverley Beech, the former chair of AIMS. Together with the other lay reps, Beverley and I transformed the dialogue with the local obstetricians and midwives.

How did you get involved with AIMS?

When I left Berkshire to live in Somerset, Beverley asked if I would take over Membership and Publications in AIMS. That was about 2001.

Can you tell me about some of the things you've achieved within AIMS?

My husband, John, helped me to create an Access database of the membership and I ran that. I also sent publication orders out once or twice a week for a number of years. Eventually the job got too big and I passed Membership over to Glenys Rowlands (who, by the way, has only just given it up). Publications, by this time, was getting busier and I was sending out orders several times a week – I was great friends with the village postmaster! All the stock of the books was kept in my house and gradually I took over ordering stock. We were all involved in each book that was published – working collaboratively with the authors.

I've forgotten the actual timeline but gradually I got more involved with the publishing side of things. In 2014 I started working for a publishing company in a nearby town, and there met Alison Melvin – a very experienced editor and typesetter. We have worked together ever since to publish AIMS books.

In addition, I led the move to Charity status, working closely with Ceri Durham and the then treasurer, Jackie Boden. This we achieved in 2015 when I became one of the founding Trustees. Over the years, I've also filled in for Treasurer, done lots of admin (arranging meetings, organising a retreat, taking and writing up minutes, writing articles for the Journal) and generally helped to keep AIMS going!

What do you most enjoy about volunteering for AIMS?

That is quite a difficult question, strangely enough! Sometimes I wonder why I have committed myself to AIMS – it's hard work, time consuming, frustrating, upsetting at times. But my main motivation, from the first days, has been to get information to women. Every time I sent a parcel out, I felt a sense of satisfaction – that is why AIMS books are so important to me. Over the years, I've learnt such a lot, so I'm now far more knowledgeable about pregnancy and birth. I gave up work to look after and educate my son – my husband worked abroad a lot so committing to work was impossible. So, I suppose volunteering for AIMS filled that gap that used to be work. I've made some good friends in AIMS – laughed and cried in equal measure. It is simply part of my life – it's what I do.

How do you manage your time as a volunteer for AIMS?

It's been different as the years have gone on – Patrick was about 3 when I started so I mainly did work in the evenings. John was always very supportive and looked after Patrick and our dog whenever I went to meetings. Gradually, as Patrick got older and could go on sleep-overs with friends, it was harder to get the dog looked after than Patrick! In later years, I've spent much more time on AIMS work, but enjoy the work and the companionship.

What changes have you seen in maternity care – for the better or worse?

We get these wonderful glimmers of hope sometimes from good stories about birth – happy mums and happy babies. I've always known, since my own experience, that there are the most amazing midwives and obstetricians out there, so I get really upset when I hear of the bad practice that is still going on, and of the struggles that excellent staff can face. I'm upset that women don't always know or find out that birthing can be good. When the NMC (Nursing & Midwifery Council) wrote in their code that nurses and midwives must treat people with kindness, respect and compassion, I almost lost hope – did they really need to have that written down?

What has been your biggest frustration in your time as a birth activist?

I don't really describe myself as a birth activist … I enable others to be by providing the 'back room' support for AIMS. I read a lot, I'm 'on social media' but I don't go out campaigning, I don't have a network, I don't often meet pregnant mums … I just try to hold AIMS together by doing my bit.

What do you hope for the future of the UK's maternity services?

I hope we can go back to more home births. I hope that most women can have just one or even just two or three midwives to look after her, like I did. I hope midwives don't continue to step blindly into a medical model and I hope that more obstetricians open their eyes and learn what birth is really about. I hope for less intervention, with medicine being there for when it is really needed. I hope that more women will learn to hypnobirth and be supported by doulas.

AIMS will be 60 next year – we will be celebrating that we have kept the organisation going, on a financial shoe-string, for so long; but at the same time, despairing that we still have to be here. That there are not enough hours in the day to do all we need to do …

Is there anything else you'd like to add?

Can I just add a plea for volunteers with an interest in administration and finance to come forward – volunteering for AIMS is not all about campaigning and working with women directly!

Article

Postnatal doulas: nurturing the family

by Nikki Mather

Nuclear family life

Within the huge variation in the types of families that we see in society today, postnatal doula support is recognised as being hugely beneficial to all new parents. So many of us move away from our families for work or university and set up life in a different city, or move into a more rural setting to begin a nest of our own, so postnatal doulas can fill in the gaps that our wider family might have filled back in the day – as well as much more.

The support each family needs looks different; no two families' requirements are the same, and even within families their needs will differ as each day arrives and as the landscape of parenthood changes. Doula support involves a range of skills to fully support each family as and when they require, and when we do not have the tools to hand we signpost to the most appropriate support. Doula preparation courses[1] provide essential information and education as well as giving guidance on how to use reflective practice and emotional intelligence effectively when working with new families.

What does a postnatal doula do?

Emotional support is the very foundation of what doulas provide: A listening ear for parents to air their concerns, or to hear parents' thoughts after a difficult time, as well as basking in the glow of oxytocin and their happiness together following a positive birth. The 'doula superpower'[2] of signposting must not be underestimated, sharing a plethora of different links, social media groups, local parenting sessions, support groups or organisations where parents can search for more information to support them where required.

Doulas listen to families' birth stories and often hear them repeatedly, listening carefully each time parents play out the scene again. Parents report feeling better about their experience when they have been listened to, had their experiences validated and not judged for how their journey unfolded. The emotional labour of so many things to think about, all the task lists and meeting all the family's needs can be difficult to navigate in the early days and weeks with a newborn baby. Doulas provide both emotional and practical support, which is flexible depending on the wishes and needs of the individual parents. Essentially, the emotional support provided by a postnatal doula and the action of just 'being there' matters; listening and providing consistent support are physiological needs of human beings for them to feel reassured and safe. The nurturing presence of a doula providing familiar and consistent support for some families is considered essential to the mental health and well-being of the family.[3,4]

Diverse skills for diverse situations

Each birth and each baby are individual and therefore have different elements of need in the postnatal weeks as each family navigates their way through the challenges of parenting. The way in which a baby is born may influence how parents feel in their postnatal recovery. Infant feeding may have a tricky start especially if interventions are required during birth or if any pain relief used has affected

the baby's biological responses in the early hours after birth.[5]

Some mothers may want a hands-on approach in the home to support the whole family, older siblings and partners, while they get to know their new baby in the early days: Having somebody else to take care of cooking a meal or two or filling the freezer with nutritional meals, or maybe just to pop in the kitchen and wash the pots piling up next to the sink; some infant feeding or breastfeeding support.

The nurturing presence of a doula providing familiar and consistent support for some families is considered essential to the mental health and well-being of the family.

Practical support can make things a little easier on tired parents in the early days. In tales of days gone by, you may have heard of how our mothers, aunts, friends and neighbours would provide the role of a doula to new parents without even having to think about it. The local 'wise woman' or the 'auntie' of the neighbourhood would be called over to tend to the everyday household tasks and help with breastfeeding in the early days, ensuring any older children were fed and watered, dressed and off to school, or the washing was hung out on the line. They would hang around, ready to serve with any support required until the parents became confident in their own parenting skills, and remained a part of each family as the children grew.

Postnatal doula support from a practical aspect has not moved away much from those stories. Preparing nesting areas for a new mother to sit comfortably in whilst underneath a nursing or bottle-feeding baby, fetching drinks and snacks to keep her energy and hydration levels up, ensuring the things that are getting in the way of parents relaxing are done, the washing turned on, the dishwasher loaded and lunch prepared for the next day.

Listening, holding and nurturing parents as they navigate the transitional experience of parenthood is the very essence of postnatal doula support.

Why hire a postnatal doula?

Quite simply put, who wouldn't want an extra pair of hands around? A listening ear, an extra shoulder to cry on. Parenting in the 21st century sometimes requires additional support to enable informed decisions to be made. With information available at the tips of our fingers, finding robust information and deciphering it and recognising evidence-based practice weaved amongst the stories and opinions of many, can be difficult to navigate for anyone – and new parents have the added challenge of sleep deprivation and the stress of new parenthood. An important element of being a postnatal doula is the ability to listen to parents' concerns whilst making informed decisions, support them in finding the information to make those decisions and advocate for them where needed to ensure their voice is heard. Better outcomes are seen for families who engage in doula support.[6]

Are postnatal doulas a privileged accessory to parenting?

Despite the media portrayal of doulas as a recent fashionable 'must-have' of the privileged,[7] doulas have been providing support to all sections of society for as long as there have been people giving birth. From the informal, unspoken agreement of friends and family who pop by and make meals, do school runs and tidy around for new parents, to organised meal plans from community centres and religious organisations, families receiving the support of others is not a new trend. For some families, the benefit of belonging to part of a community or having family close by is not possible in their lives for one reason or another. Postnatal doula support appears in many guises, ranging from the personal option of being able to hire and pay privately for postnatal support as an agreement between the family and the doula, to receiving charitable sessions from a voluntary organisation such as the Doula UK Access Fund or Doulas Without Borders. Charitable organisations request support and signpost to doulas who work voluntarily for families who are being supported by Refugee Action, Refuge, Women's Aid and more. Many doulas also provide free support via local community birth groups and helplines. Payment plans and skills swaps are also seen, where families see the benefit of having postnatal support without the

means to pay in full. The benefit of continuity, of dedicated support and of the empowerment families experience with doula support is clear regardless of socioeconomic status; however, improving the outcomes of marginalised groups is a key benefit where doula support is provided.[8,9]

A typical day in my life as a postnatal doula

I wake at 5am to a text message from a new dad providing me with a birth update and letting me know the placenta is ready to process (I'm a trained Placenta Remedies Provider).

I grab a coffee (or three!), and head out to my first family at 6am. It's a half-hour drive and it's icy this morning – the first frost of the year.

In my role as a postnatal doula, I arrive to support a family after they've had a sleepless night with their newborn baby.

My visit is for 2 hours. I pop a sling on, ready for a baby to snuggle in should I need it whilst I fold up the dry cloth nappies and replace them on the drying rack with freshly washed nappies.

Mum is feeding her baby when I arrive and once he is fully satisfied with his belly full of breastmilk, mum hands over the smiley baby so she can head off and grab a refreshing shower and some much-needed breakfast. Making the best use of my time as a postnatal doula is important to this family. Both parents are exhausted, and mum tells me she's not had time to brush her teeth in the past 24 hours, let alone grab a shower or enough water to drink. I pop the baby snugly into the sling and continue my way around the rooms; tidy around, sort any baby paraphernalia out around the house and make a tidy nest again on the sofa, complete with snacks and water for the day. I chop some root vegetables ready for roasting and pop them in the oven with the timer on as I'll be gone when they're ready to come out. As mum comes downstairs, I give her a hug, hand her a cup of tea and pop a sleeping baby down out of the sling and into his crib so I can head out again to the next family.

My next visit is to a new family I have not met before who are struggling to feed their baby. Mum has called me on the evening before my visit and wondered if she was doing something wrong because her baby would latch on well, and then sleep very quickly, not swallowing much at all, and then come back 20 minutes later. This cycle of on-and-off feeding was leaving her and the baby without any rest.

I arrived and made us both a cup of coffee. I listened to mum explain her journey so far, the issues she has been experiencing and a little about her birth story so I can build a picture of any external factors that may be affecting where they are currently. We discovered that baby was being held a little away from mum's body, so baby needed to stretch and crane her neck to reach the breast. This quickly tired baby out and so she fell asleep after a couple of minutes of active drinking. I supported mum to change her position a little and hold baby close. She was a little hesitant because of her sore and lacerated nipples. Once baby was tucked in close and able to latch on quickly, she took a huge mouthful of breast and drank well for 20 minutes, falling off the breast fully satisfied. Mum couldn't believe the baby was so relaxed and full – milk drunk! Such a little tweak to positioning can make all the difference.

My third stop is a mum with a 5-week-old baby, another breastfeeding visit. I am trained as a breastfeeding counsellor, which is additional training to being a doula, and it's an invaluable skill when supporting parents postnatally.

Off I go again to collect this morning's placenta. It's 12pm and I am aware I need to eat. I grab a salad from a cafe as I drive towards the new family's house. Being a birth and postnatal doula quite often means I skip a meal if driving lots on a busy day and so protein bars, dried nuts and fruit seem to be my go-to snacks to keep me going.

I arrive to collect the placenta and congratulate the new parents who are now at home after their birth in the middle of the night. I pop on some gloves, check the temperature of the placenta to ensure it is sufficiently cooled and, after showing the parents the amazing placenta and all of its fascinating functions, I take off a piece for the smoothie. My smoothie kit is already at their house and I leave dad with the piece of placenta to blend with fruit for his wife as he gets his gloves and apron on – he has been very excited about preparing this for his wife. The remaining placenta is safe in the cool bag and I head home to process it into capsules.

After preparing the placenta and placing it in the dehydrator overnight, I settle down with a hot drink. I log

on to the laptop to check my messages and emails. I organise my diary for the next few days and set up some games with the kids who have been with their dad at home today as he took a day off to be with them. Dinner will be ready soon and I have some admin for my volunteer roles to do too before the evening is over.

I am hyper-aware throughout the day that I am also on call for a birth. There is always an acute awareness of the possibility of leaving everything with very short notice, dropping everything as soon as the call comes for me to be with a birthing family. Parents-to-be keep me updated with any changes in how they feel or any signs of labour and I often have some notice before the time comes to jump in the car. No babies today, so I continue my evening with emails, follow up calls and texts, and relax with my children after dinner. I aim to sleep early so I can start over again tomorrow with the next placenta encapsulation step and a trip to the post office to send the capsules to their owner. Doula Last Words – 'unless I'm at a birth'.

Nikki Mather is a birth and postnatal doula at The Doula Element, covering Greater Manchester and Cheshire. Alongside her doula role, Nikki specialises in infant feeding and works alongside Yorkshire- and Cheshire-based Milk Matters.

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Story

Jenna's Home Waterbirth Story

When my partner and I were considering trying for a baby we talked about what we wanted and what scared us about the idea. One of the things which I wanted was the experience of being pregnant, while giving birth itself terrified me utterly. As it turned out, I had a horrible pregnancy, feeling nauseous and fatigued for most of it, and giving birth was actually a tremendously positive experience for me.

I knew I wanted a home birth, and started Active Birth Yoga classes locally (when I was well enough to go). Initially the response I got from the various people I encountered medically to my having a home birth was very positive, but gradually a note of caution slipped in, until I began to feel that I was just one big walking hazard, despite being 'low risk'. Towards the end of my pregnancy the tone changed dramatically to one of implying that I was putting myself and my baby at risk by not being in the hospital. Both AIMS and my yoga teacher were very supportive, first of all in warning me that this might happen so I was prepared for it, and secondly in helping me to formulate a response.

I hired a pool from my yoga teacher and set it up. One midwife tried to tell me that the floor would collapse under

it once filled. I checked with the people who had built the new floor when we moved in and they said that was nonsense. I didn't appreciate being scared like that, and I used humour to help me through it. I referred to my pool as my 'pond' and threatened to have actual frogs in it. I settled for a selection of rubber ducks, which I figured I would throw at anyone who tried to scare me like that at the actual birth.

My due date came and went, and the midwife at my GP practice said 'We'll book you in for a sweep'; she looked surprised when I said no. She then said she would book me for an induction two weeks after my due date. I said I wouldn't go, but she booked the appointment anyway. I was very scared of the induction process, and determined to avoid it. The AIMS book 'Inducing Labour: Making Informed Decisions'1 was invaluable to me in reassuring me that I was not mad to refuse induction and giving me backup. I was sad that all this was such a fight.

The Monday of that week I had a 'show'. I was very relieved, and excited. I was also surprised by how different that was to how I imagined. I hadn't been well enough to get to any NCT classes while I was pregnant, so maybe I would have known more if I had. When I asked the midwife later about it she said that the show could vary a great deal. After that I started to have contractions on the Tuesday night, but they were quite far apart. I got my TENS machine out and tried to sleep, without much success. The Wednesday morning my partner called the hospital to ask for a midwife because the contractions were now every few minutes. They demanded to speak to me. Forewarned of this, he had to talk strongly to them before they accepted that he was just as capable of reading them my NHS number off my notes as I was. They said there weren't any midwives available; he said we wouldn't come to the hospital. A midwife was found.

She came, was lovely, and said that she thought it would be a while but that she would expect I would have had the baby by the end of the day. After she left, my contractions slowed down again, which was also a surprise to me. A quick Google revealed that this was not abnormal, and I settled on the sofa to watch films with my TENS machine. The night arrived and my contractions were now very strong, but 20 minutes apart. I tried to sleep in between them.

Early in the morning on Thursday I got up and started pacing around. I became slightly inarticulate and told my partner that I was getting in the pool now. It took him a while to realise that I meant that he needed to call another midwife. He did, had another fight with the hospital and another midwife appeared. She told me she had to do a vaginal examination to see if I was dilated enough to get in the pool. She sent my partner away, and did the exam. I was surprised how painful it was, and I can't even describe the shock, anger and sorrow I felt when after she had finished she said 'I just did a sweep while I was in there' – without my consent, and despite it saying clearly in my birth plan that I wanted minimal intervention and clear discussion (with my partner involved) before any procedure was carried out. I decided that I had to put my feelings about what she had done to one side and not let her mess up my birth, so I did. I promised myself I would complain later, and I did. The response I got from the hospital was laughable, but I didn't have the energy by that point to pursue it further than my initial letter.

I ran off to the pool and hid in the farthest corner of it away from her. I knew that other midwives were coming soon so I hadn't got to put up with her for long. I took some photos with my partner's help at this point to regain a sense of control and start enjoying myself again, and this is one of them.

Contractions in the water were a lot less painful than outside of it. I loved being in my pool. Two new midwives and a student (I had already consented to her being present) arrived, read my birth plan thoroughly and made approving noises. I felt surprisingly good considering how much it hurt. Looking back on it, what was different than all the other pain I have felt in my life is that there was no sense of injury or trauma with it, no anxiety, it just felt right, I was at peace with it not scared of it. So, it was much more bearable than other pains I have felt.

By about 2pm I was exhausted. I knew I could manage the pain, but I was so tired that my muscles were starting to cramp and my legs were shaking. I tried getting out of the pool for a bit and felt like lead. One of the midwives gave me a lovely back rub. I agreed to a second vaginal exam (which speaks of how great these midwives were that I would trust them after my earlier experience), was told I was doing well, 8 cm dilated, probably a couple more hours to go and eventually got back in the pool with some gas and air. I found that screaming out and kind of growling was really helping me, and it took me a while to work out how to do this alongside the gas and air.

They told me I could start pushing, I said I already was. I thought I was going to explode. They said the baby's head was coming, invited me to put my hand down and feel it, I did, regretted it because it felt very weird and bulgy, and apparently said 'There's no way that's coming out of there!' They laughed; I expect they had heard that before. And eventually at 4.30pm-ish, my baby was born, the student midwife caught her and brought her out of the water.

I sat back in the pool and abruptly felt amazingly calm and clear as she was put on my chest. I just cuddled her and gazed and gazed into her eyes as she gazed at me.

The midwives got excited about finding out whether she was a boy or a girl. I hadn't cared at all until they started asking to check, but then I was delighted to find out I had a daughter.

My partner and I had a moment of calm together before they asked him if he wanted to cut the cord, which had gone clear by this time. Then I had to birth the placenta, which was horrible because I was so tired, and I had got out of the pool again. This was the least dignified part of the whole affair as there were a lot of membranes; the midwife who was helping me did a great job before taking me for a shower. I couldn't walk unsupported because I was so tired.

The three midwives who had been there with me all day had to leave as their shift finished, but two other midwives arrived, did me some very neat stitches (I had a small second-degree tear which I had barely felt) and showed me the basics of breastfeeding. Then they left me on the sofa cuddling a naked baby, who promptly pooed all over me. Welcome to parenthood – unbelievably tired, covered in someone else's bodily fluids yet unbelievably happy!

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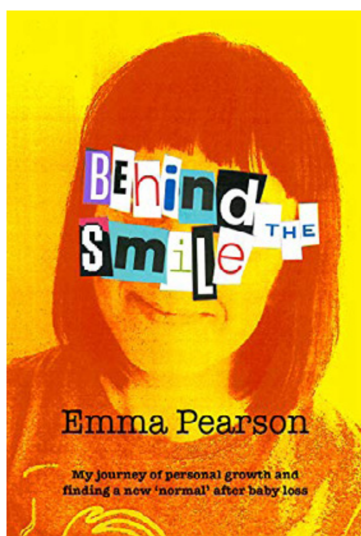
Book Reviews

Behind the Smile

by Emma Pearson

Published by the Solopreneur Publishing Company Ltd
ISBN 978-1-9164415-2-1
234 pages



Anyone who has suffered the death of a child will be familiar with the stark contrast of life 'before' and 'after'. This book documents the journey of one woman finding her new 'normal' after the devastating stillbirth of her twin sons.

Emma Pearson writes directly and openly about her experience of infant loss, pregnancy after loss and rebuilding a life around the grief. The book also brings home the point that, as indicated in the title, you can never know how someone is truly feeling, especially if they put on a brave face. Emma is refreshingly honest about her struggles and it was incredibly moving to read how she has been able to set up a charity that helps families through subsequent pregnancies and parenting after infant loss,1 whilst also going on to have two more children.

Emma's story provides a compelling insight into the aftermath of life after a baby is stillborn or dies in the neonatal period. It explores how further inadvertent upset to those suffering might be avoided by the provision of supportive care, not only immediately after the bereavement but also further down the line in subsequent pregnancies and postnatal periods. It is heartening to read Emma discussing how lovely the maternity staff were during her pregnancies, especially the midwives on the labour ward. On the other hand, health visitors in Emma's story do not get such a good review; this is perhaps an area for service improvement. It was lovely to read how Emma decided to fundraise for the hospital that provided her care, and managed to renovate the bereavement suite with the proceeds.

Infant loss is a difficult subject to write and read about, and at times 'Behind the Smile' makes for emotional reading, but the overall vibe is positive and encouraging. Emma has done a superb job in making her story accessible in this way. The book is inspirational, and I would recommend it not only to bereaved parents, but to anyone who may come into contact with parents who have lost a baby. At the very least, this book deserves a place on the reading list of every trainee maternity care worker, and I am sure that it will be of wider interest too.

Reviewed by Jo Dagustun

Further reading

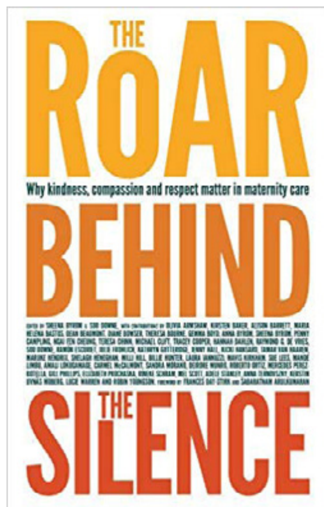
1. To find out more about the charity that Emma founded, JOEL: The Complete Package, please visit the website: http://www.joeltcp.org/

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

The roar behind the silence: Why kindness, compassion and respect matter in maternity care

Edited by Sheena Byrom and Soo Downe

Published by Pinter and Martin Ltd.
ISBN 978-1-78066-180-3
256 pages



With this paperback, Sheena Byrom and Soo Downe – both well-respected figures in the professional and academic fields of UK midwifery – aim to contribute to improving maternity services both in the UK and further afield. They seek to do this by providing 'information, inspiration and practical suggestions to support maternity care workers, policy makers, and maternity care funders across the world in their quest to deliver sensitive, compassionate and high quality maternity services'.

Across its 32 short chapters, the book certainly provides lots of useful information and thought-provoking ideas from a wide range of authors (a good mix of well-known 'celebrities' in the world of birth and some newcomers) on why kindness, compassion and respect in maternity care really matter. As such, the book should provide much comfort and moral support, as well as practical suggestions, for those professionals who might be feeling isolated – and perhaps despondent – in their efforts to introduce these ideas into their local workplace. Some of the chapters also reach out to a broader audience. For example, I found Kerstin Uvnas Moberg's contribution on how different types of care have the potential to radically alter the physiological process of birth particularly good.

AIMS Journal readers will not need convincing, of course, that many birthing women still experience far too much unnecessary distress in their encounters with the maternity services. The publication of this book demonstrates that this message is being heard. As such, the book is a very welcome addition to the broad-based campaign to raise awareness of this issue, building on the ambitions of the current Maternity Transformation Programme in England and of similar change programmes in other countries. It is a great quick guide for birth campaigners to the many initiatives and ideas in this area, each of which holds great promise in terms of supporting improvements in our maternity services. For women and families who have recently used the maternity services, this book might also make for a great present idea for your favourite caregivers instead of the usual chocolates: the brevity of individual chapters makes it highly suitable for a highly motivational pick-me-up during a well-earned staff tea-break. Or, if you are part of your Maternity Voices Partnership (MVP), you might want to recommend it for purchase by your local staff library, so that everyone on your MVP has a chance to brief themselves on this important topic.

Reviewed by Jo Dagustun

A host of book reviews are available on the AIMS website.

See the full list *here*

AIMS AGM

&

Volunteers Mini Retreat

When: 12th September 2019
Venue: Old Chapel cottage, Belper, Derbyshire DE56 1AZ
http://www.derbyshire-holidays.com/cottage.php?id=oldchapel

The AGM is being held in a lovely part of the country and the house itself is a ten minute walk from Belper train station (which has good links to mainline train stations) and there is also some car parking available nearby. We hope that you will take this opportunity to join us to discuss our plans for the future and we will also take time out to cook together and relax.

We invite all our members to join us for the AGM on Saturday 14th September. Arrive 10:30 am for an 11:00 am start and we will plan to run the meeting through to 4 pm. But you would be most welcome to join us for breakfast and stay and eat with us in the evening. Contribution to a shared lunch would be appreciated.

Should you require any further information, wish to attend the AGM or to send apologies, please contact our Office Manager, Isabelle Pearcey (isabelle.pearcey@aims.org.uk).

We hope to see you in September!