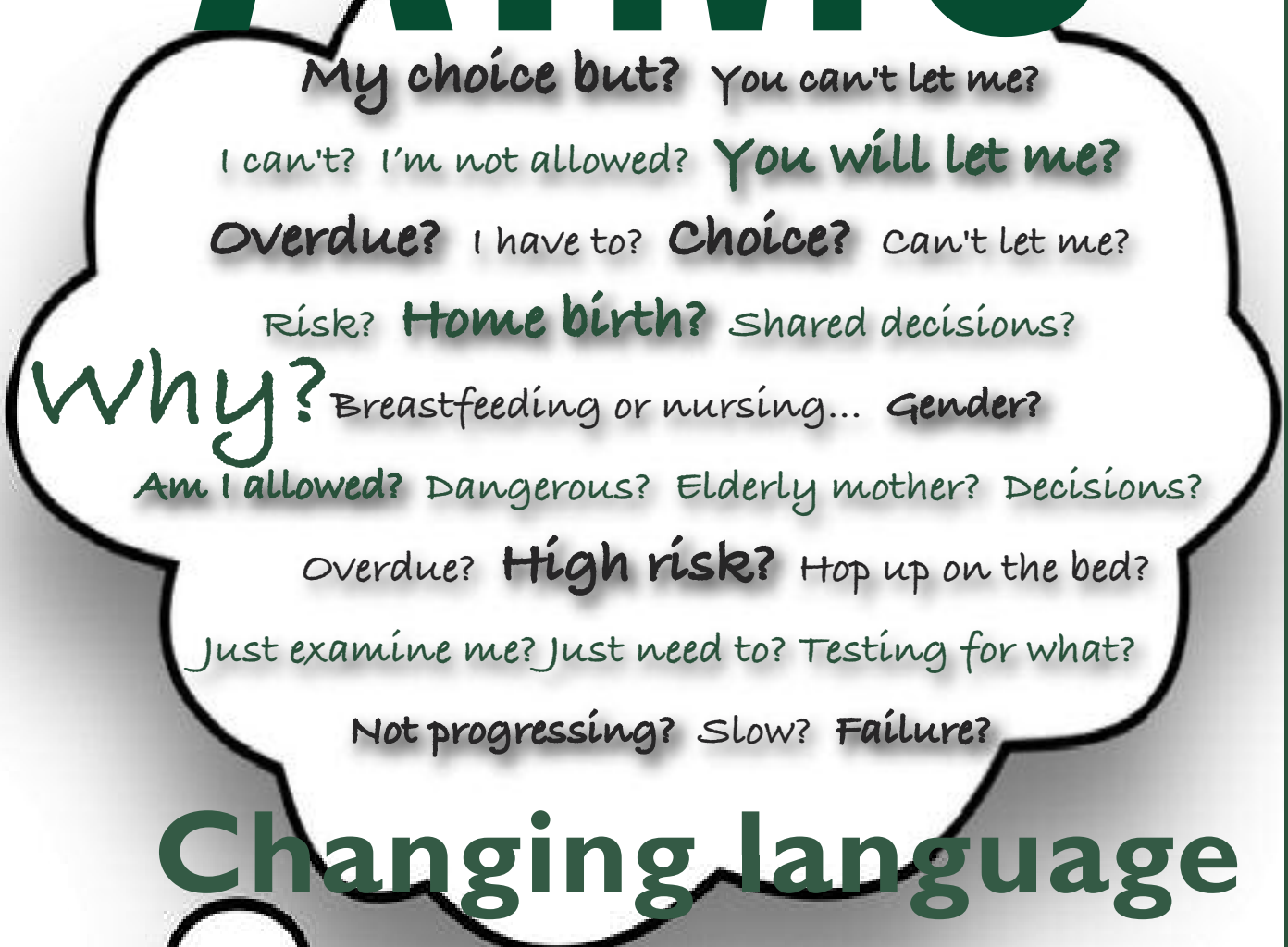
Association for Improvements in the Maternity Services

AIMS Journal Vol:29 No:2 2017

AIMS



Changing language

Stopping coercive language - what else to say

He's not the mother – LGBT parents and language

Positive language and Down's syndrome

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Diary

AIMS AGM

23 September 2017
See back cover for more information.

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

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

The Maternity Transformation Programme

Learning from the early adopters and pioneers
London
15 September 2017
Chaired by Prof Helen Young
Focus on delivering the Maternity Transformation Programme in practice including learning from the early adopter and pioneer sites.
www.healthcareconferencesuk.co.uk/event/1317

The Future of Maternity Services and Care

London
28 September 2017
The recommendations of Better Births and provides information on how to implement those recommendations.
www.insidegovernment.co.uk/future-of-maternity-services/

Women's Voices

Inspiring Future Maternity Services
Royal College of Obstetricians and Gynaecologists, London
14 October 2017
How the human rights framework fits into maternity care, discussing the idea that 'safe care is personalised care'.
Speakers:
Elizabeth Prochaska
Prof Cecily Begley
Sheena Byrom
Milli Hill
Catherine Williams
womensvoicesconference.wordpress.com/speakers/

Feminism in London

14-15 October 2017
Institute of Education, London
To advance education on gender equality by showcasing activists, academics, NGOs and their work.
filia.org.uk/about-the-conference

UNICEF Baby Friendly Conference

Telford 22-23 November 2017
The largest conference on infant feeding in Europe, the UNICEF Baby Friendly Conference brings together the latest research and information on supporting successful breastfeeding.
www.unicef.org.uk/babyfriendly/training/conferences/annual-conference-2017

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

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

AIMS

campaigning for better maternity services since 1960

AIMS

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Vol:29 No:2
ISSN 1357-9657

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Printed by
QP Printing, London
Tel: 07593 025013

Cover Picture:
Illustration by Vicki Williams
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Coercion or communication?

Emma Ashworth discusses the importance of being mindful of what we say

What are words if you really
Don't mean them when you say them?
What are words if they're only
For good times then that's all.
When it's love ya you say them
Out loud these words
They never go away
They live on
Even when we're gone.

Chris Medina – What Are Words

The words we use are the most powerful influence that we have in the world. How we choose to communicate with other people can create love or despair, peace or panic, they can be the difference between a positive birth and birth trauma.

Language matters, and that's the focus of this edition of the AIMS journal. There has been a remarkable shift in the past few years, with an understanding of the power of words on people during pregnancy, birth and beyond. Penny Simkin writes, in her article, *'A Day You'll Never Forget— The Day You Give Birth to Your First Child.'*

'The most important finding of the study was that the women's satisfaction was not associated with the length or difficulty of their labour, or the need for interventions or pain medications. Their satisfaction was associated more with how they were treated by their doctors and nurses'

How they were treated, how they were spoken to, what words were used.

Specific uses of language and how it can impact on women and pregnant people and their families is discussed in Emma Ashworth's article on page 13. How words are used to protect the Trust and not to inform or support women, is the focus of Yolanda Forster's piece on page 10. Mari Greenfield (page 7) discusses how language can support or undermine LGBT+ people who are pregnant or the partner of a pregnant person, and she explains the different needs of different people who do not identify as heterosexual. For instance, what language do you use to support a pregnant trans man?

Emma Pickett, a lactation consultant and chair of the breastfeeding support charity Association of Breastfeeding Mothers, considers the use of the word 'breastfeeding'. Is it the right word? Breastfeeding is so much more about 'feeding'. Are we limiting what we are saying, with the words that we choose to describe an action?

New to this journal is a centrefold – a pull-out to pin-up poster all about language – what's good, what's bad, and what really just needs to stop. Please do take it out and pin it up somewhere where lots of maternity staff will see it! Take it to your MSLC and share it there. Encourage people to copy it and share it widely.

There really is a change happening around language. For years, we in AIMS have been systematically working through NICE consultations, adding in not only our considered responses to particular sections, but also suggesting language changes which we are finally seeing in the latest releases. Women, it says, should be 'offered' interventions. Low risk has become 'healthy women and babies'. Maternity campaigners remind midwives and doctors that they catch babies, and sometimes assist in their births. Women birth their babies, and then pizzas can perhaps be delivered a bit later! But still, every day, we hear women being told 'you can't', 'you have to', 'we'll just' and, of course, they ask us, 'Am I Allowed?'

Wouldn't it be wonderful if every woman knew that the only person who makes decisions about her body is herself. I urge anyone reading this to reflect on all the language that they use around maternity, and consider what changes they can make to the words they use and how they use them. Little by little we will change language – and when we change language, we change maternity.

Emma Ashworth
Emma is a doula, breastfeeding counsellor and an AIMS Trustee and volunteer

What is AIMS up to?

Our Primary campaign for 2017 remains Continuity of Carer and as a key part of this AIMS was part of a wider collaboration of organisations which brought the Celebrating Continuity conference to Leeds (full report below).

AIMS' other huge project this year is the continuing work on its new website. We are delighted to have information pages written by fantastic authors, and the new site will be much easier to use, and have more accessible content than the current site. We are still fundraising for this and would hugely grateful for any contributions (mydonate.bt.com/events/website/252237).

Deborah Hughes has written our latest pregnancy information book – this time it's **Gestational Diabetes**. This issue frequently arises on our helpline, and Deborah has brought the latest research together into this beautifully illustrated, clearly written book which is now available on our website under 'shop'. We are continuing to work on other titles, and if you are interested in writing a book for AIMS, please do contact us via publications@aims.org.uk.

Speaking of the helpline, it's as busy as ever and we are looking for volunteers to help. If you are well versed in birth issues and women's rights and a lay person, and would be interested in joining the team of volunteers, please do email helpline@aims.org.uk. You will be given all the support you need, and fully mentored through the process. You can do as much or as little as you like, and initially your responses would be by email, allowing experienced members to offer guidance and help if needed.

This year, the helpline has helped many hundreds of families and we are seeing worrying trends since the removal of statutory supervision. This, and other NMC related issues such as the insurance situation for IMUK members and confusion around the NMC's processes are being kept under a very careful AIMS watch. Beverley Beech was present at the meeting with the NMC on 5 May 2017, and AIMS continues to pressure the organisation to resolve the issues that it has in the support of both pregnant women and midwives.

Celebrating continuity

One Year On
Thackray Medical Museum, Leeds, 8 April 2017

This collaboratively-organised conference provided a long-awaited opportunity for birth activists in the North of England (and anyone else who finds Leeds a more accessible venue than London) to gather together following the publication of Better Births (NHS England, 2016). Perhaps most importantly, it provided a space to draw strength and inspiration from each other, ably guided by the chair for the day, Sheena Byrom, in preparation for what will likely be a tough and gruelling effort as we seek to get our local commissioners and maternity services to embrace and deliver the recommendations of Better Births.

A particular challenge will be how to convince commissioners of the value of an approach to services which sees a relational model of care (continuity of carer) as key to achieving improved outcomes for all women and babies. In that context, the event was rather exquisitely timed, coming just a few weeks after the outstandingly positive endorsement of the Albany's model of care in an influential scientific journal (Homer et al, 2017), a model which has the principle of relationship midwifery at its heart. This positioned the conference very nicely indeed. For us activists working at the local level, we surely need the answer to one question above all others: how do we get our local commissioners to say to our local maternity service providers: 'yes thank you, we'll fund the Albany model here'?

dedicated and long-standing birth activist

But back to the conference itself ... If anyone still needed convincing, Julia Cumberledge's opening presentation persuasively outlined the incredible amount of dedicated consultation and effort that sits behind the 2016 Better Births report and its recommendations. She is a dedicated and long-standing birth activist, and it was very good to have her at the conference in person. Unfortunately, Julia was unable to stay for questions. That was a real shame, as I'd have really liked to hear her speak to what was, for me, the huge elephant in the room. Some readers will recall how her 1993 Changing Childbirth report (Department of Health, 1993) was similarly welcomed, but how its delivery over the following 20 years left much to be desired. So in line

with the conference's strapline, Rhetoric into Reality, Policy into Practice', what is the likelihood of this latest report making a lasting difference?

One answer to that question, of course, was in the conference hall itself. The likelihood of Better Births becoming reality at least in part depends on the dedication and commitment of birth activists and birth workers across England and Wales to keep focussed, to work diligently, to regularly scrutinise local plans, drawing on all of our collective resources, to encourage our local commissioners to follow the national agenda clearly set out in Better Births. Yes, every area will have its differences and local challenges, but Better Births is now THE national plan that should help us all, in our local efforts, to achieve an improved maternity service for all women. Thankfully, too, we don't need to do it on our own of course: the attendees at this conference represented just the tip of the iceberg in terms of the people who are ready and able to get stuck in to this task.

how midwives might be best prepared to provide continuity

Every presentation that followed offered much inspiration and motivation. From Cate Langley's enthusiastic presentation on the challenges of offering women continuity of carer in rural areas, via an energising demonstration of how one Yorkshire NHS team has recently embraced the opportunity to work more closely with their independent midwife colleagues, to One to One's heart-warming explanation of how they gladly offer continuity of carer where they are contracted to do so by the NHS, one presentation after another offered a vision of improved services for women and their families. To hear about the way that Airedale Hospital has supported independent midwives following the recent NMC decision to stop midwives relying on the IMUK indemnity scheme from practicing intrapartum care was particularly positive. Airedale has shown what strong midwifery leadership can achieve. The Trust will benefit hugely from the skills and experience of the independent midwives who will be working with the Trust midwives to share knowledge, and the women in the care of IMs will continue to be able to receive their care from them.

In the wide range of workshops that followed, participants were able to focus on further crucial components of the long-overdue transformation of maternity services, including how to engage with commissioners, how midwives might be best prepared to provide continuity, how we can lead change, whether from within or outside of the maternity services. The Voices workshop was particularly strong in reminding us of the importance of ensuring the full participation of service-users in the much-needed transformation of maternity services.

AIMS has argued for many years that service-users hold a wealth of skill and knowledge about birth

AIMS has argued for many years that service-users hold a wealth of skill and knowledge about birth. This workshop underscored this vital truth. The discussions that took place throughout the day were not, of course, without some controversy. There was a useful debate on what was really important about the notion of continuity of carer, where it will be important to ensure that this focus doesn't turn into a useless tick-box exercise. There was also some discomfort about the notion of contracting out NHS services, even to 'friendly midwife-led organisations' such as One to One and Neighbourhood Midwives. These are tricky issues indeed, as we are all feeling our way in how best to progress from where we begin. Our starting point – and the need to move forward – was reinforced by the two afternoon presentations from Lisa Common and Helen Shallow, based on their recent PhD research into, respectively, the organisational context of maternity service delivery and the deficiencies of early labour 'care' organisation.

A huge thanks to everyone who contributed to making this conference happen (and in the North of England too!). It certainly highlighted how there is plenty of work for birth activists in the years ahead, to turn the policy recommendations of Better Births into reality. I would be pleased if this conference led to an ongoing series of annual gatherings, with the aim of providing an energising and nurturing space in which birth activists can come together to compare notes and provide mutual support, to ensure that the hard-earned recommendations of Better Births don't fall by the wayside. The 2018 National Birth Activist Conference anyone?

Jo Dagustun

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He's not the mother

Mari Greenfield looks at language, LGBT and inclusion

When lesbian, gay, bisexual and transgender (LGBT) people have children, the language commonly used by those providing maternity care can be either inclusive or exclusive, as can the assumptions that lie behind that language. In this article I am going to talk about both my experiences as a lesbian mother who has given birth and about the experiences of other LGBT parents, including parents I have worked with as a doula, and as reported in academic texts and the press. There are examples of good practice and poor practice.

How do LGBT people conceive?

In order to understand the barriers that LGBT parents might face, it is important to understand that LGBT people may create families in different ways. For the purposes of this article, which is about birth, I am going to leave aside options that include adoption, and having children from a previous relationship. Lesbians and bisexual women may have babies as a single parent, or as part of a couple. Single lesbian and bisexual women are likely to face the same assumptions and language barriers as single heterosexual women. Therefore, in this article, I will concentrate on LGBT people having babies within a same-sex relationship, or as an 'out' transperson (or both).

Lesbian/bisexual women couples may have conceived using sperm from a fertility clinic, or they may have conceived using sperm from a 'known donor'. Their intentions may be to raise the baby with the two women as the only parents, or if using a known donor, there may be additional parents involved in a variety of roles in the baby's life.

Gay and bisexual men may become parents through a co-parenting relationship with a single woman, or a lesbian/bisexual woman couple. They may also become parents through surrogacy. Their role in their baby's life may include the baby living full-time or part-time with them, or not living with them at all. It may be that only the genetic father is intended to have a role as a father, or it may be that he and his partner are intending to have an equal parenting role.

Transmen and transwomen may also become parents. This may be as the partner of a genetic parent, or through being the genetic parent themselves. They may be in same-sex or opposite-sex relationships when they become parents, or they may be single.

What are LGBT people's experiences of giving birth?

The academic literature shows that there are specific issues faced by LGBT parents during birth. Similarly, press accounts show that the experience of being the non-biological mother can include being dismissed and not treated as the mother, as Montbaston (2017) says to the point where:

'I ended up in tears saying that I felt I constantly had to justify that I was the baby's mother'.

Montbaston's experience also included people assuming she, as the more feminine presenting partner 'should have' been the pregnant one. Post birth, her experience was that when she did introduce herself as the mother, and talked about her partner, it was assumed that she had given birth, and her partner was a man, even when she said

'My partner is a woman. She had a baby on Sunday' (Montbaston, 2017)

This impacted whether she was allowed to go and get food from the trolley for her partner, who was assumed to be a man, and therefore not allowed to have the hospital food. For Montbaston this lack of recognition as a partner and parent was distressing. For Montbaston's partner, it meant a newly postpartum woman who was not able to get out of bed was likely to be denied food.

Research by Maccio and Pangburn in 2012 links these experiences of non-inclusion to a slightly elevated level of post-partum depression in lesbian birth and 'co-mothers'. This finding is reinforced by the work of Abelsohn, Epstein and Ross in 2013, which found that 'non-birth lesbian, bisexual and queer' parents' mental health in the perinatal period was affected by four groups of factors;

- biology, connectedness, and relatedness
- social recognition, including recognition from Maternity Services
- social support
- changes during pregnancy, which should be discussed by the maternity care provider

This means that maternity care providers getting the support right for LGBT parents has an impact on physical and mental health of the genetic and birth parents, non-birth parents, and the baby in very real ways.

What problematic assumptions might those involved in perinatal care make?

Most people conceive within a heterosexual relationship, with the woman giving birth. Recognising that this is a majority experience is fine, but assuming that this means that all people conceive this way leads to the difficulties like those above.

It is problematic for lesbian/bisexual women couples when maternity care providers assume the woman's partner will be a man, and the genetic parent of the child. It is problematic for gay/bisexual men when it is assumed that they will not be involved as a father, or that only the genetic father will be involved, or when it is assumed that his partner will definitely be involved (as this may not be the case).

In the circumstances of a gay/bisexual man/couple becoming parents through surrogacy, healthcare providers

need to recognise that the birth choices are still the birthing woman's to make. However, all involved may have decided that the postnatal decisions are for the father/fathers to make (or they may have not decided this). Clarity is needed, for the parents, and the healthcare providers.

For transmen and transwomen having children, the problems may become even more complex. Transitioning can include taking hormones, and sometimes having surgery, which can affect the person's ability to be a genetic parent in the future. In the UK, the NHS has the discretion to offer to freeze eggs or sperm prior to transition, but can also refuse to do so. The number of applications which are accepted/refused are not known. This year, Cross, a 20 year old pregnant transman, chose to be public about the fact that the NHS's refusal to freeze his eggs led him to have few choices;

1. Never be a genetic parent, or

2. Wait many years to medically transition, or

3. Have a baby as a single father at a younger age than he would have ideally chosen.

there are not always simple substitutions that can be made to improve the language used

Cross chose the last option, but in an article by Dale (2017), expressed unhappiness that he had been put into this situation, when he would have preferred to have had the choice to become a parent later on, and possibly as part of a couple.

Choices about birth may also affect the transitioning process for some transpeople. Research by MacDonald et al (2016) into transmen's experiences of birth and infant feeding suggested that more than one man had: *'actively withheld his desire to have children from his surgeon, worried that any questions about breastfeeding would hamper his chances of obtaining the surgery.'*

Further difficulties can be experienced simply getting access to services. MacDonald himself reports that during his second pregnancy, after 'worrying symptoms' led him to need to go straight to the hospital, he was denied access to the obstetric unit by a security guard, and had to: *'come out to them as transgender and explain a lot of my backstory in the middle of a hallway alongside other people who were also trying to get past the security desk… that didn't feel particularly safe.'*

Most of the difficulties discussed above stem from same group of assumptions. These are that:

- It will be a woman giving birth
- If she has a partner, he will be a man
- These two will be the only parents of the baby
- Genetic parents, legal parents, and those raising the baby are the same, and the terms are interchangeable.

How does the language used reflect these assumptions?

Many forms, computer records, and written policies relating to pregnancy and birth will have a space for 'mother' and one for 'father'. Sometimes, they genuinely do want the details of the two genetic parents – for example NHS forms which calculate the probable height the child will be as an adult, or which record likely allergies. Other times, the details actually sought will be about who will have care of the child, or who will be present at the birth, or who will have legal responsibility for the child.

In recognition of the latter situation, some NHS Trusts have replaced 'father' with 'partner' on some policies and forms. Where such substitutions have not been made on forms, some individual practitioners will substitute 'partner' for 'father' when talking to women, if they are aware that the parents are a same-sex couple. This is well-intentioned, but not always helpful. For example, in my own first pregnancy my midwife, in an attempt to be inclusive, asked my partner about her family health history, which was entirely irrelevant to the risk factors for our baby, but did lead to a referral to a consultant for a genetic condition that exists in my partner's family!

Other problems exist for gay men becoming parents. The substitution of the word 'partner' for 'father' may exclude gay men who are not the partner of the birthing woman. Also, when surrogacy involves egg donation to a gestational surrogate, simply having one space for 'mother' in forms may not be accurate. Health details of both the egg donor and the surrogate may influence the pregnancy and birth.

It is problematic for transmen when it assumed that only women can become pregnant, and that pregnant people will all use terms such as 'mother' and female pronouns such as 'she' and 'her'. It is problematic for transwomen who are genetic parents when it is assumed that the person who supplies the sperm that creates the baby will use male pronouns, and the terms 'man' and 'father'. In some cases, this can lead to real difficulties, such as for Yuval Topper-Erez, a transman, and his husband, who struggled to register the birth of their baby in Israel. The problems arose because legally, male parents could only be recorded as 'father', and two biological fathers could not be listed on a birth certificate.

For some transpeople, the language used for body parts can reinforce any underlying dysphoria. For example, MacDonald et al's (2016) research showed that many transmen preferred to term their nursing relationship as 'chestfeeding', rather than 'breastfeeding', as 'breast' denotes gender. However, different people will prefer different terms, and (as with partner for father), simply

substituting one term for another will not necessarily improve the experiences of all LGBT parents.

How could we improve our language?

Inclusion is something which many maternity care providers are striving to achieve, which is very welcome. Moves towards greater inclusion in language can be seen in the common adoption of the term 'partner', rather than terms such as 'husband' and 'father'. However, as shown above, it cannot simply be a case of replacing these terms, because the realities of LGBT parenting do not conform to a two parent, two genders, model. Improving our language needs to start from the recognition that there may be more than two parents, and different parents may have different roles (genetic parents, legal parents, parents who are raising children). Equally, in LGBT families, a parent's gender does not necessarily denote their role.

This makes it difficult for those supporting LGBT families, as there are not always simple substitutions that can be made to improve the language used.

The answer to this difficulty may be a process of rethinking how we approach our own understandings of the perinatal family:

- Be aware of what assumptions you have. We all have assumptions, but being aware of what they are is a necessary first step to being open to alternative possibilities.
- Don't be afraid to ask questions, but think about whether they are necessary.

If you don't know whether the baby's genetic health history is known, it is fine to ask if it is. Equally, if you are not sure what pronouns a person prefers, ask. However, questions about why parents decided how to conceive/who was to carry the child/for non-medically relevant details of transition are not actually necessary, and can be upsetting.

- Think about gendered terms.

For convenience, we can slip into using terms such as 'the mother' and 'the father', but these can be problematic for LGBT families. 'The mother' implies there is only one mother, and assumes that the person who is pregnant is going to identify as a woman and a mother. There may be one mother, two mothers, or no mothers when LGBT people have children, and the same is true for 'the father'. Using names instead of roles can avoid this.

- Think about what you actually need to know.

As mentioned above, simply substituting one term for another does not lead to inclusion, and can lead to inappropriate questions and/or referrals. Before asking a question, think about what you actually want to find out, and then phrase the question accordingly.

Yuval Topper-Erez with his partner and two children, on the day that Yuval(a trans man) gave birth to his second child

- Ask open questions.

'Who are the baby's parents?' and 'who gave birth?' are much better questions than 'who is the real mother?' or 'where is the mother?'

- When you have been told something, record it.

Asking about someone's gender, pronouns, or who their partner is once is perfectly fine, and often welcome. However, once that information has been obtained, the same question should not be asked repeatedly, or by multiple people.

This process can be applied by individual professionals to their interactions with clients. It can also be applied by organisations, in particular as an aid to work through and improve their forms, recording systems, policies and practices.

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

Mari Greenfield

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Institutional leaflets

Yolanda Forster looks at the difference between communication and manipulation

Antenatal literature is now available on the websites of many hospitals making them a window from which parents can access information about the services which are on offer. This method of sharing may be cost effective for hospitals, could provide visually attractive and possibly comprehensive information while avoiding the high cost of printing and distributing the same information in a range of leaflets. These booklets also potentially assist the hospitals in providing information that is *'centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.'*[1]

Previous research on patient information booklets has found that service users often ignore these leaflets for many reasons, which include the text being inaccessible due to low literacy skills, or alternatively, that those with high literacy levels find them to be patronising. Remarkably, research has also shown that that medical staff expect them to be ignored! The evidence on patient information literature focuses on the needs of the medical staff to provide enough information to achieve compliance to the treatment they propose rather than to focus on informing people, in this case typically healthy individuals who are experiencing a normal life event, to make personal decisions.

Booklets being accessible online makes for easy sharing within women's immediate social circles and with wider communities on social media and parenting message boards. As they can be shared they become potentially powerful documents in the impact they could make in the community. The language which is used is therefore worthy of critical analysis to illuminate the messages which they carry. Information can be revealed, hidden, and ignored in order to confer power to an institution or to individuals. Institutions and their agents, in this case the maternity units and the staff of consultants, midwives, radiographers and so on, are privileged to information which they reveal in ways which may prioritise the institution's interests over the interests of its users and indeed sometimes even its staff. Scholars of critical discourse studies (CDS) are 'committed to social equality and justice' and 'specifically interested in the discursive (re)production of power abuse and the resistance against such domination'[2] in real life settings, making the language of birth a topic ripe for CDS examination.

Ambiguity in language: risk

The word 'risk' is used routinely in antenatal language in peer to peer conversations and in maternity appointments. 'Risk' is also routinely used without clarity in definition as there is a layperson's definition but also a legal one which is defined by the Health and Safety Executive (HSE). The HSE definitions of 'risk' and 'hazard' are frequently conflated in everyday conversations and this conflation is evident in antenatal language. Using the definitions provided by the HSE, pre-eclampsia, for example, is a hazard, that is, a condition or situation in pregnancy in which there is a risk, a probability, of injury.[3] Conflation of meanings outside the HSE definition becomes more problematic when the definition of risk includes hazard and 'liability', as one hospital's risk management strategy does.[4] Liability is entirely outside the scope of the HSE's legal definition of risk.

The Pregnancy Information booklet available online from City Hospital Sunderland[5] states, *'If you are medium risk you will be advised to deliver in Hospital.'*

In the quote, the hospital has labelled women as high, medium, or low 'risk'. Following the ambiguous definition of risk that is used by City Hospital Sunderland,[4] the woman is now designated as a hazard by the hospital. This conflation of terms also aligns with the common definition as seen in the Oxford English Dictionary which states, *'a person or thing regarded as a threat or likely source of danger.'* Women then conceptualise this statement in antenatal literature and conversations with healthcare professionals as *'I am high risk.'* Instead of, *'I have a condition which increases risk in my pregnancy.'* In this statement there is no room to recognize that women in fact have a temporary condition which presents a complexity in her care and which can usually be mitigated with skilled care and monitoring. Instead, by conflating the definitions of a hazard and a risk with that of liability, her personhood is further threatened as her entire being is negatively objectified and she is now viewed as a potential liability to the maternity unit's interests.

The absence of language that supports her well-being reinforces the unbalanced approach to the information within the booklet. This focus on risk-based narrative contributes to feelings of anxiety that women experience and which further marginalises the woman and her ability to achieve informed consent. The midwife's role as 'with woman' is compromised as she is the representative of the hospital whose role is now to manage the 'risks', that is, manage the woman in order to reduce the hospital's liability rather than assisting a woman to make the decisions she wants for her care. During antenatal appointments, some maternity staff find ways to compensate for the paucity of workplace language that supports well-being and informed consent while reducing anxiety, however these practitioners are often taking the initiative without the explicit support of the workplace – and, sometimes, actively against it.

Leaflets – What they offer and what they tell you!

'The following observations will be offered to you:

- *'Listening to your baby's heart rate every 15 minutes until you are fully dilated, this will be every 5 minutes once you are fully dilated.*
- *'Your vital observations will be taken as follows- Pulse rate hourly at a minimum, blood pressure four hourly at*

a minimum, and temperature 4 hourly at a minimum.
- *'Vaginal examinations are usually offered at 4 hourly intervals.'*[5]

While every aspect of maternity care is optional, the vast majority of women are unaware that they can decline any care which is offered by maternity services without compromising their rights to other support and care. The increasing social media chatter about care being optional may be a reflection of why the booklet discusses this aspect as an offer. While text that discusses physical observations is careful to state that these are offers, the language that surrounds this offer does not convey the fact that physical monitoring can be declined. The omission of information about declining a procedure reinforces a cultural perception that a course of action is more a prescription than an offer. Within the technocratic language of the text there is little opportunity to discuss making decisions which are personalised to the woman. This bias adds weight to the already powerful cultural norm to acquiesce to what a health professional offers. The surveillance of the woman's body and her cervix is representative of the surveillance of birth regardless of place of birth.

Looking at the words used, there is no actual person who is undertaking the actions which are 'offered'. The midwife is disembodied and the woman is a passive recipient, erasing the woman as the person who is actually the one giving birth. The clinical vocabulary transfers institutional language into the birth setting, a normal life event regardless of where it occurs. Information gathering gains privilege to protect the institution's interests in the event of a legal dispute and takes primacy over the ancient midwifery skills of quiet attentiveness: listening, observing, intuition, and harnessing knowledge of midwifery experience. These ancient skills are not easily documented on paper notes and are excluded from the institutional birth story. A birth attendant is expected to 'do birth', but doing birth is more likely to bring intervention while doing 'nothing' opens the space for a woman to 'do birth' the way her body is designed to work.

Special Information

'Once the baby is delivered and the midwife has finished providing care, you may remain at home and enjoy this special time as a family. It is essential that at some point the baby has a neonatal check performed by a member of the neonatal team, to minimise impact on your family time the neonatal unit have agreed that the neonatal check can be completed within 48 hours.'[5]

The booklet states that the Newborn and Infant Physical Examination (NIPE) is 'essential' rather than the fact that this examination is an offer which can be declined, done by someone else or done in the home. It is worrying that the text regarding the NIPE Screening misleads parents into construing that the responsibility for the screening test lies with the parents. Instead of using language which fosters understanding of the goals of the test, parents are misled into believing that they are obliged to complete the NIPE. This is accomplished by an appeal to the authority of the 'neonatal team' and suggesting that the team has 'agreed' to a 48 hour window so that the family can enjoy this 'special' time at home. Seeing that birthing at home is the historic and prehistoric norm, the co-opting of hospital birth as the norm obscures the fact that nothing is special about home birth. It is an ordinary life event that unfolds in unexceptional settings.

Linguistic analysis of the text, *'the neonatal unit have agreed that the neonatal check can be completed within 48 hours'* confers decision-making rights from the parents to the neonatal unit. Furthermore, the text applies emotional pressure for parents to comply with a deadline well within the 72 hour range which Public Health England sets for hospitals. It is worth reflecting on the possible reasons that a hospital has decided to mislead parents regarding this aspect of the test.

Another example of misinformation in a booklet where emotional pressure on parents is applied was uncovered while conducting research for this article.

It states in italics: *'Please note that it is illegal for any person to deliver a baby other than a registered midwife or medical practitioner, or student midwife or medical student who is being supervised by a midwife or doctor, unless in an emergency,'*[6] alluding to the Midwifery Act 1902 to imply incorrectly that lay individuals present at a birth could inadvertently practice midwifery without a licence. This type of misinformation creates needless anxiety at a time which is already fraught with change and insidiously obstructs parents from making an informed decision on place of birth. While the booklet quoted above has been removed from the website,[6] a leaflet from which it probably derives its provenance remains active.[7]

A more detailed review of the language in antenatal booklets would be useful to discern the patterns of language in the literature given to women. Language matters since it reinforces ideas in the public consciousness as well as creating the discourse through which midwives and women enact their roles.

Yolanda Forster

Yolanda is a modern foreign languages teacher with an MA in Applied Linguistics. Her interest is in the analysis of the language of home birth information.

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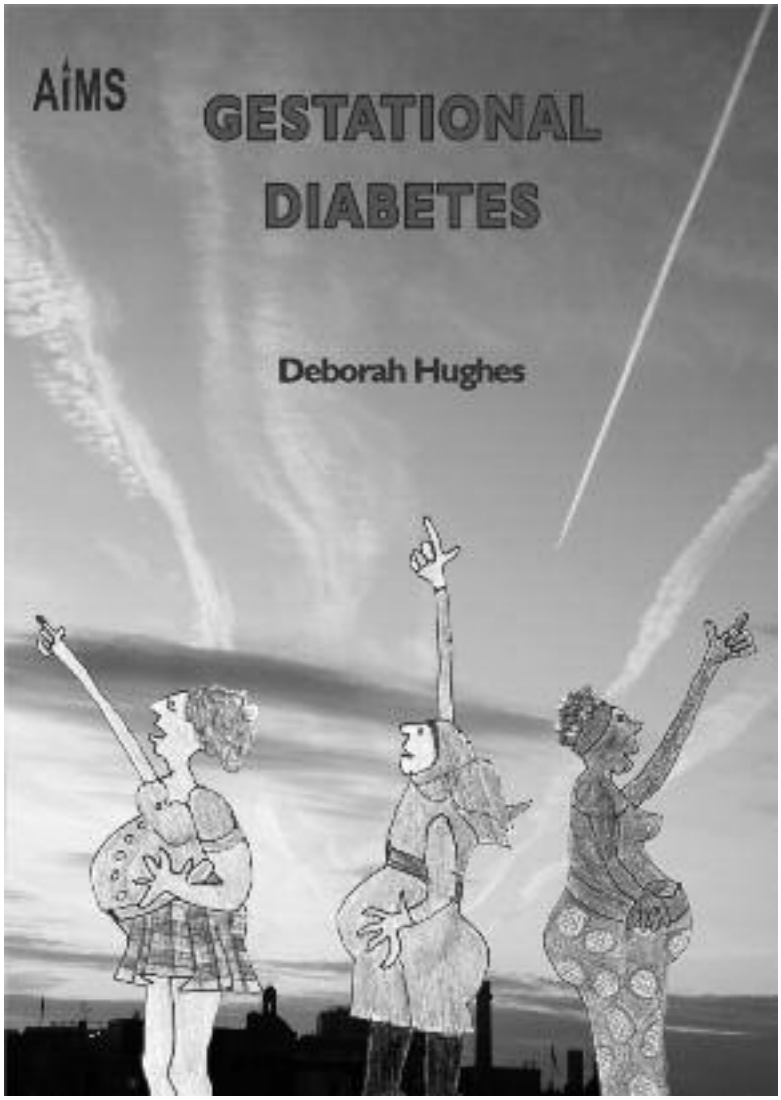
Gestational Diabetes



By Deborah Hughes

Illustrated by

Jennifer Williams

AIMS receives a great many requests for information from women who have been diagnosed with Gestational Diabetes (GD) or are faced with the decision about whether to be tested for it. We know from the AIMS helpline and social media that questions about GD are a concern for a significant number of women and that there is pressure for women to submit to routine care as set out in hospital guidelines. We hear frequently from women that they do not have the information they need to make decisions.

This latest book from AIMS is a very welcome addition to our growing collection of publications. Deborah says 'I hope this book gives you helpful midwifery care around the matter of gestational diabetes by providing information and the time to consider your situation'. In addition it will be a significant source of information for midwives, student midwives, doulas, hypnobirth practitioners and others who work with women.

For the first time, we have a professional illustrator – Jennifer Williams – who has worked with Deb to produce an array of great infographics and insightful, often funny, illustrations which bring the book to life.

Gestational Diabetes is available from the AIMS website, priced at £8.00.

Be mindful of what you say...

Emma Ashworth discusses how language can be used to support informed decision making

The language around birth has changed over the years, with 'choice' now being the way that women are supposed to retain control over their bodies and their births. Unfortunately, in reality 'choice' is not a choice for many women. Even the NMC has joined in on this rhetoric with their often repeated phrase, *'We support choice, but it has to be a safe choice'*. Who defines safety and what does choice mean if choices are limited?

AIMS often states that we should ditch the word 'choice', which implies a menu, and, as we have seen, items on a menu can be withdrawn. The word decision implies agency and would therefore be a more appropriate term. But how do we make our decisions? How are we to retain control of our bodies when language is used to undermine and coerce us, and to limit our options – often without the health carer being aware of this. Examples of this are *'which hospital would you like to choose to give birth in'* (not offering other places of birth), *'would you like us to try to turn your [breech] baby, or would you prefer to book a section?'* (not offering support for a vaginal birth) and *'do you want vitamin k orally or by injection?'* (an assumption that it's being given and no option for it not to be given).

This coercion starts during pregnancy, in antenatal meetings with the midwife. What generally happens is that the midwife tells us what they're going to do:

'I'll just do your bloods now'

'So lie on the bed and we'll have a listen in'

'We'll book your scans then'

If you are a midwife and you're reading this, please be honest and think for a moment. When was the last time that, instead of saying, *'I'll just do your bloods'*, you said, *'One of the things that we offer to you in pregnancy is blood tests. I'll just go through with you what these tests are so that you can tell me whether or not you want them. The decisions are always yours to make and you can decline or accept any or all of the tests.'*?

All of the above phrases put the decision making and control in the hands of the midwife. It is the midwife who is looking after the woman – which is quite appropriate – but she is also, usually quite inadvertently, undermining the woman's control of her body and her pregnancy and taking the control upon herself.

Similar issues arise with women being undermining women at the start of labour. Telling a woman *'you're not in labour yet'* because she's not reached a magic dilation point, when she's in need of support and may be in significant pain, is confusing, scary and absolutely the antithesis of the role of a midwife to be with woman. The woman might be afraid: *'If this isn't labour, how bad is it going to get?'* Or she might be angry: *'I AM in labour! Why won't they listen?'* Neither of these emotions are conducive to a straightforward birth, and neither help women to trust midwives once they're permitted over the threshold of the hospital.

Coercion may be heard during labour. How often do these phrases get repeated?

'Here's your room. Just get yourself into your things and pop up on the bed'

'I'll just examine you now'

'I'm just going to break your waters – is that ok?'

Let's look at these in more detail. Getting women onto the bed is so often talked about as a problem and yet still happens, every minute of every day. The bed immediately becomes the centre of attention. The woman is expected to comply, and, thanks to cultural norms, assumes that being on the bed is where she 'is supposed' to be. She will often lie down, as this is what we normally do when we get onto a bed. She will immediately be stepping away from the path of active labour, because her pain levels are likely to rise when lying down, her labour might slow down, and the idea of getting up may be more than she can consider – even if she's encouraged to do so. Not only does she have to overcome her physical discomfort, but she also has to have a hugely powerful cultural barrier broken down – she has to understand that we don't HAVE to labour and/or birth on a bed, and be confident that she will be supported to do otherwise.

Consider instead what happens when hospital midwives say, *'Here's your room. This is your space – feel free to explore and look around. Labour often feels better if you're more upright rather than lying down. Remember, this is your personal birthing space, so just lean on whatever you want to, or sit, or stand, or even, if you wish, lie down – it's entirely up to you. If you want some suggestions of what might feel good, let me know. Here's how to use the lighting – often it feels good to have it lowered but you're in control of this – change it how you want, when you want.'* Women who have wonderful midwives like this can hear this message, *'This is my space and I am OK to look at things and move around within it. I am not confined to the bed, but I can use it if I want to. I have some control over this space and while it's all new, it's not solely the realm of the hospital. I have some control and that makes me feel more safe and secure.'* According to research on birth trauma,[1] feeling out of control is more likely to lead to birth trauma, and feeling in control is more likely to lead to a positive birth experience, so ensuring that the woman is the leader of her birth from the very moment she enters her birth room is more likely to ensure that she exits it having had a good birth.

... Continued on page 16

Refle

Is it helpful? Is it k

Stop saying…

Delayed cord clamping

I'll just take your bloods

Due date

Against medical advice

I'm just going to…

Just don't…

You'll need a consultant to sign off your home birth

Choice

Eye rolls

I'll see you at 40 weeks for your sweep/book an induction

At least you have a healthy baby

I'll ask doctor if you can

I'll just give you the injection to stop you bleeding

Consent!

Let's have a listen in

You have to

We'll let you

Deliver

Failure to progress

You're not in labour

We'll give you until...

That's brave

Get angry with your baby

Just hop up on the bed

I'm just going to…

High risk

I'll see you at 40 weeks for your sweep/book an induction

It's for the sake of your baby

Breast is best

Incompetent cervix

Baby not behaving

Due date

Woman non compliant

You'll need a consultant to sign off your home birth

PUSH!

ect...
kind? Is it truthful?
Start saying…

Birthed *Feel free to use the space in the room as you wish*

We recommend that you She gave birth

We can listen in to your baby and the information that we'll get is..., and this will be useful because…

Born Optimal cord clamping It's your decision

Breast is normal *Baby needs a little help/time*

One of the things that we offer is a range of blood tests, which look at xyz

Decisions **Woman/baby has specific care need**

Due month *Would it be ok if (then explanation)*

Consultants don't sign off home births *Women have the right to birth at home and trusts have an obligation to support them*

Be kind Be respectful ***We also recognise the pain from our experience, or injury to ourselves. This matters too***

MS

It's not up to doctor

There's no failure, unless it's failure to wait.

Even in the best environments, sometimes birth needs additional help.

If a woman says she's in labour, she's in labour

You're nearly there - you're doing so well!

I'm just…

'I'm just going to examine you'

'I'm just going to break your waters'

The phrase *'I'm just'*, or similar ones such as *'I need to'* or *'So what we'll do now'* are not requests, and they're not asking for permission. Adding *'is that OK'* is not giving the woman the space to provide informed consent. We're British! We don't say *'actually, this is not OK'* very often, even when it's very much not OK. Women often don't realise that vaginal examinations are optional – and yet when else can we put our fingers inside someone else's vagina without them properly consenting? We cannot walk up to any other stranger and say, *'I'm just going to put my fingers inside you now.'* Why do midwives and doctors think they can with labouring women?

AIMS truly recognises the horrific pressure that there is on health staff to perform tasks according to guidelines and in a certain timescale. We understand that if midwives and doctors were to take the time to explain to women in their care the pros and cons of vaginal examinations, or breaking their waters, or any other intervention in birth, they will very quickly find that they are being pulled aside by their line managers. But, what's the alternative? The alternative is that women are being inadvertently assaulted by the people who are caring for them. Without complete and proper consent, the default is that these interventions, no matter how well intended, are, in law, assault. Women need and deserve care givers who recognise this and who themselves are not prepared to be bullied into assaulting women, and midwives need service managers to support them to support women.

'Everything seems fine, but I just need to get a quick trace, for the sake of your baby.'

'We don't want anything to happen to your baby.'

Even women who are firmly making their own decisions in their pregnancy can be shocked at how they can be coerced in labour. The physiological changes which happen during birth leave women vulnerable to the use of language, meaning that coercive phrases such as *'it's for the sake of your baby'* can be hugely powerful as a method of making women do what the health worker wants them to do.

In situations where there are real concerns women need to be given information in a calm manner in order to be able to fully understand the situation and to be able make clear informed decisions without feeling threatened. Scaring women into accepting tests or intervention is never acceptable, and the effects of this unkind and manipulative language can stay with a women for a lifetime. Birth trauma is often more about what was said and done to a women than an unavoidably difficult birth. Making women feel unsupported or vulnerable can lead to births slowing down or stopping, and trauma to the woman who thinks that something might be wrong. This is not just in labour. A very frequent complaint to AIMS is from women whose obstetrician has informed them that they must consent to an induction because otherwise they are putting their baby at risk of dying due to 'post dates', high BMI, and even being high risk due to a previous premature birth – with this pregnancy now at term. It is very common for us to receive calls or emails from extremely distressed women who had felt completely confident in their bodies and their births, only to be utterly undermined by such statements, and left in a state of utter confusion. They've felt patronised, ignored and dismissed, and they feel that the doctor somehow thinks that he or she is going to be more affected by the tragic loss of a baby than the parents themselves. Telling a woman that the most precious thing in her life may die if she does not conform to a guideline is simply cruel and utterly wrong.

As already mentioned, AIMS recognises the way that midwives are put under horrific pressure to comply. Peer to peer and top down bullying is anecdotally very common in midwifery. Midwives have reported hearing phrases from their colleagues such as *'You're brave, doing that…'*, *'Oh here she comes with her pinards and a cloth to bite down on'* and *'I hope you've got your excuses ready for matron'*.

Midwives and doctors go into their professions to care for people. The environment that they work in can change how they interact with all of those around them, their peers and those in their care. However, our actions remain our own responsibility. We recognise how hard it is to do, but AIMS very much appreciates and values those who stand firm against the pressure and the person who talks kindly to others. Find like-minded people – they may not even be in the same Trust as you – but they are there (ARM is a great place to start). Be the person you want to be, and the person you want others to be.

No matter how wonderful each midwife is, they're still fighting against a culture steeped in patriarchy and the false assumption that 'patients' (a word that just does not belong in maternity) should do what the doctors say. How often do we hear women telling other women, *'they won't allow you to…'*, *'I can't believe they let you…'*, *'oh, that's brave/unusual'*. There's a reason why the AIMS book Am I Allowed is our best-selling book. This is your body, your baby, your choice. Those words have power – don't let them be taken away.

Let's look towards a day when Am I Allowed is only spoken by health professionals asking permission of women, instead of women who are trying to get the support they need to birth as they want. When *'I can't believe they let you'* is a statement of outrage between health professionals about their behaviour to women, and not about a woman who has had to stand her ground to get what she needed.

The only person who speaks the words that you say is you, and the words you say have power beyond anything that most of us can imagine. Use them well.

Emma Ashworth

Emma is an AIMS Trustee, doula and breastfeeding counsellor

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No tragedy to see here...

Jane Ashwell Carter shares her experiences of the language used around Down's syndrome

Early in November 2016, I was one of a group of first year student midwives on our induction day at the maternity unit we would be training in for the next three years.

The highlight of our day was to be a talk by the antenatal screening coordinator, a very experienced, incredibly knowledgeable and passionate midwife. We all listened intently, and I was not the only one who made a mental note to message and ask if I could have an extra placement with her for a couple of days to see this most fascinating side of midwifery. Then, she finished her talk with the phrase 'tragically, in the last two years six babies have been born with Down's syndrome in this area'. Later that day, I went home to my daughter, who is one of those precious six, picked her up and told her she was a tragedy. She gave me a big wet kiss and squalled to go back down and continue playing with her adoring brothers. Move along now people, no tragedy to see here.

The language that we use around Down's syndrome, (Trisomy 21), and any other diagnosis, is important, with families, to others, and between health carers behind the scenes in the staff room. Trisomy 21 is where a person has an extra copy of chromosome 21. A fetus or baby may be diagnosed with Trisomy 21, but they are not a 'Down's baby' and they do not 'suffer from' the condition. If it is relevant to the conversation, they are 'a baby who has Down's syndrome', and if not, they are simply 'a baby'.

NICE guidelines on Antenatal care for uncomplicated pregnancies 2017, state that women *'should be offered information and screening tests to check whether your baby is likely to have Down's syndrome'*. Prenatal testing is offered to every woman, and the Fetal Anomaly Screening Programme Standards 2015-16 also state that *'high quality information should be imparted to enable women to make informed choices'*. However, when the Down's Syndrome Association (DSA) ran a survey of new parent members, they found that 63% of respondents could not remember receiving any information on Down's syndrome before consenting to the test. Midwives at the booking appointment have a huge amount of information to impart and record in a short space of time, but it takes less than a minute to mention that the test being offered is screening and not a diagnostic tool, along with the basics as stated on the NHS Choices Screening webpage. Too often, the information is missing, although the negative language is not. Rather than the loaded word 'risk', NICE uses the phrase 'how likely' a baby is to have Down's syndrome. Other acceptable phrases involve 'chance' or 'possibility', as these do not put a value judgement on the baby. Giving parents a leaflet to go home with after screening tests have been carried out does not facilitate informed choice.

Many parents report that after receiving a 'higher chance' screening result, they felt rushed into invasive diagnostic testing, even though the risk of miscarriage from these procedures was often higher than the probability of a positive Down's syndrome diagnosis. In the event of a positive diagnosis, healthcare professionals may have the assumption that the pregnancy will be terminated. One mother reported that she received a telephone call to tell her of her son's prenatal diagnosis and to ask if she would like to make an appointment to 'interrupt the pregnancy'. She declined, and subsequently heard nothing more. She was given no counselling, no discussion or information on Down's syndrome, not even a leaflet in the post. She was not signposted to the DSA or local groups. In her own words *'I was completely left to it'*.

There is no doubt that there are good practitioners, and sensitive, honest discussions are had in lots of places. Sadly, in others, parents may be rushed into decisions without time to process the news, and discussions often focus on all the things a child with Down's syndrome cannot do. It is not uncommon to hear of families who have had to sit through long spiels about disability, mental impairment, shortened life expectancy, social ostracism and heart problems while still trying to take in the news. It would be more honest to begin the conversation by explaining that many babies with Down's syndrome will be born fit and healthy, although some health conditions are more common for them and that some of these are serious. They will all have some degree of learning disability, but this varies considerably from child to child. This approach, together with questioning to see what the parents already know allows a chance for parents to ask questions and explore the issues with their care provider, rather than being told what to think. Offering contact with child development centres or local support groups may be helpful, and the Down's Syndrome Association helpline also welcomes calls from parents who would like more information with which to consider their options.

Ambiguous terminology and phrasing should be avoided as it can result in misunderstandings. A mother at a local support group recounted how she was told after an anomaly scan that she *'would not be bringing her baby home'*. She understood from this that her baby was likely to need to stay in neonatal intensive care for a while. After her baby was born, she learned that the sonographer meant that her baby had a heart defect which meant that her baby was unlikely to survive past birth. Thankfully this diagnosis was wrong and her daughter is now a robust and happy three-year-old, who underwent open heart surgery shortly after birth, but this clearly underlines the need to be extremely aware of the language that we use.

When Trisomy 21 is suspected at birth, the first thing that friends, family and health carers should remember is

Daisy Carter

that the parents have just had a new baby. Congratulations are in order. Health carers, please do not draw lots to see who is going to 'break the bad news' – parents need factual information about their precious baby, not an opinion. The phrase 'I am sorry' is not appropriate, and nor are syrupy comments about special parents getting special babies. Just be positive and say the same things that you would say to any other new parent, because that's what these parents are – new parents.

It can be distressing for parents to be told their baby 'has to be' taken away for tests. All tests, including heart scans, can be done with the parents present, and it is important to remember that these tests are 'offered', not mandatory. We were pushed hard to consent to karyotyping (a blood test to count chromosomes), at birth, yet not being genetically diagnosed until the age of two in no way prevented access to services or care for our daughter. Be clear with the wording used when offering tests so that the parents know that they are the ones who are making the decisions. This empowers them at a time when they may feel quite overwhelmed.

Lucky parents will encounter professionals like the consultant paediatrician who performed a heart scan while I held our daughter. She discussed everything with us immediately, there was no anxious wait, and she assessed our level of understanding before explaining both her findings and the implications of these. Despite discovering our daughter had two heart defects, we came away reassured by her positive and caring manner. A far cry from the paediatrician on the children's ward who rolled her eyes, looked at the ceiling and tapped her foot when I tried to explain that I was unhappy to give formula. Please, always remember you are dealing with new parents who are short on sleep requiring support and family centred care.

Our personal experience of health professionals and their language has been varied. Daisy was born at home under the care of an Independent midwife who was a model example of how to talk to new parents. During all the emotions we went through, her language and attitude were always positive. It was clear that, to her, Daisy was a precious baby who just happened to have an extra chromosome, and she celebrated the arrival of the first 'extra special baby' under her care. She kept a close eye on us for weeks until we had our breastfeeding established, completely supported us, and never once doubted that success was around the corner for us. This was in stark contrast to the midwife sent from the hospital who we called to arrange her postnatal check. Despite telling them we suspected trisomy 21, she had not been told. Immediately, she lowered her voice and began to list all the things that could be wrong with her, saying she had to go to hospital immediately as she would be unable to feed (despite the fact she was clinically well and breastfeeding beautifully). Her student sat silently, appearing horrified and refusing to look anyone in the eye or reply when spoken to. It was a strange and disconcerting encounter.

Too often we hear that children with trisomy 21 'don't breastfeed', or 'have trouble' breastfeeding. Babies with Down's syndrome may indeed have some extra challenges to feeding if they have heart issues, hypotonia (weak muscles) or other conditions related to Down's, but almost all of these can be overcome with excellent support and determination. Formula may be recommended, further undermining parental confidence and autonomy if they have chosen to breastfeed. Breastfeeding offers many important benefits for all babies and especially babies with Down's syndrome. For example, breastfeeding is important for a healthy immune system, and some babies with Down's syndrome are more prone to infections, especially respiratory infections. The action of breastfeeding encourages optimal jaw development, which can be helpful as some babies with Down's are born with a high palate and small jaw. Instead of saying that babies with Down's syndrome cannot breastfeed, it is more helpful to explain that these babies can get immeasurable benefits from breastmilk, and while it may sometimes be more challenging, there are many organisations which can offer support and information. As with all breastfeeding support, it is a case of supporting women who DO wish to breastfeed with positive language and practical support, without alienating or antagonising those women who choose not to.

Babies with Trisomy 21 might need medical care, but so do many babies. We, their parents, may need specific support, but so do many parents. How we are supported, and the language used when speaking to us, can make a huge difference to how that journey begins.

Jane Ashwell Carter

Support networks and links:
Down's Syndrome Association
www.downs-syndrome.org.uk
Breastfeeding support is available from the breastfeeding charities such as The Association of Breastfeeding Mothers, La Leche League, NCT and International Board Certified Lactation Consultants (IBCLCs).

Breast language

Emma Pickett asks if we are sending out the right messages

We all know the power of language and there surely can't be a time when it matters more than in the world of maternity. New mothers and parents need to speak and be heard when it comes to their birth and in describing their own feelings about this new stage in their lives.

Those of us who support them need to ensure we listen and empower parents to make their choices with all available information.

And what a pain it is when the basic vocabulary we have at our disposal sends unhelpful messages and puts roadblocks in our way. Even when we set out with the best intentions, the tools we have been given trip us up.

As a lactation consultant, I'm talking about the word 'breastfeeding'. It's a word I use a hundred times a day and it's incredibly unhelpful. It creates enormous misunderstandings and confusions that do babies and their carers a massive disservice. It wastes so much of our time.

For starters, we've got 'breast'. It's a word not all of us want to use to describe a part of our bodies. Some prefer 'chest'. Some prefer 'boobs', which feels friendlier. Some have historically felt that highlighting the label for the part of the body which our society has so powerfully sexualised, immediately puts us at a disadvantage when it comes to encouraging new mums and a new acceptance of breastfeeding in a bottle-feeding culture.

'Nursing' is often used as an alternative in the English-speaking world but I don't know many outside of the USA who are comfortable with that. For me, it feels like a step too far to avoid saying the word <whispers> breast. If you told me that you'd seen a woman nursing in the local library, I'd assume that meant she was dishing out some bandages. I've got three dictionaries in front of me and nursing is all about caring for the sick, infirm and elderly. New babies are powerful and wonderful and far from 'sick'. Wet nurses may have done some 'nursing' but that hasn't always been to the benefit of mothering or new baby and parent relationships. And if we're going to call breastfeeding 'nursing', the internet search is going to become a very confusing experience.

However, all that said, I can cope with the word breast. It's the attached word 'feeding' that I really object to.

If we spend an hour talking to a new parent about 'responsive parenting' and 'relationship building' and how we expect babies to come to the breast frequently and how communication with your baby is paramount, to then call it 'breastfeeding' is potentially damaging.

'I can't work out if he's hungry.' 'He can't be hungry. He's only just fed.' 'I don't want her to use me like a dummy.' 'I'm trying to stretch him a bit between feeds so he'll feed better.'

There are apps for measuring feed length, gadgets that measure how much a baby is swallowing, parents who are renting scales and weighing babies before and after feeds to assess millilitres of intake. It's all about the milk, milk, milk.

IT'S NOT FEEDING! OK, it's a bit about feeding… but there is a world beyond that and beyond it simply being about milk. Does your baby want to return to the breast again? Fabulous! Is he coming because he just wants some more milk? Maybe not. That's fabulous too.

It's great to empower parents to recognise milk transfer and effective swallowing but it must come alongside the message that sometimes it's not about milk transfer. It's about a love transfer. This teeny tiny new person wants to be connected to you. They were born and as far as they are concerned, you are still one. They want to smell you and taste you and be warm with you. They don't know why and YOU don't have to know why either. We don't always have to know why a baby wants to come to the breast. It's OK to not know if your baby is hungry or whether they need comfort.

Call it 'breastfeeding' and immediately so much is devalued. Comfort is secondary and unimportant and even 'off-topic'. There are parents who genuinely think that when a baby stays on beyond active swallowing and especially if they fall asleep, they are failing some test, and yet the exact opposite is the case.

When we make the breast all about milk, we are the ones failing new mums and teeny new people who desperately rely on us to get the communication right.

In German, breastfeeding is 'stillen'. From the same root as the English word 'still'. You are creating a sense of tranquillity in the baby, giving them an inner stillness and peace. Now, that's better. It doesn't always seem to be etymologically accurate when you have a toddler practising breastfeeding gymnastics while simultaneously humming the Peppa Pig theme tune, but we can all get behind it.

But what can we English-speaking people do? 'Stilling' is just a bit too close to the world of gin-making. I think we're stuck with 'breastfeeding' or rather 'breastfeeding-but-of-course-it's-so-much-more-than-just-breastfeeding-sometimes-I-wish-it-wasn't-called-breastfeeding-as-that-devalues-so-much-of-the-experience'. Less snappy within the name of a support organisation it must be said. But perhaps talking about the flaws within the vocabulary is a good way in to making sure parents get the right messages about what matters to their baby and what will end up mattering to them.

Emma Pickett
Emma is an IBCLC and Chair of the Association of Breastfeeding Mothers

Midwifery unit closures

Gill George highlights the situation affecting women in Shropshire

On 29th June, the Board of Shrewsbury and Telford Hospital Trust (SaTH) suspended all services at the three Freestanding Midwife-led Units (FMUs) serving rural areas in Shropshire. This affects the towns of Oswestry, Bridgnorth and Ludlow, and the rural communities surrounding them. The suspensions will be for up to 24 weeks, although campaigners fear it will be a permanent move. There has been no consultation with service users. This appears to be an effort to lead to permanent closure.

The service losses are even wider than the loss of the FMUs. Women in rural areas are suddenly no longer being offered the choice of a home birth. The accessibility of local antenatal and postnatal care will be reduced from a 24/7 service to a 9–5 service – and in practice, availability is even less than this. We know of Ludlow women travelling 30 miles to Shrewsbury for antenatal care, and Oswestry women no longer being offered home postnatal checks, and having to travel to hospital a matter of hours after giving birth.

There is no confidence locally that the FMUs will re-open for births. If they do, it is likely to be with a pared down service that midwives regard as unworkable and unsafe; campaigners believe this will itself be a prelude to complete closure.

This is an organisation that struggles to listen to parents. The findings of a recent internal review into the safety of the maternity service were reported to selected 'stakeholders' at a meeting on 27 June. Sadly, the bereaved parents who had lost their babies through avoidable deaths were not regarded as stakeholders, and were excluded from the meeting. They were reduced to standing outside in the rain, lobbying the people going in. One bereaved mother had abuse shouted at her by an official stakeholder – a middle aged man with no interest in or knowledge of maternity care. Another bereaved mother had to sit on wet ground, in the rain, to breast feed her new-born baby. Not an occasion where SaTH covered itself with glory.

There is a current NHS Improvement review of SaTH's handling of at least 23 incidents of baby deaths or cases of avoidable harm. The latest MBRRACE report has identified SaTH as continuing to be an outlier in its high rates of perinatal mortality. Genuinely this is a troubled organisation, with a long way to go to achieve high quality care.

Campaigners are certain that cost cutting underpins the closures, but SaTH has another explanation. The current rationale is that the rural FMUs have to be closed, and their midwives transferred, when there is staff sickness at the Consultant-led Unit at Telford. (Staff sickness rates are actually low and fairly steady, but nevertheless, this is the explanation from SaTH).

The 'Better Births' aspiration is to offer women increased choice of community settings for birth, and to achieve a substantial transfer of low risk births from Obstetric Units to Midwife Led Units and home births. The solution to SaTH's over-dependence on Consultant-led care cannot be to close Midwife-led Units, and to deny rural women home births, as we are now starting to see. This is not choice, and nor does it provide women with optimum care. Campaigners argue that SaTH must employ enough midwives to provide safe and consistent care across all settings – and that SaTH has to promote its FMUs instead of working hard to undermine them. And if the Consultant-led Unit is so busy, why on earth can women not be supported to use midwife-led units instead?

the implications for their health and wellbeing are profound

This is a very rural area. Road networks are poor, and public transport infrequent and expensive (where it exists at all). The stripping back of accessible local care affects relatively small numbers of women and babies, but the implications for their health and wellbeing are profound. Centralisation is superficially cheap – but carries very real long-term costs. In the last few weeks, two women in Ludlow have given birth without midwife support, because it simply took too long for the midwife to arrive. It is close to inevitable, given the distances, that there will be more cases. We can expect, too, to see an explosion in the number of 'lay-by births'.

The brilliant midwifery support available historically at our rural FMUs has, by anecdotal report, achieved good rates of breast feeding and offered excellent support (and referral on where needed) to women with postnatal depression. SaTH has not considered these very important outcomes.

Shropshire campaigners are appealing for help, for maternity experts to use their knowledge and networks to save the FMUs in Oswestry, Bridgnorth and Ludlow. It is a desperate situation, and expectant mothers are very scared and uncertain about what is going to happen to them. This is no way to spend your pregnancy.

Gill George
Chair, Shropshire, Telford and Wrekin Defend Our NHS

Better midwifery regulation

Katherine Hales reports on the progress of the campaign #Savethemidwife

Over the last year, members of the Association of Radical Midwives (ARM) have expressed the concerns felt by many midwives about the loss of the Midwives Rules and statutory supervision. These protected the midwife's obligation to her duty of care to attend a woman in childbirth, even when her situation put her outside standard NHS Guidelines. The system of statutory supervision allowed a midwife to engage with her supervisor and a woman in her care to devise a safe and satisfactory care plan to all concerned.

We were also aware of the loss of the statutory midwifery committee which advised the NMC, and a dearth of midwifery leadership in all areas including education. We were told that we were to be 'led' by the chief nurse for England, Julia Cummings.

We proposed to launch our campaign at our study day in Wigan, in March 2017, however, in December, just before Christmas 2016, Independent Midwives were informed by the NMC at short notice that they would be unable to practice as self-employed midwives as the NMC stated that their insurance was not sufficient to indemnify them. The NMC refused to give any advice as to what would constitute sufficient indemnity, and the ruling seemed to be rushed and ill considered. This would mean that women who were expecting to be cared for by their midwives would have to seek care elsewhere, or be forced to birth alone, and the midwives concerned would lose their livelihood. This led to the organising of an urgent meeting at the HQ of the RCM in London by many interested midwives and lay people including Beverley Beech, AIMS Chair, to accelerate the campaign and devise a strategy. We sought expressions of interest and ideas from the meeting held in Wigan in March and hope to have an action plan after our next meeting on 20 May 2017 in Peterborough.

On the 5 May 2017, around 200 mothers, fathers, babies, midwives, birth activists and supporters gathered outside the offices of NMC at 23 Portland Place London. Many travelled a considerable distance to support this vital campaign. Speeches were made by Becky Reed, midwife formerly of the Albany Midwifery Practice, who told us about her long ordeal at the hands of the NMC. It took five years for her to receive a 'no case to answer' result. Ruth Weston (birth campaigner and AIMS member), Paula Cleary of Birthplace Matters and Michelle Quashie also spoke. There was a range of banners, songs and chants some of which can be seen on the #savethemidwife Facebook page. Deb Hughes was in an authentic and eye-catching 'Call the Midwife' uniform! Caroline Flint, who suggested and organised the demonstration, was also with us. A number of photographers appeared and there was a report in the Daily Telegraph. Please let us know if you heard or saw any other reports.

We are able to report that Rachel Dufton, NMC communications officer, offered to meet with a small group of us. Ruth Weston, Paula Cleary and Beverley Beech represented the lay voice, while Deb Hughes and Katherine Hales (ARM) represented midwives. We met with CEO Jackie Smith, Rachel Dufton, and Emma Broadbent (Director of Registrations.) We had a 45 minute discussion with all present raising important points of concern to midwives and parents. We managed to cover quite a lot in the relatively short time, including the loss of the Midwives Rules and statutory supervision; the lack of midwifery leadership and erosion of midwife autonomy; the importance of a strong midwifery profession in protecting women's rights in childbirth and informed choice (amply demonstrated by international research), lack of appropriate standards for education and practice, the potential for home birth to be less accessible as NHS trusts' contractual power over their staff overrides 'duty of care' to attend a birth, the place of UK midwifery as a global gold standard, and independent midwifery and the decisions taken recently by the NMC which seem to have been badly considered and implemented from a lack of knowledge and understanding of the issues. All present reported disappointment with the lack of a considered or timely response to all petitioners whether midwives or lay people.

Jackie Smith spoke for the NMC and stressed several times that the NMC's role was to protect public safety and was not a voice for midwives. We are, of course, aware of this but the inattention of the NMC to questions and concerns from lay people led to the conclusion that they are not fulfilling their role in protecting the public either. Jackie reminded us that we have a new midwifery panel, a midwife advisor and Professor Mary Renfrew is working on educational standards. She stated that statutory supervision was ended by the DOH not the NMC. Having read the minutes of the meeting at which the decision was made we felt that the NMC had made no attempt to counter the DOH view. We were interested in how much actual influence the midwifery panel and advisor may actually have and how and by whom they were appointed.

Jackie Smith undertook to explore the possibility of undoing the statement about midwives being unable to attend friends or family, but would not comment on the independent midwife situation; we later heard that IMUK has obtained a judicial review and their case is going ahead.

We intend to write to thank Jackie Smith and the NMC for meeting with us and will monitor their undertaking to engage more appropriately with users and midwives and will request a follow up meeting in early autumn.

Katherine Hales
National Coordinator, ARM

Semana do bebe

Lucy Potter shares her experience of the Leeds Baby Week

The city of Leeds launched its first Baby Week in September 2016. The week-long event aims to bring together maternity, children's and families services hosting activities and seminars, with representation from public, private and voluntary sectors.

The concept was originally taken from the Brazilian Semana do Bebe; a national early years initiative now funded by UNICEF which over the last 17 years has helped reduce infant mortality, increase awareness in breast feeding and help connect services with indigenous communities. The research and evaluation rests with promoting national policies and improving service delivery to babies, infants and toddlers.

The idea to implement Semana do Bebe was taken on by mum of two, family outreach worker and community activist Lucy Potter. In 2013 Lucy embarked on a travelling fellowship to seek good practice overseas and bring it back to her own community in Beeston and Holbeck in Leeds. Lucy was invited to attend a seminar in Canela (South Brazil) and witnessed Semana do Bebe first hand. She was inspired to bring it to Leeds and said; *'There is so much good work happening in Leeds, so many passionate workers helping parents to engage with services in Leeds. It's Baby Week waiting to happen! Wouldn't it be great if we could have one week that brings that together in all sectors and celebrate this work?'*

South and East Clinical Commissioning Group offered financial support to get Baby Week started, with plans to make it an annual event. The funding enabled a launch, with guest speakers and activities in local children's centres. As well as the CCG, there was support from Child Friendly Leeds and Leeds Beckett University who were involved and helped promote the week. There was parliamentary involvement including Cllr Jane Dowson Deputy Executive Board member for Children, Families, Apprenticeships, Cllr Lisa Mulherin Executive Board Member for Children and Families and the Lord Mayor Cllr Gerry Harper 2016/17. Child Friendly Leeds helped team up with other private stakeholders, to host stalls at the events and run activities such as Bumps & Babes with a baby wearing walk and pram push, and demonstrations from the West Yorkshire Sling library. Also included were Health Visitors and Speech and Language specialists from Public Health.

Similar to the Brazilian model of promoting policies, Baby Week helped promote The Best Start Plan, a targeted early intervention policy for families, and the Leeds Maternity Strategy including more personalised services from community midwifery teams and the launch of the Buddy App with content tailored to Leeds. Most of the family support services in Leeds are underpinned by the third sector, so there was an involvement with a variety of voluntary services including; Home-Start, NCT, City of Sanctuary. Bosom Buddies and young dads from Health for All and Leeds Dads, with the main purpose to help raise awareness on the first 1001 critical days of an infant's life and improve access to services for families.

Baby Week has opened up the stage for all different areas of maternity services to meet, and provides opportunities for professionals to network and communicate across sectors.

Baby Week gives a chance for voices to be heard and stories to be shared. The organisers are currently preparing for this year's Baby Week event 11th – 16th September 2017. If you are interested in finding out more about Baby Week and a full list of participants please see www.babyweekleeds.com or contact lucy@babyweek.com

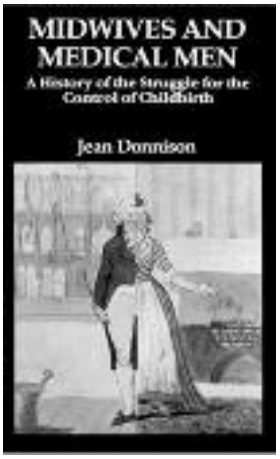
Lucy Potter

Louise Hulton (1970 – 2017)

The AIMS committee were very sad to hear about the death of Louise Hulton on the 31 March 2017, former AIMS secretary (from 1998 – 2001) and invaluable volunteer. Louise did a tremendous amount for women and babies and maternity care, not just within AIMS but with other organisations, and through her own campaigning. One of Louise's greatest achievements in this area was the creation of the Hulton Framework, which was designed to keep women's experiences at the centre of all medical care. The Hulton Framework was integrated into World Health Organisation guidelines and was a key part of the huge international reduction in maternal deaths over the past ten years.

Louise's energy and passion for her work, and life in general, was evident to all those who met her. She is fondly remembered by those who worked with her within AIMS. We offer our sincere condolences to her husband, Rupert, and their children.

Jean Donnison (1925 – 2017)



In 1977 Jean published her classic work 'Midwives and medical men: a history of the struggle for the control of childbirth' a book that should be read by every midwife and mother. She pioneered research into the history of midwifery and childbirth and championed midwifery as a separate profession. She was a valuable source of well-researched historical information and so willing to give of her time discussing current maternity issues. Despite her declining health she was always willing to respond to those who sought her advice and wisdom. She will be sorely missed.

Frédérick Leboyer (1918 – 2017)

Known for his groundbreaking 1974 book Birth Without Violence (made into a documentary film on 2008), Leboyer was a game changer in maternity and obstetrics.

While by no means the first to argue that interventions in birth were potentially damaging in some cases, he was the first person to be able to have his concerns widely heard for the impact on the baby during birth. At a time when some routine operations were performed on babies without anaesthetic, because it was still considered that newborns couldn't feel pain, Mr Leboyer (he preferred Mr to Dr) argued that the birth process for babies could be hugely traumatic, and that we should do what we could to minimise this for them, as well as for the mother.

Under his care, birth room lights were dimmed to aid the transition to light for the baby, and to reduce over stimulation. He advocated immediate skin to skin and optimal cord clamping – and not surprisingly, his methods were scorned and rejected by other medical men of the time who felt that doctors needed bright lights to decide whether a baby's colour was acceptable, and that violent crying was a sign of a healthy infant.

However, parents continued to press for their providers to support his methods, and slowly, changes were made that we see in some of today's birth rooms. Leboyer's understanding of birth from the baby's perspective – that some interventions, even if necessary – may be brutal and traumatic for babies as well as their mothers - was instrumental in changing firmly held beliefs and practices, and leading to more births without violence.

Songs from the NMC march

When you Call The Midwife

to the tune of 'let it be'

When you Call the Midwife, you are
Calling someone who can see
Birth's a natural process… Let It Be
If the Midwife's frightened, or is
Bullied to conformity
The birth you want won't happen
Can't you See?

NMC, NMC, NMC, NMC
Midwives won't be bullied… Let Us Be

Women need a midwife full of
Wisdom and integrity
If we're to keep birth normal – Let It Be
If IMs are the iceberg there are
Hundreds more beneath the sea
Midwives won't be bullied. Let Us Be.

Let Us Be, Let Us Be, Let Us Be, Let Us Be
Midwives won't be bullied. Let Us Be.

It's no way to have a baby

to the tune of 'It's a long way to Tipperary'

It is no way to have a baby
On a conveyor belt
It is no way to have a baby
If only pain and fear is felt.
How long's a normal labour?
How long's a piece of string?
It is just no way to have a baby
With the clock tick-tocking…

It is no way to have a baby
Without people you know.
It is no way to have a baby
Feeling rushed, not safe and slow
Goodbye legs in stirrups
Farewell facing the wall
It is just no way to have a baby.
It is NOT 'One Size Fits All'

Words by Rix Pyke, with (very small) alterations by Becky Reed and Suyai Steinhauer

AIMS' new website

The AIMS website is packed with articles and information which is invaluable for women and families, however the interface is old and creaky, and has been in need of an overhaul for some time.

Now, more than ever, families are seeking evidence-based, woman-centred, accurate information sources. AIMS continues to be the organisation which is trusted to provide independent pregnancy and birth information, to campaign for women's human rights in birth and for better birth services, and to offer woman to woman support via our helpline.

We have been incredibly lucky to have had some wonderful contributors writing for us, and our design and creation team have created an attractive and streamlined website. The new site will still include the information held on the current version, such as back copies of journal articles, but it will also have fresh, up to date information with a search system to make everything so much easier to find.

We are continuing to seek experienced writers who would like to offer unique articles for the site. We have a list of topics that we would like to include, and are also very open to suggestions. If you would like to discuss this with us, please contact webmistress@aims.org.uk

If you would like to help in other ways, our current huge need is to continue the fundraising for the site. We have a BT MyDonate page here mydonate.bt.com/events/website/252237

Has AIMS helped you? Would you be willing to fundraise for us? Would your friends and family chip in, too? Posting the link on your social media would help us hugely, and spreading the word through your networks is what will get us to our target and get this website out there for us all, now and in the future.

AIMS: There for your mother, here for you. Help us to be there for your daughter.

How AIMS has helped me

I very much appreciated the support of AIMS during my last pregnancy. I was feeling pressured to accept certain tests and interventions and was unsure of the full reasoning for them and I didn't want to accept things which were not appropriate, but was struggling to get the answers I needed from local care providers. After some fantastic conversation about my rights, the latest evidence and a refreshingly honest and open dialogue, I felt well informed and confident in my choices.

Thank you AIMS.

Lyndsey Dawn Kindred

I read your guide about induction and whether you need it when I was pregnant with my first baby. It really helped by enabling me to be fully informed of the pros and cons and to resist an induction when I was a week 'overdue'. I went on to have a lovely, natural birth with no pain relief. I recommend your book to all pregnant women. Thank you!

Michelle Chandler

Reviews

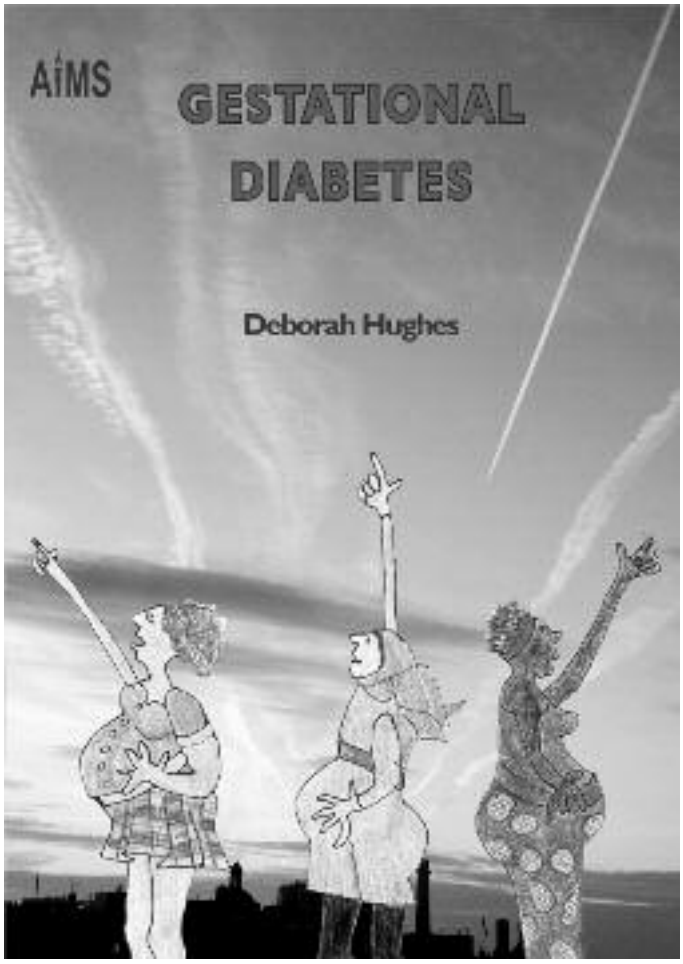
Gestational Diabetes

By Deborah Hughes
AIMS, June 2017
ISBN 978-1-87441-339-4
also available as an e-book.

News Flash – AIMS has just published a new book about gestational diabetes.

AIMS is very pleased to announce the publication of our new book, Gestational Diabetes. We know from our helpline, and from social media, that that many women diagnosed with gestational diabetes, (GD) are concerned because they are under pressure to submit to routine care, but feel they don't have the information they need to make important decisions that potentially seriously impact on their own health and that of their baby. This book addresses that problem.

AIMS commissioned Deborah Hughes, an experienced and respected midwife, to write this book setting out the issues, the research and the options. It will enable women to take time to think about tests, treatments, and lifestyle changes; what they need and want from their health care professionals and to learn from accounts of other women's experiences, highlighting how varied experiences and decisions can be. We are very grateful to Deborah for taking on this very complex subject. She carefully takes the reader through why there is a concern, what is known about the risks and what may help in terms of lifestyle changes and treatments. We believe this book will make it much easier for women to understand what is happening to them as it explains what risks and benefits may be involved with not just GD, but also with being tested and or treated.



Jennifer Williams worked with Deborah to provide the helpful infographics and insightful, often funny, illustrations that bring the book to life.

This book will enable the reader to make her own assessment of the risks and benefits. At AIMS we know that one size doesn't fit all.

Shane Ridley

Why Starting Solids Matters

By Amy Brown
Pinter and Martin, 2017
ISBN 978-1-78066-500-9

My admiration for this series of miniature books grows with each one. Why Starting Solids Matters is another little gem of a book. Amy Brown is ideal as the author: she has researched infant feeding for at least a decade, her PhD was on the importance of baby led breastfeeding and she has continued to research the influences on breastfeeding and the introduction of solid food. In her introduction she summarises the aims of the book, which are to look at the guidance behind introducing solid foods, the evidence behind it and the wider context. She asks whether there is one right way to introduce solid food or is it better to respond to your individual babies needs, (as she says, 'Spoiler: responsiveness is the key').

She has also been bringing up her own three children, so while her examination of all the factors around starting solid food is informed by a thorough understanding of the evidence, her words on the subject are warm and wise. I do think this is an ideal book for mothers who want to understand the exciting business of introducing babies to the world of the pleasures of food and eating.

I hope that those who advise mothers will read this book too. It is very sad when professionals respond to mother's anxieties with scanty, contradictory or, even worse, patronising advice. I'm afraid that this can happen in the area of nutrition where professionals often receive very little training. (Try asking your professional advisors how much training they got.) I am reminded of a young mother I know who wanted to discuss moving on from breast milk with her health visitor, and was under pressure to introduce cow's milk. When she told her that she was trying goat's milk for her son, the HV replied in a scandalised voice, *'but goat's milk is for baby goats'*. The young mother replied *'and cows milk is for… ?'*.

Much of what Amy Brown says about introducing solid food might seem like common sense but mothers' confidence can be undermined by well-meaning public health messages and by commercial interests in the field of breast milk substitutes (as Why the Politics of Breastfeeding Matters in the same series so brilliantly identifies). Of course this has also happened to some extent with commercially produced baby foods where there is money to be made in suggesting that introducing solids into a baby's diet is inherently difficult, requiring much pureeing and so on.

Amy Brown's background is in psychology and she reminds us that when babies are ready to eat they are programmed to do so, generally with gusto, and to eat what we eat with us. Eating is a social affair with important cultural aspects: we don't have to teach babies to do it. This little book is a gem of enlightened and informed common sense, which should reinforce women's confidence in their ability to cope with each stage with growing ease and enjoyment.

Gill Boden

The Positive Birth Book: A new approach to pregnancy, birth and the early weeks

By Milli Hill
Pinter and Martin, 2017
ISBN 978-1-78066-430-9

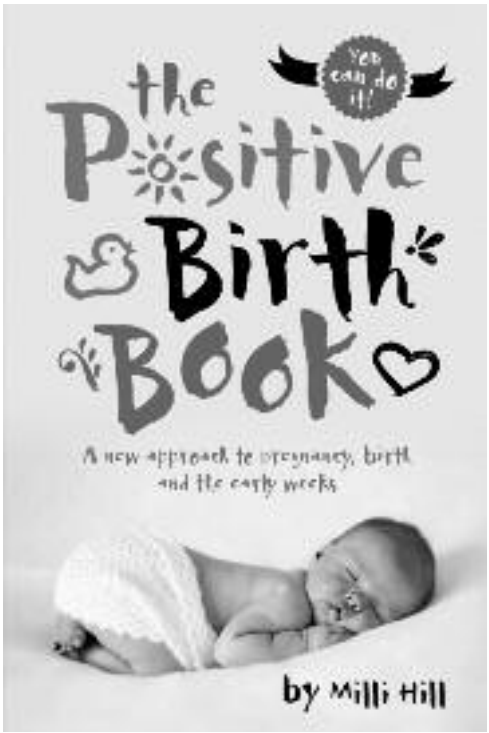
The Positive Birth Book is exactly what it says on the tin: it is described as *'challenging negativity and fear of childbirth and brimming with everything you need to know about labour and birth and the early days of parenting'*, and that is what it is.

The cover is colourful with a particularly gorgeous baby picture; the tone is upbeat and cheerful. Milli Hill covers what you bring to birth, what labour is really like, an A to Z of coping strategies, choice, planning your positive home birth, hospital birth, birth centre and caesarean birth and concludes with birth of a mother. Her style is chatty and friendly; she uses phrases such as 'fabby dabby' and suggests that Independent Midwives 'give a shit'. I guess that it is aimed mainly at first time mothers who would not necessarily consider themselves 'alternative'. Milli seems to assume that her readers will not necessarily embrace 'hippiness' and, for example, when discussing the importance of the microbiome that readers may find the idea of bacterial seeding 'yucky'. Her tone is one of exhortation to question the medical consensus around birth and ask women to reconsider, saying for instance the there is *'plenty of solid evidence'* for moving freely in labour but does not give references for her recommendations. She does however recommend some books including the book The Microbiome Effect and includes many resources including an idea of where to look for evidence.

The layout with illustrations and stories is attractive, and I particularly like sections on such things as 'mother blessing', 'Zwischen', (the last days of pregnancy), 'gender reveal parties', 'Mother Assisted Caesareans', some of which are things many women, me included, might never have thought. She briefly mentions relactating which is another thing that most women don't realise is even a possibility.

The Positive Birth Book has been published during the battle to retain Independent Midwifery: Milli is very positive about IMs and suggests that the personal budgets mentioned in the recent National Maternity Review will enable women to choose continuity of carer, I hope she is right. I also hope that her book will fulfill its purpose of bringing ideas about birth now considered alternative back into the mainstream again.

Gill Boden



How you can help AIMS

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

If you are not already a member, you could join

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

Visit www.aims.org.uk

AIMS AGM

George Fox Room
The Priory Rooms,
40, Bull Street
Birmingham
B4 6AF

Saturday, 23rd September
10 for 10.30 start, to 16.00
Please bring your own lunch as we are not able to do a shared lunch as we normally would.

AGM will include a preview of the new AIMS website, a discussion of the future of the journal and other AIMS campaigns.

All members welcome.

Donation to AIMS

A Big Thank You to the Chichester Home Birth Group for their amazingly generous donation, of £1,000, to AIMS. The group was founded in 1986 and campaigned locally for home births, organising 27 conferences to promote home birth and good midwifery care. When the group disbanded they decided to donate some money to AIMS to enable us to continue our campaigns for better maternity care.