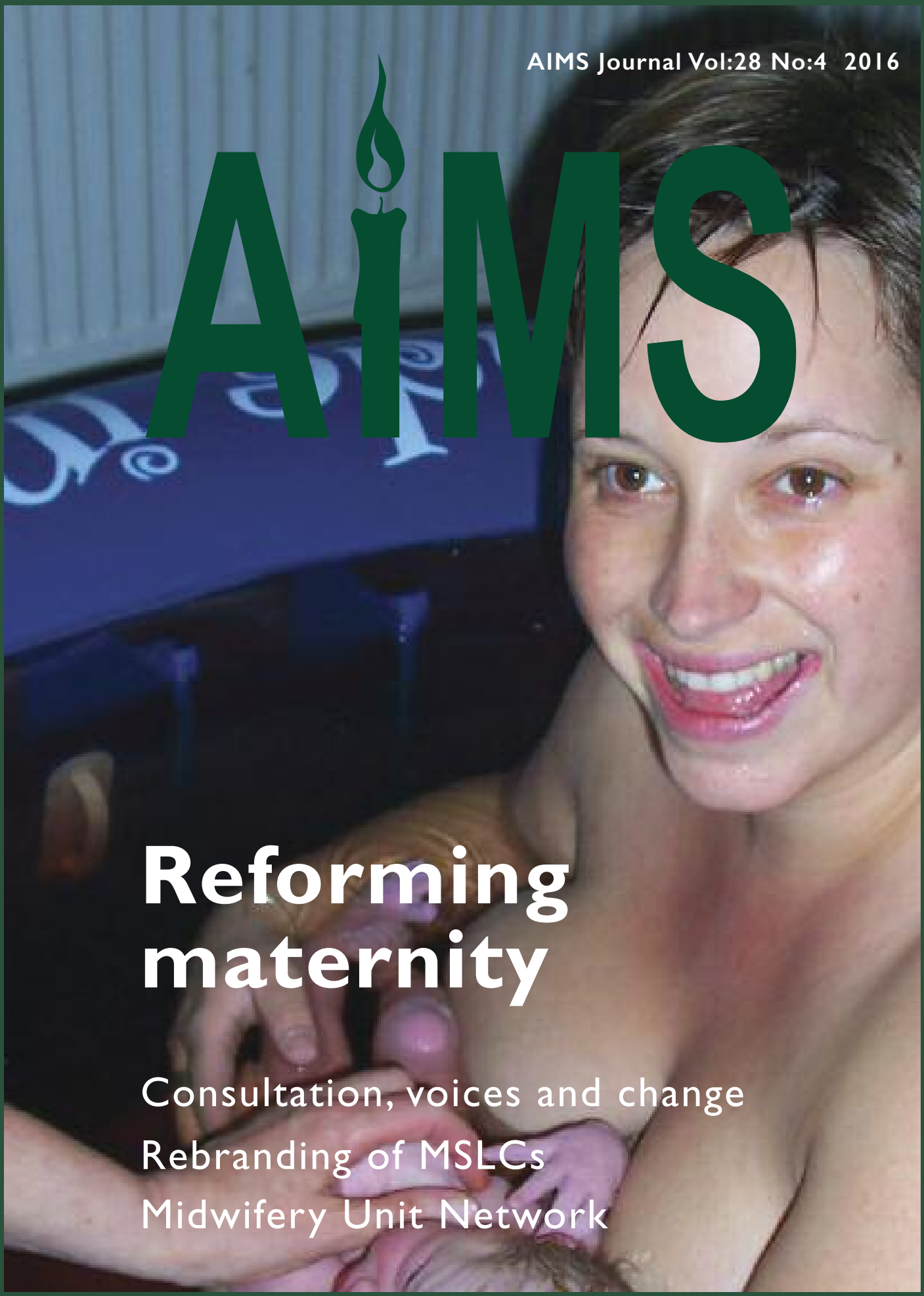
Association for Improvements in the Maternity Services

AIMS Journal Vol:28 No:4 2016

AIMS



Reforming maternity

Consultation, voices and change

Rebranding of MSLCs

Midwifery Unit Network

www.aims.org.uk

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Diary

AIMS meetings

The next AIMS meeting is to be scheduled for the spring.

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

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

Human Rights in Childbirth

2–5 February 2017
Mumbai, India
Dr Rinku Sengupta has played a leading role in helping reduce caesarean section rates at Sitaram Bhartia.
For more details contact: indiaconference@humanrightsinchildbirth.org

Improve your chance of achieving a VBAC

8 February, 2017
Effraspace, Effra Parade, London,
Prof Cecily Begley will present the findings of the Optibirth Study, designed to achieve more vaginal births after caesareans.

FREE admission (funded by OptiBirth)

The first 20 bookings will receive a free copy Birth After Caesarean by Jenny Lesley
For more details contact: talks@aims.org.uk

NCA/Nascer em Amor
Better Birth – for all
18 February 2017
Cascais, Portugal
Join the debate about a series of crucial issues that can make birth better, for all. A day of inspiration, empowerment, knowledge exchange, support and networking, aimed at families, health professionals, lay organisations and activits.

For more information please visit nasceremamor.wordpress.com/

Towards Zero Suicide

Preventing Suicide, Saving Lives
23 February 2017
The Studio, Birmingham.
Chaired by Lawrence Moulin.
A one day CPD certified conference focusing on suicide prevention through updates, practical case studies and extended focus sessions.

Further info visit: 10times.com/zero-suicide-birmingham

Celebrating Continuity

8 April 2017
Thackray Museum, Leeds

For more information please see the back page of this Journal or www.celebratingcontinuity.org.uk

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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AIMS Research Group
A group has been established to review research for the Journal. If you are interested in joining the team, please email research@aims.org.uk

Vol:28 No:4
ISSN 1357-9657

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Printed by
QP Printing, London
Tel: 07593 025013

Cover Picture:
Continuity in action.
© Becky Reed

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A little history lesson

Beverley Beech explores the 'rebranding' of MSLCs

Professor Norman Morris was an obstetrician who really respected women, and introduced many practices that are taken for granted now, but were revolutionary then.

He invited fathers to attend the births of their babies, and stopped the practice of routinely shaving women's pubic hair and giving them enemas. In 1960 he gave an inaugural lecture at the opening of the new Charing Cross Hospital and emphasised the need for improvements in the way in which some mothers were treated during childbirth. This was followed by the setting up of the Maternity Services Committee in the House of Commons and resulted in the publication of a document 'Human Relations in Obstetrics'.[1]

By 1970, AIMS was calling for this document to be updated and persisted with this call throughout that decade. In 1976, following a meeting with the Department of Health and Social Services, AIMS received a letter which stated *'You asked us to consider a revised publication of this document. We have given this some thought and agree that it could be usefully revised and reissued and we will be looking into this further in the coming months.'*[2] At a meeting with the then Minister of Health, Gerard Vaughan MP, AIMS was assured that the document would be published *'soon'*. Two years later AIMS was informed that the document was *'with the Royal College of Obstetricians and Gynaecologists'*. A ministerial official revealed, sometime later, that the RCOG had refused to be *'dictated to by a bunch of civil servants'* and were unco-operative. AIMS persisted in demanding a re-write of this document.

AIMS persisted in demanding a re-write

In 1981, in order to resolve this impasse, the Ministry announced that it was forming a multi-disciplinary committee to consider all the issues in maternity care, and that a lay representative would be on the committee. AIMS immediately asked for a minimum of two lay representatives and the Ministry agreed. They appointed the Countess of Limerick and the Honourable Mrs L Price. They turned out to be two women who were extremely able in committee work. They convened regular meetings with interested childbirth groups (such as AIMS, NCT and others) and compiled a list of issues which the lay group representatives felt had to be addressed in the reports. Considering that they were two lay voices in a large committee of over 30 members they were amazingly successful in persuading the Committee to accept the majority of their proposals. The result was a series of three booklets 'Maternity Care in Action' which considered the issues and recommended good practice. (Part 1 made recommendations about antenatal care and was published in 1982, Part 2, published in 1984, focused on intrapartum care and Part 3, published in 1985, addressed postnatal care).

The Committee also recommended that every Health Authority should have a Maternity Services Liaison Committee (MSLC) with lay representatives on it. Many Health Authorities and, subsequently Trusts, took up this proposal, but the enthusiasm throughout the country was patchy – some MSLCs had no lay members and other areas had no MSLCs at all.

some MSLCs had no lay members and other areas had no MSLCs at all

Initially the requirement was that every Trust should have an MSLC which should be made up of commissioners, providers and users of maternity services of which a third should be lay members. In 2006 the Department of Health issued guidelines, based on the 1995 guidelines, to inform healthcare managers, commissioners, practitioners and others on ways in which local MSLCs, acting as independent advisory bodies, can work effectively and contribute to improving maternity services in line with the needs and wishes of local women. The MSLC web site is available at www.chimat.org.uk/mslc

AIMS now understands that MSLCs are to be renamed Maternity Voices Partnerships (MVPs). It will be interesting to see if this 'rebranding' is just a change of name or whether there is a significant change of function.

Change of title or not MSLCs offer women the opportunity to change the system, and if you want to see change then seek out your MSLC lay member and see what you can do.

Beverley Lawrence Beech

References

1. Morris N (1960) Human Relations in Obstetric Practice. Lancet. 1960;1:913.
2. AIMS Quarterly Newsletter, October, 1976

Reforming maternity

Beverley Beech and *Gill Boden* talk about maternity transformation

The Maternity Transformation Council, chaired by Baroness Julia Cumberlege (who also chaired the National Maternity Review), is working to enable change that will ensure the majority of women have a midwife who will care for them antenatally, during labour and post-natally: this would provide real continuity of carer.

As we have said so often, the research demonstrating the benefits of case-load midwifery and community based care is growing by the day, and the government has finally accepted that for a fit and healthy woman a home birth, or birth in a Free-standing Midwifery Unit (FMU), is safer than birthing in an obstetric unit. This is the most important change we could envisage to improve and transform the experience of birth for women.

There is an urgency to the process, not just for the sake of women, but also in the interests of the profession of midwifery. There is a real danger of seeing the profession dividing into midwives and obstetric nurses. Midwives have been drawn into hospitals over the last 50 years, and, rather than being midwives skilled at observation, examination and support, they are under pressure to become obstetric nurses focused on reading fetal heart monitor traces and setting up drips and epidurals. The woman is then left alone with her with her partner, friend or husband. Midwives, under-staffed and over-worked, have become unable to give women the kind of one-to-one support and midwifery care they ought to have.

Some skilled and caring midwives who have challenged institutional pressures to maintain the principles and skills of midwifery have left the profession, sometimes after seemingly punitive and long drawn out Conduct and Competence procedures, conducted by the Nursing and Midwifery Council (NMC), or have simply burned out.

The Midwifery Committee of the NMC, which has been relied on by women and midwives to safeguard standards and practice, has been slowly whittled away, to the extent that the committee of eight members, which did not even have a practising midwife on it, has now been disbanded and there is just one midwife on the Nursing and Midwifery Council itself. We also fear that the NMC has presided over diminishing education standards for midwives. Students learn about normal birth in the universities, but they do the majority of their practice in centralised obstetric units, where they are lucky if they see a single normal birth by the time they qualify. When on the Midwifery Committee, as a lay member, Beverley Beech suggested that student midwives should be required to attend at least five home births during their final year. Indeed, those units that claim that they do not have sufficient midwives to attend a home birth could ease their problems by ensuring that the second midwife was a third year student.

This erosion of midwifery practice leads to midwives, who despite being dissatisfied with their working conditions in the large centralised obstetric units, are resistant to change, because they are anxious about attending a woman at home, without hospital equipment and without support from their Trust. Instead, staff are tempted to put enormous pressure on a woman intending to birth at home, either by sending her off for multiple tests, or by undermining her confidence:

'The main midwife did succeed in scaring my partner into picturing me bleeding uncontrollably, either from lack of iron or placenta praevia, and I said, "I don't think I'll be haemorrhaging, I am not anaemic, and if I do start bleeding he can drive me to the hospital – it's not going to be so bad that I die in my house." The midwife then said she couldn't guarantee how quickly I would be seen to if I came to the hospital during labour as an emergency.' [The hospital concerned has less than a 2% home birth rate and claims that women do not want home births].

If change is to happen then women have to make their voices heard, not only at an individual level but also collectively. Maternity Services Liaison Committees, now to be re-named Maternity Voices Partnerships, when properly set up and supported, offer a means for midwives and women to negotiate change. If you are not on an MSLC then investigate how to get on one at www.chimat.org.uk/resource/view.aspx?QN=MSLC_ABOUT

Women who persist with their intention to birth at home are often the ones who succeed. Rachel Ellman, was one and after the birth of her baby she pursued her complaint about her fight to get a home birth and the Trust Board in her area took it seriously, see page 23.

Jenny Reeve pursued her complaint about King's Lynn Hospital failing to provide a midwife for a home birth and received £1,000 compensation. Other women, similarly denied support attended a Trust Board meeting to make it clear to the Trust that their attitude was unacceptable and contrary to their Human Rights. The Trust has since set up a 'temporary' home birth service, but the local women will have to keep agitating to ensure that this 'temporary' service becomes permanent.

Free standing Midwifery Units are vulnerable and often closed with the excuse that they are not being used despite having better outcomes. Last year, in a heartening development, a small group of midwives and birth activists committed to supporting and promoting midwifery units have set up a network, with the objective of supporting the midwives, and encouraging innovation so that each unit will no longer feel isolated. See page 8 and www.midwiferyunitnetwork.com.

The opportunity for change is here, but it will not happen unless women and midwives act to make it so.

Beverley Lawrence Beech and Gill Boden

How many really know?

Gemma McKenzie asks who understands what normal really looks like

Recently, I read an article by Christiane Schwarz in the German midwifery magazine, Hebammen.[1] In it, the author explored how labour is currently managed and questioned the reliability of the research underpinning it.

In particular, she focused on contractions, their ideal length, intensity and frequency. One of her points was that maternity professionals may actually be unaware of what 'normal' labour looks like. The risk is that interventions are then unnecessarily employed to control labour, to speed it up, intensify it, or to assume that natural physiological breaks are pathological and need fixing.

My mind began to contemplate this issue and I couldn't help but wonder whether the same point applied not only to labour, but also to childbirth. I asked myself whether we – and by that, I mean society and the maternity profession – actually know what normal labour and childbirth looks like? Do midwives and obstetricians ever witness it? And perhaps most importantly, is it written about in the medical literature?

I am not a midwife, but I do read medical, midwifery and bioethical research. In those studies, I sense what Scammell and Alaszewski describe as *'an ever-closing window of normality,'*[2] based largely on concepts of risk, the medical profession's fear of litigation and the process of birth being dictated by charts, timescales, phases and stages. But I think this is also coupled with a skewed sense of normality based on what health care professionals actually perceive and experience as 'normal'.

I thought back to the births of my own children. When I was pregnant with my third baby, I remember the midwife asking me whether my previous babies had been 'normal vaginal deliveries'? With a shudder, I recalled the events of the previous births and was informed, that yes, these deliveries were indeed 'normal.'

Really? In my mind, there had been nothing 'normal' about my son's birth. I'd been induced for being 'post-dates'. My husband had been sent home, and I was left in early labour, alone, in a hospital gown in a bright shiny room. Everyone around me was a stranger. I was strapped on my back to a bed with a syntocinon drip in my arm. The contractions became a murderous, brutal, excruciating pain, inflicted by a machine and controlled by a third party. By the time my husband had returned, I was covered in vomit and was hallucinating. Faces came and went, cleaners, paediatricians, an obstetrician, midwives. I was then paralysed from the waist down, before someone took a pair of scissors to snip and widen me. Two midwives then held my legs up and back as I pushed for two and a half hours to bring my son into the world.

And my midwife perceived this to be 'normal'?

I really have to wonder how we got to this point. I am reminded here of the cat analogy written about by Tricia Anderson in her article *'Out of the Laboratory: Back to the Darkened Room.'*[3] She starts by highlighting how cats need to be in a dark secluded space to have their kittens, and then goes on to imagine that a group of scientists wanted to research how cats give birth. The scientists take the pregnant cats and put them in a brightly lit laboratory, and study them with monitors and probes. Over the years, the scientists discover that the cats were becoming distressed and their labours erratic. Consequently, the scientists developed tranquilisers to ease the cats' distress and technology to improve their labours. As time went on, new generations of scientists arrived and they had no idea that moving the cats into the laboratory had originally been an experiment. The end result was that everyone now believed that cats do not labour well and the safest place for them to give birth was at the laboratory.

lost sight of what 'normal' actually is

The analogy certainly strikes a chord with me. The maternity system seems to have lost sight of what 'normal' actually is. Perhaps there is some relevance here to the distinction between 'normal delivery' and 'normal birth.' In the eyes of a health care professional who works within a system where women are regularly induced, frequently undergo episiotomies and often birth on their backs, my experience probably does reflect a 'normal' delivery. My midwife had probably seen this scenario a hundred times over – maybe more. As a result, it was well within the confines of what she would deem 'normal.'

However, I, as the pregnant mother, do not deliver babies. I birth them. So, what may be deemed a normal delivery, may in fact be a million miles away from a normal birth. And it is this knowledge of what normal birth looks like – just like in the cat analogy – that seems to be disappearing over time. It is being buried by partograms and delivery wards and syntocinon drips and epidurals.

So, what is a normal labour and birth? I would argue the jury is still out on that point. My personal opinion is that each woman, (and possibly even each baby) has her own normality, her own physiological quirks and nuances that mean there may never really be an accurate, across the board standard. And I would argue that until we

know more it is probably dangerous to try and create one. What I do know is that my own third birth was as close as I am ever going to get to experience my normality.

After much soul-searching and for numerous complex reasons, I decided not to have a midwife present for the labour and birth of my daughter. It was two weeks after my estimated due date, and I made a little nest in my living room with candles, a deep birthing pool and a roaring fire. After five days of slow labour, there had suddenly been a surge of intensity in the pain. But it had been manageable, because I wasn't physically tied down and restrained. And perhaps most importantly, my own body was creating that pain – it wasn't artificial or man-made. There were no measurements; I had no idea how ripe my cervix was, or how many centimetres it had dilated. I moved around and for not one second did it ever cross my mind to climb onto my bed and lie down on my back. The contractions came and went. Perhaps they were regular. Perhaps they were all over the place. I made no note of them.

What I do remember, however, is that after some all-consuming, knee buckling contractions, the pain suddenly stopped. For forty minutes, there was nothing – not even the sensation of being pregnant. Everything had switched off. Yet something else had switched on: instinct. I knew with 100% certainty that my baby was absolutely fine. I ate toast and drank tea, and lazed about in the pool.

It took mere seconds for my daughter to be born. This rest and be thankful phase was like having a foot on the pedal when waiting for the traffic lights to turn from amber to green. There had been no pushing involved. Standing, I had instinctively and involuntarily expelled her from my body. It was only later that I learnt Michel Odent had coined the term Fetus Ejection Reflex – in our society, a phenomenon rare to experience and even rarer to witness.

So, what are we to make of all this? Exploring the concept of normality won't be easy, but it is not a task we should shy away from just because it is difficult. We need to better understand what happens during normal birth, so that health care professionals can more confidently pinpoint abnormality. Conversely, such an understanding may also help to highlight when maternity professionals don't need to intervene. At the moment, research seems to be heavily weighted in how to deliver babies, how and when to monitor, to measure, to surveil and to begin an intervention. And it is my belief that much of this is done under the presumption, or at least an acceptance, that women don't labour and birth well.

Worryingly, much less is written on how women actually birth babies, and most of the medical literature that I have seen contains very little – if any – input from birthing women. More studies need to include the narratives of mothers, and these need to converge with traditional medical research so as to create a more accurate understanding of normality during labour and birth. Perhaps in the right environment, with the right support and understanding, phenomena such as the Fetus Ejection Reflex would become many women's birthing normality. But if the maternity system continues in the direction it is going, that is something we will never know.

Gemma McKenzie

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2. Scamell M and Alaszewski A (2012) Fateful moments and the categorisation of risk: Midwifery practice and the ever-narrowing window of normality during childbirth. Health, Risk & Society. 14:2, 207-221. doi: 10.1080/13698575.2012.661041
3. Anderson T (2002) Out of the Laboratory: Back to the Darkened Room. www.pregnancy.com.au/birth-choices/homebirth/homebirth-articles/out-of-the-laboratory-back-to-the-darkened-room.shtml

Home birth and the NMC

An abrogation of responsibility to women, infants and midwives

The Nursing and Midwifery Council's (NMC) key statement giving guidance on the responsibility of a midwife to attend a home birth has been quietly withdrawn, without any notification or consultation, using the excuse that the NMC was moving over to a new web site.

The NMC claims that its Code of professional standards reinforces midwives professionalism yet it states that *'Employer organisations should support their staff....'* By using 'should' rather than 'must' the NMC has undermined the midwife's professional autonomy. How can the NMC possibly protect the public when it has allowed Trusts to determine whether or not a midwife attends a birthing woman at home?

The NMC has now abolished the Midwifery Committee, and only one midwife sits on the Council. The Education and Standards Team has no midwifery members and the pre-registration education and training standards make no mention of home birth as an educational requirement. Is it any wonder that so many midwives are uncertain and anxious about attending a home birth and that the transfer rates are so high?

In an article in the British Journal of Midwifery Beverley Beech argues that the NMC must be held to account for failing to uphold women's right to choose a home birth and the midwife's responsibility to attend.

For further information see: Beech B (2016). Home birth and the regulator: An abrogation of responsibility to women, infants and midwives, Br J Midwifery, Vol 24, No 12, P11-13.

Midwifery Unit Network

Mary Newburn talks about a new association of people committed to achieving change

Last year I received an email from Sheena Byrom OBE, midwife consultant. Would I be willing to become an advisor for a small group of midwives committed to supporting and promoting midwifery units? What was the initiative exactly, I wanted to know. How would it work? What would its governance be? If I was going to give advice, I wanted to know the context.

My questions prompted Sheena, Lucia Rocca and Felipe Castro to ask me to join them as one of the co-founders of what we call MUNet for short. My brief is for parent and public involvement. Having worked for the women's and parents' charity NCT for almost three decades and been a member of NCT for almost four – my eldest son is 40 next year(!) – I have some experience as a service user advocate. My other skills are in policy and research.

I hope you will go and explore the MUNet website, www.midwiferyunitnetwork.com. Sheena is the lead for website development. She has done a great job in setting up an attractive, welcoming platform to provide information and – more importantly – for midwives and services users to share their experiences, resources, and ideas.

We are delighted to have support from the Royal College of Midwives, who helped to finance the London launch in April and with whom MUNet have launched webinars to provide guidance to midwives in need of management or marketing support. Fortunately MUNet has a long list of expert advisors from all countries of the UK, from research, education, practice, service-user involvement and management, so there is relevant help we can offer.

At MUNet, we use 'midwifery unit' and 'birth centre' interchangeably. Sometimes it is more relevant to highlight one term and sometimes another. Birth centre emphasises a philosophy of care[1] (see the policy briefings at www.midwiferyunitnetwork.com/what-is-a-midwifery-unit/). Midwifery unit, as used in the Birthplace in England study, describes the professional group providing care. 'Midwifery', can also mean a defined practice and philosophy. The Lancet Midwifery series defines midwifery as:

'Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families.'[2]

Unity makes strength

The network exists for the following reasons:

- to enable midwives and others who use and value birth centre care to have an easy means of networking and supporting each other.
- to maximise opportunities for innovation and help to solve practical challenges, minimising the need to 'reinvent the wheel'.
- to create a community; midwives developing and/or working in freestanding or alongside midwifery units never need to feel isolated or alone.

The network can signpost commissioners, managers and maternity services liaison committees (MSLC) to relevant policy, up to date evidence, and practical documents, such as suppliers of equipment and furnishings, different approaches to training, and eligibility criteria. There will also be a strong focus on supporting and reporting clinical audit and research from a variety of perspectives.

There is a facility for direct messaging on the 'contact us' page so that sensitive or confidential issues can be talked through with an experienced midwifery leader.

The network will also enable the media to find out more about midwifery care and midwifery units. This will enable more of the public and professionals to learn about a 'social model' of care for healthy women and newborn babies that is responsive to their social, emotional and physiological needs.

Guest blogs

So far, one of the most interesting and dynamic parts of the website has been the blog page.

The first blog was written by Consultant Midwife, Tracey Cooper, at Lancashire Teaching Hospitals NHS Foundation Trust, who was a member of the NICE Intrapartum Care guideline development group. The blog, A Taste of success: Two midwifery units in Lancashire (October 2015), describes how Chorley freestanding birth centre was refurbished in April 2013, following a successful bid for environment funding from the Department of Health. Tracey used the available research evidence and the support of local service users to make a really strong case for midwifery unit development. The findings from the large Birthplace in England prospective cohort study were key. The study included over 64,000 'low risk' women, including 28,000 who planned to give birth in either an alongside or a freestanding midwifery unit (www.npeu.ox.ac.uk/birthplace/results). The Lancashire team raised sufficient money to also develop a new alongside birth centre at Preston. You'll find photographs of Baroness Cumberlege opening the birth centre and a video of midwives and parents from Chorley, which is also on YouTube.

On 18 July, Midwifery Unit Network supporters were out in force for a conference at Preston, organised by

Tracey Cooper and Cathy Atherton, Head of Midwifery, to celebrate four options for care: home birth, freestanding birth centre, alongside birth centre and hospital care. Even the Trust CEO turned out for the occasion!

The next blog post published by MUNet was by Dr Mandie Scamell, medical anthropologist and midwife specialising in risk and the maternity services in the UK. Mandie joined City University in 2013 from the Florence Nightingale School of Nursing and Midwifery at King's College London. In 'She can't come here': birth centre criteria and ethics[3] (November, 2015) Mandie asks *'Is it ethical to turn women away from midwifery care offered in a birth centre?'* and states: *'The answer to this question I think should be no! But are we brave enough as a profession to stand up and say this? Do we have a strong enough professional identity to stand up against the irresistible logic of risk calculation?'* Mandie and colleagues from City University held a conference in July to present and discuss some of these ideas in more detail.

are we brave enough

For those of you interested in women's rights to use birth centres, the latest blog at the time of writing, 'Midwifery Units in Northern Ireland' (July 2016) by Seána Talbot, service user and MSLC Chair, presents the criteria for new, differentiated, eligibility criteria for freestanding and alongside birth centres in Northern Ireland. These criteria as published by Guidelines and Audit Implementation Network (GAIN), suggest that alongside units should have a broader, more inclusive policy than freestanding units.[4] The blog post provides links to videos for six of the eight midwifery units in the province.

There is also a blog about the development of The Meadow Birth Centre, Worcestershire (June, 2016) where a 'bespoke maternity team preparation programme' was developed for the staff, alongside physical changes to the physical environment. This included 'a physiology refresher for all stages of labour; aromatherapy training; team building activities; conflict resolution and emergency skills n drills'. Midwives also went on 'observational placements' to well-established birth centres to see the kind of culture and practices in action that they would need to develop.

In February 2016, I contributed a blog on midwifery units – films of birth, virtual tours for parents and antenatal preparation to explore and provide a flavour of some of the information and messages parents might find if they search the web, and inspire others to make films and share information about units in their area.

Birth Centre Beacon Sites

MUNet and the Royal College of Midwives are working together to launch Birth Centre Beacon Sites as means of sharing good practice. The scheme will recognise those NHS Trusts and Boards with:

- Significant numbers of births in freestanding and/or alongside midwifery units;
- A clear philosophy to provide personalised care, promote physiological birth and support women as they become mothers, and their partners and the wider family;
- Systems for midwifery development, multi-disciplinary learning and case review.
- A desire to share learning with other midwifery units about vision, set up and on-going organisation, what has and hasn't worked, etc.
- A willingness to host visits from other midwives wishing to develop birth centre services, and arrange placements for student midwives and midwives wishing to develop their skills
- Participation in research relating to midwifery units and national audit.

If you know of a Trust or board with good practice to share, please encourage them to connect with the network. And get in touch yourself if you have ideas or need help to mobilise support for a birth centre in your area. We're especially keen to get more on the website from service users. We'd welcome any feedback and relevant video clips.

Mary Newburn

Mary's blog Birth Talk is at marynewburn1.com/

Facebook: follow Midwifery Unit Network cause and/or the Midwifery Unit Network closed group for discussion.

Twitter: follow @MidwiferyUnits and include us when you tweet.

Midwifery Unit Network and the Royal College of Midwives are supporting Shrewsbury and Telford Hospitals NHS Trust to host a fantastic community conference on 13 February, Implementing the National Maternity Review in Rural Areas: Better Births – Shropshire and beyond #SaTHFMU. Tickets are a bargain at only £35. Full details and booking at bit.ly/onlinebookingMU. Speakers include midwifery leaders Kathryn Gutteridge, Denis Walsh, Tracey Cooper, Cate Langley and Gill Walton, and parents supporting midwifery units in Ludlow, Oswestry and Bridgnorth. Chaired by Baroness Cumberlege.

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Why we need care for all

Nerea Pla Domench shares her experience as a volunteer midwife in Eko Station refugee camp

At the last meeting of ENCA, the European Network of Childbirth Associations a Spanish representative, Jesusa Recoy, suggested that every country should establish, as Spain has done, an Observatory of Obstetric Violence, so that examples of poor practice can be collected and exposed. This is an example of the 'care' some migrants receive in Greek obstetric units (and our Greek contacts tell us that this kind of 'care' is not uncommon).

Around 11am, M calls me, his wife's waters have broken and she has just gone to the medical post to be taken to hospital. It's her first baby, she's frightened and he's nervous. I follow the ambulance in the car with a colleague, but we're not welcome at the hospital. We wait with M in the corridor whilst staff come and go. At M's request, I ask if I can go in with her and they reply that first the doctors have to see her: everybody seems really angry here.

After a long while, a woman, supposedly a midwife, asks me about the waters breaking and when the contractions started, they tell me she has a closed cervix and they're going to do a caesarean. I suggest walking up and down for a while, but I'm told that they don't do that there. The doctor adds that it's dangerous because having broken waters, she could have a prolapsed cord. I wonder how the cord could get through a closed cervix, it seems absurd, but I smile, and say, 'ok, ok, can I go in?' Finally, 'Yes!' They let me go in and hold B's hand. She's looking terrified, I look into her eyes, we breathe through the contractions together and she calms down. Five minutes later they throw me out of the room, saying 'Spanish midwife, go out' – they're going to examine her again. After this, they don't let me go back in again at all.

standing at the toilet door, almost stealthily, M looks at her with tenderness

When B goes to the toilet, M, my colleague and I make the most of the chance to be with her, standing at the toilet door, almost stealthily, M looks at her with tenderness and she looks scared and in pain. At that moment a picture of a prison scene comes into my mind.

She goes back into the room and we give her words of comfort, in a language she doesn't understand, (she speaks Arabic and we don't). She is alone. I'm frightened that they'll take B away without letting us know so we watch carefully; the staff avoid catching our eye, we wait nervously. After a while we see a stretcher being brought and without saying anything to us, they take her away. M and I start running to catch up with them since nobody answers our question of where they're taking her. I'm running as though it's not real and I imagine that for M it's even worse.

When we manage to get close to the stretcher, the person pushing it says they are going to do a caesarean. We go off to have something to eat. I take a sandwich to M, who is waiting nervously. He doesn't want to move away from the spot in case he misses seeing his wife and daughter when they come out.

At 15:30 B comes out on the stretcher, half asleep. She doesn't know where the baby is and the person in charge of the stretcher is not very clear. We follow the stretcher, there isn't a curtain in the room or any other means of having some privacy for the three new mothers who sleep at hardly a meter's distance from each other. 'What about the baby?' Nobody answers. In the next door room there's a baby in one of the incubators. M looks lovingly at the baby, although he doesn't know if the child is his. I ask if the baby is B's daughter and nobody answers. It seems surreal and cruel to me. There are no words to describe my feelings at that moment. I can't imagine what the father is feeling; after a war, months in a refugee camp, the uncertainty, he's denied the joy of seeing his daughter. I can't think what it must be like for the mother, after all they've gone through. And those final hours of fear, pain and the frustration of not being able to follow the natural process of giving birth and then not being able to see her daughter and have her at her side. After several attempts we finally get an answer, 'Yes, she is B's daughter'.

What a relief! We look at the baby and wish her all the best whilst the father smiles at last: in spite of the situation, it's a beautiful moment. At last they know where their daughter is. After more than an hour a nurse, with a stern look on her face, puts the baby in the cot next to B's bed so that she can see her but not touch her and in a strict voice she tells M to leave her there. As soon as the nurse goes, the father puts the baby with the mother: the baby soon starts sucking at the breast. I hope this scene is repeated hundreds of times, day after day, although I doubt it in this hospital in Kilkis. We know from experience that dry milk is automatically provided to all new mothers. A little later we leave them. The baby is back in the cot, B is resting and M is looking on with tender, loving care.

Nerea Pla Domench
Translated into English by Jan Adamson

Eko Station refugee camp is situated at Polikastro, in the North of Greece.

The latest from Ágnes

Donal Kerry provides an update on Ágnes Geréb's fight for freedom

Another October 5th has recently passed, and with it the 6th anniversary of Ágnes's arrest and imprisonment. Before writing this latest update I went to sit with Ágnes in her apartment to discuss what we would include.

Since my July update the main legal event that happened was the verdict handed down on 26 September by the Appeal Court in the five cases where Ágnes had previously been found guilty (Nov 2015 verdict). The Appeal Court not only upheld the guilty verdict but extended the suspended prison sentence from one year to one-and-a-half years and also increased her suspension from working as either a doctor or midwife from three years to five years.

This was a terribly disappointing outcome for Ágnes and her lawyer as they had worked very hard in putting forward significant new legal and medical material which the court simply didn't properly engage with. Consequently, they feel they have grounds to submit the Appeal Court proceedings to the Supreme Court to seek a judgement as to the overall handling of the cases. All dealings with the Supreme Court in this matter should be finalised in the first half of 2017.

blatant injustice involved in being singled out and treated so differently

Ágnes said that these latest verdicts made her feel really sad because of the blatant injustice involved in being singled out and treated so differently from how similar current hospital birth deaths (such as from shoulder dystocia) are processed without any criminal aspect whatsoever. She is also saddened by the changes in the home birth world in Hungary where the services, because of high costs, are now not available to everyone and in many ways she sees "*the soul of home birth as having gone missing'*.

But equally she is so heartened by the joys of her family life, through her interaction with friends and her community and with the wonderful support she continues to receive from so many at home and abroad. She is also commencing her third year of study in the area of homeopathy as part of a four year degree course from a university in London. And on 19 October it is lovely to write that Ágnes gave a presentation at the HRiC European Summit Conference in Strasbourg, France. Details on link: www.humanrightsinchildbirth.org/event/europe-2016/

There are two remaining active court cases, both recently re-opened, which are currently underway in a special court and the final decision on these is scheduled to be issued in January 2017. If their original guilty sentence of two years imprisonment is confirmed or increased, then the only thing preventing Ágnes from being taken directly to prison after the court would be the existence of a presidential pardon request that she initiated in 2012 on the heels of these sentences. Hopefully, the courts will finally find in Ágnes's favour, but if not, then it will be time to marshal our forces and bring our voices to try and bear on the decision making processes of Hungarian President Áder. I will, of course, contact you all should a powerful campaign in this matter need to be urgently started.

What is now clear is that the end-game of the current events around Ágnes, precipitated with her arrest and imprisonment on 5 October 2010, will likely come to a conclusion in the first half of 2017. Our minimum concern should be to keep Ágnes out of prison, to retain her continuing freedom to work in all areas not restricted by the courts and for her not to be grievously burdened by legal costs accruing from her long and brave fight to defend her freedom, her professional reputation and her right to work in the arena of birthing to which she has been so committed all of her professional life.

Lets aim to do this.

With warmest regards and thanks

Donal (Kerry)
International Spokesperson
Justice for Dr. Ágnes Geréb Campaign.

More background information on the case against Ágnes can be found at legalfunddragnesgereb.net/landing-page/court-cases/

AIMS Note

Dr Ágnes Geréb was a leading obstetrician who was prevented from supporting normal, physiological, birth in hospital, so she trained as a midwife and supported (with her team) over 3,500 home births for some 17 years. During that time three babies died, two at seven and 14 months old and one at birth from shoulder dystocia. See AIMS Journal, Vol 24, No2, 2012, p20. Between four and seven babies die of shoulder dystocia complications in Hungarian hospitals each year – no hospital doctor has ever been prosecuted.

Instant access

Jean Robinson suggests that information sharing should extended to patients

I have been wondering for a long time why we cannot have instant access to our own health records in the NHS we pay for.

Why do we have to go through the rigmarole of formal application, form filling, and paying a charge of 'up to £50' – which has become the basic fee – for written hospital records? We know from our callers that many people struggle to find such a sum, or simply cannot afford it.

The reason we often suggest to those who contact us that they access ALL their records, is to check for inaccuracies – or in some cases downright lies. In the case of maternity care early access is crucial because if a midwife, doctor or health visitor believes that the embryo, fetus or infant may be at future risk, this may result in a report to social services, and set in train a number of damaging and threatening interventions. We have known a number of cases where such reports have been based on misunderstandings, misinterpretations, or even downright malice when the woman has made a justified complaint or even has cause to do so.

It is not just maternity and child care, but ordinary patient care too. Being now an elderly great grandma, I have signed powers of attorney for health and social care for my children. If I am unable to take decisions for myself, I trust them to do the best they can for me. And I would like them to have instant access to my records so that they know what is going on.

Did you know that there is a Maternity and Child Health Database and that your records are on it?

Did you know that there is a Maternity and Child Health Database and that your records are on it? You have the right to know what's on it AFTER you have made a formal application. A Children's Database is now being prepared. Parents and older children will have the right to see what's on it – again after they have filled in the appropriate form. Any suspicion of risk or neglect to a child will already have resulted in multi-agency sharing of data – social services, police, schools, nurseries, and possibly any voluntary agencies involved too. Why are we so worried about multi-agency sharing, which is so common, and has been little questioned? Because we have seen many instances of the problems which arise. These are groups with different professional languages, a different ethos, different purposes, different codes of ethics. And, unlike health care professionals, although they could be sacked, they do not have a code of conduct which could strike them off and prevent them working in that profession again if they breach confidentiality.

Schools, in particular, can leak child protection data like a sieve, and soon all the mothers at the school gate are likely to know.

impression it is all fact

The combined story from the agencies ends up as a blend of 'hard' data (for example, results of blood tests) and 'soft data' (the thoughts of a social worker or health visitor), which can be blended together and give the impression it is all fact.

Social workers are often ignorant about what medical diagnoses can mean, and that they can be wrong. Before the parents can access the original records to challenge them, and produce proof of inaccuracy, the myth has been created and all these agencies have perceptions of them which are very hard to shift.

One of the most horrifying cases I have ever encountered involved two highly respectable parents who had identified a paedophile who was a professional working with children in the NHS. They were puzzled to find that the mother was subsequently viewed as 'mad' and was said to have been sectioned for mental illness a number of times. The careers of both were damaged, since the information somehow spread.

It took them years to find out, and prove, that totally false records of her serious 'mental illness' had been created in hospitals in different parts of the country in towns she had never visited. I was with them when we obtained the final proof, and I shall never forget it.

AIMS wants everyone who uses the NHS to have the right to see all their records merely by requesting them and producing proof of who they are, and to have instant access to their own data on every Database. A reasonable charge could be made per page for photocopies. And carers who have powers of attorney should also have that right. If I had not been prevented from seeing my late husband's records, his care during his final illness would have been so much better.

Jean Robinson

Consultation or tokenism?

Beverley Beech highlights the difficulties in making information work for women

During the summer of 2016 AIMS was approached by the staff at Frimley Park Hospital for comments on their poster 'Feeling Your Baby Move', the poster is on page14.

This was AIMS response:

We welcome the opportunity to comment on the Frimley Foundation Trust's proposals for reduced fetal movement advice. The following are the comments and views of the AIMS Committee members:

The Poster

We feel that the whole tone of the poster is scary and we are concerned that this will alarm and stress women rather than helping them to relate positively to their baby and know when something is not right.

What we feel would be more effective is something that focuses on helping women to feel their baby's movements and learn what is normal for their baby. This is beneficial to all women, not just those whose babies happen to have a problem later on.

This could then be accompanied by a clear message about how a small number of babies may have problems, but the majority are fine, along with how many babies with problems change their behaviour or move less, and that the research has shown that when women's instincts about their baby's movement are listened to, and action taken, this may reduce the number of babies who die in the last weeks of pregnancy. This then needs to be followed by clear assurance that the midwife will listen and take concerns very seriously; and go on to provide women with details of their options for accessing support.

It would be helpful to say that this advice is given as a precautionary measure and that most babies will nevertheless be fine. The comment that 'Around half of women who had a stillbirth noticed that their baby's movements had slowed down or stopped' needs to be set in context of the much larger number of women who will experience a temporary reduction in their baby's movements when the baby is not at risk.

We would suggest the poster should indicate that the advice applies to those who are later in pregnancy, and re-wording the warning, for example, 'tell us about this straight away'.

The latest Cochrane advice does not find reporting of reduced movements of proven benefit – www.cochrane.org/CD009148/PREG_management-of-reported-decreased-fetal-movements-during-pregnancy. But, we are aware that times have changed since then – largely because women who had reported reduced movements and had a stillbirth have complained about how their concerns were ignored. bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-12-S1-A10

RCOG current guidelines – www.rcog.org.uk/globalassets/documents/guidelines/gtg_57.pdf

Note: This guideline states: *'the UK identified that an inappropriate response by clinicians to maternal perception of RFM [reduced fetal movements] was a common contributory factor in stillbirth'.*

The issue is about women being listened to and taken seriously if they think something might be wrong rather than raising fear.

Women need reassurance that they will be listened to (and that has to be the reality which it often isn't in the accounts we receive) not to be frightened by arbitrary measures of something that is not really measurable.

Therefore we suggest that the poster needs to say

If you are concerned about your baby's welfare – talk to us – we are listening, we will take you seriously

We also suggest the following changes to the poster:

Suggest removing the statement *'It is not true that babies move less towards the end of pregnancy.'* There are women whose perfectly healthy babies do move less towards the end of pregnancy.

The statement ***'Get to know your baby's normal pattern of movements'*** is a more helpful statement.

Delete *'You must NOT WAIT until the next day to seek advice if you are worried about your baby's movements.'*

Replace with: ***'If you are worried about your baby's movements then do contact your midwife and discuss your concerns.'***

'Do not use any hand held monitors, Dopplers or phone apps to check your baby's heartbeat.' Add: ***'Doppler monitors expose the baby to higher levels of ultrasound and the long-term effects of this are still unknown. Just as importantly, false reassurance can be gained by a mother picking up her own heartbeat instead of her baby's.'***

The Care Bundle

The outcome measures for reduced fetal movements are based on the percentage of women reporting RFM who have received the leaflet and 'understood the message' – but if women have not received the leaflet, or not understood it, they may be less likely to report RFM than those that did and skew the results?

If the measures are to be of any use they need to check that ALL women have had and understood the information, not just those that acted on it. In order to show that the intervention has been effective, they would need to be looking for an increase in the proportion of women who actually report RFM following the

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Frimley Health NHS
NHS Foundation Trust

Feeling your baby move is a sign that they are well

Most women usually begin to feel their baby move between 16 and 24 weeks of pregnancy. A baby's movements can be described as anything from a kick, flutter, swish or roll. The type of movement may change as your pregnancy progresses.

How often should my baby move?

There is no set number of normal movements.

Your baby will have their own pattern of movements that you should get to know.

From 16-24 weeks on you should feel the baby move more and more up until 32 weeks then stay roughly the same until you give birth.

It is NOT TRUE that babies move less towards the end of pregnancy.

You should CONTINUE to feel your baby move right up to the time you go into labour and whilst you are in labour too.

Get to know your baby's normal pattern of movements.

You must <u>NOT WAIT</u> until the next day to seek advice if you are worried about your baby's movements

If you think your baby's movements have slowed down or stopped, contact your midwife or maternity unit **immediately** (it is staffed 24 hrs, 7 days a week).

- **DO NOT** put off calling until the next day to see what happens.
- Do not worry about phoning, it is **important** for your doctors and midwives to know if your baby's movements have slowed down or stopped.

Why are my baby's movements important?

A reduction in a baby's movements can sometimes be an important warning sign that a baby is unwell. Around half of women who had a stillbirth noticed their baby's movements had slowed down or stopped.

<u>**Do not**</u> use any hand-held monitors, Dopplers or phone apps to check your **baby's heartbeat**.
Even if you detect a heartbeat, this **does not mean** your baby is well.

What if my baby's movements are reduced again?

If, after your check up, you are still not happy with your baby's movement, you must contact either your midwife or maternity unit straight away, even if everything was normal last time.

<u>NEVER HESITATE</u> to contact your midwife or the maternity unit for advice, no matter how many times this happens. For more information on the baby movements talk to your midwife.

introduction of the leaflet, and how many of those women actually needed an intervention?

We would like to see all hospitals collecting statistics around this intervention, and would like to know whether you would be able to provide the following details before and after the poster goes into use.

1. The number of women who report RFM
2. The rates of intervention and outcome in that group
3. The rates of stillbirth, induction, caesarean section and other outcomes which may be affected by reporting of RFM.

Carbon monoxide tests

We are aware that Trusts are under pressure to carry out CO testing of all pregnant women, but we are very concerned about this. It seems there are two real problems with this – one is about informed consent, and the other is about surveillance taking priority over support. Helping women to stop smoking can only happen by trusting and supporting those women, and we are finding more and more women who are concerned about the surveillance aspect of antenatal care. This is leading women to conceal things rather than to turn to midwives for support.

When such tests are offered, women need to know that they can decline or accept, and be assured that if they decline they will not be hassled to change their mind. They also need to know that if they accept, then they need to know in advance how they will be supported after they receive the result of the test. They need this information in order to make an informed decision about whether or not to accept the test.

Having identified smokers it appears that they are to be referred to the stop smoking service or 'other action'. Please could you clarify for us what other actions are included here? We wonder whether this might be a factor in referral to social services, which many women are particularly anxious about, or is it to provide them with continuity of midwifery carer which we note the care bundle does not mention?

Now that many women have stopped smoking we know that it is particularly the poor and stressed part of the population who continue to smoke, the advice has conflated smokers and small babies without addressing the possibility that there may be other causes why a woman is carrying a small baby. These actions risk spoiling the trust between midwife and mother and influence some women to avoid health professionals altogether.

We note that continuity of midwifery carer has reduced the numbers of women who smoke and suggest that this initiative would have a greater effect.

The response from Frimley Part Hospital said:

'I took your comments back to the working group today; they were very grateful that you took the time to review and feedback to us. Your comments are valued and it is clear that you have spent a lot of time considering the information but unfortunately we cannot make any major changes to the poster, as it is a national campaign. All we have done locally is format the poster from the national "Saving babies' lives, a care bundle for reducing stillbirth" document so that the information can be displayed on one page.'

So, what is the point of seeking comment when there is no intention of acting upon it? AIMS has now written to NHS England to ask them to consider our comments.

Do check if this poster is being used in your area and send your comments to chair@aims.org.uk.

Beverley Lawrence Beech

Letter to AIMS

Fathers in the birth space

In 1961, I wanted to have my husband with me for our baby's birth; and was refused. In 1963, in another hospital in Edinburgh, another consultant agreed. In 1965 in York, I was at first refused: only doctors' wives could have their husbands, said the consultant. But I slipped through the barrier, by being a professor of biology's wife. All went well; and after that, all women in that maternity unit could have their baby's father with them.

This little history raises questions. Why did I want my husband so much? How much did I feel spontaneously and how much was I influenced by AIMS, magazine articles, etc.? Why was I determined and confident? That is easily answered: reading the AIMS Journal and feeling approved of and socially supported by its members, though I knew none personally.

Why did social status – being married to the right man – matter so much? Why did one successful case of a non-doctor father have such a far-reaching effect? Whatever the answers, the conclusion is clear: know what you want; feel socially justified; ask for it; and sometimes you will receive it.

Charlotte Williamson

Charlotte is a long-standing AIMS member

Women's voices 2016

Inspiring Future Maternity Services

King's College Hospital, 1 October 2016

There were many wonderful and inspiring speakers including obstetricians, midwives and doulas, writers, bloggers and most importantly many passionate women and mothers telling their birth stories.

This was a day for people from a variety of backgrounds to share birth stories and experiences. Stories from medical professionals and service users interspersed with thought provoking poetry from doula and hypnobirthing teacher Katie Edwards.

The wonderful **Sheena Byrom**, OBE kicked off the day looking at the Birthplace study statistics of low-risk women, all of whom would have met the criteria for MLUs or home birth. Some interesting statistics were that although 87% of women gave birth in obstetric units [only 25% chose to give birth there] 9% gave birth in alongside Midwifery Units, 2% in freestanding Midwifery Units and although only 2% give birth at home, 10% of women said they would prefer a home birth. Sheena spoke about what goes on behind the scenes in maternity units and the need for change and referred to her thought provoking book '*The Roar Behind the Silence*' which is a great resource for health professionals.

although only 2% give birth at home, 10% of women said they would prefer a home birth

Florence Wilcock, a consultant obstetrician at Kingston Hospital NHS Trust [the only obstetrician at the conference] and co-founder of #MatExp gave a talk highlighting the difficulties of an obstetrician's job and her work with matexp.org.uk – identifying and sharing best practice between maternity services.

Rebecca Schiller, chief executive of Birthrights, freelance writer, mother and doula spoke about her work with the Human Rights charity www.birthrights.org.uk/ and her recent book for Pinter and Martin, '*Why Human Rights in Childbirth Matter*', and read extracts from books such as '*Well Behaved Women Seldom Make History*' by Laurel Thatcher Ulrich which gave us all food for thought.

Milli Hill a mother of three, writer and founder of the ever growing grass roots organisation, The Positive Birth Movement, expressed her passion about women's need to talk to each other and the positive outcome from sharing their experiences and information. Her book about the Positive Birth Movement will be published next spring.

Beverley Lawrence Beech, honorary chair of AIMS, writer, researcher and campaigner spoke about *The History of Encouraging Change in Maternity Care* and the work of AIMS. **@JennytheM**, a clinical midwife and social media expert, who has very successfully promoted immediate #skintoskin, and Beverley Beech both called for us all to have the courage to push for change, to speak out and stand up for women's rights.

Laura James, chair of Bromley Maternity Voices, award winning NCT antenatal teacher and mother spoke about her passion for MSLCs and explained why they are so valuable in improving maternity experiences nationwide. Laura is part of NCT Voices, a team who organise development days for MSLCs and work towards improving maternity services and encourage mothers to feedback their experiences.

Several mothers who are also writers, bloggers doulas and campaigners told their birth stories and their varied experiences of maternity care. **Susanne Remic** – ghostwritermummy.co.uk, **Claire Kay** – who runs Facebook groups Birth Story Listeners and Birth Trauma Christian Encouragement Group, **Louise Oliver** – doula and NCT Breastfeeding Counsellor and **Jody Deacon** – a Radiographer and baby carrying consultant.

Their stories included traumatic birth experiences, being unsupported in their birthing choices and postnatal mental health problems. They are all strong, courageous women who have managed to use their experiences to form face to face support groups, on-line support and discussion groups to help other women who are experiencing similar problems. They have helped support hundreds of women and will continue to support many mothers and families and also work towards making important changes in our maternity care system. Their voices were heard, we all listened, cried and cheered them along, the overall message was one of hope, if enough people act, speak out, write about and campaign then maternity care will change.

'I urge you to play your part in creating the maternity services you want for your family and your community. Voice your opinions ... and challenge those providing the services to meet your expectations.' Julia Cumberlege, Chair of the National Maternity Review Team, Better Births report 2016

Sue Boughton

Continuity of Carer

Rhetoric into Reality, Policy into Practice

King's College Hospital, 13 April 2016

In April this year AIMS, together with Neighbourhood Midwives, Sandwell and West Birmingham Hospitals NHS Trust and the Royal College of Midwives, organised a successful conference to explore how to encourage Continuity of Carer and the implementation of the Better Births proposals. A key issue is informing and persuading commissioners to commission such services.

The event included a range of workshops on the issues that would ensure the efficacy of continuity of care; one of these was an inquiry into the role of commissioning. Participants were encouraged to imagine good commissioning that would enable them to deliver continuity, then asked them to imagine what they would do if they were a commissioner and offered them the opportunity to share one piece of advice with a commissioner.

This is a short summary of the report of the feedback prepared by the partners in the event and Georgina Craig from the Experience Led Care (ELC) programme: Experience Led Care, a social enterprise organisation which came into existence to investigate how health and care systems could design services that would improve peoples' lives by finding out what matters to the users and providers of the services

The feedback itself came from over 50 frontline teams and senior midwifery leaders. They suggested that good commissioning would be relational, that is from commissioners who are engaged, committed and approachable; who seek to work in partnership to improve care with mutual respect and high trust with a positive mindset; who invest in well designed engagement and involvement processes to involve midwives, GPs, MSLCs with lots of user involvement; closing feedback loops and working with a 'wellness model', valuing different outcomes and nurturing innovation.

In answer to the question of how to nudge relationship-centered care that creates continuity, participants felt that continuity of commissioner was important too. Too much moving on meant that commissioners neither knew, nor understood enough about the maternity services. Commissioners could shadow midwives as part of their work, be open to change and listen more. They should be evidence based (they could read the National Maternity Review); be transparent with the budget; make the money follow the woman; give additional tariff to providers who can provide 85% of midwifery care from the same midwife; measure health gain far more broadly with longer term measures of satisfaction, breast feeding and family health and monitor staff recruitment and retention, sickness rates.

Perhaps the most important message participants sent was that commissioning must be a partnership, one that also involves strategic clinical networks.

The Albany Practice has repeatedly been held up as a prime example of the impact of continuity of care. Photograph courtesy of Becky Reed©

Participants stressed that they want the same things as commissioners, that is a high quality safe service, meeting the needs of the community they serve, *'... predicated on commissioners understanding the lives of those providing care and the families they serve'*. They felt that two-way dialogue is key to great commissioning. They wanted commissioners to allow long-term outcomes for women and families to influence decisions on funding and saving on costs and to really consider what outcome measures are set by asking whether or not they will make a difference.

AIMS would like to see the ELC report taken very seriously and used to inform commissioning in England.

Georgina Craig

Note

In response to public demand a further 'Continuity of Carer' conference is now being arranged in Leeds on 8 April 2017, see the back cover for further details.

Perineums and positions

Perineal injuries and birth positions among 2992 women with a low risk pregnancy who opted for a homebirth.

Edqvist et al

BMC Pregnancy and Childbirth (2016) 16:196

Reviewed by Gemma McKenzie

The study

The researchers aimed to explore the prevalence of perineal injuries at home births. Between 2008 and 2013, 2992 women in Norway, Sweden, Denmark and Iceland, women who had low risk pregnancies, spontaneous labours, and either had a planned home birth or planned a home birth and transferred into hospital were studied. The attending midwife answered a questionnaire one week after the birth. Women who ended up with a caesarean section or instrumental delivery in hospital were not included in the study. The questionnaire captured:

- Demographic data.
- Birth position.
  This was divided into two categories:
  Flexible sacrum positions
  These positions expand the pelvic outlet and take weight off the sacrum (the large triangular bone at the base of the spine) – kneeling, standing, all-fours, squatting, using the birth seat, lateral (lying on one side).
  Non-flexible sacrum positions
  Semi-recumbent (reclining), lithotomy/supine (lying on one's back).
- Perineal injuries.
  These were reported as:
  Non-sutured injuries (no tear at all, small abrasions or minor injuries)
  Sutured injuries (stitches)
  Episiotomy
  Severe perineal trauma (SPT was defined as involving the anal sphincter complex).

Results

Four major points emerged from the study.

There was a low prevalence of SPT and episiotomy, which did not differ between the countries. This adds to the growing body of evidence that suggests home birth for women with low risk pregnancies is associated with positive maternal outcomes and low levels of intervention.

Episiotomy was associated with giving birth in a non-flexible sacrum position. Interestingly, however, 30% (nine women) of the women who underwent an episiotomy did so in positions other than semi-recumbent or supine. These positions included lateral, squatting, and all fours, with five of the episiotomies taking place under water (presumably in the birthing pool).

No association was found between flexible sacrum positions and SPT or sutured injuries.

The most frequently used birth position was kneeling (24.6%). However, for primiparous women (those that have not given birth before), the most frequent position used was semi-recumbent (29.06%), followed by kneeling (19.1%).

may incorporate factors that could have an effect on perineal trauma

AIMS Comments

One limitation to the study was that midwives were only asked to document women's positions at the moment the baby was born, presumably when the baby leaves the mother's body. Perhaps of relevance to perineal injuries would be (where possible) to have also documented the positions a woman adopted while pushing her baby down the birth canal (including the duration of the pushing stage), during crowning, when the shoulders emerged and then finally the position during 'birth'. Taking this wider view of birth may incorporate factors that could have an effect on perineal trauma, whilst also avoiding the presumption that women birth statically.

The researchers also admit to limitations within the study. Importantly, it is impossible to know how the attending midwife influenced the woman's birthing position. Further, there is a lack of information as to whether skilled midwives were adopting practices that prevented perineal injuries during birth. There is also a lack of information as to whether midwives' experience and training enabled them to accurately assess and classify the perineal injuries, especially as midwives from four different countries were entering the data.

Regardless of the limitations however, this study reinforces the message that where a woman births can affect the likelihood of interventions and the extent of any perineal injuries she sustains more than the position she adopts to do birth her baby.

Induction and age

Randomized trial of labor induction in women 35 years of age or older

Walker KF, Bugg GJ, McPherson M, McCormick C, Grace N, Wildsmith BA, Bradshaw L, Smith GCS, Thornton J.

New England Journal of Medicine, March 3 2016, Vol 374, No.9
www.nejm.org/doi/pdf/10.1056/NEJMoa1509117

Reviewed by Gemma McKenzie

Context and aims of the study

The rate of caesarean section is 38% among nulliparous women (first time mums) in the UK who are 35 years of age or older and 50% among those who are 40 years of age or older.[1] Further, there are higher rates of obstetrical intervention among older women than among younger ones.[1] The study was designed to see whether induction of labour at 39 weeks' gestation for first time mothers aged 35 years or over, would reduce the rate of caesarean section deliveries.

Methodology

The study was a randomised controlled trial, which took place within 38 NHS hospitals and one Primary Care Trust.

Women eligible to take part in the study were those who:

- Were nulliparous (first time mums)
- Would be 35 or over on their expected due date
- Had a singleton, live fetus in the cephalic (head down) position.

Even if a woman satisfied these criteria, she was excluded if:

- Her baby had a known congenital abnormality that would lead to neonatal death
- There were any indications that she may have problems in labour, such as evidence of fetal compromise
- There were any indications that she may have problems with a vaginal delivery, such as placenta previa
- She was to have expectant management, for example due to gestational diabetes
- She had had a previous myomectomy (removal of fibroids from the womb)
- She did not have an ultrasound examination before 22 weeks' gestation
- She had undergone IVF with a donor egg.

The number of women who took part in the study was 619. Participants were randomly assigned either to undertake an induction of labour between 39 weeks 0 days and 39 weeks 6 days, or to undergo expectant management. Expectant management would mean that the mother would wait for spontaneous labour, unless a situation arose that would require either an induction or caesarean section. If a mother in the expectant management group went beyond 41 weeks and 0 days (at least seven days past her due date), she could undergo an induction if she wished. The researchers then captured data regarding the medical outcomes of the births and compared this data between the two groups.

The participants also filled out a Childbirth Experience Questionnaire (CEQ), which was sent to them one month after the birth. The questionnaire has 22 questions and a copy can be found at ctsu4.nottingham.ac.uk/ts0918/docs/Childbirth_Experience_Questionnaire_CEQ.pdf. The contents comprise questions such as:

- I felt strong during birth
- I was tired during labour and birth
- I felt happy during labour and birth
- Some of my memories from childbirth make me feel depressed
- I felt that I handled the situation well.

Women then responded with ticking either agree, mostly agree, mostly disagree or totally disagree.

The purpose of this questionnaire was to see whether induction of labour at 39 weeks or expectant management had an impact on women's birthing experience, and to then compare the results between the two groups.

Results

The study did not conclude that inducing first time mums aged over 35 at 39 weeks' gestation would prevent stillbirths.

The researchers were clear in their conclusion that:

'Our trial did not address whether induction of labour at 39 weeks of gestation can prevent stillbirths.' They conceded that to explore this issue would require *'an extremely large'* study.

There was no significant difference between the induction group and the expectant management group with respect to the frequency of caesarean sections.

The rate of assisted vaginal deliveries (such as use of forceps or ventouse) was higher in the induction group than in the expectant-management group, but that rate was not statistically significant.

Inducing first time mums aged over 35 at 39 weeks' gestation had no reported short-term effects on mother or baby in comparison with women who had expectant management.

The researchers were clear in stating that they analysed short-term effects only, that is that they did not look at any physical, mental, emotional or psychological long-term effects to either mother or baby.

The researchers conceded that there were a number of observational studies that have suggested a possible association between early births at 37-39 weeks' gestation and subtle long-term effects on children's development and educational attainment, when compared with births between 40-41 weeks' gestation.

The short-term physical effects centred on the period during birth and immediately after, such as whether a mother haemorrhaged or the baby required oxygen.

In comparison to the women who were induced at 39 weeks and the women who had expectant management, there were no significant reported differences with the satisfaction they felt regarding their birth experiences.

AIMS comments

As highlighted above, the study does not prove that inducing women who are aged over 35 can prevent stillbirth. This was not the aim of the project and as highlighted by the researchers, to explore this issue would require an extremely large study. Further, any conclusions that the researchers can draw are not generalisable to all women aged over 35, as the study only focused on first time mums who had 'low-risk' pregnancies and who gave birth in a hospital.

Although there was no significant difference between the induction group and the expectant management group with regards to the number of caesarean sections and assisted deliveries, the figures in both groups suggest highly medicalised births. The following bullet points outline and explore the relevant figures:

- 304 women were induced between 39 weeks 0 days and 39 weeks 6 days (the induction group).
- Out of those 304 women 98 (32%) ended up with caesarean sections.
- Four of the 98 women who had caesarean sections had also had an attempted assisted vaginal delivery with the use of instruments.
- 115 (38%) of the 304 women had assisted vaginal deliveries.

This means that 213 (70%) of the women who were in the induction group ended up with either assisted deliveries or with a caesarean section.

- 314 women had expectant management.
- 103 (33%) of those ended up with caesarean sections.
- Seven of the 103 women who had caesarean sections had also had an attempted assisted delivery with the use of instruments.
- 104 (33%) of the expectant management group ended up with assisted vaginal deliveries.

This means that 207 (66%) of the expectant management group ended up with either assisted deliveries or with a caesarean section.

It is also crucial to remember that within the expectant management group, 154 (49%) of the women still had their labours started with a medical induction. In total, from the figures it appears that out of 314 women in the expectant management group, 178 (57%) of the women had their labours induced or acellerated.

Due to the frequent use of induction in the control group (the expectant management participants), the study is therefore very narrow. Consequently, it is not a comparison of the outcome of inducing a woman at 39 weeks, with the outcome of leaving her to continue her pregnancy until she goes into spontaneous labour, as over half of the expectant management group were induced anyway. Further, given that induction featured heavily in both groups, it is perhaps unsurprising that there were very few medical differences in the outcomes between the induction and the expectant management groups.

What becomes clear in this study, is that the reason these births were so highly medicalised needs further exploration. Were there such high levels of assisted deliveries and caesarean sections because first time mums aged over 35 labour and birth 'badly'? There is research suggesting that women over 35 are at higher risk of various obstetric problems in comparison with women under 35, but that is not the same as saying that women over 35 have a high risk of experiencing those problems. Nor is it the same as saying there are high rates of these problems with women over 35. This is highlighted in the following point made by the researchers:

'The risks of perinatal death, hypertensive disease, gestational diabetes mellitus, placenta previa, and placental abruption are higher among women 35 years of age or older than among younger women.'[2]

Bearing this point in mind, and taking a wider view of the study, it is unclear whether the factor triggering such high rates of assisted deliveries and caesarean sections is the age of the woman, the frequent use of induction, or the perception that older women labour and birth 'badly', and the consequences of that, such as more restrictive birthing environments and limited birth choices. As a result, the study is only useful in the sense that it concludes that there are no differences in short term outcomes between first time mums aged over 35 who are induced at 39 weeks, and first time mums over 35 who follow the usual obstetric pathway. In both scenarios, the outcome is very high rates of assisted deliveries and caesarean sections. But the crucial, underlying reasons as to why that is so, do not form part of the study and are therefore not explored. Further, the role of induction of labour in these high rates of assisted deliveries and caesarean sections – regardless of when it happens – is also not considered, but is something that needs to be researched.

There are also relevant issues regarding the researchers' conclusions about women's satisfaction levels and their birthing experiences. First, it is certainly arguable that a questionnaire may not be the ideal way to capture the complexity and depth of information required to fully understand how a woman feels about her baby's birth. Information captured numerically is very limiting when trying to learn about another person's experiences.

Second, undertaking the questionnaire only a month after birth may be somewhat premature. In AIMS' experience, it is not uncommon for women to develop symptoms of birth trauma months or years later, and in particular, during subsequent pregnancies. Third, not all of the women who took part in the study completed the questionnaire. Seventeen per cent did not return it. Finally, even without all of these limitations, the CEQ does not give any information about women's satisfaction with their births over the long-term, which would be particularly relevant if they gained a different insight or perspective after having more than one birth.

Conclusion

Regardless of what the media or the maternity services may suggest, this study is very narrow in its conclusions and does not apply to all pregnant women aged over 35. Further, it does not provide any insight into the prevention of stillbirth. What the study can conclude however, is that for a low risk first time mother aged over 35, who births in hospital after an induction at 39 weeks, there are no differences in short term medical outcomes for her or her baby, in comparison to the same type of woman who is not induced at that point in time.

it does not provide any insight into the prevention of stillbirth

There are several other conclusions that can also be drawn. The first is that first time mums aged over 35, birthing in the hospital environment, even when labelled 'low risk' are likely to experience high rates of instrumental and surgical deliveries. The crucial question as to why this is so, however, remains unanswered. Looking at the control group (the expectant management participants), we can also conclude that first-time low risk mums aged over 35, birthing in the hospital environment, also experience high rates of induction. Again, the reason that this is so, needs to be explored more fully. Third, given the high rates of induction and the frequent instrumental and surgical deliveries, it is crucial to discover whether one is causing the other, or whether the determining factor in all of these assisted deliveries and caesarean sections is age.

Finally, a questionnaire is a very limited tool to gather information on women's birthing experiences. What is particularly concerning is its focus on the short term, and the lack of insight into how a woman may feel much later on, once she has digested her experience and is no longer consumed by the needs of a newborn. What would be particularly useful is follow up research on the long-term physical, mental, emotional and psychological effects between the two groups in the study, and additionally whether there were any differences between the women who were induced – regardless of when – and those who were not. Such research would provide greater clarity and context to the present study.

AIMS experience of the 35/39 study

Since the publication of this study, we have had many women contact us via our helpline to ask for advice regarding induction of labour for women aged over 35 and its use to prevent stillbirth. Although the study itself is usually not cited, it appears that there may be some pressure on women aged over 35 to be induced based on a misinterpretation of the 35/39 study. There is some indication that this pressure is coming from midwives and other health care professionals.

The confusion surrounding the study may come from the website[3] the researchers used to explain, promote and recruit for their project. It states:

'Starting labour a week early might prevent a small number of stillbirths, but it might also lead to longer labours and possibly more Caesarean births. To find out, we need to compare these two different ways of managing women.'

This very confusing paragraph suggests that the researchers are in some way looking at preventing stillbirth with their study. The reality is that the study was far too small to be able to explore this subject. As Sara Wickham points out in her blog post,[4] this may be because the researchers could not recruit enough women who were willing to undergo induction of labour at 39 weeks. Even the researchers concede that 86% of the women eligible to participate in the study, declined to get involved.

Consequently, regardless of what the researchers hoped to achieve, the necessary number of women required to explore whether inducing first time mums aged over 35 at 39 weeks decreased the stillbirth rate, did not materialise. It is therefore wrong for anyone to suggest that this study is evidence that women aged over 35 should be induced in order to limit their risk of having a stillborn baby. That was not the outcome of the study, and the researchers were not in a position to explore that issue.

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Caesareans and obesity

Association between cesarean birth and risk of obesity in offspring in childhood, adolescence, and early adulthood

Changzheng Yuan, ScD et al

JAMA Pediatr. Published online September 06, 2016. doi:10.1001/jamapediatrics.2016.2385

Reviewed by Virginia Hatton

In 2013 the film Microbirth drew attention to the growing research on caesarean birth and obesity. Now a study published in July 2016 in the Journal of the American Medical Association Pediatrics provides more evidence to support this association. Researchers used data from the Growing Up Today Study, a prospective cohort study conducted from 1996-2012. The study included 22068 children born to 15271 women. Information was collected from the women via questionnaire when children were aged 9–14 through ages 20–28. The study used a larger sample size than similar previous studies in Germany and Canada which failed to demonstrate a statistical significance in the increased risk of obesity after caesarean birth.

This study was designed to account for potential confounders which had not been included in previous studies on this subject, particularly maternal pregnancy BMI, but also pre-pregnancy smoking and duration of breastfeeding. The study did not investigate lifestyle and behaviour factors for obesity because none precede both exposure (in this case birth by caesarean) and outcome (risk of obesity). Importantly, the study data lacked details of the specific reasons for caesareans, whether women laboured at all, what other interventions were used during labour and birth, such as artificial rupture of membranes, and antibiotic use during pregnancy or labour and delivery. It is also difficult to apply the findings of the study to the general population as the mothers were all nurses participating in a long-term health study (Nurses' Health Study II) and the authors noted that minorities were underrepresented.

The study found that individuals born by caesarean were 15% more likely to become obese during follow-up than those born vaginally. This association was stronger (30% increased risk) among individuals without known risk factors for caesarean section (risk factors included maternal pre-pregnancy raised BMI, gestational diabetes, hypertensive disorders, smoking, advanced maternal age, gestational age at birth, and birth weight). Vaginal birth after caesarean birth was associated with a 31% lower risk of individuals being obese compared with those born via repeat caesarean delivery. The within-family analysis showed that those born via caesarean had 64% higher odds of obesity compared with their siblings born vaginally.

This study was limited to examining the association between caesarean birth and obesity, however it did point to the growing evidence that higher risk of obesity associated with caesarean birth may be a consequence of differences in gastro-intestinal microbiota established at birth. Whether differences in microbiota in individuals are sustained long-term remains to be evaluated.

Additional research is still necessary to address whether increased rates of obesity translate to increased risk of adverse cardio-metabolic outcomes such as diabetes, heart disease or stroke among individuals born by caesarean.

We need a health system that meets 'the needs of the person/patient'

BMJ 2015; 351 doi: dx.doi.org/10.1136/bmj.h4448 (Published 17 August 2015)

'"Over one billion people worldwide do not get the care they need." Health care traditionally focused on meeting the needs of the person/patient. The advances resulting from medical technologies has shifted the focus of consultations towards specific diseases and their specific interventions. As a consequence the personal experience of illness is ignored, resulting in the medicalization of day to day experiences and the inevitable rise in overdiagnoses and harmful interventions.

'Medicine needs a value shift – refocusing on what really matters – the person/patient. Most people are healthy most of the time, as White et al have shown in the 60s, community health follows a Pareto distribution, i.e. 80% of the community is healthy or at least healthy enough not to need medical care, 16% require primary, 3.2% secondary and 0.8% tertiary care. The need to refocus on the person/patient is especially important with rise of chronic illness in an aging population. Person/patient-centered consultations are complex, having to navigate at times competing needs without there being any one correct strategy, however, we need to acknowledge that the consultation is production unit of healthcare – the place where decisions are made about the use of limited healthcare resources.'

Doing things differently

Rachel Ellman highlights the importance of being heard and supported

This is the story of the birth of my second child at home, and of why that choice was so important to us. It is also the story of how difficult it was to get the support and information that we needed to plan the safest, calmest birth that we could.

My first son was born on the operating table, where I'd been brought after several hours of second stage for a forceps delivery or caesarean section, then left by the surgical team as they were bleeped to yet another emergency. We'd been alone through nearly all 18 hours of violent, chemically-induced labour (all on my back, in unbearable pain, so that the CTG machine would maintain contact – though the team were too busy to monitor or react to it). That moment in theatre was the first time that we had the undivided attention of a midwife: suddenly, my body could work again.

The whole experience left me physically and emotionally debilitated. The hospital Trust told me afterwards that, had I or our son been harmed, they could not have stood by the care we received: it was not safe.

In retrospect, my partner and I realised we'd been too passive in the decisions made about that first birth. When I'd developed obstetric cholestasis (OC) late in my first pregnancy, we meekly followed the hospital's forthright advice and had an induction at 37 weeks. The risks of this procedure, and an understaffed labour ward, were not explained to us, while the (unknown, little-researched) risks to the baby of going to full term with OC were emphasised.

So, safety was my key motive in planning the birth of my second child: I want to highlight this, because it makes me angry and sad to so often hear home birth described as the risky option. Hippy. Daring. The subtext is that home birth is a choice made by overconfident people, who value their own beliefs or comfort more highly than their child's safety

I had a list of things we felt were important to a good, safe birth, that I did not have the first time, and it became clear that I was most likely to get them at home: a midwife with me; a labour that began and progressed without chemically-induced violence, and put as little stress as possible on the baby; access to a fast medical response if needed, and to maximise my chance of doing the physical work of labour effectively and without unnecessary suffering by being able (allowed! encouraged, even!) to stand, move around, eat, drink, urinate, stay conscious...

We gathered information, and gained confidence in our plan, through support from our local Positive Birth Group and from AIMS and from our very good GP. At midwife appointments, however, I had to face negative or fearful attitudes towards home birth, and a lack of support finding and interpreting information.

I didn't develop obstetric cholestasis until week 35 of my second pregnancy, so I was entirely healthy when at my first midwife appointment I mentioned that I was considering home birth this time, if it was safe for me and my baby.

The midwife wrote and typed into my notes *'wants home birth against advice'* and refused to remove it the next time I saw her (the only midwife I saw twice in the whole experience). She told me she had *'seen babies die'* when women and GPs *'pushed it'* by avoiding induction with OC. I said how terribly sad it was that these stillbirths had happened, and asked her what evidence she had seen that OC was the cause, and please could I read it, but she had none.

Even GBS was raised as an obstacle to me having a home birth, although I'd tested negative for it in my previous pregnancy.

I tried to book in with a neighbouring borough's dedicated home birth team, but they told me I lived too far away – although I could have given birth in their local hospital.

It was arranged for a senior midwife to sit down with me and make an action plan

Eventually, on the advice of the AIMS helpline, I contacted the head of midwifery at my NHS Trust. Things changed then. It was arranged for a senior midwife to sit down with me and make an action plan – for home birth if I was healthy, for blood tests for OC and to meet a consultant to help inform my choice, if I developed it.

Finally, at 35 weeks, convinced this baby would come early, I booked in for a home birth. I promised the midwives I'd get something written in my notes from a consultant to say we'd understood the risks, if I did have OC – I didn't want them to feel exposed or stressed when attending the birth, as they clearly would otherwise.

Meanwhile, I'd prepared for the birth: for me, planning on having a baby at home meant I felt fully responsible for how this would go. I had planned, exercised,

researched, hired a birth pool and essentially trained myself in a way I hadn't the first time round. I felt ready, and calm.

I started to get the OC symptoms that same week, and my liver function tests deteriorated. My partner and I had many re-readings of the OC Greentop Guideline and concluded that still, the safest birth place for us seemed to be at home. We even calculated that we would get faster emergency care if we were transferred in an ambulance (which of course we would agree to) than if we were stuck on a busy labour ward.

At 37 weeks we saw the consultant, who was excellent. We asked him to outline fully the risks for us of both hospital and home, which he did – and he had no concerns about our choice to be at home. He wrote those magic words in our notes. Then he offered me a sweep – which I accepted, as I felt it was better to have the baby as early as I could before the OC worsened. He found that I was already 2cm dilated.

I walked all the way home from the appointment, pushing my 2-year-old in his buggy. As I hoped, this got the contractions started. Just as I'd visualised, I went properly into labour when my partner came home from work. We called the community midwives at 9pm and our first midwife arrived at 10pm.

The room was quiet, and candlelit. Our 2-year-old was asleep upstairs. I stood throughout labour, leaning on my partner, using hypnobirthing and breathing relaxation as contractions became more intense.

All the way through, I felt in control: I was actively doing something – not being 'done to'. In between supporting me through contractions, my partner filled the birth pool. The midwives were a quiet and reassuring presence, but rarely touched me.

There was some pain, as I neared full dilation: but no fear. The baby's heart rate on the Doppler was rather high at first, but in contrast with the fraught response to the CCG in hospital, the midwife suggested I drink lots of water – and his heart rate normalised.

When the second midwife arrived at midnight she did the first examination I'd had, and found me to be fully dilated. I got into the warm pool and my waters broke immediately with a couple of strong surges. Then the next powerful surge – just one – was my baby. He came out in one rush and the midwife said, pick up your baby! I picked him up, held him to me in the warm water and he began to feed, while I relaxed and waited for the cord to stop pulsating. Second stage had been only three surges, and the whole labour only a handful of hours.

Later, I got out of the water and the midwives supported me to deliver the placenta naturally, while our newborn enjoyed skin-to-skin with his dad for the first time.

The next morning, I got up, had a shower and then carried my two-year-old in to joyfully meet his new baby brother.

I cannot over-emphasise how empowering and

significant this calm, lovely birth has been to me and my family. Not only did it result in a healthy, calm, happy baby and mum: it feels like a redemption of the traumatic experience we had the first time.

I had not realised how important it would be to me to really take responsibility for the birth myself, to do rather than be done to, and to avoid repeating the terrible fear (for my baby, for myself) that went with a loss of control to painful and dangerous medicalised processes that were poorly explained and scantily supported by medical evidence.

Thanks to this birth we have had the best possible start as a family of four. But we had to fight for it. I feel that my experience shows how both mothers and midwives are poorly empowered with the information/training and trust required to do the work they really must be allowed to do themselves, to plan a birth. I only wish that the support and information were available to every woman, to make whatever birth choice is safest and kindest for her and her baby. I salute the work of AIMS, of the Positive Birth movement, and of all professionals within the NHS who are working towards making this a reality.

Rachel Ellman

Following her birth Rachel was invited to share her

experiences and thoughts with hospital management. in order to better help them support women in the future.

The minutes of that meeting are shared below.

Barts Health NHS Trust – Trust Board Meeting Minutes 6 July 2016

The Chief Nurse and Ms Reading, Director of Midwifery, introduced Rachel Warrington who was attending to relate her experiences of maternity services at Barts Health NHS Trust. Ms Warrington had previously shared with the Trust Board her experiences of the difficult circumstances and troubling experiences surrounding the birth of her first child and she had returned to provide details of her experience of the birth of her second child.

Ms Warrington outlined the details of her first birth, which had been complicated by her development of obstetric cholestasis, a condition which affected the liver and resulted in increased bile production. The implications of this condition for pregnancy were not well established but older research material suggested an increased risk of still births. Her extremely difficult labour had resulted in surgical intervention and her overall experience of the birth of her first child had been one of trauma and feeling disempowered. Ms Warrington had been determined to avoid a similar situation with her second pregnancy and, appreciating her increased risk of developing obstetric cholestasis again, had read widely and actively discussed the options with clinicians. This had included the option to have a home birth, which she had reviewed with her obstetrician, Mr Matthew Hogg, to ensure that this was considered clinically safe and supported.

Ms Warrington provided details of her home birth and contrasted the positive and very personal experience of this when compared with her previous labour, which had been dominated by anxiety. She highlighted potential areas for further improvement, particularly regarding the communication between community midwifery services and hospital clinicians. She indicated that an early consultation with a community midwife had been negative about the home birth option, due to her condition, and that she had documented in the notes that her decision had been 'against advice'. Ms Warrington emphasised that she would not have pursued the home birth option without clear clinical support. A recurring concern during the pregnancy had been that this midwife would have been subsequently called to attend her birth. She explained that, due to the relatively rare nature of her condition, she had needed to involve senior clinicians regarding whether or not intravenous antibiotics would be necessary (which would have required hospital attendance) and recognised that she had had to pursue this with senior staff (including Ms Reading and Mr Hogg) to ensure that their support was confirmed and documented to ensure that this directed other clinical staff accordingly. Finally she noted the increasing appetite among expectant mothers to consider a home birth and suggested that improvements could be made regarding the organisation of community midwifery services practically and clinically to support this. In particular, she noted the need for better information to support expectant mothers considering this option.

The Director of Midwifery felt that these comments had been extremely valuable and would help to inform the planned Maternity Review, which the Trust had embarked on, and particularly regarding how midwifery services could be more effectively tailored.

Midwifery care?

AIMS recently received the following letter...

I had my midwife appointment today and I feel so frustrated with the way she treated me.

We had to go over my birth plan and so I showed her the plan I did and she reacted as if I had done some sort of quick research online and have no idea what I am talking about.

She made a sarcastic comment when checking the baby's heart rate, *'Hey baby sounds like your mum has definitely figured out what she'd like to do with you!'* And she told me things like:

- not opting for induction after 41 weeks is just silly as the placenta is old and I am putting the baby at risk so she said, *'we'll definitely want to induce you at that stage. You can refuse but we will make it very difficult for you with asking you to be here daily for EFM checks.'*
- *'If labour isn't progressing quick enough, we will break your waters as that's an easy way to get things going again.'*
- *'We need to do vaginal exams of course, how else can we measure your progress?'*
- *'You can only opt for physiological third stage if you are not bleeding, otherwise we might have to just give you the hormone and apologise for it afterwards...'*
- *'If you have an emergency C-section, [your husband] won't be allowed in the theatre as the hospital staff don't like it when a man comes in as they often pass out!'*
- *'Vacuum extraction is only possible if baby is far down enough in the canal otherwise forceps will be safest and so that's what we'd use.'*
- *'Never heard of vaginal seeding and that's not a procedure here so a simple skin to skin if all is well after c-section will be allowed.'*

What AIMS means to me

Sarah-Jane Currie and *Elizabeth Bradley* share what AIMS means to them

I am not sure where I first heard of AIMS, I remember it being mentioned in a publication I was reading and I had heard of it before and it inspired me to actually take a proper look at what they did.

As I continued on my journey and more and more I was going against the 'norm' – we decided to birth without medical assistance – making informed choices and taking responsibility for my birth, we were shocked by the misinformation being given to us by our midwife. I had a concerning letter from the Trust full of misinformation and scaremongering, I needed help going up against this and someone again mentioned AIMS. We contacted AIMS' helpline by email, and Beverley Beech quickly replied with not only the recommendation of an immediate response to the Trust, but also the bigger picture – the next steps including contacting the board and the CEO of the Trust. This not only helped me to counter the letter I had received but also lay the foundation of change within that Trust.

I was 30+ weeks pregnant at the time, and such a task was simply too big for us to undertake alone. We are forever grateful as I honestly believe that this led us to be more confident in our choices and decisions without overwhelming us at a time when we wanted to enjoy our pregnancy. It was a joint effort, Beverley and AIMS helped and suggested plans, letters and other appropriate actions. But the decision was always ours, with AIMS working with us. Around this time I also purchased books from AIMS and I use these a lot with clients as well as having used them on my personal journey.

Elizabeth Bradley

Sarah-Jane Currie and family

I would say everyone involved with birth should know about AIMS, professionals and parents alike. All pregnant women should be given information about the services they offer and the publications available. This is what I love so much about the publications that AIMS offers, so much information but always at the forefront is the mother's choice. Informed decision making is vital at such a time as pregnancy and labour, and this is what AIMS champions.

Sarah-Jane Currie
Sarah is a mama of four and a birthworker

I heard about AIMS through my NCT contacts – I'd been an NCT volunteer for a number of years.

AIMS has helped me in my second and third pregnancies as well as in my breastfeeding journey. They gave me the confidence to challenge what I was being told I was 'allowed' in my birth plan.

Then later, AIMS helped to give me the confidence to push for support when I was told that I should formula top up my third baby when I wanted to exclusively breastfeed.

AIMS offers information, resources and support for any new or existing parent.

Elizabeth Bradley
Elizabeth is a mum to three, editor and copywriter running her own business

Reviews

Birth in Focus

By Becky Reed
Pinter and Martin 2016
ISBN 978-1780662350

The beautiful cover photo, the photos inside, the introduction by Ina May Gaskin, the women's stories told from different points of view, and the conclusion by Sue Brailey, provide a strong, coherent message that is powerful, profound and simple – when women and midwives know and trust each other birth nearly always unfolds straightforwardly, and when it doesn't, it can still work well for the woman, her baby and her family. The combination of stories and accompanying photos weave into a holistic, reassuring story about the diversity, normality and magic of birth: *'birth as it should be* {…} *safe, secure, surrounded by love and genuine happiness, caring and support'*.

The stories include women from different cultures and circumstances. They include women of different ages expecting first or subsequent babies, women having twins, breech babies, babies after previous caesarean sections, women with medical conditions, women having home births, water births, hospital births and caesarean sections and women with male, female or no partners. This is not just a book about normal birth, it is a book about keeping birth as normal as possible while supporting each and every woman no matter how her birth unfolds, so that she can start her life as a mother feeling positive, strong and capable.

Through these extraordinary ordinary photo stories, themes about the Albany Midwives' care and its impact emerge which show the importance of:

- inspiring women and families to believe that women are strong and capable birth givers and mothers
- providing good information and trusting women to make good decisions for themselves and their babies
- the long-term impact of relational midwifery care – *'years later, I still feel that wonderful sense of joy and achievement [...] They [midwives] gave me safety and protection.'*
- respecting and accommodating each woman's needs, beliefs and decisions in order to provide truly individualised support for her and her family
- having the skills, knowledge and honesty to discuss when medical help is needed – enabling decisions to be made quickly
- keeping pregnancy and birth as normal as possible whatever the circumstances
- supporting a women during transfers from home/normal birth to hospital/assisted birth so that the woman retains her sense of agency and she and her baby are kept safe emotionally and spiritually as well as physically
- cultural sensitivity, *'it reminded me of being back home and I felt at ease'*.
- humility, alertness, the ability to wait or act, and the experience to entertain the unexpected, *'as midwives we know that all labours are different, and that we will never (however much we pretend it) be able to predict what will happen'*.

The photos are not the usual soft focus, or as Hermione Wiltshire puts it in the book, *'sanitised photographic platitudes'*, of birth prevalent in our culture, but *'real, raw labour and birth'* photos which are integral to the book. They bring the stories to life and inspire visceral confidence in birth.

Ina May Gaskin suggests in the introduction that the positive outcomes achieved by the Albany Midwifery Practice in South East London could be achieved almost anywhere, if the birthing woman is the focus of maternity care policy-making and practice. Evidence agrees with this. The stories demonstrate that keeping the woman in focus and maintaining excellent outcomes is achieved through midwives:

working with the community to inspire trust and confidence thus changing the predominantly negative culture of birth (*'we often talked about birth being an everyday miracle'*)

being able to make skilled judgements about normality and when help is needed

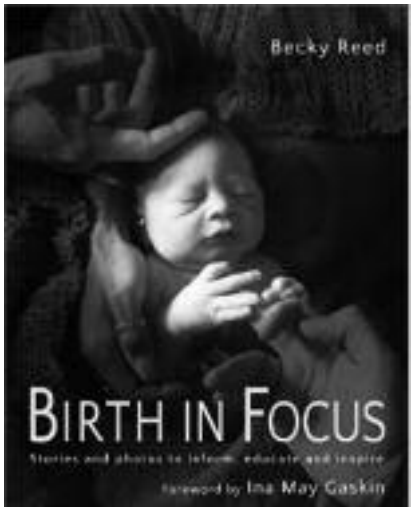
having fast and easy access to medical and other services

advocating for women and providing clear information and advice, especially if women are making decisions outside usual policies and practices.

In the final chapter, Sue Brailey provides a clear, compelling and accessible theoretical framework drawing on a wide range of research, showing why and how the women cared for by the Albany Midwifery Practice had such excellent outcomes, how the Practice sustained itself so successfully, and how women's and midwives' autonomy was enhanced.

I applaud Becky Reed for her skillful weaving together of stories and photos, her deep respect for women and birth and for a book that could and should be read by women, families, midwives, student midwives and birth workers. A gem of a book, not to be missed.

Nadine Edwards



How you can help AIMS

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

If you are not already a member, you could join

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

Visit www.aims.org.uk

Celebrating Continuity

Saturday 8 April 2017

Thackray Medical Museum, Beckett St, Leeds LS9 7LN

Whether you are a woman expecting a baby, a commissioner or a chief executive choosing and providing local services, or a midwife, student midwife or doctor giving care; whoever you are or whatever your role, 'Celebrating Continuity' is the most important maternity care conference of 2017 and is not to be missed.

Chaired by **Sheena Byrom**

speakers and workshop leaders to include:

Baroness Cumberlege Independent Chair of the 2015 National Maternity Review
Georgina Craig National Director, The Experience Led Commissioning Programme
Helen Shallow Research Midwife
Kathryn Gutteridge Research Midwife
Mavis Kirkham Professor of Midwifery
Ruth Weston Birth Activist

Register now: (insert web link to come from Debbie)

While the evidence, policy and demand for more continuity of carer models has never been stronger, in today's fragmented and overburdened maternity service, the reality of having a midwife you know and trust can feel further away than ever. The opportunities to practice in this way are few and far between and, where they do happen, they often start out in a burst of energy and hope and then either fall at the first hurdle or are gradually eroded over time.

Why Attend

This conference will explore what the barriers and challenges are to this way of working and, most importantly, how we can overcome them.

It recognises that there is a shared interest in finding a range of different solutions – some of which may look very different to the way care has been delivered in recent years and

It seeks to answer the question – does providing more continuity for women automatically have to mean additional burnout and increasing stress for midwives or is there a way to make it a win-win for everyone?

Organised by a collaboration of:

Association for Improvements in the Maternity Services (AIMS) • ARM (Association of Radical Midwives) • Neighbourhood Midwives • One to One Midwives • Positive Birth Movement
Sandwell and West Birmingham NHS Trust – home of Serenity and Halcyon Birth Centres • Royal College of Midwives.