Association for Improvements in the Maternity Services

AIMS Journal Vol:28 No:2 2016

AIMS

Back to the Future

Looking at opportunities for real change

Addressing obstetric violence

40 years from Winterton

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Diary

AIMS meetings

2 July 2015, Camberley

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

AIMS AGM

and campaigning workshop

Saturday 24 September 2016
York

AGM 10.30 for 11.00 start

AIMS members only

Lunch 1.30 – 2.30

For AIMS members and those attending the workshop
Please bring food to share

Workshop 2.30 – 6pm

Your chance to share experiences and to think about how we can bring about positive changes

(Please let us know in advance if you plan to attend)

For further information please email talks@aims.org.uk
Please contact secretary@aims.org.uk if you wish to attend the AGM or send your apologies

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

The Five Year Forward View for Maternity Care
The Implementation Challenges for Better Births and to Personalise and Improve Care
Tuesday 6 September 2016
Central London

Guest of Honour address from Baroness Cumberlege, Chair, National Maternity Review

see policy-uk.com/event/2177/
Contact e.mccarthy@policy-uk.com or 0845 647 9000

Manchester Home Birth Conference 2016
Saturday 8 October 2016
Manchester

Speakers include:
Annie Francis
Maggie Howell
Nicola Mahdiyya Goodhall

Buy tickets on Eventbrite
Enquiries: 0161 826 6555 or see manchesterhomebirth.org.uk/conference/

Midwifery Today Conference
19–24 October 2016
Strasbourg

Speakers include
Sally Kelly, Michel Odent, Hermine Hayes-Klein and Verena Schmid

Contact
conference@midwiferytoday.com

Association for Improvements in the Maternity Services
founded in 1960
by

Sally Willington 1931 – 2008

AIMS
campaigning for better maternity services for over 50 years

AIMS

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Cover Picture:
Becki Caig and her son Joseph. See her birth story on page 24.
© Shaun Caig

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Conferences and campaigns

Beverley Beech and *Nadia Higson* highlight some of the activities AIMS has engaged in recently

In April Beverley Beech travelled to Berlin to attend the 23rd annual ENCA meeting. The meeting was attended by representatives of lay organisations from eleven European countries.

The focus of this meeting was obstetric violence and delegates reported a range of incidents that had occurred or were common in their country. The variety and extent were concerning. For example: Liz Kelly, the Irish delegate, pointed out that *'women have no rights in maternity care, and abortion is illegal'*. Midwives who do not comply with home birth restrictions (such as staying with a woman who refuses to go into hospital) face draconian sanctions and there has been a series of maternal deaths in hospital as a result of their law which gives mother and fetus equal rights. (See AIMS Journal, Vol26, No1, 2014)

The European Network of Childbirth Associations (ENCA) offers the opportunity for childbirth groups throughout Europe to keep in contact, discuss problems and issues, and exchange information and research to enable delegates to argue for the changes we all want. AIMS is very active in supporting and maintaining these contacts.

Celebrating Continuity: Rhetoric into Reality, Policy into Practice – Nadia Higson's impressions

In response to the National Maternity Review AIMS, in collaboration with Neighbourhood Midwives, the Positive Birth Movement and Sandwell and West Birmingham NHS Trust, and with the support and sponsorship of the Royal College of Midwives (RCM), organised this conference on 13 April.

The conference brought together midwives, maternity services liaison committee (MSLC) reps, campaigners, birth workers and others with an interest in continuity of carer. Delegates described this conference as *'Inspiring'* and *'thought-provoking'* and several commented on how good it was to be with like-minded people. The delegates probably got as much from the informal exchange of ideas as from the formal sessions, valuable as those were.

The opening speaker, journalist Beverley Turner, described continuity as *'Never being with a stranger on the potentially scariest day of your life'* – something that affects the whole family, and not *'just a women's issue'* as it is too often seen by media bosses and politicians.

Baroness Julia Cumberlege, Chair of the National Maternity Review, said that continuity of carer had been *'the most challenging part'* of the report. Women and their families are asking for it, the evidence is compelling as it delivers better outcomes for women, babies, midwives and obstetricians, but the challenge is not only to achieve but also to sustain this model of care. A new system will evaluate the progress of clinical commissioning groups (CCG) in improving maternity services, and NHS Improvement has some funding for a number of Trusts to pioneer Personal Maternity Budgets.

Professor Lesley Page, reporting on the recent Sheila Kitzinger Symposium, emphasised that different care models can work, but relationship-based continuity is the key to improving health outcomes: *'Relationships are not an add-on, they are crucial'*. The evidence for health benefits is so compelling we can no longer ignore it, but the benefits go beyond clinical outcomes, for example, increased reporting of domestic abuse.

Some audience members expressed scepticism that continuity was achievable or sustainable with the current shortage of midwives and funds, but others pointed out that it is working in a number of places; and Lesley Page argued that continuity protects against burn-out, as long as case-loading midwives' time is ring-fenced and not diverted to other parts of the service.

I attended two of the five workshops. **Women's Voices,** with Milli Hill of the Positive Birth Movement, featured three mothers sharing extremely moving stories of the impact that continuity or lack of it had had on them. In **Commissioning for Continuity** Georgina Craig of the Experience Led Commissioning Programme challenged us to put ourselves in the shoes of the CCG and think about how commissioning can drive positive change: what outcomes should they be measuring?

In the afternoon Dr David Richmond and Lesley Page presented a joint statement from the two Royal Colleges in support of multidisciplinary working and continuity of carer. This was followed by the inspirational Jill Hutchings, detailing the amazing outcomes achieved by her case-loading team in a very socially-disadvantaged area of Southampton.

We are now planning another conference at the end of October or beginning of November in the Leeds area.

Battling for birth at home

Over the last year AIMS has supported a number of women who have wanted to birth at home and have been given a variety of reasons why this is not possible. In the majority of cases, providing the woman makes it absolutely clear, in writing, that this is what she wants and that she expects a midwife to attend, the Trusts do ensure that a midwife attends when called. This is not the case, however, in King's Lynn, where the Queen Elizabeth Hospital management and the Care Commissioning Group have done everything possible to avoid providing a home birth service. See page 27 for more information.

Other activities

Through My Donate (mydonate.bt.com/charities/aims), we have raised just over £2000, including Gift Aid, towards the website. These donations have enabled us to start work on the website but we will need to continue our fundraising efforts to achieve our target of £6000.

The latest addition to the AIMS book list, Group B Strep Explained, by Sara Wickham is selling well, and our Helpline continues to help women and families by email and telephone.

Several AIMS members organised screenings of the VBAC film Trial of Labor (details can be found at www.trialoflabor.com) and we are still looking for Microbirth screening volunteers.

Beverley Beech and Nadia Higson

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Back to the future

Gill Boden and Beverley Beech look at what has not happened since Changing Childbirth

Since our last journal the Maternity Review for England has reported. There is, unsurprisingly, emphasis on safer care, better postnatal and perinatal mental health care, multi-professional working and personalised care, all of which is to be welcomed, but the great cause for celebration among childbirth activists, and the element that we feel will most clearly improve all the outcomes of birth, is the strong emphasis on continuity of carer.

The chair, Dame Julia Cumberlege, in her foreword says:

'We found almost total unanimity from mothers that they want their midwife to be with them from the start, through pregnancy, birth and then after birth. Time and again mothers said that they hardly ever saw the same professional twice, they found themselves repeating the same story because their notes had not been read. That is unacceptable, inefficient and must change.'

Annie Francis looks at the Maternity Review in more depth on page 19.

Many of the recommendations echo previous reports, as Tania McIntosh shows on page 6, including the earlier Cumberlege report, about which Julia Cumberlege says:

'20 years ago I produced a report as a government minister, Changing Childbirth, which sought to describe a modern maternity service, as we moved into a new century. Great strides have been made in transforming maternity services in those last two decades. Despite the increasing numbers and complexity of births, the quality and outcomes of maternity services have improved significantly over the last decade. The stillbirth and neonatal mortality rate in England has fallen by over 20% in the last ten years.'

We welcomed that report too. At the time it seemed possible that the UK could achieve an enviable position internationally, with healthy mothers supported by well-trained midwives who respect their autonomy, mothers with complicated pregnancies given the specialist treatment they need and birth seen as a social, psychological and spiritual event which is part of family life.

This ideal is nowhere near being met and it must be due largely to the impact of underfunding of the services, the way they are structured around obstetric units, shortages and fragmentation of midwifery care, and a risk-averse culture that tends to concentrate resources on the acute services. This new report emphasises the preventative power of continuity of care and carer to keep the vast majority of women healthy and confident throughout their pregnancy. This could achieve straightforward births with low demands on the health service in the long run and with huge benefits long-term in public health; the research evidence shows that continuity of carer reduces pre-term birth and early fetal loss.

The current review introduces the principle of NHS Personal Maternity Care Budgets. While sufficient resources are crucial and the notion that the funding should follow the woman is important, concerns have been expressed that the principle of personal budgets and vouchers, rather than appropriate spending on each woman according to her needs, could be a Trojan Horse which could allow for topping-up with private care, causing further inequality and fragmentation of the services. This is something that we hope to explore in detail in future issues of the journal.

we have an opportunity for positive change but it depends, to a large extent, on midwives and women working together

There is no doubt that we have an opportunity for positive change but it depends, to a large extent, on midwives and women working together. In April we helped to organise a conference, Celebrating Continuity, with Neighbourhood Midwives, the Positive Birth Movement, Sandwell and West Birmingham Trust and the Royal College of Midwives. We hope this conference will be a significant turning point in making continuity of carer a reality for many more women over the next few years: our summer journal will focus on the issues and ideas that emerged, along with a review for those who weren't able to join us on the day. A second conference is planned in the north of England later this year.

In this journal we explore some of the consequences that arise when services are under-resourced and risk-averse. The extent and effects of obstetric violence, bullying and how women's rights and confidence are eroded are highlighted particularly by Hannah Gray's account, on page 21, of how midwives attempted to use Social Services to punish her family, and Sarah Holdway's problems with her health visitor, on page 23.

There is real opportunity for change: women and midwives need to make clear demands to make sure that the principles underlying successive government reports are delivered in practice.

Gill Boden and Beverley Beech

Article

A celebration and a warning

Tania McIntosh looks at Changing Childbirth

Being a historian as well as a midwife brings rewards and challenges. It gives me a different slant on things, and can be helpful in putting short-term worries about maternity care into a longer-term perspective.

Mostly this can be a positive experience, but occasionally it gives me the sense of being trapped on a merry-go-round. Things change but they also stay the same. A case-in-point is national reports into the maternity services. Since 1959, when the Cranbrook report was published (recommending that beds should be available for 75% of women to have their babies in hospital), reports seem to come round on average every ten years. The Peel Report of 1970 worried about the cost effectiveness of domiciliary midwifery services and said that there should be hospital beds available for all birthing women. The Short Report (1980) decided that birth was analogous to an intensive care situation in terms of the catalogue of dangers it unleashed, and came within a whisker of outlawing home birth. Both Short and Peel are remembered and condemned by midwives and consumer groups for their one-size-fits all approach to birth; with the one size very much being a hospital birth, preferably in sterile conditions. The last big report was Maternity Matters, which came out in 2007 and which, until recently at least, the government was claiming was still the foundation for maternity policy in England and Wales. And now we have a new report, the National Maternity Review, chaired by Baroness Cumberlege and charged with having another look at the organisation of maternity services.

Ok, so I have missed something out: a title that is still referenced and remembered by midwives and consumer groups with affection and pride. That publication is Changing Childbirth, which came out in the early 1990s and changed everything. Although it focused on England and Wales, the debate it unleashed crossed continents. The talismanic power of Changing Childbirth is, I suspect, one of the reasons why there is hope around the current National Maternity Review. Julia Cumberlege, who chaired the group who developed Changing Childbirth, is also leading on this current review. This article explores why Changing Childbirth was so revolutionary and so powerful and why, ultimately, it was unable to change everything in the ways that it seemed to promise. It is a thought provoking tale, reminding us that whatever the long view of history, time and place are everything.

'Changing Childbirth' is mostly used as something of a portmanteau term to bring together what were in fact two separate reports. The first report was arguably the more significant, but lacked a catchy title or the fetching orange cover we associate with the printed version of Changing Childbirth. In 1991 the House of Commons Select Committee on Health, under the Chairmanship of Conservative MP Nicholas Winterton, took it upon itself to explore the state of maternity services. This was done at the behest of another politician, Labour MP Audrey Wise, who had been horrified at the content of the Short Report and the way in which it demonised the experience of pregnancy and birth.[1] Consumer groups such as AIMS had been rubbing against government policy and obstetric will for some years; the active birth movement was growing, as was debate around the safety and utility of increasingly routine interventions such as ultrasound. However, in terms of taking evidence, what the Winterton committee did, and how they did it, was revolutionary. As Winterton said:

> *'We allowed virtually any interested body or individual to give evidence…we were able to interview individual women who had actually given birth at home…allowing a mother who had recently given birth actually to breastfeed while giving evidence.'*[1]

debate around the safety and utility of increasingly routine interventions

The committee took evidence from women, consumer groups and midwives as well as policy makers and doctors. The idea of taking submissions from midwifery groups, never mind lay people, when considering the maternity services was startling. Cranbrook, Peel and Short had relied primarily on 'experts'; by whom they meant medical practitioners in one guise or another. Needless to say, obstetricians were not enamoured of the Winterton report when it came out, feeling their point of view and expertise had been marginalised in favour of mere women.

A further clue to the revolutionary nature of the committee's work can be found in the AIMS quarterly journal for the autumn of 1991, which across three pages reviews the submission the organisation made to the Select Committee. In some ways the submission has a slightly off-kilter quality, because it seems so recognisable yet somehow so different. This is partly because of the use of language; concepts like 'control' and 'continuity', which were to first have expression in the Winterton Report, are only hinted at in AIMS's work, but the direction of travel is clear.

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AIMS said:

'…women should be able to choose a midwife as the first point of contact for maternity care…the midwife should be able to decide, with the woman, on the most appropriate antenatal care for each mother booked…'

Choice, partnership working … concepts which now we take for granted in terms of rhetoric if not always of action but which were almost subversive at the time (as evidenced by the Medical Defence Union, which, as AIMS pointed out, used to advise doctors that women did not need to consent specifically to anything that happened to them in hospital; the act of walking through the door was taken to imply consent).

However, the document, together with those from other groups such as NCT, was revolutionary not just because of the language it used and the ground it covered, but in the way it brought evidence to bear on issues. 49 separate pieces of evidence were cited by AIMS in support of their arguments. The submission included evidence around place of birth, types of birth, birth attendant and interventions; it ran to 30,000 words and was apparently produced in eight weeks. Using evidence was still a new concept in maternity; as Archie Cochrane had once complained, the maternity services were a notoriously evidence free environment where the expert held sway.[2] Evidence given to the Winterton Committee by various groups including AIMS challenged the message around maternity care by using evidence instead of simply belief.

Apart from the ideas discussed and the evidence brought to bear, the other revolutionary element of the submissions by AIMS and others was that the committee accepted it at all. Shock piled on shock when the report came out in March 1992; AIMS had not only been received sympathetically, they had been listened to and heeded. Beverley Beech commented in the AIMS Journal that the presentation of the report by Winterton had *'the quality of a dream'* and that to hear women put centre stage meant that *'some of us burst into tears'*.

It was not hard to see why; the Winterton report accepted there was no evidence that hospital birth was the safest option and no reason why women should not have choice in maternity care. In the same edition of the journal, Beech hinted at ructions to come; midwives were gleeful, obstetricians harrumphed, insisting that honestly they did know best and had everyone's best interests at heart. Once the initial euphoria wore off, AIMS reflected the concern that the government of the day more or less buried the report alive by damning it with faint praise and 'offering an expert committee' to look in more detail at the issues raised by Winterton. There was a strong sense towards the end of 1992 that the Winterton report had flared briefly and brightly but would quickly be forgotten.

If the government hoped that 'the Expert Maternity Group' would bury Winterton, then they were very much in for a surprise. In the spring of 1993 Changing Childbirth, as the Group titled their report, was published and many at AIMS burst into tears all over again. Changing Childbirth put the woman at the centre of care, calling for known carers and respectful and meaningful communication between all involved. Some of the language mirrored the submission put forward by AIMS:

'The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having first discussed matters fully with the health professionals involved.'[3]

It was about more than just language however; the whole point of the document was that it was a call to arms and that it would be a catalyst for real change. Looking back, Cumberlege reflected that:

'So we were determined it wasn't just going to be a philosophical document, it was actually going to have action plans, targets and we wanted a grip to try and get things to happen…'[4]

In some ways the Winterton and Cumberlege reports changed everything. They were helped by the simplicity and power of the message, a fact that was recognised by Cumberlege:

'I do remember having to go before television cameras thinking this is really a very comprehensive report, how am I going to put over in three minutes the essence of this report, and that is where the three Cs arose, because I had to boil it down in my head, and so it was about choice, continuity and control.'[4]

The language of Changing Childbirth has remained embedded in the maternity services. However, the simplicity of the message masked the complexities of translating words into action. As Nadine Edwards pointed out at the time, the report was not government policy, only a consultative document.[5] The imperative to action could be twisted, watered down or ignored. The challenge was to take the power of the rhetoric and translate it into practice and in this Changing Childbirth stumbled. This was partly because it skated over the difficulties of bringing different groups and disparate services together in a coherent whole. More fundamentally it missed the signs that medicalisation, yoked to obstetric and social complexity, was increasing and would continue to do so.

The challenge of the current National Maternity Review and everything it brings in its wake is to learn the lesson of Changing Childbirth. The language can be as powerful as you like, the research as clear-cut and definite, but without coherent strategies for managing different stakeholders and demands, the move to action is easily lost.

Tania McIntosh

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Article

Risk and contingency

Jo Murphy-Lawless talks about the politics of birth and risk

When I see news headlines or hear media reports about the latest research on pregnancy and birth, I find myself growing tense as I wait for the near inevitable use of the word 'risk'.

I do so knowing that the very notion of 'risk', its history, and why it has come to dominate our thinking in these last three decades, is largely hidden from those who must use it. Yet its use has become an imperative of the work of clinicians in interpreting individuals' needs and circumstances and supporting them as an active, skilled clinical presence. Equally, it is an imperative for me as a sociologist to make sense of the changed conditions surrounding birth, which themselves reflect broader disquieting shifts in our society that have actually brought to the fore why we focus on 'risk' in the way we now do.

In June, 2014 the Guardian reported on an American study, which found an '*increased risk*' for women who gave birth within 18 months of their first baby; the risks were of the very premature birth of the second and a '*high*' risk of that second baby having a '*birth defect*' and '*childhood behavioural problems*'.[1] The RCOG, when asked about the research, said that women should leave a year's space (ibid.). There is no question that premature birth may carry significant complications with long-term impacts and consequences, hence a clinician's view might be that we need a risk assessment approach to forestall as many factors as possible leading to prematurity. So this stream of research becomes what Anthony Giddens[2] terms '*colonising the future*', that is taking the abstract systems of science and attempting to apply them in such a way as to bring about a '*reduction in life-threatening risks*'. Typically, this is done by instituting larger research programmes, but also in stating increasingly tightly configured guidelines and protocols to capture these new 'risks' in order to pin them down in a clinical setting.

However, these are not neutral actions. This is a dual movement of creating more scientific 'knowledge' and then writing guidelines to match the new evidence. It is the same conventional workbench science with all its capacities, allied to new technologies, which has promised us for well over half a century to bring about vast improvements for all. And in one sense this has been so: the elimination of dangerous communicable diseases and many other forms of life-threatening ill-health, ensuring safe water and sanitation and so on.

However, the devil is in the detail, and working within this frame of reference, there is detail in relation to this current research that lies beyond individual clinicians' line of vision to bring about effective change. The report on prematurity[3] and the RCOG response recommended birth spacing to counter the associated risks. This is a rational (and therefore correct) programmatic approach which can be translated into a guideline. However, the very women who might need to hear that message about birth spacing are probably the least able to listen, with least control over broad areas of their lives.

The study[3] focused on women who gave birth to a single baby in Ohio. The demographics for Ohio put the lives of at least some of those 450,000 in context:

'a child poverty rate of 24 per cent, poverty impacting particularly on single parents and African American and Hispanic children, and high levels of teenage pregnancies.'[3]

there are significant numbers of women in deeply vulnerable circumstances

In other words, there are significant numbers of women in deeply vulnerable circumstances. Knowing this, how might we refocus on the risks of premature birth?

The data from Sandra Lane's[4] Why Are Our Babies Dying? are insightful in this regard. Lane painstakingly examines birth patterns from Syracuse, NY, a city which has had the highest perinatal death rates in America for several decades of African American infants. Lane presents the complex picture that lies behind such figures: institutionalised racism, poverty, unemployment, poor housing, drugs, and a lack of state support have all contributed to '*excess perinatal mortality*'.

Sandra Lane terms this excess of mortality experienced by the poorest women in the United States as a form of '*structural violence*' located in a profoundly unequal society, one which is accelerating in its impacts on the poor and the excluded. Poverty kills, and this constitutes a structural risk that has never been distributed equally across the population. As individuals, of course many clinicians, be they midwives or doctors, know this and attempt to work with it as best they can.

But what results, in a complex and overlapping scenario, is that pinning down 'risk' in the narrower sense, armed with the algorithmic pathways of 'risk assessment' approaches, and then proceeding to make recommendations on '*optimal birth spacing of 18 months*'[1] may be entirely the wrong thing to do. Wrong because we are facing much deeper 'risks' for many vulnerable women that escape the logic of the risk management strategies which have come to be favoured.

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Another example of the problematic pinning-down of risk can be read through the discussion of recent research in The Lancet.[5] The research comments on prematurity in the course of examining cause-specific mortality and the extent to which deaths in the first 28 days following birth make up an increasing proportion of deaths in the under-5s. This is an international study of a number of countries, but it cites the UK as having one of the higher rates of death in the first 28 days. When interviewed about this, one of the researchers, Professor Joy Lawn, cited a number of risk factors leading to premature birth, amongst which two caught my attention:

- Increasing rates of obesity.
- Increasing rates of caesareans, the rate now topping 30 per cent.

Michael Marmot[6] and Richard Wilkinson and Kate Pickett[7] have pointed out that rates of obesity are accelerating in the most unequal societies and that more equal societies have far lower rates. Tim Lang from the Centre for Food Policy in City University London has shown[8] that the poorer you are, the more likely you are to have to rely on the mass-produced dense-energy foods sold most cheaply through the supermarkets. So a worsening crisis of food poverty can be said to be contributing to higher rates of obesity in women, again generating concrete risk factors that in many respects lie beyond the power of the clinician in how she or he must currently work. There is a connection here between deepening social inequalities and the increasingly narrow approaches to risk calculations. It is as if we sense the immense damage we have done to our social fabric. However, the extent of the damage invokes a panic which doubles back to seek out yet more calculations about risk rather than searching elsewhere to bring about far sounder approaches to how we care that acknowledge the depth of inequality.

A third brief example perhaps will show how we do not, indeed cannot, see that individual woman. The very welcome Maternal Mental Health Alliance report on the cost of not attending to perinatal mental health both for women and their children[9] looks at the problem of non-disclosure for women and relates this to both the lack of information and lack of trust, quoting the 2013 RCM research which stated that 40 per cent of women see a different midwife at each antenatal appointment. That 40 per cent and the realities it points to of completely fragmented antenatal care sound like a risk to me.

All these examples reflect a radically changed climate from the 1980s when we hoped for and worked towards the equal presence of voice, agency and evidence in working with every pregnant woman; when Marsden Wagner hoped that the consensus conferences on appropriate birth technologies would move to a '*scientific evaluation*'[10] in the widest possible sense (remember, he involved sociologists and birth activists in those conferences); when the first edition came out of Effective Care in Pregnancy and Childbirth, with a similar focus on evidence and the hope that it would make sense to everyone involved in birth and welfare and best care – women, midwives, obstetricians, policymakers.

We could not really see then the straws in the wind, like the 1979 Conservative Party election manifesto[11] with the promise to introduce private beds into the NHS as the first move towards turning the NHS into a marketplace.

What has happened? Is there a connection between how gaps have opened up between how the major health institutions, providers and researchers see health and the experiences of ordinary people? How have so many protocols and guidelines which emphasise certain approaches to risk become more important than seeing all the other risks of living, those structural risks for poorer people? Is it not urgent for us to ask how our society, which prizes scientific and technological advances, has permitted these devastating gaps and inequalities to take root? And crucially, why they are accelerating?

How have so many protocols and guidelines which emphasise certain approaches to risk become more important than seeing all the other risks of living?

These last three decades mark a turning point in which we can see that we have become less and less confident about how we are to make progress, or even what we might count as progress. In an era of what sociologists like myself term late modernity or 'liquid modernity', our everyday realities most frequently point to far more precarious lives and, by implication, they show us how our systems are less able and less willing than ever to support people, all of us, as part of a wider community.

There is a strong sense now that anything, however improbable, can be a 'risk' and this is coloured by the belief that we have no intrinsic skills to deal with the unexpected. The monumental growth of 'risk thinking' has run alongside the often ruthless intentions of our public bodies to set limits on their wider social responsibilities and to deny the work of building collective security with all of us, for all of us.

The use of risk assessment tools, which form a core component of contemporary clinical services, prevents us from being clear-sighted about this late modern society

which, in Wendy Brown's summary, is '*over-regulated and under-resourced*'.[12] Placed in this light, how much weight can be given by clinicians to these risk assessment tools, given all the pressures to conform to increasing constraints from policies that target cuts in funding?[13]

Our technocratic society, which constantly assures us that still more progress is in the offing, is seriously open to question and to its ethical regulation by all of us.

The scandal at the heart of the Francis Report on Mid-Staffordshire was that lack of ethical regulation. There were risk assessment schedules by the dozen, yet these could not capture the real risks people were confronting in a hospital that was dangerously understaffed and dangerously demoralised. These issues were not picked up by so-called regulatory bodies who could only read risk assessments set by limited terms of reference. These bodies sent in reports which asked as few questions as possible, not least to protect their own continued existence.

Since that 1979 straw in the wind about the NHS, risk has come to be defined as narrowly as possible, while there is a real and growing sense of concrete risks which overwhelm the poorer and more vulnerable on a daily basis. Within what Nicolas Rose,[14] another sociologist calls the '*neoliberal logic*', risk management and risk reduction have '*come to replace other forms of professional action and judgement*'.

We need to get skilled-up about the weaknesses of these risk discourses

What is to be done? We need to get skilled-up about the weaknesses of these risk discourses that inevitably support institutions over the individual midwife working with women in need of the best possible care.

We need to strengthen local actions to bring together once more voice, agency and evidence on the part of women, midwives and obstetricians in our communities, to make space politically. Above all, we need not to be afraid of being political in order to secure better practices that reflect our principles about birth. We must do this collectively and very quickly.

Jo Murphy-Lawless

Independent Midwifery Insurance in Ireland

In the wake of the withdrawal of indemnity insurance by the Royal College of Midwives for their members in the 1990s, and the very recent imposition of an EU cross-border directive requiring indemnity insurance on the part of any independent practitioners, independent midwives in the UK have responded in a number of different ways – setting up social enterprises, private companies or working self-employed.

Independent midwives in Great Britain currently provide a private service as well as a limited NHS service, which will rapidly expand if the recommendations from the maternity review are implemented. All of these organisations are able to continue to offer women choices in how and where they have their babies.

Independent midwives seeking to provide home birth in Ireland face a very restrictive contract with the Health Services Executive (HSE), the national overseeing body. The HSE will provide indemnity insurance but will not permit HBAC, for example. Private business ventures outwith the HSE regulations are also problematic. Their birth packages are very expensive, and thus out of reach for many families, not least because of the cost of indemnity insurance from their multinational corporate provider, in line with the EU directive. That provider has just removed insurance for a HBAC in Ireland, and one can be certain this was a calculation based on profit-taking, not on an assessment of care provided or risks to mother or baby.

For a statement on HBAC insurance in Ireland and Northern Ireland see neighbourhoodmidwives.com/hbac-insurance/. For more information please see AIMS Ireland aimsireland.ie.

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Violence in obstetrics

Beverley Beech reminds us why change is long overdue

In April this year I attended the 23rd annual ENCA meeting in Berlin and presented a paper on Violence in Obstetrics (see my report under What is AIMS up to on page 4). This is an issue that is attracting international attention and shocking stories are emerging from many parts of the world of harsh and cruel treatment.

While we complain about maternity care in the UK, it is, in the main, a great deal better than in almost any other country and we are the envy of much of Europe. That does not mean, however, that there is no violence in obstetrics in this country. It may not be as extreme as the experience of 'Kelly' in the USA, detailed below, but we are not immune from obstetric violence. It usually takes the form of paternalistic coercion rather than overt physical violence, ranging from bullying women into agreeing to a range of unnecessary or avoidable interventions, surprisingly often backed up by references to threats of a dead baby, to reports to Social Services, if the women do not comply. Most often it consists of disallowing women legitimate decision-making on the grounds that health professionals always know best.

Sheila Kitzinger, as long ago as 1988 wrote that *'Birth in western society has become an institutionalised act of violence against women.'*[1]

The extent of the violence, however, is shocking. A study looking at 65 (mainly qualitative) studies in 34 countries across all geographical and income-level settings found that:

'physical abuse (slapping or pinching during delivery); sexual abuse; verbal abuse such as harsh or rude language; stigma and discrimination based on age, ethnicity, socioeconomic status, or medical conditions;

'neglect, poor rapport between the carers and the women; ineffective communications, lack of supportive care and loss of autonomy were widespread.'[2]

One could add to that list the examples of health professionals using threats, or actual reports, to Social Services as a means of control or revenge when the woman decides not to accept professional advice. Increasingly, the AIMS helpline receives enquiries from anxious women who have been threatened in this way.

Other forms of violence include giving partial or loaded information to encourage the woman to agree, such as: 'Your baby could die.' So common is this tactic that there is a name for it – *'The dead baby card'* and there is even a research paper acknowledging this tactic.[3]

Obstetric violence is not restricted to physical or emotional abuse; it also covers those medical interventions that are carried out routinely, many of which have little or no evidence of benefit: for example, episiotomy, putting women flat on their backs and the majority of caesarean operations.

Female genital mutilation

When this issue is raised many women think of clitoridectomy, the practice in some parts of Africa of mutilating babies and young girls. While the inhabitants of developed nations express horror at such practices they fail to notice that we in developed countries practise a form of genital mutilation all of our own, and we carry it out on adult females. It is called episiotomy. By highlighting episiotomy as a form of genital mutilation I do not in any way wish to diminish the horrors of other types of FGM.

'restrictive episiotomy policies appear to have a number of benefits'

Routine episiotomy was widely used in the USA but it was not adopted in the UK until the 1960s, when its use began to rise dramatically. By 1967 it had reached 25% and by 1978 it had reached 53.4%. Some London teaching hospitals had a 98% episiotomy rate and AIMS has examples in the files of women who were given episiotomy after the baby was born because the midwives were afraid of criticism for failing to do one.

As long ago as 2009 a systematic review of the research revealed that *'restrictive episiotomy policies appear to have a number of benefits compared to policies based on routine episiotomy. There is less posterior perineal trauma, less suturing and fewer complications, no difference for most pain measures and severe vaginal or perineal trauma, but there was an increased risk of anterior perineal trauma with restrictive episiotomy.'*[4]

The violence of an unwanted episiotomy, however, reached new heights in America in 2014. A woman called 'Kelly', having her first baby, was cut 12 times by her obstetrician after clearly saying NO. She had already told the staff that she had been raped and sodomised twice in her life and wanted them to tell her before doing anything to her body. Her family videoed the assault. Neither the doctor's colleagues nor the hospital took any action when she complained about her treatment. What is just as bad is the reaction of her friends and family; they felt that she should 'get over it'. She decided to sue for the violation of her right to informed consent and refusal. She could not find a lawyer to take the case, having approached 80 lawyers in California. She finally found one and there are more than half a dozen similar cases, for forced c-sections and other forms of violence during birth, pending in other states.

See www.humanrightsinchildbirth.org/kellys-story/ and improvingbirth.org/2015/04/kelly-update/

It appears that American women have no enforceable right to informed consent and refusal during childbirth.

Flat on their backs

At a WHO conference in Brazil in 1985 Professor Roberto Caldeyro Barcia (past president of the International Federation of Gynaecology and Obstetrics) who carried out early research on positions in labour, stated that *'There is only one position worse than laying on your back for the birth, it is hanging by your heels from a chandelier'*. When a woman lies on her back the coccyx cannot move, but moving her increases the space in the birth canal by around 3cm. How many babies have ended up being delivered by forceps or ventouse because their mothers were required to birth on their backs? The Care Quality Commission survey found that *'the most common position for women to be in when they gave birth was lying down with legs in stirrups (35%). A further 24% were lying flat or lying supported by pillows. It should be noted that 15% of women had an assisted vaginal delivery, which would normally require stirrups.'*[5]

A study of birth position and obstetric anal sphincter damage of 113,000 spontaneous births found that the greatest damage was caused to women who were on their backs. Squatting and a birth seat position involved an increase in risk among parous women.[6] Sadly, the research did not look at women who adopted a hands-and-knees position or leaning forward over a birth ball, for example.

How much more research is required before midwives stop pressuring women to birth on their backs?

Caesarean operations

The World Health Organisation has stated that there is *'no health improvement for either mother or baby when caesarean operations exceed 10%.'*[7]

In the UK the caesarean rate in many obstetric units is already over 30%, even higher if the woman has private care, and the caesarean rates are increasing throughout the world. If 30% of men in the UK were to have major abdominal surgery, of which two-thirds was avoidable or unnecessary, there would be a national outcry.

Rather than focus on why there are so many avoidable caesarean operations the media focuses on 'the woman's right to choose', or worse, accusing women of being 'too posh to push'. Few informed women 'choose' a caesarean operation; those that do often have had previous trauma and feel that this is the only way they can control what happens to them during the birth, or they are persuaded that a caesarean is the only option. A midwife sat with a woman during a consultation about the options for birthing her breech baby where vigorous persuasion to have a caesarean was applied. When the midwife looked at the notes later, the consultant had written 'woman's choice.'

In 1997 a woman was forced to have a caesarean operation on the grounds that she was at imminent risk of dying. The judge who issued the court order authorising the caesarean was not told that the woman had been confined to a mental health ward where she was not visited by a midwife for two days. She subsequently sued and the judges found that detaining her under the Mental Health Act was unlawful and so too was the caesarean operation. She was awarded £40,000 damages. The judges stated: *'In our judgement while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment.'*[8] Fortunately, that view persists today, but it has had little effect on the rising caesarean rates.

Induction of labour

Active management of labour was developed by Kieran O'Driscoll in Ireland as a means of rushing women through the labour ward as fast as possible, (see AIMS Journal Vol:10, No:2, 1998). AIMS campaigned against the routine use of induction and acceleration, and for a time enthusiasm for it appeared to decline. Previously, it was used to speed up 'prolonged labour' but now active management is increasingly used on those women whose pregnancies exceed 40 weeks, and in some areas exceed 37 weeks. Few women are told of the risks or how painful an induced or accelerated labour can be.

The effects on the women

A small study by Hazel Keedle and colleagues in Australia looking at the reasons women choose to birth at home after a caesarean section found that the women were determined that they were never going to repeat their previous experience: *'It's never happening again'; 'treated like a piece of meat'; 'you can smell the fear in the room'*. Their response to having succeeded in a home birth after caesarean were *'I felt like superwoman'* and *'there is just no comparison'*.[9]

Experiences of mistreatment during childbirth have far-reaching consequences for women and communities outside of the direct woman–provider interaction. Prior experiences and perceptions of mistreatment, low expectations of the care provided at facilities, and poor reputations of facilities in the community have eroded many women's trust in the health system and have impacted their decision to deliver in health facilities in the future, particularly in low- and middle-income countries.

Some women may consider childbirth in facilities as a last resort, prioritizing the culturally appropriate and supportive care received from traditional providers in their homes over medical intervention. These women may desire home births where they can deliver in a preferred position, are able to cry out without fear of punishment, receive no surgical intervention, and are not physically restrained.[2] Other women often suffer in silence. They develop postnatal depression or, even worse, post traumatic stress disorder.

As long ago as 1988 Jean Robinson, the President of AIMS, drew attention to a famous essay by Peter Lomas. This is what she wrote:

'When hearing women's accounts I am struck by their sense of powerlessness, and I have often thought of Peter Lomas's famous essay on the effect on a labouring woman's mental state of her dread of envy of those around her.[8]

When I read his original piece, I was concerned that he described only the mother's perceptions, and did not explore how far the envy she felt in her attendants was real, and whether she might have genuine cause to dread it.'[10,11]

But eighteen years later he wrote: *'Is it possible that a fear of envy is not necessarily a neurotic one or confined to mothers who break down – but one based on an unhappy reality which causes her to propitiate those around her by making costly sacrifices?'*[12]

He describes a syndrome we know only too well – the mystifying apparent passivity of women in the face of mistreatment on the labour ward: *'She does not violently claim her baby when he is taken from her and left to cry in another room.'* His theory fits only too well some of the scenarios women describe to AIMS. Months or years later they are calling us to describe the anguish and anger they could not express at the time.

Sadly, I know of no country in the world that collects mental health data following childbirth. We know from anecdotal accounts that abuse of women in childbirth can result in serious postnatal depression and post traumatic stress.

The latest Confidential Enquiry into Maternal Death[13] found that, of the maternal deaths one in seven, died by suicide, but the statistics could be a lot worse as data is only collected up to a year after the birth. Almost a quarter of the women were known to Social Services, but the report makes no comment about whether the women that Social Services did not know about had deliberately concealed their problems for fear of having their baby removed. In one of the highlighted cases the baby had been removed. We know from our helpline and enquiries that women's fear of Social Services taking their baby is very prevalent.

It really is time that the emotional and psychological impact of poor birth experiences is properly researched, and significant improvements made to the provision and quality of postnatal mental health services.

The effects on the staff

It is now generally recognised in the UK that the current system of large, centralised, obstetric units is dysfunctional and damages both birthing women and the staff who work there. The majority of these units are short staffed and function in an atmosphere of stress, fear and bullying: fear of failing to follow overarching regulations, even when they are not appropriate for the individual woman or baby; fear of failing to keep 'adequate' records so that the staff focus more on the records than the woman; fear of being sued; fear of retribution if the 'rules' are not obeyed.

In The Lancet's 2014 Midwifery series a comment noted that *'discrimination and abuse was linked to, and reinforced by, systemic conditions, such as degrading, disrespectful working conditions and multiple demands'*.[14]

When midwives and doctors work in such conditions it is no wonder that birthing women are mistreated.

When the woman knows her attendant and has developed a relationship with her or him during the pregnancy, the quality of care improves and, as a midwife once commented to me, *'it is much more difficult to be unkind to a woman you have got to know during her antenatal care.'*

There is now a small mountain of research demonstrating that continuity of midwifery carer has a very powerful effect that enables women to birth normally without the need for a whole range of pharmacological and technological interventions, and it has significant implications for the long-term health of both the mother and the baby.

The rush to force all women to birth in hospital arose without any evidence whatsoever, and no-one asked the women what they wanted. The result is not only damaging to women; it is also damaging to the staff. The time for change is long overdue.

Beverley A Lawrence Beech

A copy of the ENCA paper upon which this article is based can be found on the AIMS website www.aims.org.uk

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Debriefing

Sophie Macfadyen shows the what, why and how of debriefing your experiences

The term 'debriefing' comes from a military background, where troops went over the details of an operation after the event to learn how it went and what should be done differently in a similar situation in the future. It is also used in this setting to assess the performance of the soldiers from an organisational point of view. By using debriefing the individual and the army aimed to learn from their experiences. In fact we all do this; every time we trip on the corner of a mat we hopefully remember to pick up our feet when we next walk over that mat!

The process of thinking about an experience and learning from it is the basis of 'reflective practice'. If you want to find out more about this then Melanie Jasper's *Beginning reflective practice*[1] is a good place to start. She introduces you to different theoretical models that can be used to guide your work when you process your experiences into new learning and understanding.

Power imbalance

In any situation where a person goes to another for help or they are told to go to another person because they 'should' then they are nearly always in a situation of power imbalance. This affects what they will bring to the interaction and what they will take from it and ultimately what they will feel and do about what they brought. There is a risk in debriefing that the interactions stop being adult to adult and become parent to child, which would change the nature of the process.

Really listening

For the last 20 years I have been working as a breastfeeding counsellor with the NCT. In this role we enable parents to achieve the feeding experience that they want. We do not have an agenda, and we aim to give them a safe place to explore the issues and concerns that they wish to. Our role is to listen, to really listen. In order to be able to do this we need to be able to switch off the chatter that is in our heads and truly 'be there' for the parent who wishes to bring their issues to us. This chatter comes at different levels; it can be 'what am I going to cook for tea?' but it can also be along the lines of the parent's story triggering similar experiences that we ourselves have had.

As soon as that happens then we run the risk of superimposing our own experiences on the parent's and not truly hearing their experience. Also if we choose to share our version then we run the risk of diminishing their experience with our more powerful one. We need to really ask ourselves, 'Who will benefit from my telling my story at this point?' The other risk is that the parent will feel that they 'should' do what you did in a similar situation, as, after all, you are the expert. It is almost impossible for two situations to be exactly the same, as the people involved are not the same; therefore the outcomes are very unlikely to be relevant. This is where the listener also risks sliding into giving advice based on their personal experiences.

In a recent article on GP self-disclosure in New Zealand Allen and Arroll[2] report a high level of self-disclosure, little training and practitioners feeling that self-disclosure brought a sense of empathy into the relationship. They also report in a literature search[3] that few studies have looked at how the patient found self disclosure and that one using simulated patients found only 4% of self-disclosure to be useful to the patient and 10% were disruptive or detrimental.

very important for anyone who is going to be in a position of power

Debriefing

So how do we get round this? It becomes very important for anyone who is going to be in a position of power in relation to another (such as nurses, midwives, health visitors, doctors, teachers) to prioritise processing their own experiences so that they notice when something that a parent says triggers something that happened to them (a red flag moment). This can be done using a personal journal (writing reflectively about those events when you notice the red flag go up). Gilly Bolton's excellent book[4] on reflective practice provides a good way to develop this skill. It can be done with a good listener giving you the time and space to explore what is behind this issue, or it can be done in group sessions where the facilitator provides the right environment for you to be able to explore your 'journey' safely.

Within NCT we start all our university training with a Level 4 reflective practice module where students explore their own experiences of life events, such as childbirth, infant feeding and parenting, using structured reflective models. Breastfeeding counsellors go on to explore their own feeding experiences through one-to-one listening practices and supervision. Our peer supporters also share their experiences in a safe confidential setting and this is the raw material on which the group build their understanding of the variety of experiences that women have. In all these cases it is the group safety and the confidentiality that help students to

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feel heard and able to reach a safe place to be aware of how their experiences continue to affect them and what their current triggers are and so become ready to support others.

The really alarming thing is that very few health professionals have explored their own experiences in this way. Many feel there is no problem with sharing their own issues and do not realise that there are implications for those they tell them to, nor that they may be telling them for their own benefit rather than for their client's or patient's. I welcome the UNICEF BFI development of booklets such as *Having meaningful conversations with mothers*. However, in order to hold these mother-centred conversations the practitioner must also consider what information she is sharing, and whose needs are being met in this.

Now we come to another problem: the word is 'debriefing' and the implication is that you do it (a bit like taking off a coat) and then it is done. However, that is not how it works. It is more like an onion. You take off the skin and then things become clear – for a while – and then you find yourself in a slightly different situation and you realise you still have issues, but slightly deeper ones. So you explore that next layer and so the journey continues. The real trick with all this is to be able to recognise when something is triggering something in you and to do something about it. That takes self awareness, and that is another article!

Sophie Macfadyen

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Facilitated debriefing of birth experiences at a workshop © Red Tent Doulas

Article

FGM

Bríd Hehir suggests a change in the way women are supported and cared for

Female genital mutilation (FGM) has been a controversial, high profile issue in Britain for some years now, as many women and girls from traditional FGM practising communities live here. There is a widespread, if erroneous, belief that this illegal, harmful practice continues to be performed here. Politicians of all hues, government departments, media campaigners, victims, survivors, charities and professionals have all contributed to this illusion.

The Home Office established an FGM Unit in December 2014 and £3m was contributed to the national FGM Prevention Programme partnered by NHS England, *'with a package of measures to support NHS staff in preventing FGM, protecting girls at risk and caring for survivors'*. That they may be helping to protect even one child from abuse and preventing a breach of their human rights is thought to justify making it everybody's business.

FGM definition

WHO defines four types of FGM, but they are only a rough guide because it's hard to categorise FGM with any degree of accuracy when it has been carried out with crude instruments. Types 1 (clitoridectomy) and 2 (Type 1 with excision of the inner labia) are the most frequently seen, but in the public mind the most severe form, Type 3 (infibulation), is assumed commonest. Type 3 is mostly limited to girls and women from the Horn of Africa. Type 4 (pricking, piercing, cutting) is the mildest form, and the most commonly diagnosed in the new, national, specialist centre for under 18s at University College London Hospital. However, even experts find it hard to confidently distinguish Type 4 FGM from natural variation. In countries where FGM is still practised it is increasingly being medicalised and carried out by health professionals, which results in cleaner, if differently damaging, cuts.

Data

The NHS estimates that 137,000 women across the UK are affected by FGM, and the NSPCC estimates that 23,000 girls under 15 could be 'at risk' in England and Wales. Individual-level data has only been collected in England by the NHS since April 2015 (different arrangements exist for Wales and Scotland). Analysed reports for the 12 months from April 2015 show that almost all of the 4979 women and girls seen were cut outside of Britain, with only 22 reported as born here. This small number is a far cry from the belief that FGM is a hidden and persisting problem here. However, I am certainly not seeking to minimise its seriousness by asking whether such a small number should form the basis for ongoing awareness raising.

Why does FGM command such interest?

This has become a perfect issue for politicians, the media and campaigners to unite around. Who could possibly condone FGM? Who wouldn't like to see an end to a practice that appals and horrifies in equal measure? Who wouldn't want to support the survivors who have been trying to highlight it for years? In the awareness-raising frenzy that's ensued over what is a largely non-existing practice here, does it matter that information has been presented simplistically; that facts don't matter much and the challenges in addressing the very real problem it represents to girls and women where it is practised, mostly in the developing world, are glazed over? I think it does.

What are the consequences?

Unsurprisingly, the many official measures adopted and implemented are hugely problematic for people from supposedly still practising communities as they are based on the assumption that FGM is being undertaken here, irrespective of the evidence.

Because of the deeply-held belief that FGM is an intensely private matter, communities are reluctant to engage in public discussion and are ashamed and angry at the fingers pointing at them in regard to it. They also feel taken advantage of due to their silence. So, exaggerated claims about the prevalence of FGM go unchallenged.

Unsurprisingly, therefore, little acknowledgement or credit is given to immigrants and their descendants in Britain and Europe who have ended the practice. Years of high-profile surveillance and scrutiny by the police and border forces, health, social care and education services, have identified just 11 women and girls who underwent FGM here, of which eight were genital piercings only, one had Type 2 FGM and two the type is unknown. In all those cases information was given voluntarily to health service staff. Even suspected Type 4 referrals are made more out of professional fear than conviction. To date there has not been a successful prosecution.

Nevertheless, organisations are encouraged to be alert, to proactively identify girls 'at risk'. Communities consequently feel surveilled, stigmatised and scrutinised. Under-18s, pregnant women, mothers and older relatives are paid particular attention.

With the advent of mandatory reporting in October 2015, registered professionals must report to the police when they see, or have confirmed, that an under-18-year-old has undergone FGM. The police will then investigate and may instigate a multi-agency response. This requirement not only removes professionals' independent ability to judge and act on a situation; it also effectively turns them into arms of the criminal justice system. This undermines patients' hard-won trust, leaving some fearful of seeking health care, knowing the possible consequences for themselves and their families. Interestingly, when the data was last reported, the police had received only 20 appropriate referrals, none of whom had undergone FGM here.

Pregnant women are coming under intense scrutiny. Immigrants have traditionally been wary of officials but have trusted NHS staff. Now, antenatal checks are being used as a way of surreptitiously introducing social workers to women who have been cut, with the intention of identifying their cutting intent for their daughters and ensuring they know that the practice has been illegal here since 1985.

However, denying intent once is not enough. It has become common for women to be asked the question repeatedly, often in inappropriate circumstances: for example, a woman in advanced labour who was questioned by a paramedic, and a pregnant woman with a sick child who was questioned by a paediatrician. If the woman who has said 'No' has close contact

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with an elderly female relative, she and her daughters may continue to be viewed with suspicion lest the woman be pressured into having her daughters cut.

A double standard operates in health care , directed by the Secretary of State for Health. Women with FGM, seen by GPs, mental health or acute trust professionals, now have their identifiable data recorded and centralised. *'The FGM Enhanced Dataset is being undertaken under Directions for the Department of Health. This provides the legal basis for collecting patient identifiable data without explicit patient consent.'* That's right. Patient consent is deemed unnecessary, *'however, transparency* (fair processing) *is required.'* Some health professionals are understandably reluctant to co-operate with this directive and it might explain why so few are centralising the required data.

The mother's FGM status must also be documented for other health professionals to see. This private and sensitive information is frequently noted in her child's health record (Red Book) for her child, or anybody else who might look, to read.

New FGM Protection Orders have also created major problems for families, resulting in police involvement, court appearances, passport removals, travel restrictions, airport surveillance, visas denied, fares lost etc. These get huge media coverage but it is difficult to establish their effect on FGM.

Working on the assumption that school children too need to know about FGM, keen 'survivors' visit schools to raise awareness. This has resulted in fingers being pointed at certain children by their peers and some being bullied. Some advocates celebrate the 'reverse socialisation' process that occurs when children raise the issue with their parents. However, this is not welcomed by all parents and has led to friction.

What should be done?

FGM has serious consequences for women and girls and should end. How this happens needs more discussion. Problems associated with current initiatives, awareness campaigns, their methods and strategies should be acknowledged because they themselves are causing harm.

It would make a huge difference to women themselves if the issue was depoliticised, kept in perspective and the campaigns scaled back.

Our priority should be to identify and support those who need help, freeing them from the constraints of asking. Some women may suffer short or long-term consequences, some may not. High-quality NHS care, mental health support and reconstructive surgery should all be accessible and sensitively provided to those who need and want them. The money allocated to the FGM Prevention Programme could be usefully diverted to this purpose.

We need to accept that different strategies are required to address the issue here and overseas, and those strategies should be decided with people in those countries.

Bríd Hehir

Bríd is a social activist, a former midwife, retired health visitor, sexual health and contraceptive nurse and fundraiser

Better Births

Beverley Beech summarises the report on improving outcomes of maternity services in England

Following the National Maternity Review team's programme of engagement with the public, users of services, staff and other stakeholders over the last twelve months, Baroness Cumberlege and her team have published their findings and their vision of how maternity services across England can be improved. The 126-page document highlights the messages the team received, makes the case for change and identifies what action needs to be taken.

The Better Births report begins by setting out their vision for the future:

'1. Personalised care, 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.

'2. Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.

'3. Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.

'4. Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.

'5. Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.

'6. Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.

'7. A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.'

The report sets out a table of recommendations for action, who should take responsibility and what timescale they should work towards.

For more information see www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Beverley A Lawrence Beech

The Irish knitting project

Jo Murphy-Lawless gives an update

On the 25 November 2015, in St Laurence's, Grangegorman, Dublin Institute of Technology (DIT) an event took place which has taken over a year to bring to fruition and which has evolved in ways that none of us could ever have imagined at the outset.

It was the knitting project which started out in the autumn of 2014 as a way to lift the spirits of midwives in training after a dreadful run of inquests about maternal deaths, all ending in verdicts of medical misadventure (see AIMS Journal Volume 27 No. 2 2015, Knitting as commemoration). We determined that we would make a knitted quilt and that we might be able to make a short documentary. In the event, support for the knitting grew so that it stretched across Ireland and to the UK and even beyond. AIMS members themselves contributed very substantially with knitting.

The system failed them

There is so much that is grievously wrong with Irish maternity services, but the eight inquests between 2008 and 2014 shone a necessary light on the sharpest of worst outcomes: how poor care, poor evidence, poor staffing, poor governance, and poor professional oversight led directly to the deaths of eight young healthy women, all of whom had sought out antenatal care early and appropriately in their pregnancies. The system failed them and their families and created the tragic circumstances with which their husbands and families will live for the rest of their lives. The system then redoubled its injury by refusing any open accountability, so that the instrument of the public inquest became the only means by which families could discover what had happened, step by step. Even then widowers had to fight for inquests as these are not automatic.

By the early summer, we had a name for our group, the Elephant Collective, which echoed the richly coloured and intricate design of the quilt's border by one of our chief knitters, Mary Smyth. By the autumn, as the last squares arrived, we had the making of a quilt more than large enough for a king-sized bed. A new king-sized bed was donated to us and we began to work on the elements for the launch of the full exhibition.

The evening of the launch acknowledged all who participated and who work to see both justice and radical reform of our maternity services. Five of the widowers were able to attend and they found themselves surrounded by over 100 people to commemorate the lives of Tania McCabe, Evelyn Flanagan, Jennifer Crean, Bimbo Onanuga, Dhara Kivlehan, Savita Halappanavar and Sally Rowlette.

The artist Martina Hynan, sitting with press photographs of the women over many months, reading and re-reading inquest reports, painted large portraits of seven of the women with a sketch undertaken of the eighth. These created such a strong presence of the vitality of all the women, their hopeful, joyful lives, that it was as if they were there with us that night. We screened for the first time the trailer of our documentary, Picking up the Threads, shot by Anne-Marie Green and edited by Emma Bowell, which asks such hard questions of a dysfunctional system for which no one in government will take responsibility.

Drama students from DIT under the direction of Mary Moynihan (who has written about the impact of the death of her mother after she had given birth in 1981) recited two poems and sang exquisitely. Caroline Kiernan sat with her needles and a large box of wool urging anyone who wanted to add to a piece of knitting, to pick up the threads of care. The exhibition will now go on tour around the country while we press for answers and a change in legislation to require mandatory inquests when maternal deaths occur.

Jo Murphy-Lawless

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The Maternity Review

Annie Francis asks whether it is an opportunity for change or 'just another report'

Looking around the other members of the National Maternity Review team as we sat down to our first meeting on 23 April 2015, I wondered if they were all feeling as daunted by what lay ahead as I was.

I needn't have worried; after an intense and brilliantly facilitated session, we finished the day with a clearer sense of the task ahead and even more important – a rough idea of where to start! At the beginning of the day, we were asked to reflect on what people tend to assume about national reviews (which can limit their impact) and what we wanted to achieve in order for this one to be thought of differently.

I was not alone in voicing my main anxiety, that it would be just another report that would be full of ideas for implementing change which might cause a flurry of interest and then join lots of other such reports sitting on a (digital) shelf gathering dust. I also wondered if we would be united in recommending a future service that had continuity of carer for the whole pathway, including birth, as its aspiration – my passionate ambition – or would we end up putting it into the 'it's just too difficult to implement' box?

Sitting in that first meeting together, we came up with a long list of the assumptions we anticipated could be made about this review – including 'it won't change anything', 'it's just about closing units', 'it will mean more rules and regulations', 'it's politically motivated', 'it isn't related to reality' and – the biggest of all for me – it will be another 'missed opportunity'. What we wanted to achieve was an equally long list – that it must be evidence based; that it will resonate with both users and staff; that it will be seen as thoughtful and considered; that it will help to break down barriers and bring about change … that it will be both implementable and implemented.

With the launch of the report[1] in February 2016, whilst there have been some of those anticipated negative responses, what I am more struck by is the willingness on the part of so many to suspend judgement. Rather than simply defaulting to a cynical 'it won't work' attitude – often without even bothering to read the detail – it has felt to me as if the reception has on the whole been positive, as if there is a broad recognition and acceptance of the scale of the challenge and a sense of wanting to give the actual ideas themselves a chance.

I think one of the reasons for this greater willingness to engage is the widely shared view that we have to find a way to move on from the fragmented, medicalised and technocratic system we have been burdened with for too long now and which has been thoroughly discredited as the means by which we improve the provision of the '*personalised, kind and more family friendly care*' described in the review … in my opinion, the fact that so many dedicated staff still manage to give that level of care within the current maternity service is a testament to their ability and desire to do so despite the system, not because of it!

People have also recognised and applauded the genuine effort – which is down to the determination of those conducting the review – to go out into the workplaces and local communities up and down the country, as well as to engage through social media, asking everyone to contribute their views about the service from their perspective and listening carefully to the messages that came back.

And what did we hear? The message, loud and clear, that women and their families – those who are the raison d'être for the service – want more continuity of carer. They also want their care to be safe, they want to be treated with respect and they want to be given all the information they need to be able to make properly informed choices. What the evidence suggests is that all of those things will be so much easier to achieve if we can reform the way we provide care so that more women can get to know just one or two midwives, working within a small team, instead of meeting a steady stream of different faces at every appointment, which is so often the norm within the current system.

The challenge of how we provide this, however, is contained within one of the other messages coming through from the listening exercise, this time from midwives … that being constantly on-call and working in caseload teams, within the current system, is generally too demanding, leads to burn out, disrupts their family life and is too difficult to implement on a large scale.

So, there we have it, the same old conundrum we've had for decades; we know what women want, we know that the evidence on outcomes supports this way of providing care and we also now know it is actually more cost effective. But, how on earth do we provide it without the midwives, who need to be at the heart of this change, paying too high a price, or at least having the perception that that is what will happen?

The key for me is the phrase 'within the current system'. What the Review does differently this time is to be explicit about the need to provide care through different models, acknowledging that a more radical approach is needed to move away from the current episodic nature of care provision, each episode often managed by a different health professional within a hierarchical and bureaucratic organisational structure.

Building on the lessons from past successful models of providing continuity (of which there have been many), there is a clear message that we have to be braver about how we implement what we know works. As a priority, we need to develop the leadership and build the structures to ensure that these ways of working have the support and energy from across the whole landscape of maternity provision – from the national bodies, from the royal colleges and from those who commission and provide the service.

This is crucial in order to securely embed these different ways of working so that they are no longer at the mercy of a

relentless short-termism. Successful caseload or home birth teams are closed down and community based care often reduced as soon as there is a financial challenge or a change in senior management or an inability to recruit because midwives grow weary of being endlessly pulled in to cover other areas (usually labour ward).

Over the past few decades, whenever we have tried to implement more caseload models or provide greater continuity in other ways, we have mostly done so using the large hierarchical and bureaucratic organisational structures which already exist. If this attempt is to be any different, we have to finally recognise that trying to fit round pegs into square holes simply doesn't work. One of the core recommendations of the Review is that the NHS needs to come up with new ways of delivering the service, which are much more focused on the community and which cut across organisational boundaries.

Without being too prescriptive or dogmatic about sizes and shapes, the proposal is for providers and commissioners to operate as local maternity systems, with the majority of care being provided in small community hubs, which ideally will also be home to other family orientated health and social services – provided by a range of statutory and voluntary agencies.[1] The key principle is that the community should be the default place to provide care and that different organisations within the hubs and across the local maternity system should have shared clinical governance and information processes agreed between them to provide seamless care which is focused on the woman and her family, not on the system itself.

In order to test these models robustly we need to encourage those CCGs who are successful in becoming '*maternity choice and personalisation pioneers*',[2] to involve clinicians and others from across the whole pathway (whether NHS or independent/third sector) – midwives, doctors, support workers, health visitors – the people needed to implement these ideas, as well as the users of the service. Then together these pioneer CCGs and the organisations working with them need to have the freedom and confidence to put their ideas into practice with tangible support and practical assistance from the centre.

The report is unapologetic in stating that improving continuity of carer is '*not an optional luxury*'[1] and that to improve on all the other indicators, such as quality and safety, we have to improve this one first and foremost. Yes, it will be challenging and no, it won't happen overnight, but thinking through some of the solutions (as proposed in the Review) should start now and should not be put off any longer. We have a clear mandate from the women who use the maternity services that they want continuity and therefore we have a clear duty to work out how we are going to provide it. The rather dismissive attitude of some providers, who in the past have turned around and said to commissioners in effect, 'Sorry, we can't do that, it's not possible,' should no longer be tolerated, then hopefully the culture that allows it, the commissioning process and the tariff will all be reformed to make that response unacceptable in the future.

The various recommendations – and the suggested ways to implement them – contained within the 126 pages of the Review are all about taking a different approach, one which challenges everyone to think outside the box, to set aside the rather limiting and unhelpful silo mentality and to genuinely reach for a more collaborative way of working.

It is impossible to cover all the recommendations in this one article and I encourage you to go to the report itself to get a proper understanding of the many different ideas contained within, including some potential game-changers such as the focus on multi-professional working, the rapid resolution and redress scheme, and the NHS personal maternity care budgets.

If you are reading this article as someone interested/involved in the maternity services in some way then my question to you is this – are you ready to engage with the ideas and proposals set out in the Review to make them a success? I hope your answer is yes, because to be ultimately successful in changing an entrenched status quo, I think it will require everyone who uses the maternity service as well as everyone who works in it to put aside their preconceived ideas and prejudices and to make an individual effort to get involved and genuinely try to make these ideas work.

My sense at the end of a very intense, challenging but ultimately rewarding process was that, for all of us who took part, there was a quiet optimism that the Review would have some practical and long lasting impact. As one way of trying to ensure that, the report includes Annex A which is a summary table of recommendations, the 'owners' of those recommendations and a proposed timeframe to implement them.[1] In the end though, history will be the judge as to whether this report, this time around, was – finally – the one that didn't get relegated to a shelf but was the catalyst to genuine and long lasting change.

Annie Francis

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When midwives lie

Hannah Gray recounts how a health professional misused Social Services

After four miscarriages and countless investigations we had given up hope of having a third baby and were happily surprised when I got, and stayed, pregnant.

During the pregnancy we had some concerns about our midwifery care with Luton and Dunstable University Hospital. There was no single issue, but there were niggles that our choices weren't respected and we should just let them tick boxes and follow their plan. We didn't want to cause any problems and decided to not make a fuss – we were informed, articulate and clear on our choices and trusted that it would work out OK.

Unfortunately it didn't.

The midwife who attended our home birth stopped my labour with her unprofessional behaviour. She appeared unable to cope with our informed choice to use water and to have a hands-off labour. At one stage she shouted at me, her nose almost touching mine, as I breathed through a contraction. She threatened to withdraw care unless I consented to internal examinations and dismissed our birth plan without reading it. It was so unpleasant that I went upstairs in tears, leaving my husband and mother to agree an alternative care plan if labour re-started.

When labour re-started it was fast; both of my previous labours were under an hour. I birthed our son in the pool in our living room supported only by my husband, with paramedics arriving seven minutes later. It was intense but beautiful. Despite multiple calls to labour ward flagging my history, on-call midwives weren't contacted initially, only arriving half an hour after our son was born.

In the days afterwards we considered complaining but decided to focus on our family – we had a healthy child and, despite everything, a positive birth experience. We spent three wonderful weeks in a bubble of happiness – our family was complete and we felt incredibly blessed.

There were concerns – we weren't discharged from midwifery care, we had a strangely intense visit from a senior health visitor, and our community midwife turned up suddenly and virtually snatched our notes out of our hands before dashing off again. All these were explained away and my husband was certain I was being paranoid.

Unfortunately I wasn't.

Out of the blue we received a call from Social Services with instructions to present our son immediately for a medical examination. They had received serious allegations that we had violently harmed our child, we had deliberately birthed without midwives present and we were keeping our son from medical care. We discovered that the midwife who had left us and never seen our son had made these unfounded malicious allegations. Our son has extensive birthmarks and had been checked by the hospital paediatric team and our GP, on the advice of community midwives, in the week after his birth.

At 7pm on a Friday night he was subjected to an emergency medical with Social Services present. No signs of abuse were identified. The doctor confirmed the diagnosis of birthmarks already made by the hospital and our GP.

We tried to contact the midwifery team to understand why they had made these allegations and were told we would never find out who had made the referral. They then tried to hide the identity of the person and how the allegation had come about.

We later discovered that, after initial allegations of violent harm were dismissed, every time Social Services prepared to dismiss the case for lack of evidence, allegations of increasing seriousness were made by members of the midwifery team. Meetings were held without our knowledge where different healthcare professionals lied, exaggerated and misused information to create a body of evidence to force Social Services to investigate.

Social Services were left with no choice but to undertake a full child-at-risk investigation. It is an incredibly intrusive process. Our older children had to be interviewed. We were interviewed separately about the intimate details of our relationship, our financial situation, our family relations. The children's clothes, bedding and toys were checked, the contents of our fridge examined.

We spent a weekend frantically cleaning our house before the inspection, trying to make things perfect. During the course of that weekend my tear re-opened but our midwifery team would provide no support and discharged us by a text message.

I cried almost continually.

I would wake and for one moment think I had had a nightmare, only to realise that we really were caught up in this ghastly process.

I would panic when an unexpected visitor arrived.

My husband spent nights awake researching our position and what we could do to protect our children. He was devastated that he was powerless to stop the hurt being inflicted on our family.

I hit bottom when I learnt that Social Services were told that I was a risk to my children due to previous postnatal depression. I have never had PND. People I had trusted were making ever more incredible unfounded allegations to prove I was unfit to mother my children. I remember handing the baby to my husband and, in tears, getting my coat to leave. I couldn't see how I could stay – it didn't matter what was true. People were determined to break up our family and would say whatever it took. I remember my husband saying I couldn't go, that he understood why I wanted to walk and walk, but we had to persevere and prove the allegations were untrue.

After six long weeks the investigation was complete. The final report that concluded we were good, loving parents caring appropriately for our children and that we had not harmed them in any way. However, the allegations remain on file and can never be deleted.

What we hadn't realised was that closing the case was just the beginning. It would take us another year of fighting to get the allegations accepted as untrue and retracted.

We requested copies of our notes from every party we had encountered – hospital, GP, health visitors, Social Services. Each request required a set of forms and a cheque. The cost of getting a photocopy of your notes is supposed to compensate for the costs incurred. In our experience the cost is set so high as to dissuade you from getting copies. We spent over £200 to get the copies but we needed those files to prove the lies.

We also requested a copy of the Social Services records including meeting notes and call records. This provided an independent third-party record of who was involved and what had been said.

I found writing my complaint letter incredibly upsetting. We knew that any complaint had to be free of emotion but I had to relive the experience and lies as I wrote it down.

The response we received from the hospital was awful. It dismissed all of our complaints, accused my husband of illegally acting as a midwife when he supported me in the absence of medical care, and made further allegations that our son had been 'immobile' at birth and that we had so violently harmed him that he had suffered 'skeletal damage'. It took a bad situation and made it worse. The response didn't even agree with written notes we had obtained.

It took hours of work to lay out clearly what was wrong with this response. We compiled a lengthy document which outlined each of the untrue statements and factual inconsistencies, cross referenced against the records from Social Services and the medical notes.

We put to one side the complaint about unprofessional midwifery care during labour because it seemed to come down to a 'she-said, you-said' situation and, as parents, our position was considered less credible than that of a professional who made unfounded malicious accusations.

After our rebuttal was sent I received a phone call from PALS. The tone of the call was so aggressive and pro-hospital that I was left sick and shaking. I was told we would have to come in for a meeting to discuss our letters.

At this point we were lucky enough to have Beverley Beech agree to advocate for us – we knew that any meeting would be confrontational and we needed someone who could be impartial to support us.

We spent hours preparing for the meeting. We had two lever-arch files of paperwork to support us, cross referenced and highlighting the 34 untrue statements made by the midwives.

On the day, my mother, husband, Beverley and I attended a meeting. The hospital had just as many people on their side of the table.

The hospital attitude from the start was dismissive. They offered to apologise for a birth experience that didn't match my expectations. I'm proud that I responded that my son's birth was incredibly positive and empowering but the unprofessional behaviour of their team in making unfounded malicious allegations against us of violent harm and their subsequent lies had hurt my family hugely and that was what we were there to discuss.

Over the next three hours we refuted every lie, every suggestion that we were at fault, backed by the evidence we had collected. Every time we asked them to show support for the statements made by their staff they couldn't. It was harrowing. We had to fight our corner and lay out the evidence that the internal investigation should have discovered.

The most disturbing part was how the wider team had closed ranks and lied, shared incomplete information and failed to even consider our welfare – 'punishing' us through Social Services seemed to be their sole objective. Social Services recorded that one midwife had told them 'that is not the outcome we wanted' when told there was no evidence of any harm and the investigation would close.

Eventually the hospital conceded that there had been a series of unfortunate events and a breakdown in procedure and that the allegations were unfounded, based on untruths and should never have been made.

Despite this it took another two months for the hospital to finalise a letter which states that for each of the 34 lies told about us the statement was incorrect and should not have been made. We received a watered down apology but those involved did not directly apologise or take responsibility for their actions and the hurt caused. This letter is attached to the front of our Social Services file.

We were promised that changes would be made, that training would be undertaken to address the failings of care and procedure. We know from other local families that this has not happened.

I now understand why other families don't complain about poor midwifery care. The process is set up to be costly in financial, time and emotional terms. The process assumes the health care professionals must be right and families in the wrong. I am not sure, knowing now how much of a toll it took on us and our family to make the complaint, that I would do it again.

I started the complaint process only wanting the individual involved to apologise for her actions, take responsibility for the hurt caused and commit to never do this again. The response we have doesn't do that and certainly does not address the harm done to my family by the allegations made against us and the lengthy, combative process we had to go through to get the lies retracted.

Hannah Gray

Health visitors

Sarah Holdway shares her experience of the strong arm of the health police

I'm no stranger to cancelling health visitors. I've had five children and over the years I have seen less and less of them, until baby three when I declined entirely.

By the time I had my fourth I had let the midwifery team know my plans to decline visits and to freebirth. I did just this and welcomed baby four into the world one snowy morning. A week later the bumph arrived with details of all the services available locally. Once more a short letter to say, 'no thank you,' and not a further peep. This, to me, is how it ought to be; I am making an informed choice and the constant barrage of 'safeguarding' is now getting far too Big Brother for my liking. Reading AIMS material recently I have to agree with 'The spy with the smile' (AIMS Journal, Vol: 16 No: 3 p4).

Recently, I had my fifth baby and this time we had been travelling I declined to let anyone know and we had our baby in the small hours in our caravan. Life trundled on, and one evening a police officer arrived on the doorstep with a social worker. My blood ran cold. I invited them in and they asked if there was a baby on the premises. I pointed to the snoozing baby and they asked various questions; 'child trafficking' was cited. Luckily, the social worker was aware of freebirth and very open to people who make their own choices, so after an hour-long conversation about our life and how we live it, they left full of apologies.

Throughout, they both looked confused and perplexed exchanging many glances asking me the same questions over and over, and they seemed shocked we had a birth certificate. The policeman interjected at one stage to say they had reports we had arrived with a baby trying to register her.

She did mention that there was a chance that an assessment would be required as new guidelines had come about that every child referred should be assessed, to avoid past mistakes.

I waved them goodbye and crumpled into tears; I felt terrified. My world was rocked. For days I replayed it all,. Did I say the right thing? What if they did assess? What if a different social worker decided we were wrong, somehow that our baby isn't in her best place; what if they decided to take her? What about the rest of the children? So many 'what ifs' rolled through my mind, I barely slept. Even now, a few weeks later, I feel so invaded.

I sought advice and have begun the process to get my file to find out what provoked a visit. While I waited, a few things emerged, the first being a letter from the health visitor team informing us of an appointment just a few days away. I called to cancel, to be met with much resistance. The 'chirpy bully' is how I term these people; they insist and insist with sweet little phrases. I felt rather threatened in a way because I could barely get a word in edgeways, with 'we won't be very long', 'we'll just weigh babe quickly', 'make sure she's ok' and, when my insistence grew stronger 'is everything ok?', 'we can help'. In between my every 'no thank you, I am cancelling, I have no desire to see a health visitor,' she had another pop-up answer. She insisted I had to see them, until I had to raise my voice and say 'I am very aware of my rights thank you, I decline to see you, please cancel'. I then followed up with a letter declining the service.

I felt furious! Why can my wishes not be met? Why is not wishing to meet the team regarded with such deep suspicion? Do they genuinely believe a mother or father is not a capable person without a 'health professional' giving the ok? Or do they feel so pressured from superiors to conform?

A chance conversation with a receptionist opened up further murky corners – a health visitor had called the caravan site demanding information; the receptionist declined to tell her anything, explaining it was not in her remit to divulge personal information. This caused the health visitor to telephone the police and Social Services – just three hours later they were in reception, asking questions such as did we visit the complex and had I been seen whilst pregnant, suggesting they were concerned because I hadn't seen the health visitor. The receptionist answered their questions and pointed them to where we stay.

This leads me to trust them even less. A message could have been left with reception for me to call if the health visitor was so worried, rather than utilise the police and Social Services – I'm still waiting to find out what she told Social Services; maybe I will never know what was said and what was truly thought.

Whilst a part of me is glad that if they truly believed a child was in danger they acted quickly and the social worker that arrived was a genuine warm, decent person, this could have gone very awry and run away with itself. I am sure there could have been a better way to deal with it.

Tuesday arrived, the day of the appointment – I decided to go out and leave my partner here to see if they arrived; nobody turned up.

Lots of thoughts ran through my mind – I could just see them to sate their concerns but I see no real reason to, I don't want to see them, I know my children are thriving, I don't need anyone to decide this for me.

I'm tired of feeling forced to comply, seeing women saying they don't want to see a health visitor and other 'professionals' but fear the backlash. One lady I spoke to here in town said to me she had to go, because she had to see the health visitor for a lecture; her eyes rolled. We had got chatting because she was breastfeeding, she told me that it's not something 'they' encourage and she feared being reported if she refused to go. It seems the tools that 'health care professionals' use, Social Services for starters, are wielded every time someone does not conform. If this carries on, what next? Mandatory visits? Is it any wonder social workers are overworked and missing genuine cases, when they seem to be called out willy-nilly.

This is not what Social Services are for, they are there to help children who need real help, not to make parents comply.

Sarah Holdway

Peace at home

Becki Caig shares her home water birth story

This was my second pregnancy. I had planned a home water birth with my first baby five years ago but I ended up being induced at 41+6 and so my daughter arrived in hospital. Her birth was fairly straightforward but it wasn't quite what I had planned, so this time I was really hoping to get my home water birth.

I had done a bit more research and had made the decision to decline induction just for being 'overdue', especially as I was less sure of my dates this time and the official due date had been brought forward after my 20-week scan. I had been getting Braxton Hicks contractions from around 34/35 weeks which were getting stronger and more regular as the weeks went on. From around 38 weeks I was feeling a lot of downward pressure and had started to get lower back ache so I knew that my body and the baby were getting ready for the big day.

At exactly 42 weeks I woke at 4.30am and thought I felt a contraction. A few minutes later another one came, so I decided to get up and get moving around to see if this was really it. I made myself a drink and sat on my birthing ball and tried to watch a bit of TV. By 5.30am I had to wake my husband, Shaun, as the contractions were getting painful and were already only a few minutes apart. We called labour ward and they contacted the midwife on call who rang us back to let us know that she was about 40 minutes away. Shaun got the birth pool blown up and started filling it while I tried to find a comfortable position for getting through the, now all-consuming, contractions. We had taken a hypnobirthing course so I was concentrating on my breathing and trying to stay relaxed.

The kids woke up about 7ish, just as the two midwives arrived, and my five-year-old nervously popped her head round the door to see what was going on. As much as I had tried to prepare her for the birth she really wasn't comfortable staying in the room with me so she went with Granny and her younger brother to get some breakfast, although she did keep popping in every now and then to check on me! I was getting to the stage where I really needed to get in the pool but it wasn't quite ready so the midwives asked if they could do an examination and check the baby's heart rate. They happily announced that I was 7-8cm which was good news! Then the pool was ready so I got in the lovely warm water and immediately felt so much better – I hadn't believed that the water could give such pain relief but it really did! I hadn't been in the pool long before I felt the urge to push and our baby arrived at 8.11am after only five or six pushes. I brought the baby up to me and had a quick peek to see what the sex was – it was a boy! Shaun then got in the pool with me and we both just sat and stared at our teeny new baby while waiting for the umbilical cord to stop pulsating.

Having our baby at home was such an amazing experience, we were both more comfortable and I felt so much more in control. The midwives were great, they supported me exactly how I had requested in my birth plan. Looking back now, I am so happy that I got the birth experience I had been hoping for and I feel so empowered – our bodies and our babies are well and truly amazing and we should trust them to do what they're designed to do.

Our little boy weighed in at 9lb 3oz and we named him Joseph Daniel. He's absolutely beautiful!

Becki Caig

Are you mad?

Libby Barton tells her story

I lowered my hand, and my eyes. The laughter was quickly hushed. Someone muttered 'Are you mad?'

I was 21, in my antenatal class preparing for the birth of my first child. The midwife had asked if anyone was having a home birth and, naïvely, I had admitted to the most heinous of crimes – trusting my body and knowing what I wanted.

Home birth was something I had thought of pretty much as soon as I found out I was pregnant. I've never been a huge fan of hospitals, and the thought of a car journey in the middle of birth was my idea of hell. I stumbled upon the Home Birth Reference Site (www.homebirth.org.uk) and started to do my research.

Initially my husband, Gavin, had the same reaction as everyone else – Why would I do that to myself? What if I needed an epidural? What if something went wrong? He was terrified. He didn't want to lose me or our baby.

Luckily I was prepared. I had found a book, Ina May's Guide to Childbirth. It was full of stories from women who had wonderful home births. It was written by an actual real-life midwife who was backing me up. Home births are safer for low-risk pregnancies. As the mother is relaxed, she is able to tune into her body and do what feels right. She is free to move around to get comfortable, and eat and drink when she needs energy. This all adds up to a birth which is (sadly) totally alien to a lot of women in the UK. Relaxed, without fear and without screaming.

I managed to convince Gavin. I reasoned that if anything did go wrong, the midwives would transfer me to hospital, which was about five minutes away in the car, less if I was blue-lighted. I reassured him that if they said it was necessary, I wasn't going to put my wishes of a perfect home birth before the lives of myself or my baby.

In the end I did have a perfect home birth. My contractions gradually built up from about 10am until I felt the need to call Gavin to come home. I was pacing, feeling pretty sore by this point, but as I remained upright and relaxed, baby was doing his thing. We called the midwives who suggested I take some paracetamol and wait for a bit. So I did. I drank water when I was thirsty and nibbled little cubes of cheese and grapes for some quick energy when I was flagging.

Gavin was timing contractions and wondering when to call the midwives again when his parents popped in for a visit! I was horrified! He clearly hadn't told them how we were progressing. His Mum, bless her, said 'It's time to call the midwives, Gavin.'

The midwives arrived and I went into the shower to help me relax and feel better about my contractions. I'm not going to lie and say it was painless. I ended up taking six paracetamol over the course of the whole day, to take the edge off, but it was nowhere near as bad as people made out. I was mentally prepared. I focussed and listened to my body. It was all gentle and powerful at the same time. Meanwhile Gavin and two midwives sat in the living room, drinking tea and eating creme eggs. That was fine by me. I could cope better when it was just me and baby, working towards the moment we would meet. Admittedly, Gavin brought me some tea and toast – it's true, this is the best food in the world!

At 11.39pm my little boy, Fox Ogilvie, was born. He weighed 8lb 1oz and was a little blue. Thankfully he pinked up, started breathing and was healthy and fine. I couldn't believe it. A little person! As the midwives stitched me up, Gavin got skin-on-skin time with our little boy. They are still very strongly bonded because of this. The midwives cleaned up, I got into pyjamas and we all snuggled up in our own bed. Bliss!

So when I next fell pregnant, it was a no-brainer. My proud husband is now a home birth advocate, completely won over. It wasn't even discussed that we'd go anywhere else. We made plans with our family that we'd call and the first ones that answered would take (our now 4-year-old) Fox away for the birth.

My due date was 10 June. Gavin's birthday, the 14th. Sure enough, at 6am on the 14th I woke up to nice strong regular contractions. I got up and paced about and took a couple of paracetamol with my breakfast. At 7am I felt that I should wake Gavin. 'We're having a baby today.'

He got Fox dressed and breakfasted, then called our families and the midwives. My Gran came to take Fox away at 8am. I was in the bathroom and being quite loud by this point. She smiled and said, 'Each one is one less.' I think she meant contractions.

Gavin had been opening his birthday presents in the other room and decided now would be a good time to show me his new power tools. I said, quite reasonably, 'Go away.' Apparently it came out as a roar.

The midwives arrived at 8.30am, having just started their shift. They asked a few questions and looked over my fairly basic birth plan (it actually said 'I do best when left alone.') My waters burst and were green. The midwife told me that baby was distressed and if we didn't progress we'd need to transfer to hospital. I thought 'Oh no you don't,' and made an extra effort after that.

Aeris Elizabeth was born at 9.19am, beating her brother's weight by 10oz. Again, the midwives cleaned up, and left us to it. I got a shower and into my dressing-gown and Gavin called everyone. Our families met our daughter when she was two hours old.

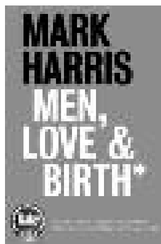
Needless to say, I am not popular with other mums when they start trotting out their birth horror stories over a bottle of wine, but I think my version sounds better.

Libby Barton

Reviews

Men, Love and Birth

By Mark Harris
Pinter and Martin 2015
ISBN 978-1-78066-225-1



There is much to celebrate in Mark Harris's book, *Men, Love and Birth*. His encouragement to fathers-to-be to develop a '*deep connectedness*' with their lovers by listening attentively, giving massages and noticing when housework needs to be done and doing it without needing to be asked, or thanked, or considered as a prelude to sex, will strike a very welcome chord with many women. This section is written so well from long experience that it is very moving, and is exactly the kind of experience that is so valuable in exploring a man's role in fatherhood, starting with his relationship to the mother during pregnancy.

What causes me unease is when the birth itself is discussed. Mark Harris describes in his own very individual style how the hormones of birth orchestrate so well in the dance between mother and baby. He points out that the birth attendants, including, of course, the father if he is there, are also affected by and in their turn affect the birth process: this is invaluable information for fathers and all birth attendants. He explores the fact that human birth has really only included the presence of fathers for the past 50 years or so and that there are good reasons why any man's presence at birth can have a negative impact. He also discusses the fact that giving birth in hospital has potentially negative effects, and there are several mentions of the advantages of home birth.

The central paradox is that when the birth process is managed in an institution with the presence of many strangers, including men, then the father's role holding a place of safety for the mother changes and often becomes crucial. Difficulties arise when men move from being protectors of a safe place in which their women can give birth safely and happily, to becoming 'birth coaches', that is taking an intrusive and even controlling role. I don't feel that the contradictions here are explored sufficiently. The premise of a hospital birth in the presence of strangers and with multiple interventions is implicitly the norm so, despite the caveats, the book does not explore a very radical approach.

The style of the book is also very 'blokey'. While I like the fact that sex is talked about (maybe in a way that patronizes men a bit), it does not explore the issue that when a birth has been taken out of women's control the repercussions for a sexual relationship can be devastating for both men and women. Finally, while the needs of men, midwives, all the other health staff, the institution and the wider family may well impact, and must be fully explored, it's possible to lose sight of the main thing: the needs of mother and baby, which must be firmly in the centre.

Gill Boden

The Ultimate Guide to Green Parenting

By Zion Lights
New Internationalist 2015
ISBN 978-1-78026-248-2

This is the best book I have come across to introduce green parenting. It's a science-based account of the ways *'we parents might be more green and raise healthier children in the process'* written by an environmental activist. It is well researched, detailed and very helpful.

Zion Lights explores all the material elements that you would expect, including more detail about nappies than many would imagine possible, but suggests that the transition to being a green parent can be made with comparative ease. However, she also explores the more contentious question, 'Is there a green parenting style?' She argues that sensitive and responsive parenting is not ideological but evidence based. Attachment parenting, often associated with bonding, breastfeeding and baby wearing, is fundamentally sensitive/responsive parenting for which there is not just much historical weight of evidence; recent neurological studies demonstrate that parental responsiveness leads to better-developed brains. The author gives the evidence on bed-sharing and co-sleeping well, and her section on birth is also informative, balanced, thoughtful and progressive and includes a plea for more midwives.

Weaning is discussed in terms of encouraging healthy eating habits and is one of the best short summaries I have read. All in all, this is a book to use as a resource or give to any parents.

Jules Cotton

A Doula's Journey – a novel

By Hazel Tree
Arts Council Funded 2013
ISBN 978-1-78299-121-2

I enjoyed this story of a woman contemplating her own background, family and future while deciding to train as a doula. The different stories of the women she helps are interwoven with hers as she discovers the mysteries of birth for herself; they are told with delicacy and sensitivity. Horticulture also features, as the heroine has an allotment, so the whole book is redolent with creation, discovery and nurturing in all its forms. This would make a lovely present for an intending doula or for an intending mother.

Gill Boden

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News

Ombudsman finds King's Lynn guilty of maladministration

Queen Elizabeth Hospital (QEH), King's Lynn is notorious for refusing to provide a home birth service. Any woman unfortunate enough to want a home birth within its area has an uphill battle. In 2012 Jeanette Stevens gave birth to her first son at home and described her experience as 'magical'. By 2014, when she was 32 weeks pregnant with her second baby, QEH unilaterally withdrew its home birth service 'temporarily'. Right up to the birth Jeanette fought the Trust and the Care Commissioning Group (CCG), desperately trying to get an agreement that a midwife would attend when called. In the end she had no choice but to engage an independent midwife. (Read her account in the next journal.)

Jeanette was not alone in her experience. Jane Reeve was also fighting to have a midwife attend the home birth of her second daughter; her story 'The battle for Cordelia' is published in AIMS Journal 28(1). Jane's first baby was born 12 minutes after her arrival at hospital, giving her no time to enjoy her planned water birth. It was sensible, and safer, therefore, for her to birth her second baby at home. She too was faced with QEH's intransigence and they justified their refusal to provide midwifery cover on the grounds that the 'temporary' closure of the home birth service was, allegedly, due to staff shortages. A 'temporary' closure that had been in place for the past three years. Jane Reeve complained to the Ombudsman that as a result of the Trust's decision she had to pay for a private midwife. The Ombudsman upheld her complaint and found that *'the length of time the Trust's Home Birth Service has been suspended without any alternative home birth provision being offered or explored amounts to maladministration.'*

The Ombudsman found that *'there is no evidence to indicate that she was denied midwifery care, but she was denied the birth of her choice.'*

He went on to state that:

'We accept that Mrs Reeve was not denied adequate maternity care as the Trust explained that she could use their Central Delivery Suite and we have taken this into account when considering our recommendations. Additionally, had the Trust explored the possible alternative arrangements to assist Mrs Reeve with her home birth request we may have arrived at a different view on her complaint. However it is due to the fact that no alternative home birth options were considered by the Trust despite Mrs Reeve's repeated requests that we have decided to uphold this complaint.

'We recommend the Trust pay Mrs Reeve £1000 as a consolatory payment in recognition of the failings we have identified.'

For more information see Parliamentary and Health Service Ombudsman Case Reference: HS-242121

AIMS Comment

Perhaps now QEH will properly provide an effective and efficient home birth service?

While the Ombudsman's ruling is welcome, his view that Mrs Reeve could use QEH's Central Delivery Suite is questionable. Research clearly shows that had Mrs Reeve given up and birthed in the delivery suite she would have been putting herself, and her baby, at increased risk, not only from the real possibility of giving birth in an ambulance on the way to the unit, but also from the risks in the delivery suite.

It is clear from recent research, and the BirthPlace study in particular, that low risk women birthing in an obstetric unit have worse outcomes that will have an effect on them for the rest of their lives: on their ability to feed and look after their babies, on their ability to become pregnant again, to have another safe and low risk pregnancy and birth. These outcomes include not just instrumental, surgical births and episiotomies, but blood transfusions and general anaesthetics. If care is to be provided on the basis of good research then it is time that the risks of fit and healthy women giving birth in obstetric units are properly addressed.

2016 - United Nations Population Award

Congratulations are due to the Polish 'Childbirth with Dignity Foundation' whose representatives, Joanna Pietrusiewicz and Ania Zdra will be travelling to New York on 23 June to receive this prestigious award from the United Nations Secretary-General. The award is in recognition of their campaigns and advocacy work over the last twenty years to inform, empower and campaign about the treatment of women in Polish hospitals.

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

The Polish members were very excited when Beverley Beech showed them a copy of Sheila Kitzinger's book 'The Good Hospital Guide'. This book came about as a result of our past Secretary, Ann Taylor, suggesting that, like the Good Beer Guide, we ought to have a Good Hospitals Guide. AIMS had no money to work on it, but Sheila asked if AIMS would be happy for her to work on this idea. The committee enthusiastically agreed. The Poles, however, were concerned that they could not challenge medical interventions, and came up with the brilliant idea of a questionnaire that would indicate how well the women were treated in the hospitals with hearts being awarded to those with the best outcomes.

The Foundation created a website www.gdzierodzic.info (which means information on where to give birth), which helps pregnant women choose the best obstetric ward or hospital by providing information about the 404 obstetric wards and hospitals in Poland. It provides answers to questions about pregnancy, labour and maternity care, as well as articles, new research evidence, and statistics. The website seems to be leading to changes in some obstetric units as doctors, midwives and decision makers read the parents' comments about them and compare them with those about other hospitals. Over the years the Foundation has been contacted by over 8,000 women from all over Poland, which has enabled them to challenge obstetric practices and empower women to demand better care.

The United Nations recognition of their work is well deserved.

How you can help AIMS

AIMS has become a charity. 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.

All AIMS members are invited to the

AIMS AGM

Saturday 24 September 2016
York

The morning business will be completed swiftly and followed by a sociable, shared, lunch and then a campaigning workshop in the afternoon.

Please put this date in your diary and try to join us.

This is a time for AIMS members, whether you are a mother, midwife, campaigner etc., to share experiences and to think about how we can bring about positive changes.

A chance to meet your committee.

Please contact secretary@aims.org.uk if you wish to attend.

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

A really easy way for everyone to help AIMS is to order cards and notelets from our website www.aims.org.uk and consider giving the new canvas bag or mugs for presents.

We really want to know what you think about your Journal

Do you find it an interesting read?
Does it provide information to help you support women?
Does it help inform you?
Are there other things that you want from your Journal?
Please would you take a few minutes to complete this questionnaire
www.aims.org.uk/journalQuestionnaire.htm
and make sure that the AIMS Journal is what AIMS members want.

AIMS members should be receiving occasional mailings from our mailchimp list, including a request to complete this questionnaire that was sent a few months ago. If you think you are not getting these mailings then please could you email membership@aims.org.uk and ask for to check that we have your correct email address.