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ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES

Place of Birth

why women don't have a real choice

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Cover Picture: © Sarah Holdway. Sarah gave birth in the peaceful surroundings of her own home.

Thanks to Nadine Edwards and Beverley Lawrence Beech for Guest Editing this issue of the AIMS Journal

Invitations have recently gone out to AIMS members inviting them to join the AIMS Members Yahoo Group. If you are not already on the group and have not received an invitation, this probably means that we do not have an up-to-date email address for you. If you would like to update your email address on our database, please email membership@aims.org.uk including your postcode.

Being a member of the group will not only allow you to have contact with other AIMS members and to hear what the current issues are for them, but also will allow the committee to keep you up to date with what we are doing, when and where the next meetings are planned to take place and what you may be able to do to support AIMS.

health.groups.yahoo.com/group/aimsukmembers

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Turning the tide?

Beverley Beech, Nadine Edwards and Debbie Chippington Derrick look at birth place choices

A significant nail in the coffin of home birth was driven home when the Peel Report1 recommended that provision should be made for all women to have a hospital 'delivery'. No evidence was sought to support this view and no women were asked if they wanted to be 'delivered' in hospital. The announcement, however, gave the green light to hospital birth for everyone and what Professor Wendy Savage later called the largest unevaluated medical experiment of all time.

When women began complaining about the care in hospital, the response was to improve the décor, put up pretty curtains and paint the walls, but the quality of care did not necessarily improve in any setting; hospital or community, as attitudes remained largely unchanged.

In 1992 the Winterton Report[2] was published and parents, midwives and others celebrated what they thought was, finally, an acceptance of what women were saying. The Government's response was to suggest that choice was of primary importance, but little changed in practice.

In the meantime, the home birth rates declined further in some areas, and have remained extremely low in most. Where home birth rates are high, then, as now, it is because a dedicated group of midwives are skilled and positive, offer choice, and support women to have them. Midwives who were enthusiastic to provide women centred care developed midwifery teams in the community, but adequate resources to maintain these were (and are) often not forthcoming, leaving midwives overworked, with caseloads that were far too large and, on top of that, were also required to work in the hospital; as a result, teams came and went and exhausted midwives too often gave up midwifery, leaving many midwives believing that continuity of care was untenable.

Women, however, despite being told that home birth was dangerous, persisted in birthing at home, and some (if they were lucky enough to have a free-standing midwifery unit in the vicinity) birthed in Birth Centres. Although new Birth Centres have opened, they, and even long standing ones are continually under threat of closure by cash strapped Trusts and Health Boards. Two of our main articles on why birth centres fail (see the article on page 14) and choosing out of hospital birth (on page 11) explain why these can be difficult to establish and what is needed for them to succeed. Our book reviews and reports also provide clues to the obstacles and enablers for out of hospital birth. An article highlighting the importance of doulas remaining independent provide insight into the different ways in which birth might be demedicalised, and the potential impact on women can be clearly seen in the personal and moving account by Lisa Sykes on page 22.

Independent midwives, one of the last bastions of gold standard midwifery care, are also under threat. An EU ruling that all health professionals must have insurance comes into effect in October 2013 and if the midwives fail to obtain insurance they will no longer be able to practice legally, as discussed on page 18. At the moment, they are often the last resort for women who want to have a vaginal breech birth, or twins born vaginally, or who decide to birth at home when they have been labelled 'high risk'. This growing group of women will have nowhere to turn, and AIMS has been pressing the Government to acknowledge the fact that many of these women will decide that they have no option but to birth at home without anyone in attendance, even though they would have preferred to have a midwife of their choice to support them.

So what of the future? The Birth Place Study, reported and examined on pages 4 and 11, has shown that healthy women and babies are safer birthing at home or in small midwifery units than going to an obstetric unit. The Halcyon Free-standing Birth Centre (described on page 8), along with other Birth Centres and other midwifery initiatives are beacons of light for real midwifery practice and independent midwives are vigorously negotiating a means of contracting their skills to the NHS.

We now have the evidence that for better outcomes for women and their babies, healthy women who are 'low risk' should be birthing at home or in a midwifery led unit (MLU). Trusts which continue to fail to provide access to free-standing birth centres and home birth for these women are not providing the best care, and are wasting NHS monies. All women should have access to free-standing birth centres and home births in order to make informed decisions about their births. Women need to have a real option other than a consultant led unit (CLU) if they are to make informed decisions about what is best for them and their baby.

After the Winterton Report[2] there was a great opportunity to promote real midwifery, but it seems that ball was dropped. The results of the birth place study and reorganisation in provision of care needs to be seen as an opportunity to pick up that ball. We need midwives to come together and to work with women to make sure that we hold onto the ball this time and run with it.

Beverley Beech, Nadine Edwards and Debbie Chippington Derrick

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Birthplace Study Conference

Holly Lyne gives a personal view of the recent Birthplace Study

Contrary to what you've probably heard in the mainstream press, the recent Birthplace Report clearly demonstrates that the safest place to give birth is at home or in a midwife led unit, and not in an obstetric unit. But the media love to twist a scientific fact in order to sell papers.

I was lucky enough to be at the launch event for this study at the Royal Society of Medicine on 25 November 2011, attended by many midwives, obstetricians, paediatricians, antenatal teachers and campaigners like myself. There was a lot of debate about the results of the study and much discussion about how increasing midwifery skills could improve the results still further.

I want to be very clear from the onset that this study only looked at 'low risk' mothers. The study compared PLANNED places of birth for these women. Those who started off at home but transferred to hospital had their results recorded in the 'home birth' category. The study was very large, nearly 65,000 women in England were included, over a two year period.

I don't want this whole article to turn into statistical overload, so I'll try to spare you the in depth analysis of the research and focus on the bits that really matter: mothers and babies, especially women, as the focus is frequently on the outcomes for babies without regard to the safety of women, in the whole birth place debate. Even the study's own summary conclusion refuses to come out and tell it like it is: Mothers are safest at home or in a midwifery unit. But that's what the results say, crystal clear. However, when babies are equally safe wherever they are born, it really comes down to the safety of the mothers to tip the scales. But sadly, the headlines did not do this and only concluded, like many other studies that home and birth centres confer 'benefits' to mothers. Heaven forbid that we say that avoiding hospital is safer.

We're not just talking about a slight increase in risk either, we're talking big numbers. For example, for caesarean sections, only 2.7% of women who planned home births had one, compared to 3.6% in Free-standing Midwifery Units, 4.3% in Alongside Midwifery Units and 11% in Obstetric Units. Some of these caesarean sections will be for genuine medical reasons that only become apparent during labour, but all the women included were healthy, 'low risk' women. Clearly something is happening in hospitals that isn't happening at home or in midwifery units and by avoiding obstetric units, most women can avoid whatever it is that is happening in hospital.

It's not just caesareans that happen unnecessarily in hospital either; it's forceps and ventouse, acceleration of labour, epidural, episiotomy, third or fourth degree tears and blood transfusions. Women who give birth in hospital are also less likely to breastfeed their babies: not breastfeeding carries long term health risks for both mother and baby.

So why am I describing these interventions as harmful? Because birth isn't about one day, it's about the start of motherhood, long term physical and mental health, future pregnancies and births. Women matter when giving birth. Our bodies and our mental and emotional health matter. One of the leading causes of maternal death in the UK is suicide. For women having interventions, recovery can be hard, infections are common, mobility can be affected, problems can occur with breastfeeding and bonding and many women can be left with both physical and emotional scars.

Why do women have so many more interventions in hospital then? Well, we don't actually know with any certainty. If true continuity of midwifery care could be provided in obstetric units, it would be interesting to know if the outcomes for mothers would be closer to those giving birth at home or in midwifery units.

The process of moving from home to hospital itself affects labour. The cocktail of hormones that we need in order to have safe, relatively pain-free births (yes, really), need us to remain undisturbed if they are to flow properly. Once adrenaline begins to flow, which is perfectly natural when going into hospital, a place for sick and dying people, then the good hormones (oxytocin and endorphins) stop and birth suddenly becomes more dangerous. It's also likely that even low risk women going in to hospital become less mobile once in hospital, i.e. they sit or lie down on the bed, which increases the pain and slows down labour, and interventions that could have been avoided often follow.

OK, so let's talk about the headlines about the babies. Overall, no matter where these women planned to give birth, their babies were perfectly well. There was less than 0.5% chance of anything significantly bad happening to their child. In fact, so few adverse outcomes were expected, that the study grouped together several things into one overall 'primary outcome' category. This included stillbirth and neonatal death, infant encephalopathy (brain damage), meconium aspiration syndrome, and various broken and fractured bones. Only 250 babies had one of these adverse outcomes, and only 32 babies died. Even for the headline worst group, i.e. women planning to have their first babies at home, over 99% of their babies had none of these problems.

What the press appeared to have done was to take the numbers out of context. The study showed that we are 95% certain that the difference in risk for babies born at home or in hospital is between 1.10 and 2.82, yet the press quoted this as babies being three times as likely to have one of the primary adverse outcomes. This is a

dishonest representation of the odds. Some papers even went so far as to declare that babies were 'three times more likely to die or be brain damaged at home' which takes the misrepresentation of the data even further. As I described above, a range of adverse outcomes were included, not just death. In fact, deaths didn't even make up the majority of those outcomes, only about 13% of the adverse outcomes were death.

I don't want to brush this increased risk under the carpet, however. I think it's important that we ask two questions about these results: Why are first babies more likely to suffer complications when their planned place of birth is at home? And what can we do about it? It would be irresponsible to assume that we can't change this, just as it would be to think we can't reduce the 40% transfer rate! Indeed, the majority of transfers were for 'slow progress' and 'pain relief'.

Undoubtedly, there are caesarean sections that improve outcomes for mothers and babies, but what the Birthplace Report shows is that a significant proportion of caesarean sections (and other interventions) could be avoided if women stayed out of obstetric units to have their babies. The implied conclusion here is that there are significant numbers of unnecessary interventions which are not benefiting mothers or babies.

I'm just going to finish by adding that as well as out of hospital births being very safe, they are also by far, the most cost effective. This Report included a cost effectiveness analysis which concluded that home and free standing midwifery units were the cheapest and safest places to birth. There are people who try to argue that providing these options is a drain on NHS resources, but now there is concrete evidence to the contrary.

So how about a shift in perception? Women flock in droves (92%) to these expensive and risky obstetric units, believing that birth is dangerous and that the doctors and facilities will protect them, when in fact, birth is generally very safe, even more so if you stay away from hospital and it is cheaper for the NHS if women stay away from hospital where possible. The very necessary resources available in obstetric units could then be kept for those births that really need them, midwives would be less stretched, all women would receive better care and the NHS would save a fortune. Home birth is safe birth. Birth Centre birth is safe birth. Spread the word.

Holly B Lyne

Birthplace Study Statistics

This is the latest and one of the largest studies of place of birth which included 64,538 women who gave birth to their first or subsequent babies between April 2008 and April 2010. The study was designed to compare perinatal (around the time of birth) and maternal outcomes for women with 'low risk' pregnancies. These women were classified as 'low risk' at the start of their labours, after being assessed by a midwife in their intended place of birth (home, Freestanding Midwifery Unit (FMU), Alongside Midwifery Unit (AMU) or Obstetric Unit).

This research shows that healthy women and babies are safer when they give birth outside an obstetric unit, in alongside or free-standing midwifery units, or at home. Women have fewer caesarean sections, ventouse deliveries, episiotomies, less blood loss, and are more likely to breastfeed. These outcomes will have benefits that this study was unable consider, such as safer future births.

The study showed no difference for second or subsequent babies by place of birth, nor for first time mothers between midwifery units and consultant units. However, a small statistically significant increased risk of an adverse outcome was shown for first babies born at home. However, in order to gain funding for the study the researchers were required to identify an outcome that had a good chance of showing a statistically significant difference between the groups.

On their own, baby deaths would have been too few to do this. So the researcher team combined: stillbirth after the start of care in labour, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus, and fractured clavicle. So, what can be said is that women are safer having their babies at home or in midwifery units, but there is no evidence about whether there is an increased risk of stillbirth or neonatal death for the baby because the incidence of this is so small.

In this study, there were 250 adverse outcomes for babies altogether, but of these, only 32 died. We would need a study which includes hundreds of thousands of women in order to detect differences in babies dying in different settings. The researchers concluded that birth for healthy women and babies is very safe in all settings. However, for mothers, birthing in out of hospital settings is safer.

The normal birth rate was:
88% for women who plan to birth at home
83% for women who plan to birth in FMU
76% for women who plan to birth in AMU
58% for women who plan to birth in obstetric units

The caesarean section rate was:
2.7% for women who plan to birth at home
3.6% for women who plan to birth in FMU
4.3% for women who plan to birth in AMU
11.0% for women who plan to birth in obstetric units

The Study also published the average costs of birth in the settings available in the UK. It shows that a planned home birth is cheaper than any other option.

On average, costs per birth were highest for planned obstetric unit births and lowest for planned home births. Average costs were as follows:
£1631 for a planned birth in an obstetric unit
£1461 for a planned birth in an AMU
£1435 for a planned birth in a FMU
£1067 for a planned home birth

Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. British Medical Journal, 343:d7400 doi: 10.1136/bmj.d7400. A summary and further information is available at www.npeu.ox.ac.uk/birthplace.

Enforcing birth choices

Elizabeth Prochaska asks if women have a legal right to choose where they give birth

As cuts to hospital budgets bite, women across the UK are finding that out-of-hospital birth provision – home birth services and midwifery-led units (MLUs) – are bearing the brunt of the austerity drive.

All too often, home birth services are being formally or informally 'suspended' due to lack of resources to employ sufficient midwives. MLUs have been closed for similar reasons, despite the fact that there is clear evidence that both MLUs and home birth services are very safe for healthy women and babies and more cost-effective than traditional hospital-based maternity care.[1] While women have the ultimate say over where they give birth and cannot be transferred to hospital against their will (unless in very rare cases they are deemed mentally incapable by a court), when out-of-hospital services are withdrawn it becomes practically difficult to exercise real choices about birth. This article explains how the law offers potential solutions to inadequate maternity service provision and that women now have a recognised legal right to choose where and how to give birth.

In common with NHS services generally, the choice of a particular maternity service is not guaranteed by legislation. Nor is there statutory guidance that compels NHS Trusts to provide out-of-hospital birth services. However, the right to choose to give birth outside hospital is a long-standing aspect of Department of Health policy. The National Service Framework for Children, Young People and Maternity Services, published by the Department of Health in 2004, stated that NHS Trusts are expected to make out-of-hospital birth available to women. The Department of Health's guidance 'Maternity Matters: Choice, Access and Continuity of Care in a Safe Service', published in April 2007, described the decision over place of birth, including a decision to give birth at home, as a 'national choice guarantee'. NHS Trusts continue to be expected to make a full range of maternity services available to all women, including access to MLUs and home birth.[2] While these policy statements do not give women enforceable rights, they do provide a useful context in any challenge to a decision to refuse to provide out-of-hospital services.

If a pregnant woman has been told by her midwife that she can give birth at home or in an MLU, she may have a 'legitimate expectation' of giving birth in her chosen location. This is simply a legal way of saying that she should get what she has been promised. Of course, the midwife can go back on her promise if she has good and proportionate reasons for doing so. Every case will depend on its own facts, but staffing shortages, for example, might potentially be a lawful reason to refuse to provide a home birth. However, where those shortages could have been foreseen in advance, a hospital ought to have contingency plans in place (such as hiring independent midwives to cover the shortfall) to ensure that there are enough staff to provide the services it has promised (and is expected by the Department of Health to make available).

There have recently been exciting developments in human rights law, which also provide women with strong grounds for challenging decisions to refuse them access to MLUs or home birth. Article 8 of the European Convention on Human Rights guarantees the right to respect for private and family life. The right is derived partly from the universal principle of respect for physical autonomy and integrity. In Ternovszky v Hungary, a case about the criminalisation of home birth in Hungary, the European Court of Human Rights explained:

'"Private life" is a broad term encompassing, inter alia, aspects of an individual's physical and social identity including the right to personal autonomy, personal development and to establish and develop relationships with other human beings and the outside world, and it incorporates the right to respect for both the decisions to become and not to become a parent. The notion of a freedom implies some measure of choice as to its exercise. The notion of personal autonomy is a fundamental principle underlying the interpretation of the guarantees of Article 8. Therefore the right concerning the decision to become a parent includes the right of choosing the circumstances of becoming a parent. The Court is satisfied that the circumstances of giving birth incontestably form part of one's private life for the purposes of this provision.'[3]

This decision establishes that a woman has the right to decide for herself where and how she gives birth and, critically, that the state has an obligation to facilitate that choice. The Human Rights Act 1998 made the European Convention on Human Rights part of English law and all public authorities, including all providers of NHS services, are obliged to act in accordance with the Convention rights.

Article 8 is not an absolute right, so justifications for interfering with it can be put forward if the justification serves one of the extensive aims set out in Article 8(2) (such as protecting the rights of others). The interference must be 'necessary in a democratic society'. This means that the justification must be proportionate, which entails striking an appropriate balance between the woman's right and any countervailing factors. It is possible that withdrawal of maternity services might be justified by reference to limited public resources or staffing shortages. But proportionality requires clear evidence of the alleged justification and will be strictly scrutinised where a woman's physical autonomy is at stake. In light of the recent conclusions of the Birthplace in England Study on the comparative cost of out-of-hospital and hospital births,[1] it may be difficult to claim that the cost of guaranteeing out-of-hospital birth is too high. In cases

where a woman is told she must attend hospital for clinical reasons the same balancing approach is appropriate, and the risk of harm to the woman or her baby must be weighed carefully against her right to choose where she gives birth.

Regardless of whether or not a woman has a legally enforceable right to choose where she gives birth, she can insist on remaining at home and cannot be transferred to hospital by midwives or paramedics unless she gives her consent. The Nursing and Midwifery Council (the regulatory body for midwives) has recognised that midwives owe a professional duty of care to attend any women who chooses to give birth at home[4] and any withdrawal of home birth services clearly breaches this duty and ought to be brought to the attention of the NMC.

A recent case of mine shows that it is worth fighting decisions to refuse to provide a home birth (even at a late stage in pregnancy). A large London hospital suspended its home birth service for a month due to staff shortages and informed women who had planned home births that they would be transferred to hospital by ambulance regardless of whether or not they consented to transfer. AIMS put a couple in contact with me who had been promised a home birth by the hospital. With only a few weeks before their baby was due, they decided to threaten legal action, relying on a legitimate expectation and the Ternovskzy case. The hospital rapidly backed down and agreed to provide independent midwives to attend all the affected women at home.

The Ternovszky case is a powerful and timely call to arms. Whether the decision is used by individual women to enforce their rights or to lobby policy-makers, the implications for the provision of out-of-hospital services are profound: women's choice must truly be put at the heart of maternity care.

Elizabeth Prochaska
Elizabeth is a barrister at Matrix Chambers

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Freestanding midwifery unit versus obstetric unit: a matched cohort study of outcomes in low-risk women

Charlotte Overaard, Anna Margrethe Moller, Morten Fenger-Gron, Lisbeth B Knudsen, Jane Sandall

The safety of birth in free-standing midwifery units (FMUs) is strongly debated, as acute complications may arise in spite of a careful risk assessment of women.

Prior studies suggest that FMU care for low-risk women is related to low perinatal and maternal morbidity, fewer interventions and a decreased use of medical pain relief compared with care from obstetric unit (OUs) care, but some are limited by, for example, the inclusion of high-risk women, low number of participants, and inadequate control of bias and confounding.

The present study aims to compare perinatal and maternal morbidity, birth interventions, and pain relief in low-risk women giving birth in two freestanding midwifery-led units and two obstetric units (OUs) in Denmark.

Key messages

No difference in perinatal morbidity was found among infants of low-risk women who intended birth in an FMU compared with infants of low-risk women who intended birth in an OU. More studies on rare adverse outcomes are needed.

FMU care had important benefits such as reduced maternal morbidity, reduced use of birth interventions including caesarean sections and increased likelihood of spontaneous vaginal birth compared with OU care.

However, 37% of primiparas and 7% of multiparas transferred during or less than two hours after birth.

Care in FMUs may be considered as an adequate alternative to OU care for low-risk women, and women should be given an informed choice of place of birth, including information on transfer.

Strengths and limitations of this study. The study compares processes and outcomes from women who have been rigorously and prospectively judged to be at low obstetric risk in two well-defined and carefully established settings in the same region.

Data are complete, as all eligible women planning to give birth in the FMU settings were included, and full follow-up on all participants was obtained.

Although the study groups were matched (and adjustment for the matching factors revealed no residual confounding) the risk of confounding by unknown factors related to women's choice of care in labour persists.

The study is available at:
bmjopen.bmj.com/content/1/2/e000262.short

AIMS Comment

This research shows the advantages of Free Standing Midwifery Units, but the suggestion that this kind of care is 'an adequate alternative' plays down the benefits this kind of care offers. This study's findings adds to many others, providing further evidence about the advantages of out of hospital birth for healthy women and babies

Halcyon Days

Kathryn Gutteridge is extending choices for Low Risk Women in Birmingham

Sandwell & West Birmingham Hospitals NHS Trust has become the proud parents of a new baby – the Halcyon Birth Centre. What a gift for midwives and women alike; it was opened in October 2011 by the newsreader Julie Etchingham. Julie's blog titled Birth Right (Posted 11 October, 2011) states;

'I think I've just been to the most beautiful place in the NHS.

'It isn't in an upmarket city suburb, or a leafy well-heeled part of London. It's in one of the most deprived areas of the country.

'The women of Smethwick in the West Midlands now have, on their doorstep, a midwife-led maternity unit which should be the envy of the country. It's called the Halcyon Birth Centre, and aims to make giving birth the most memorable and cherished experience of women's lives.

'There are no bleak institutional corridors, no forbidding desks. The walls are curved and painted in restful lavenders and pinks, there is an aromatherapy room – a garden and a communal area for tea and coffee, shared (crucially) between families and staff to ensure there are no barriers, real or psychological, between the midwives and the women who come to give birth.

'The birthing rooms themselves are beautiful, with furnishings which would be at home in a boutique hotel. Fairy lights twinkle in the ceiling, there are plumped, luxurious cushions on the bed – and each room opens onto a courtyard garden.'

Julie had been involved with the Trust earlier in the year where she investigated the current national situation of Maternity Services and how we have approached our quality and clinical issues.

The decision to invest in a brand new build of a free-standing birth centre may seem controversial in today's climate of financial constraints. However, the closure of Sandwell Maternity and its reconfiguration to City Maternity site was the precursor for this. As with any closure of a maternity service the Overview Health Scrutiny Committee (OHSC), made up of local councillors and ministers decided after a period of consultation that Sandwell women should have a place to birth their babies. Therefore the decision to invest in a free-standing birth centre was made supported by local people and the committee.

The funding for the venture is an interesting model that was devolved from the primary commissioners of that area - Sandwell Primary Care Trust (PCT). They owned a piece of land that already housed a PCT building for an Intermediate Care Centre on an accessible route. Although the preferred location would have been more central to West Bromwich itself, the proposed site actually is on the main bus and rail route and easily accessible. Once the funding model was agreed – which was based upon the birth tariff for each woman, tenders were sent out for construction companies to bid. An interview process selected the successful bidder and the one who met the brief of; *'a small, bijou spa hotel extending our project "Your Birth in our Home"'*. The successful company was West Hart and LSP Partnership Ltd. who understood the brief completely demonstrating sensitive and innovative designs.

The project team formed: it consisted of head of midwifery Elaine Newell, consultant midwife Kathryn Gutteridge, PCT commissioner for Maternity Janine Brown, PCT project manager Guy Carson and the design team. The clinical focus was based upon the success of the Serenity Co-located Birth Centre and therefore the construction company spent a lot of time understanding

how this model works. They went away, coming back with ideas and designs to discuss with myself and Elaine. It is safe to say that the designers were intuitive and insightful and understood what we were trying to achieve and that we wanted to maintain what was successful at Serenity Birth Centre.

As with many projects of this nature the vision does not always match the reality, however, in this case we were not disappointed. Involving a local art college and a well known local sculptor we commissioned some external and internal art work which would feature some of the ideas we were developing based on the name of the birth centre and on birth. We gave the artists the theme of 'The Tree of Life' and they came up with some fantastic ideas which are part of the finished build.

Project Brief

A free-standing facility for the women of Sandwell and surrounding area; with capacity based upon 350 women giving birth annually that is incremental over three years whilst establishing itself.

The building itself has three birthing suites which are roomy and built around the courtyard garden. Imagine a spa hotel with your own suite and sensitive décor that has French doors opening into the garden – this gives you some idea of what we have achieved. The designers were told that each room should have its own identity either in colour or shape but there are basic requirements that are non-negotiable. The rooms are named Tranquillity, Harmony and Grace and each has:

- A fixed birthing pool
- Seating for parents and visitors
- A double bed – not on immediate show
- Room for Bradbury mats and other birthing aids
- An ensuite wet room
- A TV, WiFi and iPod docking station
- A changing station for baby
- Storage that is both discreet and practical
- Clinical materials available, but not immediately on show

As demonstrated in the photographs this was achieved. The entrance is similar to a reception area in a hotel with a curvaceous desk and comfortable seating for visitors. Overhead is a specially designed mobile (designed by art college) of different bronze leaves that flutter high above, signifying the 'Tree of Life' and how each tree produces its own unique leaf. Behind the reception area is a sculpted tree and each baby born is represented by parents choosing a leaf and writing their child's name on it to hang on the tree.

There is a Therapy room whereby treatments for women can be performed using aromatherapy and reflexology, both before and during labour. All low risk women who use our service are offered aromatherapy during labour; we have a programme of pre-blended oils that are used throughout the labour process that can make a difference to their experience.

Following the rooms around to the dining area is a comfortable seating arrangement and dining table. We encourage the family to look after the labouring woman's nourishment whether that is preparing her food in our family kitchen or just making a pot of tea. The clinical storage is behind the main staffing area with a bay for the resuscitaire to be accessed for emergency use.

We have weekly tours of Halcyon with our midwives and maternity assistants giving information about the service and what women and their families can expect. Giving birth in a free-standing birth centre is a decision that takes into account the possibility of a transfer outside of hospital. We are 3.5 miles from the hospital labour suite and this has been a reassuring factor for both midwives and families. The front of the building has an ambulance bay so that the woman can be transferred swiftly.

The staffing model has been decided and supported by the established co-located Serenity Birth Centre. All calls come into Serenity and a programme of updating and rotation of community midwives into this facility has supported our community colleagues to participate in this exciting venture. There have been some problems in changing a well established community programme of activity, however they are now much more willing to be instrumental in the development of this service. The PCT has continued to make investments into our community midwifery model and have supported us with increased funding for midwifery.

Basing all of the clinical activity on a very new model such as the Serenity Birth Centre has not been without risks. However after the first year's clinical data outcomes it was evident that this was working and should be adopted as the continued model for our free-standing Halcyon Birth Centre. A brief synopsis of the outcomes for the Low Risk population at SWBH NHS Trust for the year 2010/2011;

- 950 women in labour in Serenity Birth Centre includes women having first and subsequent babies
- 808 actual births
- Transfer in labour rate of 14.9%
- Spontaneous vaginal birth rate of 94.1%
- Caesarean section rate of 3.26%
- Assisted birth rate of 2.63%
- 53.5% of all women labour, birth and have physiological 3rd stage in water
- 100% of women are actively moving during their labour and birth
- Use of Pethidine is 5.3%
- 2.21% of women were transferred for an epidural
- 9.5% women had episiotomies
- 34% of women required perineal repair
- Babies requiring admission to the Neonatal Unit was 3.26%

The overall positivity of the outcomes and the knowledge that the processes and governance arrangements are working is why the development of Halcyon has been possible in such a short time frame.

So far we have had 51 babies born at Halcyon and some very happy parents. It is a birth and short stay facility so during the postnatal period, women sometimes stay as little as two hours with some women staying a little longer, but most are home within 12 hours. Midwives are trained to perform the neonatal examination so the parents can have continuity and consistency in their care.

We are attracting women from around the region to see what it is we can offer. It is not just beautiful surroundings, this is about a vision that supports women

Baby Nega and her delighted parents, supported by Halcyon midwives

in our home together with their families. We understand the importance of the family unit, the difficulties women have in leaving behind their children, we make it possible for them to be together. When the birth is over and the baby is in its parents' arms – we all celebrate together. It is time for that baby to plant its feet firmly in the soil; to grow and begin its journey into life knowing that its parents were together through labour and beyond.

Halcyon means calm and tranquil, or 'happy or carefree' and is associated with the Kingfisher calming the raging sea before the winter solstice to lay her eggs in her nest on the water. Well we have a serene and calm birth centre with water in every room and our midwife is the Kingfisher who guides the woman through the rolling waves of labour to the calm of her birth.

I have a passion for supporting women with birth choices whatever they may be; I believe that women deserve the very best we can provide for the birth of their child; it is after all a unique life event. The care women receive during childbirth will stay in their memory for life so it is incumbent upon us to do the very best we can.

Kathryn Gutteridge
Consultant Midwife and clinical lead for low risk care.
Supervisor of Midwives, Aromatherapist, Psychotherapist

Second Midwife

If, instead of sending out two midwives to every home birth, Trusts and Health Boards ensured that, where appropriate, the second midwife was a student midwife they would not only reduce costs, but would also begin to develop a cohort of midwives who had seen normal, straight forward births and are confident at attending home births.

Furthermore, if the Nursing and Midwifery Council insisted that student midwives should attend at least three home births in their final year, more midwives would gain a better understanding about the social context of birth, birth physiology, the importance of disturbing the woman as little as possible, and the very real differences between an obstetric delivery and a normal birth, and thus gain a better appreciation of a social model of birth.

Choosing out of hospital birth

Juliet Rayment presents some findings from the Birthplace in England Research Programme

There's been a lot of talk in recent years about choice in health services. Back in 2004, the White Paper, 'Choosing Health: Making healthy choices easier'[1] suggested that we might all be able to choose to be healthy. 'Maternity Matters: Choice, access, continuity of care in a safe service'[2] put women's choice of where they could give birth top of its agenda. The current NHS reforms have been justified to us on a promise that they will increase patient choice and that increasing choice is an indisputably good thing. However, 'choice' is not as straightforward as it might seem.

This article presents some findings from four case studies of English NHS Trusts: Seaview NHS Foundation Trust, City NHS Foundation Trust, Hillside NHS Trust and Shire NHS Trust (all names are pseudonyms) carried out as part of the Birthplace in England Research Programme.[3, 4] The Case Studies examined the maternity services of four 'best performing' English Trusts (According to the Health Care Commission Review of Maternity Services in England, 2007). Seventy two interviews were carried out with service users and their partners and another eighty-six with staff and local stakeholders at the four Trusts. Fifty observation visits were also made to the Trusts during 2010.

Speaking to women and their partners, to healthcare professionals and commissioners in these four case study sites exposed how women's choices are frequently both constrained and unequal. In order to make a choice, women required information, access to local services and to feel safe.

Information

Making choices requires information about opportunities available and there was evidence that even within a local area, women were being given differing advice and information. When obstetric units were the default option for most women, access to information about alternatives was crucial for women to be able to choose out of hospital birth.

One woman in Seaview described the importance of getting good information about her options:

'I have to say at the beginning I never, ever thought of having a home birth. It wasn't even on my … it wasn't even on my radar. In fact I think one of my friends had had one a few years before and I thought she was barking, absolutely barking mad. But I didn't have all the information, in terms of, you know that people could have home births and that, you know, if everything was straightforward in your pregnancy then there's no reason why you can't, basically, which was a message which we were given. (…) if you've got your information then a woman can make a choice accordingly really.'

Postnatal woman 1, Seaview

Even in the same area, professionals appeared to tailor information according to their assumptions about what women wanted or what would be most suitable for them:

'I think she probably assumed that it would be hospital so she just circled that bit on the front of the notes, and that was about it. Until we starting talking about it at the antenatal classes and then I brought it up at one the meetings with the, the midwife. But that was quite late on. (…) I just said that I'd been considering a home birth… and they were really positive about that, they thought that was a really good idea, which I was quite surprised, I thought it would've more sort of… "oh we prefer hospital."'

Postnatal woman 2, Seaview

Access

Choice of place of birth relied upon there being local services available. Particularly in rural areas, women's choices were limited simply because they had no local out of hospital birth places available to them:

'[The Freestanding midwife-led unit is] just a bit far…I don't think I'd have handled an hour's journey, [laughs] I'd be on the roof! And as well I've got all, like my mum lives round the corner so as soon as I had the baby she came in. So it made it better.'

Postnatal woman, Hillside

By offering a number of freestanding midwife-led units, Shire, a rural trust, was able to offer more realistic choices to women. Their units were successful because they were not just a midwifery concern:

'The local geography makes it difficult for people to get to the OU out of hours so the local units are crucial.'

Obstetrician 1, Shire

'It's a quality service. I think when you run clinics in the peripheral hospitals and you realise how much quality they provide, quality service they provide, and, you know, for the women it's just a lovely environment to give birth.'

Obstetrician 2, Shire

Feeling safe

Most of the women and partners we spoke to had chosen to birth in an obstetric unit. This reflects the findings of the Birthplace cohort study that only 8% of 'low-risk' women in England plan to give birth in midwife-led units or at home.

Many women chose an obstetric unit because they were concerned about the risk to them and their babies of birthing elsewhere and women described making complex personal risk assessments when choosing to birth out of hospital. The obstetric unit was understood as a place that was assumed to be safe, with the other birth places then progressively 'less safe' the more different they were from that institutional hub: first alongside midwife-led units, then freestanding midwife-led units, then birth at home. Different birth places were

believed to be safer than others, not simply because they were geographically closer to the obstetric unit, but because they were closer to the medical model.

The birthplace cohort study found that a significant number of women (between 21 and 26.4%) were transferred into obstetric units during or shortly after labour. Worries about transferring during labour were a key reason women chose to birth in an obstetric unit and these concerns were shared by women who lived close to the hospital, as well as those who lived further away:

'I definitely didn't want to have the baby at home, I just thought if anything goes wrong and you're at home it's like … although I only live like 15 minutes, 10 minutes away, it's still the thought that when you're in hospital you've got all that help at hand, right there.'

Postnatal woman, Hillside

While transfer, or escalation of care within the obstetric unit, could be distressing and frightening, it was not inevitably a negative experience. Careful explanation of events by professionals had a positive effect on women and partners' experiences, as this woman in Shire explained:

'They were calm and knew exactly what they were doing, explained a bit about what it was they needed to do but weren't going into the absolute nth degree, because you're not in a position to take in loads and loads of information.'

Postnatal woman, Shire

Women felt safer when they were listened to and when staff acted on their concerns, even when complications developed during labour. Partners and other supportive companions helped to ensure that women who were worried about their own health were heard and taken seriously and this had a profound effect on their feelings about their birth:

'After they gave me the epidural and they pressed the crash button (...) so many people were sticking needles inside of me and I was really scared and no one could explain to me what was going on. My sister had to tell them all to stop that, let them basically explain to me cause I was telling them no one should touch me cause I didn't know what was going, because I was really scared and I was like what is going on with the baby and what is going on with me cause by that time I was so numb from basically from my neck all the way down and I didn't know what was going on.'

Postnatal woman, City

The Birthplace cohort study showed that the incidence of birth interventions in fact decreased the further women planned to birth from the obstetric unit. However, the case studies interviews demonstrated how important it is that we do not underestimate the value of women feeling safe in hospital, even if their risk of intervention is higher:

Woman: They ask me (…) maybe you want it at home or hospital, and I says, 'of course hospital' it's…it's…

Partner: More safe.

Woman: Yeah, more safe.

Interviewer: Can you explain that to me? Why should it be more safe?

Woman: Because in … at home, ok, it's midwife, but don't have this all apparatus … the apparatus.

Partner: Instruments.

Woman: Instrument, if something happened, of course it's better in hospital because it's a lot doctor, more midwife, more professional.

Partner: Yeah (…) and we mentally feel more safe.

Postnatal woman and partner, City

Supporting out of hospital birth

The Birthplace in England Cohort Study has given the best available evidence to date that women deemed to be 'low-risk' would benefit from planning to birth outside of the obstetric unit. However, as we live within a culture that normalises obstetric unit birth, how can midwives support out of hospital birth whilst respecting women's need to feel safe?

The case studies can give us some ideas:

- Midwife-led units need support from community midwives, who initiate those first conversations with women about place of birth. Communication between midwives working in different parts of the services is important, as inequality in the way information is given to women means inequality in who uses those services.
- Successful midwife-led units are led by midwives who work well with their obstetric colleagues to ensure their support.
- Women benefit from clear information from health practitioners, and support from their birth partners and companions, especially when complications develop during labour.
- Normal birth can be supported within the obstetric unit when midwife-led units aren't available because they don't exist, are too far away to be a realistic choice, are closed or women do not want to use them.

Juliet Rayment

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Birth Centre Closures

Beverley Beech highlights some of the issues

Over the years, an endless stream of government statements and official reports have stressed the right of women to choose where to give birth. As long ago as 1994 a report by the National Perinatal Epidemiology Unit in Oxford stated 'For some women, it is possible but not proven that the iatrogenic risk associated with institutional delivery may be greater than any benefits conferred.'[1] Since then research has revealed that the iatrogenic risk is GREATER than any benefits conferred.[2]

As long ago as 1989, AIMS Journals[3] were questioning the wisdom of closing local Midwifery Units (then usually called GP units), which, as is common today, were proceeding despite vigorous local opposition. The closures were given impetus by the notorious Short Report[4] which recommended that home delivery and isolated GP units should be phased out, and the majority of women 'delivered' in large obstetric units. No evidence was offered suggesting that this would improve care or outcomes.

In 1992 the House of Commons Select Committee published its findings, following an extensive investigation into maternity care, and commented that 'the choices of a home birth or birth in small maternity units are options which have substantially been withdrawn from the majority of women in this country.'[5] It recommended that these be made available.

In 2003 another House of Commons Committee looking at choice in maternity care stated that *'We accept that local configuration of services is a matter for local determination but given that pregnant women are not able to travel long journeys to give birth, if midwife led units are not available local choice is severely constrained.'*[6]

The BirthPlace study not only demonstrated better outcomes, it showed that there were substantial financial savings too

Over the years endless groups of parents have protested at losing a much-loved local maternity unit or birth centre, but the juggernaut grinds on; occasionally, a new birth centre is established, but often does not last long. Studies of birth centre outcomes were often dismissed as being too small to provide valid results, but now we do have a study[2] that shows what most parents have suspected for a very long time: birth in small, local, free-standing midwifery run units have better outcomes for fit and healthy women when compared with similarly healthy women who were 'delivered' in large, centralised, obstetric units.

The BirthPlace study not only demonstrated better outcomes, it showed that there were substantial financial savings too.

On average, costs per birth were highest for planned obstetric unit births, as follows:
£1631 for planned birth in an obstetric unit
£1461 for planned birth in an alongside midwifery unit (AMU)
£1435 for planned birth in a free-standing midwifery unit (FMU)
£1067 for planned home birth

Cue – a national campaign immediately to establish more of these units and a training scheme to re-educate and support midwives to encourage and support normal birth. So we dream. Instead, in these times of financial cuts the Trusts appear to be determined to close the few free-standing midwifery units that exist, so why worry about a little matter of research evidence?

The latest rash of small Birth Centre closures include: Darley Dale and Corbar in Derbyshire; the Jubilee in Humberside and the Andover Birth Centre in Hampshire So concerned is AIMS about these closures, that on the 16 February we wrote to the Minister of Health, (see www.aims.org.uk/Submissions/letterMinisterHealthFeb2012.htm) pointing out that in view of the evidence, not only are the Trusts losing money by perpetuating large, centralised, obstetric units, (a minimum of £200 additional cost per birth); but they are also reducing the numbers of potential fit and healthy women and babies by maintaining these huge units.

AIMS has asked the Minister to intervene and take positive action to provide a maternity service that is truly responsive to women's and babies' needs. While the Minister questioned the Trusts' decisions, it all boiled down to 'the provision of local health services ... is a matter for the local NHS'. So, no change there then!

Beverley A Lawrence Beech

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Article

Why Birth Centres Fail

Mavis Kirkham, Ruth Deery and Deborah Hughes offer a case study

In 2010 we published 'Tensions and barriers in improving maternity care: the story of a birth centre'.[1] This anonymised birth centre was opened following an excellent feasibility study. Its clients were highly satisfied with their care, the building was well suited to its purpose and its original, dedicated staff were recruited specifically to work there. Nevertheless the birth centre was wound down and after only five years, it was closed in 2007.

This birth centre came out of the closure of the local maternity unit. During the public consultation before the closure, the health authority decided to explore the option of a birth centre so that giving birth locally remained an option for some women. The acute trust, responsible for maternity services, was opposed to this plan. However, the health authority proceeded with the feasibility study, which strongly recommended a birth centre, staffed by midwives who were committed to a birth centre concept.[2] Under some duress, the acute trust accepted the plan, despite opposition from many trust managers, obstetricians, general practitioners and midwives.

After studying the views of all those involved we concluded that the birth centre lacked support from local midwives, who were mourning the loss of their local maternity hospital and trying to adapt to working in a more distant centralised unit. They saw the birth centre as a small and ineffective gesture towards keeping maternity services in their town, though, in other circumstances many of them may have supported its woman-centred and midwife-led philosophy. The birth centre posts were advertised externally and appropriate midwives were appointed.

Despite their commitment and initial successes, these midwives gradually left the service because, lacking support from trust management, they were unable to develop the birth centre as they aspired to do. The opening hours of the birth centre were then restricted, community midwives who were already overstretched were required to staff it; bookings decreased and the service spiralled down.

Midwifery managers were given the extra responsibility for the birth centre as well as their existing work. They also had to cope with the ever-changing management tiers above them in the trust, and its constrained financial circumstances. The Birth Centre underwent a rapid succession of changes in its short life, which took it ever further from the model proposed in the feasibility study and accepted by the commissioning health authority. Each intervention exacerbated staffing problems and led to a reduced service for women. No strategic move was taken to defend that service or retain its midwives.

Inter-professional collaboration and trust are regarded as essential for developing a social model of maternity care, promoting physiological birth and improving services.[3, 4, 5] Yet, no one in this study saw it as their role to facilitate the development of such trust and collaboration between professionals. Indeed the evident lack of collaboration around the birth centre served to undermine trust. The Birth Centre midwives themselves had little power to develop the social model of birth at any wider level than their relationships with individual mothers. When their antenatal role was removed and the opening hours of the Birth Centre were restricted, even this central relationship was threatened. This threat to relationships was not acknowledged by management when these cuts in the service were instituted. Indeed some managers argued that these relationships should be curtailed because they were seen as 'elitist' and deviant from the prevailing medical model, rather than as a very different social, midwifery model which could coexist with mutual benefit.

Birth centres have long been established as midwives' territory,[6, 7] where they feel secure, to which they are committed,[8] and which provide a safe base within which they can exercise their clinical skills. The midwives in this study were not able to establish their territory and felt isolated from, rather than integrated with the mother unit, not just geographically but professionally and philosophically. It is difficult for midwives to facilitate safety and empowerment for women if they feel threatened and undermined in their work setting.

This Birth Centre was no one's baby, but it was part of a NHS trust where all those concerned, except for its original midwives, felt that they had more than enough to cope with without it. No one in a position of power championed the birth centre. It seems vital for any birth centre's success that it has champions amongst the powerful in the local community and in the NHS structures in which it is situated. In such circumstances it is scarcely surprising that it failed to thrive.

As a result of this research, other studies and our experience of working in birth centres, we made a number of recommendations to help those considering establishing a birth centre, or seeking to retain one. These included:

1. Birth centres need allies including:
   - Support from committed local service users
   - Midwives who want to work with the autonomy and full use of their skills that a birth centre makes possible.
   - Midwifery leadership and management committed to the birth centre; leadership within the birth centre with access to senior management and involvement in the forums where the birth centre will be discussed. At least one senior midwifery manager committed to the birth centre, who will support it in

management forums and liaise between it and other services.
- Obstetricians in the unit where transfers are received who understand the role of the birth centre.
- Supportive GPs

2. Education is important for all involved. Self-awareness and skills of facilitation and relationship are essential for all involved and learning together can be very helpful. Further development on leadership within midwifery is crucial.
3. A clear vision and targets for the birth centre need to be agreed and understood by all of the staff who work in or link with the birth centre.
4. Public relations are important and regular meetings of all those who support the birth centre can ensure smooth running and be able to anticipate many potential problems.

Fear of Excellence

The current market values now underpinning public services create considerable problems.[9, 10] The desire to cut costs means that staff use of time is increasingly strictly controlled. In this situation, management, far from striving for excellence, tends to fear it[11] and we hear the terrible arguments for closing birth centres, and other innovative services on grounds of 'equity', meaning the lowest common denominator of service provision. This approach, for those who hold it and for those who battle against it, has the sad result of lowering everyone's expectations of maternity services.[12]

In the reality of the modern, cash strapped NHS, excellence is a distraction and managers are required to use all their energies in coping with budgetary pressures. In this context the medical and the centralised industrial model of maternity care is taken as the norm and the social model of care, as exemplified in birth centres, is seen as deviant. Professional dissonance follows for midwives. There is just no energy to think of a different way of doing things, even where, ironically, it may save money. In a society which fears birth, a fear of difference is evident, as well as a fear of excellence.

Recent Developments

Recently we have seen the closure of many birth centres. Over the years Mavis Kirkham has been to many meetings to defend the birth centres at Darley Dale and Buxton. In the past a rallying of local support and producing evidence of their excellent clinical outcomes has been enough to save these centres from threat of closure. The meetings last year were very different. The funders accepted that these units were centres of excellence yet they were seen as a luxury which could no longer be afforded. It was firmly stated that money could be saved by closing the units which was needed for other services such as coronary care. One cannot argue with the statement that it is cheaper not to provide a service! There was no sense in which money was ring-fenced for maternity services and no-one cared that money spent on good maternity care now could save on the coronary care budget in future years. Behind all this was the assurance by the local consultant maternity units that they could absorb the cases that currently went to the birth centres at no extra cost. There seemed to be no concern that those units would thereby be slightly busier and presumably the care given would be slightly worse.

Once again, there was no aspiration to excellence or a desire to retain excellence by those who hold the purse-strings. The consultant units had no real interest in the birth centres and the lowest common denominator of service was seen as acceptable. Both these birth centres are now closed, despite massive public opposition locally and their long and excellent histories. This demonstrates that birth centres, like many women-focussed phenomena, are backed by the establishment only when it is easy to do so. In more challenging times, the lack of deep ideological, institutional and political commitment is exposed. This relates to all services for which women are the main beneficiaries, not just birth centres and demonstrates how far feminism (or what remains of it) still has to go to secure women-focussed services for the long term, in good times and bad.[13]

Despite the official rhetoric of maternal choice, other birth centres have recently closed. There is no strategic assessment of maternity services, simply the lopping of items, such as birth centres, which can be identified on a balance sheet. Never has the gap between the rhetoric and the reality of maternity services been greater.

Mavis Kirkham, Ruth Deery and Deborah Hughes

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Article

'NHS doulas'

Adela Stockton looks at the issues around doulas working within the mainstream services

I must confess to being purist, some might say idealist even, when it comes to doulas. For me, it's about The Relationship between the doula and the mother or couple, and equally, about the opportunity for women to take back responsibility (or power) for their own birthing experience.

The fact that the mother selects and enlists her doula on her own terms, based on a shared sense of ease with and trust in one another, means that the doula is utterly hers. Their relationship has time to develop and grow during their prenatal meetings, when so much of the groundwork in preparation for birth takes place; in this way, the doula comes to understand how it is that this woman wishes to be supported, begins to know what it is that this father requires to feel comfortable in his role during labour and birth or early parenting. Once labour commences, the doula is then able to 'be' with the mother or couple from a place of mutual understanding, when often there is little to 'do', and after their baby is born, as Lao Tsu's ancient proverb states, the new parents can indeed proudly declare: 'We did it ourselves!'[1]

It makes little sense to me therefore, for a doula not to have met the mother she is going to support until labour has already started, and it seems peripheral to the point of the doula if she is allocated to parents by the midwife-in-charge at their point of entry to the birthing unit. As the research suggests, continuous support is more effective when it is *not* provided by those associated with the hospital.[2] Such may be the case, however, for the 'NHS doula', sometimes known as a 'Birth Buddy', who increasingly can be found working shifts on a voluntary basis in maternity units, from Aberdeen to London, around the UK. Mostly, NHS doula projects have developed out of local women's initiatives to support birthing women in their community on a voluntary basis, which have then duly been incorporated by the Primary Care Trusts (PCT). At least one project is awaiting formal evaluation due in early 2012, some are in the pipeline while others already appear to be well embedded.

Despite the currently more widespread recognition of the benefits of her role, if there has been one ongoing grumble about doulas, it has been regarding the issue of accessibility. It has been suggested that the doula is only for women or families who can afford to pay,[3] despite the fact that there has been a consistent effort among the doula community to counteract this. National network Doula UK[4] has a Doula Access Fund in place for example, and some doulas offer their services on a voluntary (although still independent) basis, such as Birth Companions[5] who support women in prison. In the past, a small number of doulas have worked through Surestart or other such government schemes, on a self-employed contract. It might be considered therefore, that the introduction of a 'NHS doula' would be welcomed, a means whereby any woman who wants one can access a doula, during labour at least, if not postpartum too.

But what about The Relationship? What about the balance of power between service user and provider? What about the working boundaries of the doula role?

In some areas, it seems that the primary aim for providing NHS doulas is to offer psychosocial support to mothers from more vulnerable groups, such as substance abusers or asylum seekers, or those from deprived communities. The idea being that the doulas do meet with the mothers during pregnancy to develop a relationship and there is an element of choice on the woman's behalf in who she accepts to support her. In other locations however, it appears that the doula is considered more as 'an extra pair of hands' in the birthing unit for whoever needs them, whether mother, couple or indeed, midwife. It may be that the doula and midwife are mutually supportive as they work side by side, but I wonder how far this set-up is conducive to the doula's primary role which is to build a relationship with and empower the mother? Furthermore, according to the Nursing and Midwifery Council,[6] it is in fact unlawful for a doula to 'assist...the medical practitioner or registered midwife...in childbirth'. And while doulas strive at all times (or should do) to maintain a positive interaction with the attending staff, if the doula is present essentially for the benefit of the midwife, where does this leave her in terms of allegiance to and advocate for the mother?

This question is even more pertinent when the NHS doula has been 'trained' by the Primary Care Trust (PCT), by tutors/facilitators who are not themselves working doulas. The discussion around how far a doula needs to be formally prepared may be ongoing, and the above scenario does not apply to all NHS doula schemes. Some 'training' programmes do have experienced doula input, such as Goodwin Doulas and the Homerton Hospital Birth Buddies, or alternatively, apparently require the new doula to have undertaken a Doula UK approved course in order to apply for the project, such as in Aberdeen. The concern of Doula UK about those who have not undertaken any such preparation however, is that these doulas may lack the background philosophy of a doula-centred approach, of 'being' rather than 'doing', as well as a real understanding of the level of privacy required to support 'undisturbed', physiological birth, thereby potentially compromising the essence of the doula role.[7]

The other longstanding apprehension about doulas is the sensitive issue of how their presence might potentially affect midwifery recruitment, even, the role of the midwife itself. As research midwife Mary Ross-Davie laments, there have always been concerns that doulas may be used 'to prop up an already underfunded system constantly seeking cheaper options'.[8] While the doula

remains an independent worker, employed by the women and their partners, whether on a fee paying or expenses only basis, I wonder how likely this is to happen. In order to protect the integrity of the doula role, it seems essential that the mother and father remain in control of who they enlist, which effectively removes doulas from the equation regarding the statutory employment of midwives. So whether doula services installed as part of the statutory maternity care system will contribute to the already dangerous shortage of midwives, remains to be seen. As we know, it is not the midwives who set the rules, rather the politically driven PCTs.

The emergence of the NHS doula sits most uncomfortably with me in several ways therefore. While I am wholly in favour of women and families being able to access the kind of support that is right for them during childbirth, I am concerned that the allocation of on-duty doulas risks undermining the mother (and father's) autonomy, that the doula role itself will be compromised and yes, that midwives will be displaced. All of which seems utterly counterproductive towards appropriately and sensitively supporting birthing families and improving the normal birth rate.

Adela Stockton

Adela is course leader at Mindful Doulas, and is currently studying for a postgraduate diploma in psychodynamic counselling. Author of 'Birth Space, Safe Place: emotional wellbeing through pregnancy and birth' and 'Gentle Birth Companions: doulas serving humanity', she passionately believes in promoting and protecting gentle birth. www.adelastockton.co.uk

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Report of the Sheffield Home Birth Conference on 10 March, 2012

There was great energy at the Sheffield Home Birth Conference. Expertly organised by Olivia Lester and Michelle Barnes, and very well attended for the fifth year running, the conference wove together the themes of endorphins, complementary therapies and home birth.

Mavis Kirkham set the tone with her presentation on Optimising Endorphins. She highlighted the role of endorphins in labour as a stress hormone and safety mechanism to help 'gentle down', slow or stop contractions – if the physical or emotional stress becomes too much for the woman. Equally, endorphins are a 'social hormone' and optimising endorphins and their intricate balance with other birth hormones is 'grounded in relationships'. It is vital that a woman feels safe in herself and in her relationships with her partner and midwife. The unique 'biochemistry between mother and midwife' means that a midwife's gentleness and calm presence, as well as her job-satisfaction and positive work-relationships (which enhance her own endorphins), contribute toward better birth.

Denise Tiran spoke about different forms of complementary therapies (manual, psychological, energy-based, pharmacological, exercise, traditional systems) and the properties, effects and contra-indications associated with some common ones, including clary sage oil, raspberry leaf tea, moxibustion and eating pineapple. Over 80% of pregnant women use complementary therapies during pregnancy or labour, though most don't disclose it. It is increasingly important that midwives learn more, and communicate with women, about the potential benefits and risks of these powerful healing modalities, and what is right for each individual.

Dynamic and engaging as always, Maggie Howell, founder of Natal Hypnotherapy and mother of five home-birthed babies, explained some of the process of hypnosis for birth. Our emotions and fears, behaviour patterns, beliefs, instincts and body language are deeply embedded in our vast subconscious, but these are open to reprogramming when we can let down our conscious guard. Through focus, breath and relaxation a woman enters a 'hypnotic state' where she can hear suggestions about how she can respond to the sensations and events of labour, perhaps specific things she fears, and learn alternative ways of dealing with these. This is not about guaranteeing a pain-free labour or controlling labour, but instead improving her expectations and coping mechanisms.

In the afternoon there was a difficult choice of excellent workshops to attend, including Maya Abdominal Massage with Bushra Finch, placenta encapsulation with Lynnea Shreif, waterbirth with Wendy Davis, Rebozo with Stacia Smales Hill, osteopathy with Chris Johnson and acupuncture with Jo Moon. Throughout the day we were able to browse and chat at many stalls and collect goodies ranging from Pinards to Rebozo scarfs, books/leaflets galore and breast-shaped cupcakes!

We heard positive news of local services and statistics from Dotty Watkins, Nurse Director/Head of Midwifery at Sheffield Teaching Hospitals. The Sheffield home birth rate is on target for 3.5%, with future plans to aid women in deciding on place of birth and to support home birth for those with 'complex needs'. Finally, Anne Richley, Sally O'Connell and Babita Williams described the creation of the Northampton Home Birth Team, which has achieved a home birth rate of 8% and a hugely successful structure where midwives 'love their jobs' and work well with community and hospital teams ... such an optimistic note on which to end the day and look forward to next year.

Jill Benjoya Miller
Active Birth and YogaBirth teacher, birth doula and mother of three

Professional Indemnity Insurance for Independent Midwives

Helen Dresner Barnes explores the erosion of choice for women and midwives

Today, a woman wishing her maternity care to be provided by a midwife she herself has selected, is able to exercise that choice.

One of the main reasons women choose to book with an independent midwife, is that they want continuity of care from a known carer. Very often they have already had an experience within the NHS that has not met their needs, or have been told that their circumstances dictate a certain course of care, which may not be acceptable to them, for example an 'elective' caesarean section for a breech presentation. Women don't want care prescribed by a system governed by tariffs and limited by human resources, where staff are not replaced when they are absent through sickness or maternity leave or where the number of staff is dictated by how a budget is used. Bank staff might be used in a hospital, but this does not happen so often in community settings. Disenfranchised from the NHS monopoly or simply exercising the right to choose, women have been able to seek alternative care from an independent midwife. From October 2013 this will no longer be the case, unless a solution can be found to the insurance problem.

The compromise a woman has had to make when seeking an alternative approach to the NHS maternity services is to accept that there is no professional indemnity insurance (PII) attached to the independent midwifery model of care. This is not because care from an independent midwife has been shown to be less safe, but quite simply, with such few midwives practising this way, they are not a commercially attractive group to insurers.

The Royal College of Midwives ceased to provide professional indemnity insurance in 1993 and whilst for a few years independent midwives could obtain PII commercially at an affordable price, this rose exponentially, effectively pricing independent midwives out of the market. Insurance premiums became so very high, that only certain private Birth Centres could afford it – but eventually, even these could not sustain this. Independent provision was priced out by the insurers' unaffordable premiums. There followed a period of negotiation with a large US based insurer which would have supported midwives work within the rules and standards laid down by the NMC, but at the last moment the company withdrew all medical cover from the UK. Independent midwives who continued to practice were left with no option but to work with no professional indemnity insurance if they were providing full antenatal, intrapartum and postpartum care. Those offering solely antenatal and postnatal care can be indemnified through the Royal College of Nursing.

The European Parliament Directive 2011/24/EU[1] effectively made PII mandatory for all healthcare professionals, as a method of protection for the public and to provide a 'remedy' against harm done in the course of care. This requirement will come into place by October 2013.

In addition, the Independent Review of the Requirement to have Insurance or Indemnity as a Condition of Registration as a Healthcare Professional[2] by Finlay Scott concluded that it should be a statutory requirement for registrants to have insurance or indemnity. In Finlay Scott's opinion, a healthcare professional working as an employee can satisfy this requirement courtesy of the corporate cover arising from various liabilities, but for those who are self employed the route for indemnity must be through personal cover. The long and short of this is that in order to stay on the professional register and practice legally, from October 2013, professional indemnity insurance will be mandatory for all midwives. Currently NHS midwives are indemnified through the Clinical Negligence Schemes for Trusts.

Finlay Scott also noted the difficulties in obtaining PII for professionals such as independent midwives and made the following recommendation 'In relation to groups for whom the market does not provide affordable insurance or indemnity, the four health departments should consider whether it is necessary to enable the continued availability of the services provided by those groups; and, if so, the health departments should seek to facilitate a solution.'[2]

In 2011 The Flaxman report,[3] commissioned by the RCM and NMC to see what solution there might be, concluded that the insurance industry regards insuring lone independent midwives and those operating outside of the NHS as very risky; and that independent midwives should form a suitable organisation that might then be considered by the insurers to be insurable.

Whilst a suitable organisation has been largely interpreted as an employment model, this isn't what Flaxman categorically stated, but it appears that as employees PII becomes easier to obtain, as indemnity sits with the employer, not the individual midwife, as Finlay Scott noted in his review. A suitable organisation might also be a not for profit social enterprise scheme, but either way, there would need to be acceptable governance and supervision in place, as well as regulation from the Care Quality Commission.

As it stands, in May 2012, no solution has been found that permits women to choose care from an independent midwife of her choice, in the way she now can, after

October 2013. On the Wirral a private company 'One to One' has contracted into the NHS to provide care for women for the whole of their maternity care. The information as to how they have been able to indemnify themselves is not forthcoming.[4]

Some members of IM-UK are also developing a separate scheme, 'Neighbourhood Midwives'[5] which hopes initially to offer care to 'low risk' women. The selection of this initial target group of women is driven by the new NHS tariff system which produces a clawback of fees if women have to be transferred back to the NHS for care. This new tariff system is likely to be very disadvantageous to any group looking after a booked low risk woman, who then develops complications and becomes high risk. Nevertheless Neighbourhood Midwives hope to eventually be able to offer care to a broader group of women, but the economic viability is as yet untested.

What is the potential effect of such changes? The knock on effect for the skilled and experienced midwives of only caring for 'low risk' women, is that midwifery skills such as those employed in vaginal breech birth, will, over time, be lost to midwives. Diminishing midwifery knowledge is both soul destroying to those knowledgeable midwives practising complex midwifery skills, and is yet another resounding nail in the coffin of women's choice and the longevity of midwifery skills.

Ironically, as the mainstay of the client group traditionally booked by independent midwives is being changed by the demands of PII and a tariff system for maternity services, within the NHS itself, there is now evidence of care being targeted specifically at those women who previously would have turned to the independent sector for care.[6] This is not, however, available to all women as local services organise their provision of care differently to one another.

There is a very clear outcome of the PII issue. Despite endless rhetoric about choices in childbirth, women will soon have the choice of midwifery carer removed. The Government, largely composed of men, who will never understand what is to birth a child, continue to dictate to women how they should experience childbirth. Whilst childbirth rights are very much a global issue, this, today, is our national tragedy.

Helen Dresner Barnes
Helen is caseload midwife, facilitating choice for women in both the independent sector and the NHS

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AIMS Position on Independent Midwifery

AIMS has always upheld the established woman's right to birth wherever she decides to, no matter what her circumstances, with or without a health practitioner. It also upholds the view that all women must have the right to birth with the practitioner and/or others of their choice, and that women should not be deterred from making decisions that are right for them due to financial constraints.

Midwives must be enabled and supported to attend women who plan births in or out of hospital settings, no matter what the woman's circumstances: these include women having VBACs, twins and breech births. AIMS is extremely concerned about the growing numbers of women it hears from, who have expressed the view that if independent midwives are prevented from practising, they will have no option but to give birth unattended by midwives or other health practitioners, as they will not engage with standard NHS maternity services.

Home Birth: The Politics of Difficult Choices. Parallels with midwifery?

'by showing someone the resources they possess to become well or achieve better health, and building their self-esteem to choose a health promoting direction of travel, they can mange their own lives. By contrast, the twenty-first century maternity service appears to be perversely determined to send out the strongest possible messages to women that they are not able to birth their babies except under close surveillance and with considerable medical assistance. Perhaps it is not therefore surprising that intervention rates are increasing, as women live up to this relentlessly negative assessment of their essential female physiology.' (p119)

Home Birth: The Politics of Difficult Choices by Mary Nolan (2011) is reviewed on page 24.

Report

Dr Ágnes Geréb - update

Donal Kerry continues the campaign against injustice

Dr Ágnes Geréb is the leading obstetrician and midwife in Hungary attending women to birth at home. She has been providing this unique service to Hungarian mothers for some 17 years.

She and her midwifery team attended over 3,500 babies safely at home. During that time, however, three babies died (two of them died 14 and seven months respectively, after their births, and the third death arose from shoulder dystocia complications at birth). Between four and seven babies die of shoulder dystocia complications in Hungarian hospitals each year, yet no hospital doctor has ever been prosecuted.[1]

On 26 April 2012 the AIMS Chair, Beverley Lawrence Beech, visited Dr Ágnes Geréb in her own home in Budapest, Hungary. When she arrived she was told that the Government of Hungary had extended Agnes' house arrest for a further period. The house arrest conditions are draconian. She is not allowed to leave her small flat, even to go downstairs to the garden, and she cannot go shopping or enjoy the sunshine. The police check up on Agnes four times a day at random times. They arrived while Beverley was there and rang the doorbell, when Dr Geréb answered it, the policeman silently handed her a paper, she signed it, and without a word he marched off.

A year ago Hungary passed legislation to legalise home birth and this year, Felicia Vincze, became the first midwife to get a licence. This good news, however, does not affect Dr Geréb's case, because her case was started before the legislation was established, and the Hungarian Criminal Justice System appears intent to continue their persecution of Dr Geréb. They have three other, equally unjustifiable childbirth cases against her in the pipeline. Their determination to stop her practising appears to have no bounds.

On 24 March 2011 Dr Geréb was convicted of the criminal charges brought against her: she appealed. On 10 February 2012, the Budapest Appeal Court announced its verdict. Her original sentence was for two years' imprisonment and a requirement to serve half of it, together with a suspension from practice for five years. At the Appeal the two year sentence was upheld, but the time to be served was increased to sixteen months, and the Court's previous ban on Dr Geréb practicing midwifery and medicine was raised from five to ten years. It is a surprising, unnecessarily severe sentence, and in many observers' view, completely unjust.

Dr. Ágnes Geréb is an internationally renowned obstetrician-midwife who was the first in Hungary to encourage fathers into the labour ward. She assisted several thousand normal births without complications and her statistics are far better when compared with those that have been obtained from Hungarian hospitals (though unfortunately, Hungarian hospitals are not required to reveal their statistics, so obtaining data is difficult). Four other midwives were also charged in the criminal courts, three of the four were found not guilty (their cases involved minor blood loss in the woman) and the fourth midwife was found guilty and given a hefty fine.

Midwife-led care in out of hospital settings for healthy women and babies, and midwifery support for all women have been shown to increase the normal birth rate, and to have beneficial health impacts. But the criminal proceedings against Dr. Geréb and other midwives are having an extremely chilling effect on the establishment of normal, community based, midwifery care in Hungary. If you have not signed the petition to the President of Hungary appealing for clemency, please do so: www.change.org/petitions/please-grant-full-clemency-to-dr-midwife-agnes-gereb.

If you would like to hear Agnes talking about her experience, you can see a short film about her on vimeopro.com/fogelmedia/a-21st-century-midwife-cultural-creatives.

Donal Kerry
For further information contact donalkerry@hotmail.com

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Elizabeth Key

We were extremely sad to learn about Elizabeth's death in April this year, and would like to celebrate her life and achievements.

Elizabeth initially gained a degree in English in 1966 at Keele University and worked as a researcher, before becoming a Registrar of Births and Deaths in Preston.

She was a highly valued member of our AIMS committee from 1983-2007, becoming our Subscriptions Secretary in 1983 until 1989, and then taking over as Publications Secretary (she had a lovely big barn for the books!) When she took over the Subscriptions Secretary role, she worked on the old AIMS Amstrad computer, with floppy disks, very efficiently! She was equally efficient as our Publications Secretary and could always be relied upon to do all she said she would do, and more.

Elizabeth brought a sense of humour and common sense to our meetings, as well as her very sharp, critical, methodical mind, which she applied to good effect, to the research on childbearing issues (and lack of) that we were beginning to grapple with. She was also a gentle, kind, thoughtful and generous person.

She was very active locally on the Preston Community Health Council (CHC) for many years and on the North West Lancashire Maternity Services Liaison Committee (MSLC) and the North West Lancashire MSLC Service User Subgroup. The MSLC Service User Subgroup met before and after the main MSLC meetings, and Elizabeth was always there to give her words of wisdom and suggest strategies for the main MSLC meetings – which she also attended without fail. Some of the successes supported by Elizabeth were an excellent leaflet about local choices in maternity care, the Health Authority agreeing that MIDIRS leaflets were to be given out in the two local hospitals, and the production of a video for the antenatal clinics providing women with information in pregnancy. She was involved in several publications including 'Influencing Health Policy at the Grass Roots - Nordic Evidence-Based Health Care' in 2001.

Elizabeth also had input into the design of the new maternity hospital in Preston, although she was very frustrated that the basic design was finalised before women and others were invited to participate. She was a regular attendee of the Critical Appraisal Skills workshops run locally by the NCT, saying she always learned something new every time. She also put the skills she learned at these workshop into practice, identifying a very poorly designed randomised controlled trial as part of her CHC work, and then working hard to try to prevent the trial from being run.

Elizabeth also contributed nationally to the work of MSLCs. She was a major contributor to the booklet on 'Maternity Services Liaison Committees, Guidelines for working effectively' produced by the NHS Executive at the Department of Health, and she championed user involvement in maternity care in many settings. Elizabeth was the first AIMS member on the UKCC (now the Nursing and Midwifery Council) Professional Conduct Committee – indeed she was one of the first lay people and served for ten years, until 2007.

Elizabeth served as a volunteer and management committee member of the Preston Well Women Centre, on the Preston Health Authority Joint Consultative Committee as a voluntary sector representative, and ran workshops for Lancaster University CARE Project (Critically Appraising Research Evidence in the NW). Elizabeth was also involved in numbers of important research projects over the years, including working with the Cochrane Collaboration, Pregnancy and Childbirth Group, INVOLVE (formerly Consumers in NHS research), and the Research for Patient Benefit (RfPB) NW Region Funding Committee.

As her husband Geoff said of Elizabeth, the work she did summed her up: 'slightly quirky and alternative on the one hand but – ultimately – academically and institutionally respectable!'

Elizabeth lived a very full life, until more recently when she became unwell, and had to withdraw from some of her activities. She made a huge contribution to furthering public input into health care, and making sure that women's views were represented. She was far too young to leave us now, and our thoughts are with her family.

Nadine Edwards, Beverley Beech and Gill Gyte

An Apology to Emily

Lisa Sykes shares her journey to empowered birth

I'm still working up to apologising to Emily. It will be 18 years in November since her birth and while I know I don't need to apologise to her, I want to.

I have three children. For Emily's birth, I had been booked into what was called the 'GP Led Unit' which was what they called a midwife led unit back then, but Emily, my eldest, was born in hospital on a consultant led unit. I guess in medical terms it may have been classed as an 'easy' or 'successful' induction. Nothing about it felt easy or successful. I was one week past the due date I had been given at my '12 week scan' so my midwife dutifully booked me for induction at 10 days past that date 'unless anything happened before then'. Unsurprisingly nothing did happen. Well that's not strictly true. I did get excited at the prospect that my baby would be in my arms very soon and really looked forward to going to the hospital on the Monday morning.

When I arrived at 8.30am on the Monday with my mum and husband and excitedly reported to the midwives' station on the ward, I was told I was too late and they didn't have a bed for me. My midwife had given me the wrong time to arrive, but I refused to leave. I'd been building myself up to this all weekend and I wasn't leaving without my baby in my arms. Eventually around tea time I was admitted and given a bed. I don't know if my unwillingness to comply and go home contributed to the way they treated me from then on but if it did, I wish I had just gone home while I'd had the chance.

The first pessaries were inserted at 7.30pm and I lay there excited and hopeful. My mum and husband were sent home as visiting on the antenatal ward was now over but, my husband assured me he would be listening for the phone call and would be right there by my side as soon as things started.

'Something' started to happen around 10pm. I spent the next couple of hours going to and from the midwives' station while the other women on the ward slept. I was dismissed each time by irritated midwives telling me 'you have ages yet', 'don't be silly, nothing is happening', 'here, have a sleeping tablet', 'here, have another sleeping tablet'. I felt like an inconvenience and not once was there a reassuring word spoken to me. As I sat trying to sob quietly on my bed I felt what I now know was the unmistakable sensation of my waters breaking. I waddled back to the midwives' station to sighs and rolling eyes to tell them I thought my waters had broken. I was told that I probably had wet myself and to go back to bed and sleep. No offer to check or even help to get changed. Just sent on my way again like a scolded child. When another huge gush of fluid soaked me, my bed and the floor I went back and pleaded with them to believe me. SOMETHING was happening! I HAD NOT wet myself! I was getting contractions! They reluctantly took me to what felt like a store cupboard; small and brightly lit, and established that, yes, my waters had indeed broken but 'I wasn't in labour'. What? How could I not be in labour? Whatever this was that was happening to me felt like labour and if this was just the start I wouldn't survive! I begged for an epidural. I was so scared. I begged them to call my husband back. But they didn't and in fact they didn't call him despite my pleas for another two hours or more. I was left alone, petrified in my broom cupboard with gas and air but not told how to use it.

Eventually I was deemed 'in labour' and moved to the delivery suite. My husband arrived and when I asked where the hell he had been he told me they had only just called him. Once the epidural was in place several uneventful hours passed with midwives popping in and out to do observations, but we were basically alone. To be honest this was probably the most pleasant part of the whole ordeal.

At some point the following afternoon it was established that I was fully dilated and I was directed to push. This is when things became unpleasant again. For over two hours I was yelled at to push. 'Push harder!' 'No not like that!' 'Be quiet!' 'You're scaring the other women!' 'You're upsetting your husband!' I was getting it all wrong. They took my husband away from me and sat him in a corner and comforted him…comforted HIM, but yelled at me. In that room I was below both my baby AND my husband. Add to that being below every other woman in the delivery suite, as I was upsetting them too. I was alone. No one stood next to me supporting me. Not even the person who I thought was supposed to. He was being supported. I was being yelled at.

I've since had my notes back and been able to establish at what point and why they decided to extract Emily from me with forceps. These words are now etched in my brain and I know they will be impossible to remove.

'Lack of Maternal Effort'. Emily's mother did not try hard enough for her.

Having pushed on my back for well over two hours they decided that I wasn't trying hard enough and although there was no sign of distress they would need to pull her out. So that's what they did. They removed her from me. To be frank I didn't care. I just wanted the whole ordeal to stop.

I don't remember the actual moment she was born in detail. I think I had opted out at that point. I now understand the term 'Birth Rape' and while I'm not sure if it was what happened to me, I do feel that Emily's birth was something someone 'did' to me. It wasn't really something I did or even felt I was an important, active participant in. It just happened to me. They put my legs up in the air and the obstetrician put the great big salad tongs up my vagina and extracted her like a tooth.

Then they all left.

I only remember one moment in the whole ordeal that someone said anything kind to me. Just before the pushing began a midwife said to me that her shift would end soon and she would be staying until I had my baby. Not exactly earth shattering or a tear jerk moment but it was the kindest, most vaguely supportive thing said the whole time.

So 14 years and a change of husband later, I was determined my next birth experience would be nothing like the first.

Thankfully the hospital Emily was born in had been demolished and in its place was a shiny new one with a birth centre on the same site. The close proximity to the hospital gave my husband reassurance that his first born, our daughter Hebe, was going to be born in the best place. That same close proximity made me a little more nervous but it was the place we both felt most comfortable being in.

When that same sensation that had been dismissed as my own incontinence greeted me again, I was excited and optimistic. We headed for the birth centre after sorting out Emily and were greeted by warm friendly midwives. I immediately felt at ease. Labour stalled a little once we were there but we were told to make ourselves at home, encouraged to get into bed together or take a relaxing bath and just let them know if we needed anything. Labour soon picked up apace and together, my husband and the midwives supported me with kind words, gentle encouragement and suggestions on positions. I laboured through transition in the birth pool and got out to give birth on a birth stool with my husband, physically AND emotionally, supporting me. Right there. Sat on the toilet seat in our en suite with me in front of him on the birth stool and the midwives knelt in front of me. Watching and waiting. Not once touching me. When I asked 'should I push?' they replied 'Do you feel like want to push?' 'Erm…no...', 'Well then don't…listen to your body Lisa…you tell us what you want to do…'

This was probably the single most empowering moment in all my births. I was doing this!

I did it.

Hebe was born 15 minutes or so later into the waiting midwife's hands and I remember it. I remember EVERY. SINGLE MOMENT. I remember what I said, how I felt, the smell of her, my husband's tears and the midwives' smiling faces. I looked at my husband as I held my little girl on my chest and said 'I want to do it all again.'

So we did…16 months later…at home.

It was a couple of days after Hebe was born when my wonderful community midwife came to visit us and first mentioned home birth. I was revelling in my healing, amazing, empowering birth experience and she said 'next one at home then Lisa!'... So when I arrived back at her clinic nine months later we talked about home birth again and the seed was most definitely sown.

The first sign our third child would be joining us soon was my waters breaking, in bed for the third time! There was nothing much really to do or organise. Emily now almost 15, decided that she didn't want to be around for the birth and was staying at my parents' house, so it seemed easier for Hebe to join her and we could get on with labouring in peace. The day was spent pottering about at home, nesting, preparing the pool, watching films, drinking milkshakes and just generally relaxing.

Around 9pm we asked the midwives to join us and shortly after that I got in to the pool. I listened to Hypnobirthing affirmations, my own specially selected playlist, and laboured peacefully in the kitchen. We knew the midwives were 'there' but they gave us the space and privacy we wanted. My birth plan had said that I did not want any internal examinations and they weren't even suggested to me. The midwife gave positive reassurance to us both and did not encourage or discourage me to do anything other than act instinctively. The atmosphere was light and easy. The labour was intense as my son decided to turn in to a posterior position for a while when I rested on my bed, but he then took the short route back and was born 20 minutes or so later, as I sat on a birth stool, again with my husband behind me but this time in our dining room. After a 10 minute physiological third stage we sat and drank tea and ate toasted currant teacakes as the midwives finished their paperwork before leaving us snuggled up in bed with our little lad, Sidney.

Most people who know me and my birth stories assume that Sid's home birth would be my 'favourite' or 'best' birth. They are all special to me for the obvious reason, but the birth that had the biggest impact on me was Hebe's in the birth centre. I would have any future children at home, without doubt, but the feelings of validation, strength, empowerment and the healing that Hebe's birth has given me can't be properly put into words. To feel listened to, honoured, supported and respected is so much more important than the venue.

I'm sorry Emily didn't get the birth her brother and sister did. She, and I, deserved better. But I am also eternally thankful for everything her birth has taught me.

Lisa Sykes
Mother of 3, Doula with Everyday Miracle
Doula Services, Birth Advocate

Quotes from the latest Confidential Enquiry into Maternal Deaths, from the chapter on Midwifery

'*Every pregnant woman has care provided by a midwife. This places the midwife firmly by her side [...] The midwife is also her advocate in ensuring that she receives the care best suited to meeting her health and social needs.*' *(p14)*

'*Midwives have the opportunity to make a substantial contribution to the public-health agenda and to maximising health gain and reducing general health inequalities.*' *(p150)*

Centre for Maternal and Child Enquiries (CMACE) (2011) Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. BJOG 2011;118 (Suppl. 1):1–203.

Reviews

Born at Home, The Biological, Cultural and Political Dimensions of Maternity Care in the United States

By Melissa Cheyney
Wadsworth, Cengage Learning
ISBN-13: 978-0495793663

This book is the result of an impressive amount of work, largely based on interviews with home birth mothers and midwives, and statistics collected on home birth outcomes for a midwifery practice in the Mid West, USA.

The book discusses how women who plan to birth at home and the midwives who support them are marginalised, at best, and vilified, at worst. The author covers a brief history of midwifery and how it has evolved over the last decades. She defines medical and midwifery models of care, but also highlights the complexities of this and how practitioners usefully draw on both models. She advocates identifying common ground between midwives and doctors in order to promote collaboration and better care for women, especially when home to hospital transfers occur. If midwives and women are afraid to transfer because of hostility from hospital practitioners, and those receiving the woman feel that every home birth transfer is a 'botched' birth, the woman is less likely to receive expert and sensitive care.

The author describes how the US health system works against collaboration and how doctors who are open to midwifery care are prevented from supporting home birth midwives. As an obstetrician explained, it is difficult for doctors to change their practice, even in response to their own scientific research: '*our standards of care come down to us from ACOG – the supreme authority on how we are supposed to practice. It takes much more than new research to change a protocol once it has been established by ACOG.*' *(p47)*

Themes covered include women's stories about how they came to plan home births and the antagonism they faced in order to do this, trusting relationships between women and midwives being at the heart of midwifery practice, the healing potential of home birth, the need for collectivity among those supporting home birth and midwives, and views on safety based in relationships:

'The closeness and depth of knowing that develops out of this approach means that midwives are often intimately acquainted with the physiological, emotional and social nuances of individual mothers and babies. They carry a depth of knowledge that comes from attending a small number of women in a continuous, individualised, and time-intensive manner, and this, midwives assert, makes them better able to identify complications and deviations from normal.' (p73)

Home birth midwives in the US risk a great deal. The author describes how a midwife lost custody of her children because attendance at home births apparently demonstrated 'social deviance' and a sign of an 'unfit mother'.

These midwives (who risk so much) are held in high esteem by the women they support. When the author was presenting her findings of the excellent outcomes of 602 home births over 15 years, a woman in the audience interrupted to acknowledge the midwives who had attended those births:

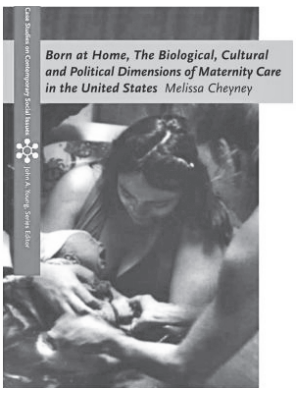
'They are our freedom fighters. They put their families and their livelihoods at risk every day to honor a woman's right to choose where she gives birth. They stand up against an all-powerful medical system so that our babies can be born gently and peacefully at home, and I think that we should stand up for them.' (p91)

Clearly the situation for women and midwives is untenable, and importantly, the author believes that the role of the researcher includes activism – moving from the 'ivory tower of academia', lobbying for new legislation and policies. She describes some of her work in this area and the challenges faced by activists (as we know all too well) and suggests ways of working to increase knowledge and collaboration.

The quotation below perhaps summarises the approach of skilled midwives who have the humility to acknowledge the benefits and limitations of midwifery and technology, and who attempt to balance these:

'Finding the balance... that's the art of midwifery' (p28).

Nadine Edwards



Home Birth: The Politics of Difficult Choices

By Mary L Nolan
Routledge 2011
ISBN-13: 978-0415557559
£20.99

This book covers the experiences of ten women who were deemed to be 'high risk', by conventional maternity care, but who nonetheless had home births. Five of the women had had babies before, and several

women booked with independent midwives. The book is based on interviews with the women, and conveys their views and experiences in some depth. The author focuses on the importance of women's and midwives' agency, and the need for women who make decisions outside usual guidelines and policies to be supported.

In setting the context, Mary Nolan discusses some of the political issues surrounding contemporary childbirth and the limitations of 'choice', suggesting that 'rhetoric about involving patients in their care as equal partners has outstripped the ability of the health service to configure itself as a democratic institution' (p57). She discusses the fear/risk culture of birth inhabited by women and midwives and promulgated by the circulating negative birth stories that undermine their confidence.

In this setting, both women and midwives struggle when women make 'difficult' decisions. Women needed midwives to be their advocates and to support their decisions, even if they did not agree with them (which is what the Midwives Rules expects of them too). They found it exhausting to keep 'fighting their corner'. All they wanted was 'care which made them feel strong, confident and safe' (p116) from calm midwives, who believed in their abilities to birth their babies and could enable them to birth undisturbed – unless help was needed.

For midwives this clearly presents an increasingly intractable problem: while women value autonomy in their midwives, this is continually undermined by midwives being judged against medical rather than midwifery knowledge, and by 'difficult' decisions made by women being seen as a failure on the part of the midwife to provide enough information for the woman to make 'correct' decisions. It is almost impossible for midwives to support women, when they are so unsupported themselves.

Mary brings out this pitting of women and midwives against each other, and the difficulty of providing individualised care, in a culture of fear, risk, blame and guidelines. For women, this translated into midwives, supervisors of midwives and even senior midwives attempting to coerce them to follow usual procedures: 'They didn't want me to follow what I actually wanted, they wanted me to follow their procedures.' (p121)

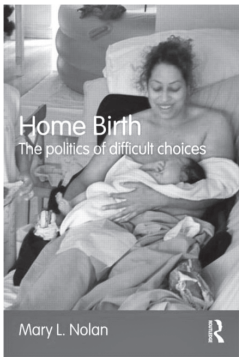
This book is powerful: it has an authenticity based on the women's own words, around which the author has built her narrative. It shows how women make careful decisions based on their own circumstances, and the profoundly negative impact of finding these decisions challenged at every turn. As Mary comments, 'It is hard to see what purpose is served by suggesting to women that they are not capable of giving birth, or how frightening them will lead to better outcomes. (p120) Yet, the lack of support and bullying some women were subject to, is staggering.

One point that is not made completely clear is about free birthing. Mary rightly points out that women have the right to birth at home. If the woman decides not to call a midwife, and invites family and/or friends to support her emotionally, this is is not illegal and her family and friends cannot be fined, unless they are pretending to be a midwife or doctor and/or take on that role.

There are so many quotations that I would have liked to include, but the one below is particularly key to the home birth debate, sits well with AIMS philosophy and may hearten AIMS members:

'challenge is the lifeblood of improvement' (p17).

Nadine Edwards



The Heart in the Womb

By Dr Amali Lokugamage
Docamali Ltd 2011
available from www.lulu.com
£12.99

This extremely readable book is fascinating. It is the story of how an obstetrician practising in a large obstetric unit in London came to plan a home birth.

It describes a personal journey of moving from an intellectual understanding of why women need holistic care to help them grow through their pregnancies and births and become the mothers they want to be, to a very deep, embodied understanding of pregnancy and birth and what women need to support them through this vulnerable and potentially strengthening time. Amali Lokugamage lays the foundations for 'crossing a bridge to another birthing world' and weaves together a holistic approach, drawing on many fields, including modern medicine.

She describes how she became more drawn in to her own pregnancy, how she began to understand the connection between a woman and her unborn baby, and how decisions can flow from that relationship – if the woman is encouraged to listen to her body and her baby. She describes how difficult this can be in our fast moving, stressful culture, where women are expected to work until late in their pregnancies and where experts and technology provide the information about the woman's pregnancy and baby rather than the woman herself. The book moves between research and experience, and stresses the need to encourage women to move from rationality to confidence during pregnancy:

'Throwing facts and figures at women undoubtedly helps them to understand their choices, but it is more important that women are guided to unlock confidence in their bodies to embrace the process of birth. Without this, an almost virulent form of fear can sabotage their innate capabilities to

birth well, quite aside from any genuine medical issues.' (p46)

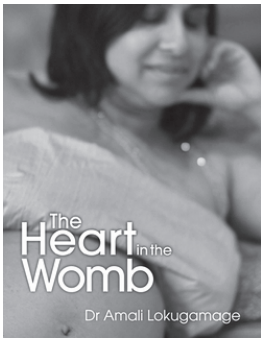
The book describes how bureaucratic institutions with an emphasis on risk mitigate against holistic care and environments that support labour and birth – but that midwives are in a position to advocate for normalising birth. She describes midwifery practices in various parts of the world that provide holistic care with excellent results and high satisfaction rates for women. She explains how interventions, when carried out routinely might do more harm than good. While supporting the appropriate use of medicine and technology – her transformation through her own experiences of being a pregnant woman and mother have led to richer reflections – that encompass the miracle of birth, how the hormones released when labour and birth are undisturbed are crucial for women, babies, families and society, and what supports this intricate system.

Undisturbed birth fosters 'love, compassion, nurturing, understanding, trust and co-operation', thus how children are born, 'shapes the collective thinking of our society as a whole' (p114): the need to think through how to best support undisturbed birth and minimise intervention in birth is urgent. Balancing benefits and harms (as Luke Zander again suggested at the recent Birthplace conference in London) seems very challenging for our 'risk averse' society but Amali's final suggestion provides a great deal of food for thought:

'A certain amount of strategising in professional life is necessary, but if this is also tempered with a more pragmatic approach, of taking life as it comes and having a receptive and flexible response to life's challenges, then it really helps one to negotiate life's chaos. Some of the most perfect solutions to life's problems are only visible in the moment and cannot be calculated.' (p118).

Nadine Edwards

Amali Lokuganage (obstetrician), Sarah Buckley (GP) and Clare Willocks (obstetrician) have set up a network for doctors who support undisturbed birth. www.facebook.com/groups/225233534204058/



Home Grown Babies

DVD
£14
Available from AIMS,
www.aims.org.uk/pubs3.htm#homeGrownBabies

Bernadette Bos is a former midwife and director of Home Grown Babies and other inspiring programmes about pregnancy and birth, including Home Birth Diaries, Special Babies and Pregnancy and Birth the Truth.

Over the years you may have seen Home Grown Babies on the TV but sadly this inspiring series has only ever been available on some obscure digital TV channel. Mainstream TV only seems to broadcast sensationalist stories which have no purpose other than to contribute to a growing fear of pregnancy and childbirth.

Fortunately Home Grown Babies is now available on DVD and includes five stories of childbirth that will both inspire and empower you. The series focuses on home birth and covers different subjects including waterbirth, gestational diabetes, hypnobirthing, vaginal birth after caesarean (VBAC) and a positive caesarean section after transfer from a home birth.

Each story takes you through pregnancy, birth and the first few weeks post-natally, giving you a personal and realistic insight into what it's like to plan a home birth in the UK today. It highlights the national shortage of midwives and how this affects a woman's right to choose a home birth and also looks at the vital service independent midwives (IMs) provide.

I enjoyed following each couple through the ups and downs of pregnancy, labour and birth, but I particularly enjoyed Clare's beautiful home birth of her first baby, assisted by independent midwife, Virginia Howes.

Bel's story was also very inspiring as she came a long way to have a home waterbirth, despite numerous obstacles, including being diagnosed with gestational diabetes and subsequently having to fight for her home birth.

Other stories include Nancy and Teewyn who used the hypnobirth technique to help them through their second attempt at a home birth. Nancy suffered a traumatic birth with her first baby after being transferred from home to hospital during labour. I was touched by how protective Teewyn was towards Nancy and how well he supported her throughout the whole process.

This DVD is a great educational resource for parents-to-be, midwives, doulas, antenatal teachers and other maternity health care professionals and it comes with a handy information booklet which includes useful facts, figures and links to further inform.

I would highly recommend this DVD. A must see!

Michelle Barnes
AIMS Committee Member

JOURNALS & BOOKS

AIMS Journal: A quarterly publication spearheading discussions on change and development in the maternity services, this is a source of information and support for parents and workers in maternity care; back issues are available on a variety of topics, including miscarriage, labour pain, antenatal testing, caesarean safety and the normal birthing process £3.00

Am I Allowed? by Beverley Beech: Your rights and options through pregnancy and birth £8.00

Birth after Caesarean by Jenny Lesley: Information regarding choices, suggestions for ways to make VBAC more likely, and where to go to find support; includes real experiences of women £8.00

Birthing Autonomy: Women's Experiences of Planning Home Births by Nadine Pilley Edwards, AIMS Vice Chair: Is home birth dangerous for women and babies? Shouldn't women decide where to have their babies? This book brings some balance to difficult arguments about home birth by focusing on women's views and their experiences of planning them. Invaluable for expectant mothers and professionals alike. See AIMS website www.aims.org.uk

Birthing Your Baby: The Second Stage by Nadine Edwards and Beverley Beech: Physiology of second stage of labour; advantages of a more relaxed approach to birth £5.00

Birthing Your Placenta: The Third Stage by Nadine Edwards and Sara Wickham: ***Fully updated (2011)*** evidence-based guide to birthing your placenta £8.00

Breech Birth – What Are My Options? by Jane Evans: One of the most experienced midwives in breech birth offers advice and information for women deciding upon their options £8.00

Choosing a Waterbirth by Beverley Beech: How to arrange a water birth, pool rental, hospitals with pools; help to overcome any obstacles encountered £5.00

The Father's Home Birth Handbook by Leah Hazard: A fantastic source of evidence-based information, risks and responsibilities, and the challenges of home birth. It gives many reassuring stories from other fathers. A must for fathers-to-be or birth partners. £8.99

Home Birth – A Practical Guide (4th Edition) by Nicky Wesson: AIMS has replaced Choosing a Home Birth with this fully revised and updated edition. It is relevant to everyone who is pregnant, even if they are not planning a home birth. £8.99

Induction: Do I Really Need It? by Sara Wickham: An in-depth look into the options for women whose babies are 'overdue', as well as those who may or may not have gestational diabetes, or whose waters have broken but have not gone into labour. £5.00

Making a Complaint about Maternity Care by Beverley Lawrence Beech: The complaints system can appear to many as an impenetrable maze. For anyone thinking of making a complaint about their maternity care this guide gives information about the procedures, the pitfalls and the regulations. £3.00

Safety in Childbirth by Marjorie Tew: Updated and extended edition of the research into the safety of home and hospital birth £5.00

Ultrasound? Unsound! by Beverley Beech and Jean Robinson: A review of ultrasound research, including AIMS' concerns over its expanding routine use in pregnancy £5.00

Vitamin K and the Newborn by Sara Wickham: A thoughtful and fully referenced exploration of the issues surrounding the practice of giving vitamin K as a just-in-case treatment £5.00

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MISCELLANEOUS

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Sunday 15th July, 2012
Royal Society of Medicine
Speakers include:
Marie Mongan, Professor Lesley Page, Beverley Beech, Miranda Dodwell
Contact: info@birtheasy.co.uk
phone: 07951102213

AIMS Meetings

15 June - Leeds
15 September - London
20 October - York
30 November - Oxford
Please contact Gina Lowdon for details of times and venues.
01256 704871 after 6pm and weekends
gina.lowdon@aims.org.uk

The Dorset Home Birth Group
Home Birth Matters
Saturday 13 October 2012
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Key Speakers
Professor Paul Lewis, Emeritus Professor, Bournemouth University
Clara Haken, Consultant Midwife for Normal Birth, Kingston Hospital NHS Trust

£30 Registered Midwives and other professionals
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Enquiries to Claire Williams
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AIMS AGM

Saturday 14 July 2012, 10am
Carrs Lane Church Centre
Birmingham
www.carrslane.co.uk

All AIMS members are welcome

Guest Speaker:
Dr Mary Stewart, midwife, educationalist and researcher
Birthplace Study Report

Discussion: **Midwifery-led Care**

contact secretary@aims.org.uk

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