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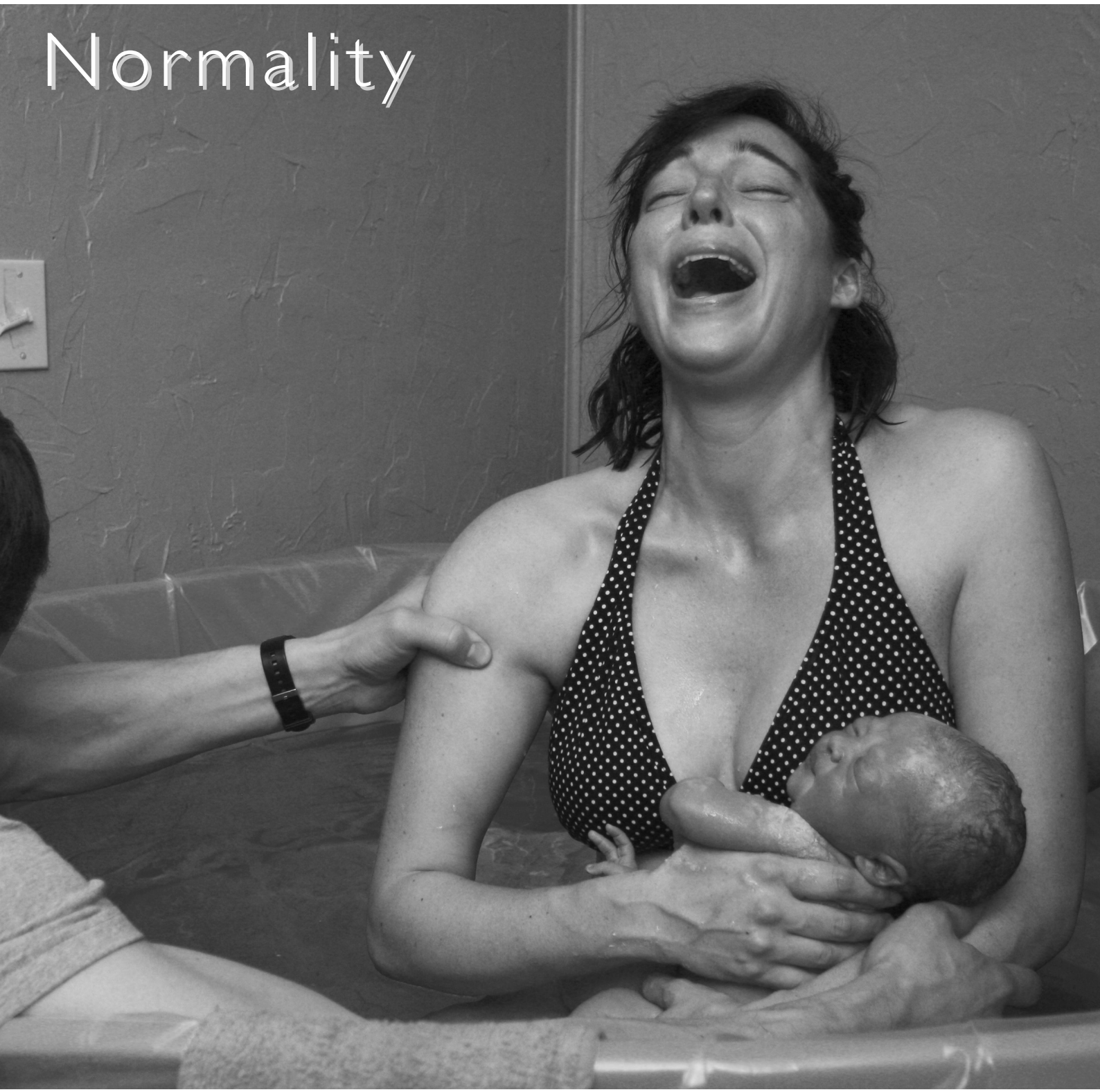
ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES

Normality



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contents

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Story on page 19

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Supporting Normality

Vicki Williams introduces a journal which shows how the system can support normality

This issue offers us a great deal of hope for the future. There is good practice out there, there are women having good births, and this journal takes a brief snapshot look at how it is happening.

In the past the AIMS Journal has looked at the shining lights in maternity care, looking at midwifery-led units like Montrose, at models of care like the Albany Midwifery Practice (which was contracted to provide NHS care), at individual practitioners such as Jane Evans, Mary Cronk and many others who do so much to provide normal birth to women, and at educators like Sara Wickham, Mavis Kirkham and the late Trisha Anderson. The one thing that they all have in common, more important than any other measure of their success, is that the women themselves are happy with the care, they feel nurtured and their praise is high. Very high. If women were truly doing something risky by considering holistic care and birth in an emotionally safe environment, if they suffered illness or injury as a result, or their children were at risk, would it not reflect in their view of the services offered? It does not take much to realise that it is rare (so rare it is newsworthy) for a woman to put her child at risk, real or self-perceived, and that if these midwife-led and home birth services were really as risky as the medical establishment would have us believe, word would get round, and then, far from being the places or people to which women flock, women would actively avoid them.

When women have a choice they vote with their feet, and when they have a real option they choose holistic and nurturing care for their pregnancy and birth. This is not the whim of those more concerned with their experience than their or their child's safety; quite the opposite: women are seeking to make birth as emotionally and physically safe for themselves, their families and their babies as they can. Women don't lightly opt for surgery to avoid 'natural' childbirth. In AIMS' extensive experience they agonise over the choices available to them. Sometimes they decide on surgical birth, when they believe it to be the safest. It is not the intention of this Journal to say how many of those women were truly safer having a caesarean, and how many were not given accurate enough facts to make a properly informed choice, but we know that women are so keen to protect their child that they will undergo major surgery, with the increased risk of complications and a painful recovery, in order to protect their babies. Sometimes it is the ultimate act of bravery to compromise your body to do what you believe is the best for your child. But it can be different; it is not usually a choice between emotional or physical safety, it is not often the case that a woman must choose between her baby and herself. Birth can be nurturing, caring AND safe for mothers and babies; often they just need to believe it, see Christine Hall's article on hypnobirthing (page 15).

Some areas have realised this. One such Trust is Sandwell & West Birmingham Hospitals NHS Trust, where Consultant Midwife Kathryn Gutteridge and her team have launched the hugely popular Serenity Midwifery-Led Birth Centre (see page 6). The decor is amazing, but that is just the icing on the cake. It is the philosophy of care which the decor reflects which makes the biggest difference. Water is used and instruments, drugs and other expensive technological interventions are reduced without any reduction in health. Quite the opposite: with easier, more straightforward births and less surgery, women are physically and emotionally healthier as a result. Initial reports are staggering: 75% of women entering the unit give birth there, and 67% go home within six hours. The entire project cost less than a million to set up. That is less than the Village Hall in my rural location cost to build!

Most importantly, though, the feedback from the women using the service is positive and the midwives working there are happy. For those interested in knowing more, Kathryn is one of the Guest Speakers at this year's AIMS AGM (notice on the back cover).

Our birth stories in this issue are inspirational. Anne Dew's story (page 19) of her birth in one of America's surviving stand-alone birth centres is summed up for me in the image on the cover: Anne, very much ecstatic, as she births her baby Elsa in water.

Alexandra Orchard's birth journey (on page 21), one cascade of intervention and one painfully planned repeat caesarean with no choice, followed by a home VBA2C, shows the contrast between what happens routinely within a technology-reliant setting and how much more relaxed things can be and how much more empowerment can be achieved with good support.

As ever, I find stories of birthing inspirational, and every birth, however it happens, is an achievement for the woman and a miracle. Sadly not all women have support to get the best experience they can, and I wonder how much of that is because the expectations of the system steer them along a path which would not have been their choice had there been options readily available.

Women still want to give birth normally, and seek out ways of doing that, and one of the many books dedicated to helping women help themselves, *Preparing for a healthy birth* is reviewed on page 25.

The review of *Tensions and barriers in improving maternity care* on page 24 shows just how hard it is to run a birth centre if the management attitudes and support are not right, and how the culture of maternity politics can influence the success or failure of a project to normalise birth. Women and midwives working together, with the support of the system, must be the real key.

Vicki Williams

Article

Normalising Home Birth

Jo Dagustun's personal reflections and a call to action

At the end of 2009, swathes of Primary Care Trusts – probably including your own – were quick to claim, in response to Maternity Matters, that they were offering local women a choice in where they gave birth, including at home. I'm sure many readers, at that point, joined with me in wishing that it were so simple. In this article, I reflect on my own feelings towards home birth as they have developed over twenty years and four births. In doing so, I suggest there has to be a personal acceptance of home birth before the option becomes credible, and the real challenge is thus how to create this 'credible option' environment for women.

An ordinary tale of ordinary bad birth

During my first pregnancy in the late 1980s, I had read up about home birth and active birth, and I was keen on both (to the extent that I specifically remember working out whether I could have a pool in my flat). But I didn't raise the issue with my midwife, as I didn't want to get into a fight about it. So I did the usual thing of transferring to hospital in labour. I recall the journey being unpleasant; I was presumably feeling the contractions as painful as well as regular. Following what I believed to be a fairly 'ordinary bad birth' (I resented in particular the routine catheterisation, and the experience was only active insofar as I was invited to climb onto a hospital bed), I gave birth eight hours later and then stayed in the hospital for a good five days (on what I recall to be a lousy postnatal ward, but at least I could put my feet up and ring the bell anytime I wanted breastfeeding support – which was generally most useful at night, from a kind and knowledgeable woman in green, who was always willing to put down her broom to come and help …)

Try, try again

Fifteen years later, I clearly had the desire to try for a home birth lodged firmly in my mind. The lousy car journey of my first labour was one motivator; not actually having a car in which to get to the local hospital was another. A home birth was planned and a large paddling pool procured. In the event, however, I was politely asked to present myself to the local hospital under the local PROM protocol. For my third and fourth births, however, I stayed at home to give birth, attended by NHS midwives.

Feel the fear and do it anyway

For some time, perhaps between birth two and three and a little time thereafter, I was quite an advocate of home birth. For me, home is not just the obvious default option, most likely to support a good birth experience. It is also, barring pathological indications to the contrary, the politically correct option. I am no braver than anyone else: I have experienced the usual fearful feelings associated with labouring and giving birth far away from the 'safety kit' of the hospital. But the strength of my political motivation has led to my position that I should 'feel the fear and do it anyway'. I realise that this is not the most inspiring motto with which to encourage other women to seriously consider the option of home birth. But it was the best one I had, until I realised last year that I was no longer even very interested in advocating home birth.

Better information equals more home birth?

During this time, I also chose to focus on the topic for a Masters dissertation. Whilst talking to women for that piece of research, I was surprised to discover how little many women actually knew about the most basic arrangements for giving birth at home. Most didn't know, for example, that the local norm was that two midwives would attend (both of whom are there to give you their full attention rather than just looking in now and again between other ward tasks); that the midwives take responsibility for clearing up any mess and serving the postnatal cup of tea and toast; that as much gas and air as you like (and even pethidine) could be accessed at home. As well as a lack of information about the home birth option, I also heard much dissatisfaction with the hospital experience. I therefore saw a clear opportunity – based on improved information and consciousness-raising – for more women to make a decision in favour of home. All in all, I believed – and liked to suggest to whoever would listen – that, if there are no indications to the contrary and all goes well, home birth has to be the jewel in the NHS maternity service's crown.

An advocate lost for words …

A few months after birth four, I was given the opportunity to talk about giving birth at home in a postnatal yoga class. I had an ideal and captive audience. I would have relished the opportunity a few years earlier. But, in the moment, I just couldn't muster up the enthusiasm to say anything much at all. I just couldn't be bothered to engage with the situation, and mumbled something rather incoherent about being happy to talk to anyone who had a specific question. Having puzzled over that experience, I have lately come to the conclusion that it reflected a key turning point in my own attitude towards giving birth at home. Through my own experience, I believe I had only then got to the point where I had really normalised home as the obvious place to give birth, to such an extent that I just found it strange that anyone would start from the perspective of not thinking that giving birth at home was the best option.

Advocating home birth versus creating an environment in which home birth can become a credible option

In UK contemporary culture, home birth is generally viewed as a marginal, and even suspect, activity. The idea that we can seriously promote home birth simply by asking women 'if they've thought about it', whether at a booking clinic or later during the antenatal period, just

doesn't ring true. My own experience points to the deep internal resistance to home birth prevalent amongst women (including myself), where we are generally exposed to decades of socialisation in favour of the hospital as the 'correct' place for giving birth. Increasing choice, then, is clearly not just about implementing overnight a policy decision to henceforth 'offer' or 'allow' the choice. It also has to be about working long-term – against a powerful dominant culture and a set of long-internalised beliefs – to support women to see home birth as a credible option for themselves. Incidentally, I believe that this is a really important goal in its own right, for wherever a woman then decides to give birth this outcome is bound to reinforce the notion of a woman's body as strong and capable of giving birth, a notion too often buried too deep for many women to access but perhaps key to improving birth experiences and to ridding us of the phenomenon of 'ordinary bad birth' (or 'ordinary bad care', as a midwife friend has suggested).

we really need a serious plan of action

If local midwives don't trust in home birth, then we're stuck …

If it is the case that whole-scale change is needed to implement this small part of the Maternity Matters agenda, I believe that it is essential for every PCT, local midwifery team and Maternity Services Liaison Committee to properly interrogate how they offer home birth 'on the ground', and to check that a single question at booking and a reference to the choice in a – possibly unread – leaflet, or at a poorly attended workshop, isn't the extent of local efforts to promote home birth. For it must surely be misguided to think that the existing huge barriers to such choice – whether personal or cultural – can be dismantled with such a simplistic approach. If we are really serious about extending the known benefits of home birth to larger numbers of women, then we really need a serious plan of action. One starting point might be to commission an in-depth audit of the beliefs of local midwives on this issue – and for the results of such an audit, and ensuing plan of action, to be discussed by the local MSLC. Because any option of home birth, if suggested by a professional who herself does not feel comfortable with the option, is highly unlikely to be read as either a credible or well-supported option by women.

Jo Dagustun

Jo Dagustun is a PhD student in the School of Geography, University of Leeds, where she is exploring the potential for the lay community – as distinct from policy or the professional community – to improve women's experiences of birth in contemporary Britain. Jo is also a lay member of her local MSLC (Tameside and Glossop, Greater Manchester) and would welcome linking up with other MSLC members interested in extending choice of birth location to all women. Jo can be contacted via email at gyjwd@leeds.ac.uk.

Quotation Corner

On 'Normality'

'Logically, the abnormal cannot be identified without a clear scientific definition of the variations of normal. Obstetrics lacks this because the risk concept implies that all pregnancy and birth is risky and therefore no pregnancy or birth can be considered normal until it is over. In other words one cannot claim both the ability to separate normal and abnormal during pregnancy and the inability to determine normality until after birth. The wide variation which occurs in the healthy experience of childbirth is too large for a single, uniform definition of "normality", which can be used to define "abnormality"'

Marsden Wagner (1994)
Pursuing the Birth Machine:
The search for appropriate birth technology,
Ace Graphics

On Achieving Normality

'…many hospitals have allocated scarce resources towards renovating their labor wards, to provide more attractive, home-like settings for birth. Such settings are undoubtedly attractive, and also provide more pleasant work environments for caregivers. It is quite possible that happier caregivers may provide better care. Nevertheless, hospitals that are considering renovations of their labor wards should be aware that there is much stronger evidence to support the need for changes in caregivers' behavior than there is to support the need for cosmetic or structural changes to labor wards. If renovations are desired, they should be geared towards factors that would encourage changes in behavior, such as removing lithotomy poles and replacing uncomfortable delivery beds with comfortable furniture and cushions.

'Efforts to change caregivers' behavior to help them to provide appropriate support to laboring women should also be introduced. Such changes do not come easily. A multicentered trial of a marketing strategy using opinion leaders to encourage nurses to provide labor support did not have the hoped for outcome. A follow-up study in those hospitals where the hypothesized improvements did occur showed that a highly involved nurse manager was critical to its success.'

Murray Enkin et al (2000)
A guide to effective care in pregnancy and childbirth,
Oxford University Press
ISBN 019263173X

The Birth of Serenity

Kathryn Gutteridge introduces a midwifery-led birth centre in Birmingham

In 2009, recruitment for midwives at Sandwell & West Birmingham Hospitals NHS Trust had exhausted all the normal creative ideas for tempting midwives to work with us. Maternity services at the Trust had experienced a long period of scrutiny from internal and external agencies which as always affects staff morale. During one of the meetings with the chief executive, he asked the question 'what would bring good-quality midwives to work with us?' The Head of Midwifery and myself simultaneously answered; 'A birth centre'; thus the new dawn of midwifery at our Trust was born.

From the agreement of our Trust board for the location and resources to develop the Serenity midwife-led birth centre (MLBC) and also funding for six whole-time-equivalent (wte) new posts plus six out of the current staffing, in less than 12 months the facility became operational. As most people working in the NHS will know this is nothing short of miraculous in terms of speed and agreement. However, when the chief executive gets behind a project anything is possible. The timing was spot on, the right people were in agreement and there was a real appetite for change within the service.

Project Brief

The brief was developed and was clear in both aims and outcomes; these are briefly outlined as;

A midwifery-led birth centre improves the training opportunities and experience of student midwives by offering exposure to a wider range of midwifery models of care and in turn assists in the retention of students once qualified.

- Promote normality of birth in terms of midwifery-led care and non-clinical environment for low risk births.
- Offer women choice in line with requirements of Maternity Matters.
- Provide a clinically safe service with a reduction in medical intervention for low-risk births.
- Support the national and local vision for Maternity Services.
- Reduce length of stay in hospital for low-risk births.
- Provide a service that attracts and retains high-quality staff and in particular midwives.
- Support an improvement in the quality of care for high-risk births as a result of providing a separate focus and resource for low-risk births. An identified benefit of having a midwifery-led birth centre is the support for a normality framework of care for low-risk women. This model of care allows the obstetric-led maternity service to focus on those high-risk cases where there is clinical evidence of benefit to the mother and/or baby for specific intervention.

Design

Serenity MLBC is away from Delivery Suite and therefore named as a co-located birth centre. It has a drop-off area and its own entrance, which is clearly signposted. The doors are CCTV linked to within Serenity and entrance is controlled by the staff only.

When arriving onto Serenity it feels very different from any clinical area, with a calming atmosphere. There is a reception area which looks similar to a hotel reception. There are five rooms, all ensuite, with walk-in wet room facilities. Each room has its own characteristic and they are named Ruby, Sapphire, Jade, Amber and Violet.

Waterbirths are positively encouraged and each room has either a fixed or blow-up pool ready to go. No bed is seen in the room until after the birth when the drop down double bed is lowered for both parents to rest with their new baby. All other birthing aids such as birth stool, Bradbury birth mats, glider chairs and birthing balls are available. All clinical equipment is housed inside the green storage and all natural wood finish furniture is for the woman and her family's storage or usage.

The shared kitchen is for staff and families alike and is much like a domestic kitchen. This leads out to a secured garden area for women and their families to use. A therapy room is located quietly away from the birthing rooms where women can receive treatments for a range of complementary therapies. The visitors can use a secluded rest room which has its own toilet facilities just for time out or if the woman wants some privacy.

location is very important

Next Steps

It was important to develop a shared vision of the end facility as we had been allocated a vacated area that once had housed the neonatal unit; located away but down a corridor from Delivery Suite. The location is very important as many co-located birth centres fail due to their position within the service. The funding for the project was set at £850,000 and this was to include all building work, refurbishments and fittings.

A project group was set up and governance arrangements made; the actual work would be delivered by consultant midwife, project manager and other key stakeholders. Regular meetings were set and a programme of activity was agreed; the minutes of each meeting were scrutinised by the project board which included redesign director, divisional general manager,

head of capital projects, head of midwifery, senior finance manager and service redesign manager. Set target dates were decided and timeframes agreed which is really important when developing a project otherwise it is easy to drift.

Some of the main pieces of work were decided and allocated; these were:

- Model of care
- Projected numbers for both activity and transfer
- Communication strategy
- Guidelines and operational model of care
- Engagement of women and midwives
- Staffing model and recruitment strategy
- Discussion with other key stakeholders

Once this plan was agreed and developed the work was quite frantic and began quickly.

Model of Care

Myself and the head of midwifery worked closely with the project manager and discussions were had about how this facility should look on completion. The project manager had never worked in maternity before but he was very innovative and excited by the challenges before him. I described a facility which would fit the name Serenity – the name had been suggested many months before by a father who was attending an aromatherapy session with his wife. I asked him what name he would call a future midwifery led service and so the name was born.

Paul the project manager visited other local birthing centres and had an idea of the model of care but I wanted to give our women something very different that would give them the 'WOW' factor. I asked Paul to consider how hospices were built around the family and patient needs and were often beautiful environments with great attention to nature. The vision and strap line for our project was: 'For one day in a woman's life – cared for with Serenity'.

The women who use maternity services at this Trust are in one of the poorest quintiles of Birmingham with factors such as;

- High poverty
- Unemployment
- Crime & drugs
- Non-English-speaking population
- Asylum seeking and immigrant populations

Many of the women were unable to understand the concept of 'low-risk' and what a birth centre could offer them. It was important to try to share these ideas with women to capture their views. Some of the community midwives held group sessions with women where interpreters were present so time was taken to show the artist's impression and existing midwife–led services. The women and their families appeared to be both excited and curious about the proposals.

It was decided that we would offer an 'Opt Out' model of care which means that if women are assessed as low-risk throughout their pregnancy they would automatically come to Serenity unless they chose otherwise.

Meetings with midwives discussed current risk assessment of women, the way community midwives supported low-risk women's births at home and how the service could be improved. In general midwives were

really open to change but for some there was an element of change fatigue. However, it was really vital to have all midwives aware of the new way of working.

Recruitment

To maintain the philosophy the midwifery team was fundamental to the success of the project. A team leader was appointed to manage the team in their daily activities and to support the midwives – support workers who would be integral to both women and their families. To ensure the calibre of midwives met our expectations a different approach was applied to the interviews. Midwives were invited for a whole day and everyone met each other over coffee.

the midwifery team was fundamental to the success of the project

Programme for the Day

- Welcome over coffee
- Introducing Serenity Model of Care
- All midwives will be asked to produce a collage which explains their philosophy of midwifery (all materials are provided)
- Break where invited midwives will join us
- Each interviewee will give a presentation explaining their collage
- Lunch
- Afternoon: Human Resources will attend and paperwork will be explained
- One-to-one opportunities to discuss personal requirements

This model of interviewing gave real insight into the interviewees' personal and midwifery belief systems and this was considered really important for this project.

Official Opening

Once the building work was nearing completion a date for opening was decided upon. Initially it was planned to be on Mothering Sunday 2010, giving a real purpose for the project. However due to recruitment completion we reviewed this and decided that we would have an official opening in April where we invited all involved in the project to attend and the centre was generously opened by Cathy Warwick General Secretary of Royal College of Midwives. Our reviewed operational opening date was set as 5th May 2010, International Day of the Midwife.

To ensure that we had offered women every opportunity to see what a birth centre looked like we had a two week period where we conducted open house tours. This was very successful and gave great feedback to the team. There was a period of two weeks prior to the operational date where all the staff began with an intensive two weeks of training and final stocks were received.

Our First Serenity Baby

As with any first day we were all very nervous and keen that it should go without a hitch. The first labouring woman was diverted from Triage around to Serenity and she was shown into her room and the pool filled with water. However a few minutes later a second woman arrived in advanced labour; she gave birth within 40 minutes of arrival and held her baby girl in her arms happy and pleased with everything. She later decided to call her baby Sakinah, which is Arabic for peaceful and serene; the local press loved the story and her parents were glad to give them their thoughts.

Ten Months Later.....

The Serenity Birth Centre has exceeded our expectations. It is a peaceful and serene place where low-risk women and their families can give birth without the trappings of a traditional delivery suite. Without exception, staff have embraced this project and feedback is positive and encouraging.

Some of the data so far has given a great boost to the model of care. Of over 800 women:

- Pethidine use – 6%
- Waterbirths including all three stages – 69%
- Position at point of birth 'off bed' – 100%
- Expectant management third stage – 45%
- Home within 6 hours – 67%
- Transfer to delivery suite – 24.3%

Data is collected in 'real time' which means a spreadsheet was set up and midwives put in data from each birth as soon after the event as possible; this

automatically calculates the monthly activity. This makes midwives very aware of our key performance indicators and then makes it much easier to keep track of trends.

Comments from visitors to the Birth Centre have been very favourable. Some women are surprised to learn that the Birth Centre is provided as part of traditional NHS maternity services; one of the reasons is the high-quality finish and the innovative room designs, wall murals and ceiling starlights. Midwives are enjoying the experience of working in a woman-centred way in an environment that encourages the best from labouring women.

Finally

This has been a real gift to me as a midwife; very rarely in a career do the signs align to bring everything together in such an extraordinary way. There was such energy about the whole process and a great deal of pride in the finished product. Women and their families have been overwhelmingly positive about the care and environment, and it is a pleasure and an honour to have been involved and continue to be so much a part of this wonderful place.

With heartfelt thanks to; Elaine Newell Head of Midwifery, Paul Scott Project Manager, Mr Paul Bosio Clinical Director, Esther Rackley Inpatient Service, Sue Murray Divisional General Manager, Mr John Adler Chief Executive and Sarah Conlon Communications. No less thanks for Jill Beckett Team Leader and the rest of the Serenity Team but especially to all the women and their families for their encouragement and support.

Kathryn Gutteridge
Consultant Midwife
Sandwell & West Birmingham Hospitals NHS Trust

Sakinah Maryam Yusuf was the first baby to be born in the new Serenity Midwifery Birth Centre on Tuesday 5 May – International Day of the Midwife. Her proud parents have called her Sakinah which is Arabic for Serenity, after the unit. Sakinah was born at 9.36am and proud mum Donna Corbin and dad Abdur Yusuf are delighted. Donna said: *'My first impressions of the unit were – wow! It is such a special unit and I had a fantastic birth. The midwives allowed me to listen to what my body was telling me and the midwives on the unit have been incredibly supportive. I am currently undertaking a nursing degree at Birmingham City University, and giving birth on this unit and seeing the job satisfaction the midwives get here has made me really think about changing my degree so that I go into midwifery.'* Dad Abdur said: *'I really think the beautiful environment and positive attitude of the midwives here really make a difference, which has led to Donna and myself having a very special birthing experience. As a dad I have been made to feel very welcome and it is great to see a birthing centre like this that has been designed with dads also in mind – I will be telling everyone about the Serenity Birth Centre at City Hospital.'*

Sunveer Singh Uppal was the 100th baby to be born in the Serenity Midwifery Birth Centre. Proud mum Gurdev Dhinsey and dad Surjit Singh Uppal were overjoyed with their birthing experience. Mum Gurdev said: *'I have had a fantastic birthing experience here at Serenity. The facilities here are brilliant, the décor and lighting gives the unit a home-from-home feel and the staff are so supportive and made me and my family feel very special. After nine months of being pregnant I felt that the birth of Sunveer was a gift and that was made possible by everyone at Serenity ... the birth being a completely natural one.'* Dad Surjit also was made to feel very welcome on the unit and the family were pleased that Sunveer's older sister Summerjeet was able to meet her little brother in a comfortable and welcoming environment.

When Victoria Delaure went into labour she did not expect to give birth at Serenity. She was originally booked to give birth in another unit in the West Midlands but is now delighted that the birth of her first child, Evan, was at the Serenity Midwifery Birth Centre after the other hospital trust turned her away due to lack of beds available. A delighted Victoria said: *'My birthing experience at the Serenity Birth Centre at City Hospital was wonderful. I wanted a natural, active birth and that is what I had as I had a water birth, which even allowed me to give birth to the placenta which benefited Evan and me.'* Victoria went on to say: *'I was encouraged by the midwives to listen to my own body and I received fantastic support and advice in how to breastfeed Evan by staff who work on the unit. Evan is mine and my partner Darren's first child and I was so happy that all my family were made to feel really welcome and part of the whole birthing experience. It made it even more special to have them all around me.'*

Midwifery 2020

Delivering Expectations – *Cathy Warwick* gives the Royal College of Midwives (RCM) response

I am delighted to be given an opportunity to write about 'Midwifery 2020 Delivering Expectations'. This report was commissioned by the four Chief Nursing Officers in the UK and was launched in September 2010. The aim in undertaking the work was to consolidate the current position of midwifery and to identify any changes needed to the ways midwives work, their role and their responsibilities and the education, training and professional development needed to achieve these outcomes. The report does not represent Government policy but is intended to underpin and inform such policy.

It would not surprise me if some midwives and women look at this report and struggle to find that which is new. In my view the fact that the vast majority of this report endorses current thinking and policy on maternity services is positive. It is always useful to confirm the direction of travel and I believe that this report can have an impact at a variety of levels as everyone works to ensure high-quality care in challenging times.

The report endorses some very key issues such as the midwife as the first point of contact and as the lead professional for all healthy women with straightforward pregnancies and the key coordinator of care for other women.

It also is to my mind of great importance that the report at last clarifies the position of midwifery in relation to some key issues. I am particularly glad to see clear statements on the role of maternity support workers and on the need to ensure that the development of interpersonal skills should be a key component of midwifery education.

I want in this short article to highlight some key recommendations that the RCM welcomes and sees as of particular importance.

Meeting women's needs

'There are two key roles for midwives that are important if we are to achieve our vision: one is that midwives are the lead professional for women with no complications, and the other is as the co-ordinator of care for all women.'

This statement confirms the midwife as an autonomous practitioner who can take full responsibility for the care of women with normal pregnancies.

This acknowledgement is important. For women with normal pregnancies we know from the evidence that midwife-led care reduces admission to hospital and reduces intervention.

It is a waste of resources for obstetricians to be looking after this group of women and whilst excellent communication between a midwife and a woman's GP is vital to high-quality care and there will be circumstances where GPs, who are up to date and integrated into the local maternity system, will care for women, the RCM believes that in most circumstances women should be directly accessing midwives for their maternity care.

The midwife's role in caring for women with normal pregnancies must not, however, detract from her role with women who have more complex needs. Whilst these women will need the involvement of other professionals, usually the obstetrician, the midwife plays a vital role firstly to ensure this group of women get the same midwifery care as low-risk women and are kept as normal as possible but also to 'mind the gap' and ensure that as a woman receives care from a range of specialists her care is co-ordinated.

The midwifery workforce

'An analysis should be undertaken of the impact of an increasing trend towards part-time working among midwives including the impact on continuity of care, mentoring students, future recruitment, predicted absence and time required for continuing professional development.'

This is another welcome statement. Part-time working is welcome and may encourage retention but heads of midwifery (HOMs) tell the RCM that part-time working requires a changed approach to service provision. For example, having a very part time workforce can affect the continuity of care women receive. Delivering continuing professional development (CPD) is also different. A midwife requires the same ongoing education whether she looks after two women or 36 women or works 10 hours or 37 hours. A commitment has to be made to CPD for all midwives and indeed Midwifery 2020 recommends this. Students tell the RCM of lack of continuity in mentoring even when midwives are full time. Imaginative solutions need to be found for such issues as part-time working is no longer the exception, but whilst we accept part-time working it is also important that we consider why so many midwives reduce their hours. Is it for the right reasons or is it because their working environment is too stressful for them to maintain full-time hours? If the latter is the case, different solutions are required.

'Each country of the UK should undertake workforce modelling projections, assuming different birth rates, working practices and retirement patterns, to ensure that robust midwifery workforce planning is in place. This modelling should be carried out at country level where policy can influence the required changes, and also needs to take account of local demographics and needs.'

This is a very important statement, particularly in England where the White Paper 'Liberating the NHS' suggests more local workforce determination. In the RCM's response to the consultation on this paper we stressed the importance of retaining a national overview whilst at the same time looking at particular local needs.

The RCM believes that one of the biggest factors influencing the need for a richer ratio of midwives to women is skill mix. Areas of the UK where maternity services are dependent on a very significant number of new or more recently qualified midwives in their workforce will require generous ratios if those midwives are to gain experience in a supportive way and ultimately stay in the profession.

'Midwives should use their advocacy role for influencing and improving the health and wellbeing of women, children and families. This will include making the economic case for committing resources so that the midwife can deliver public health messages in the antenatal and postnatal periods, and ensuring that there is a midwifery contribution at policy, strategic, political and international level'

there must be adequate funding for midwives

The need to focus on public health is acknowledged by all four countries but the midwives' critical contribution in this area has not always been recognised. For some women her engagement with her midwife will be the first significant contact she has with health services and the trusting nature of the relationship she makes with her midwife should open up the possibility of delivering important messages. Perhaps the fact that maternity services usually sit within the acute sector has helped the midwives' role in this area to be ignored and most recently our justifiable focus on one-to-one care in labour has potentially led to midwives being drawn back into hospitals. If midwives are to contribute to the public health agenda to their full potential then there must be adequate funding for midwives in the antenatal and postnatal period and midwives wherever possible should be based in community settings. It is extremely worrying that in England the very recently released White Paper on Public Health 'Healthy Lives, Healthy People' mentions midwifery only twice. Not a good start. It is vital that the importance of midwives in promoting public health is stressed in our responses to the current consultation.

'Qualified maternity support workers/maternity care assistants should be employed within a nationally agreed framework, which defines their role, responsibilities and arrangements for delegation and supervision and makes it clear their role is to support and not replace the midwife.'

The RCM believes that MSWs and MCAs can make a vital contribution to the delivery of maternity services and as I visit maternity units around the country I see many well-educated MSWs doing appropriate work. However this is not always the case. Only recently a newly appointed HOM told me that she had found that the bereavement service in her unit was being exclusively run by a band 3 support worker. High-quality midwifery care is not a series of isolated tasks which can be separated out and given to someone else to do without compromising safety. Midwifery care cannot comprise a series of observations and recordings with the emotional support and personal caring able to be packaged up and handed over to someone else. Given the very rapid changes that are taking place around the UK in the deployment of MSWs/MCAs we must urgently progress this recommendation.

'NHS providers should ensure that appropriate support systems are in place so that the skilled midwifery workforce can carry out essential clinical duties, this means ensuring appropriate 24-hour administrative, domestic and operating theatre support as such duties are not an effective use of midwifery time.'

In many maternity units midwives are effectively prevented from doing midwifery work due to the increasing demands of IT systems, the paperwork associated with risk management systems, the form filling associated with performance monitoring etc. This recommendation supports our realisation that we are not using highly trained professionals well. This is now generally accepted but a long way from being rectified.

However, there are two additional points I would want to make here. The first is that this is not just about routine form filling. In my view in many units many midwives are now finding themselves unable to do their jobs properly because of the total domination of risk systems. Of course, we must ensure safe care and team work, audit, reflection and good communication are the greatest contributors to that, but in some units there are not enough midwives to give care because four midwives are working on CNST submissions and in other units guidelines are being imposed in such a way that highly qualified professionals no longer are thinking about the care they give. We must let midwives be midwives.

'A more flexible career framework should be developed to support midwives in practice and in research and education, enabling experienced midwives to combine both specialist and advanced contributions to practice with the core role of the midwife.'

And finally the RCM is delighted to see this recommendation. Not only is it excellent that at last we are clear as a profession about the difference between advanced and specialist practice but it also highlights the critical importance of keeping all elements of midwifery integrated. The old structure of the managers, the clinicians and the educationalists has, I believe, done maternity services a disservice. Whatever our main career route, our ability to speak up for women and to deliver high-quality maternity services will be enhanced if these roles are integrated. Our voice at the table will be the more powerful if the manager or teacher speaks with a hands on knowledge of practice or the clinical midwife speaks with a knowledge of research. We have a lot to learn from other professions in this respect.

So overall an excellent and welcome report. The RCM has been delighted to be closely involved in its production and looks forward to working with other organisations across the UK to take it forward.

Cathy Warwick
General Secretary of the Royal College of Midwives

Midwifery 2020

Quality midwifery care that meets women's needs – feedback from BirthChoiceUK

Miranda Dodwell

Cathy Warwick's article has highlighted some of the key messages of the Midwifery 2020 (M2020) report, Delivering Expectations.[1] I was a maternity service user representative on the M2020 England steering group and a member of the Measuring Quality Workstream. This article explains some of the work done to keep women and their partners at the heart of the M2020 programme, and how the quality of midwifery services, including women's experience of care, can be measured and improved.

The key messages of the report begin by focusing on how midwifery services can meet women's needs. In its first key message, the report says that women and their partners want a safe transition to parenthood and they want the experience to be positive and life enhancing. We know that women don't want to put their baby at risk, but at the same time they recognise that birth is much more than just a medical event. It is a personal, social and cultural event, a transformative process. We also know that having a positive experience of birth gives women the best start to motherhood, and therefore also gives their baby the best start in life. So it's important that women don't have to choose between safety and a fulfilling experience, a point which is recognised in that same key message – quality maternity services should be defined by their ability to provide both. The report says that enabling all women and their families to have this positive and safe experience of pregnancy, birth and early parenting should be the focus of a midwife's work.

promoting and protecting opportunities for normal birth

In the Measuring Quality Workstream, we looked more closely at what quality maternity services might look like and how quality could be assessed, with a view to facilitating ongoing improvements in quality. This work was written up in the M2020 Measuring Quality Workstream report.[2] Some of the findings were informed by work done by NCT on promoting and protecting opportunities for normal birth and these have been published by NCT in their report Normal birth as a Measure of the Quality of Care.[3]

We started off by looking at the current focus on quality in healthcare policy generally, which has been defined in England, Wales and Scotland as comprising at least three aspects – safety, effectiveness and patient experience (Fig.1). The bottom circle in Figure 1 has been called 'patient experience' or 'person centredness' but here it is labelled 'women's experience' because it relates to midwifery care. Figure 1 is based on the work of Lord Darzi.[4] The concept of these three aspects of care has been confirmed by the coalition Government as still being relevant to the NHS in England and is included in their Outcomes Framework.[5]

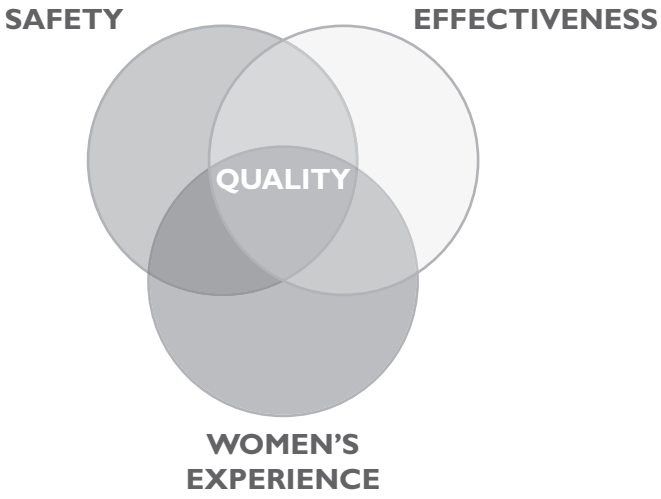

Figure 1: Aspects of quality

Therefore we can consider that high-quality midwifery care is delivered when that care is safe, effective and results in a positive experience for women. This is a very important concept as it means that women's experience is no longer just the 'icing on the cake' but an integral ingredient of quality: care which impacts negatively on women is not high-quality care.

Now we know what we mean by quality, what can we do to improve it, and how will we know if it is improving? A key message from M2020 is that the success of maternity services should be measured in terms of:

- safety (actual and perceived)
- effectiveness of care
- the experience of the woman and her partner

Thus M2020 recognises that the views and experiences of women and their partners are important when measuring quality. It also adds to the definition of quality by thinking about what we mean by safety. This is not just clinical safety in terms of perinatal and maternal mortality, but also how women perceive safety, whether or not they feel safe. This can mean whether they feel there are enough staff to look after them, that they are not left alone and afraid, and whether there is good communication between staff and with themselves.

What aspects of midwifery care could be measured to indicate that it is of high quality? M2020 helps us again by suggesting we look at evidence: *'Midwifery practice which has been evidenced as being safe, effective and valued by women can be used to develop meaningful quality indicators'*.[1] This means that when we find research evidence of practices which tick all three boxes – safe, effective and meet the needs of women – we can use these to develop 'quality indicators' (specific data which can be collected to assess the quality of midwifery care).

Several aspects of midwifery were considered by the Workstream to see if there was evidence to show that they fulfilled all three criteria of safety. One example we looked at was providing the opportunity for uninterrupted skin-to-skin contact between mother and baby immediately following the birth.

Skin to skin contact

A Cochrane Review showed that it was safe, in that there were no adverse effects either short term or long term.[6] It was also effective care with good outcomes such as more women initiating breastfeeding and a longer duration of breastfeeding. Skin-to-skin contact also reduced infant crying and increased mother/baby bonding that was still evident a year post-birth.[6]

Evidence that women value skin-to-skin contact comes from a qualitative study called *'I just wanted to love, hold him forever': women's lived experience of skin-to-skin contact*.[7] This study leaves no doubt about what this time means to women.

'As he was placed upon me, he was quiet and he opened his eyes and he looked at ME. I remember that's when I began to cry, because it was like he was looking at me and saying: "Here I am mum, you're my mum", and it makes me emotional thinking about it.'[7]

evidence does show that skin to skin contact ticks all the boxes

So research evidence does show that skin-to-skin contact ticks all the boxes: it's safe, it's effective and women value it. Furthermore, this is a practice which is recommended both by the NICE intrapartum care (IPC) guidelines[8] and the Standards for Maternity Care.[9] Therefore the extent to which women have skin-to-skin contact could be used as a quality indicator. The latest data from the Care Quality Commission (CQC) show that this varies in hospitals from 65% up to 100%.[10]

There are examples of other midwifery practices for which there is research evidence that these can improve quality of care. There are more details and research references in the NCT report Normal Birth as a Measure of the Quality of Care[3] which informed the work of the Measuring Quality Workstream.

Midwife-led care

We can ask the same questions:

- Is it safe? A Cochrane Review found no adverse outcomes.
- Is it effective? Women who had midwife-led care were more likely to have a spontaneous vaginal birth, less likely to have an epidural or an episiotomy and were more likely to start breastfeeding.
- Is this practice valued by women? The Cochrane Review found that midwife-led care improved women's experiences, providing them with more personalised care during pregnancy and increased the likelihood of experiencing feelings of control during labour.

This practice therefore ticks all three boxes and suggests that providing midwife-led care would improve the quality of maternity services. It is also recommended by the NICE antenatal guidelines,[11] is recognised in the Standards for Maternity Care[9] and has formed part of Department of Health policy.[12]

providing midwife-led care would improve the quality of maternity services

Supporting the use of natural and low-tech comfort aids for pain relief

- Is it safe? The NICE IPC guideline found no adverse safety outcomes from women using non-pharmacological methods of pain relief although this has not been ascertained for all complementary therapies.
- Is it effective? There is evidence that using some non-pharmacological methods of coping with pain can reduce medical interventions. Upright positions for labour and birth can reduce pain, instrumental delivery and episiotomy rates. The use of water for pain relief reduces the need for epidurals.
- Is this valued by women? There is evidence that the majority of women value giving birth with a minimum of drugs, provided that they feel they can cope. Qualitative research evidence shows us that the way midwives support and guide women through their pain can allow them to feel confident and positive about their ability to cope with the pain of labour. The attitudes of midwives around their pain can have a profound effect on how women feel about their labours in the longer term.

Again, there is evidence that some methods of coping with pain tick all the quality boxes. Using upright positions and water for comfort and pain relief are practices recommended by NICE.[8] The RCOG[13] have

even recommended adopting a 'working with pain' approach such as that advocated by midwife Nicky Leap.[14]

Women's experiences on this have already been recorded for every trust in England by the Healthcare Commission maternity services review in 2007 and again in the more recent CQC 2010 survey.[10] We already know which maternity units aren't very good at offering these opportunities and encouraging women. For example in 2007 15% of labouring women surveyed were not able AT ALL to move around and choose the most comfortable position – and in some units this was as high as 34%. This has improved in the 2010 survey where 9% of women surveyed were not able to move around, with the highest unit having 21%.

These are just three examples of midwifery specific indicators which could be used to monitor quality. Others include providing one-to-one care in labour, offering choice of place of birth, and supporting women to give birth with an intact perineum.[2,3]

Some of these practices can be facilitated by individual midwives; for others it might take team-working or changes in service provision to enable them to happen.

important that women's views of their care can be recorded and used

Measuring women's experiences

As women's experiences are now regarded as an integral part of assessing quality of maternity care, it is important that women's views of their care can be recorded and used for quality improvement. A key message of the Delivering Expectations report is that *'the views and experiences of women and their partners are an important part of measuring quality. Effective tools for collecting information about their experiences of care should be developed and widely used.'*

The NHS Outcomes Framework anticipates using the CQC maternity services survey of women's experiences to monitor improvements. This will take place every three years with 2010 being used as a baseline. As local sample sizes are small, however, (typically about 200 women per trust) caution will have to be taken in considering the significance of improvements. Local maternity service commissioners and providers should develop their own ways of collecting women's views.

Extending the definition of quality

Another key message from M2020 on the topic of measuring quality is that the three aspects of care are not enough, and there are a further three aspects which need to be taken into consideration. It proposes that the definition of quality should be further enhanced to take account of all six dimensions of quality: person-centredness, safety, effectiveness, efficiency, equity and timeliness. Perhaps most important of all, equity of care means that quality of care does not vary with a woman's age, ethnicity, postcode or socio-economic status. When all of these six aspects of care come together this is true high-quality midwifery care.

In conclusion, we know that women value maternity care which is personalised, co-ordinated by a midwife they know and trust, and which puts them at the centre of care. Providing such care is safe and reduces medical intervention, and therefore would improve the quality of maternity for women.

Miranda Dodwell

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Hypnobirthing

Hypnobirthing antenatal educator *Christine Hall* shares how she believes birthing experiences can be changed for women and why we need to look at the problem from another direction

50 years ago the amazing Association for Improvements in the Maternity Services was formed. It emerged because women in this country were not getting their needs met during their births.

Everyone was waiting to start the crusade, the NCT was established, Sheila Kitzinger was writing about it, the time was right, the mood was right. In our numbers we began to have a voice. I joined when I had my first baby 43 years ago, not because I had had a bad birth – in fact my body had been at its most wonderful. I birthed very efficiently, with an intact perineum, but I had been alone for much of the labour and my partner was not allowed to come into hospital with me. I was 20, we weren't married and this was 1968, so it is possible that if I had made more fuss he might have been able to be there.

I joined up to campaign for women to have the things which I had achieved: dignity, kindness from staff when they were there and an encouragement from well-trained midwives that my body knew what to do and would do it. An intact perineum made my post birth experience an easy transition and I was encouraged to breastfeed. I felt elated and I could have climbed Everest and I knew from my very core that this was how women should have babies.

So we marched and arrived at the door of government asking for change. We wrote letters and had some positive answers. We marched and arrived at the doors of hospitals. We marched with our babies and our banners to keep hospitals open ... and we watched them close.

Frederick Leboyer had been there, Ina May Gaskin had already set up the farm, Michelle Odent was around, Caroline Flint talked and wrote about continuity of care. Mary Cronk supported women birthing babies as women should have babies, with safe calm around them.

Wendy Savage marched with us, Yehudi Gordon left The Royal London and opened a private unit to get the rich and opinionated behind us in the drive for change. We could taste it, we could feel change coming.

All the time with AIMS there we knew we had fact-based information. Margery Tew obsessively kept data, and all the time Beverley Beech spoke and wrote and marched. I made a film for Channel Four which was supposed to show how birth should be.

There are many and wonderful people I haven't acknowledged from those earlier times but they know and we all know how many were there and how important they were and still are.

Governments changed and changed again. Consultants were both good, amazingly good, and they were bad and stunningly bad. Hospitals opened and closed and opened in a new form, birth centres opened and closed. Most midwives carried on being passionate and resolute. Women were still asking for safe births with dignity and respect.

The new runners came along, the fantastic, life-changing Albany midwives. Annie Francis and her meticulous new brand of note-taking midwives surged forward, the new beacon to keep the light shining. Last year Annie told me, 'Believe Christine, we can feel change coming, this time we are so close. Government wants this, it can happen.'

AIMS is still here, NCT is still here and all the ever-emerging new mums are still here. We are still banging loud on the same old doors and they open and close.

AND NOTHING CHANGES … except that Beverley Beech says the ceasarean section rates rise and rise.

So now to the contentious bit. The moment I have feared to write about.

50 years of passion and we haven't changed it

50 years of passion and we haven't changed it.

If we can't make others change, we have to change the way we campaign. The way we inform women. The way we move forward to better birth for women. This is very simple, so simple but so hard to do.

Change is so hard to contemplate, but endlessly getting nowhere is harder still.

If we take a deep breath and look at what IS there and not what isn't, we can make changes for women which are so profound, so cost effective, so simple and so life changing that we will look back rather foolishly at how close it has been to us for decades.

The AIMS Journal is negative. Supportive, informative and triumphant but negative.

The NCT class is a wonderful place to make lifetime friends, and don't let's knock that, it's a national treasure, but its birth content is negative and doesn't get results. From eight women, two will have a good birth because, like me their bodies are kind, three or four will have planned or emergency caesareans and the other two or three will have a birth they would rather not talk about, 'Not what I planned, well I had the whole lot really, never mind it's the baby that's important.'

I feel I may be injecting myself with a lethal drug to be saying this about two such important institutions but I have taught birth for 32 years and I believe it to be true.

For the last five years or more I have taught hypnobirthing and that, my friends … or ex-friends … is the way forward.

It is so simple and it works. It is a more developed Grantley Dick-Read which went on to be NCT before NCT changed its drive. It works in a very short time even in a system braced against believing in it. Midwives can't go on disbelieving it because the proof is there. Hospitals have to believe because, never mind women, the numbers work. Women believe it because it gives them what they hope and believe they can have. Women and their chosen partner learn how to self hypnotise, how to trust their bodies and their babies during the teamwork of their birth experience. They quite literally and very simply reprogramme their subconscious minds to believe that what they tell it will happen will indeed happen.

I have taught this method to couples from all backgrounds. They have to commit to five weeks of classes, daily listening to CDs, reading a book, or having it read to them if they can't read. They always know that nothing in life is certain and that managing their expectation is very important. They are constantly reminded that when a woman holds a live infant in her arms after the powerful experience of labour, she is never a failure. We don't have many women who are not enriched by these experiences and we know that some women simply have a harder time than others but from my classes of five or six couples, I haven't reached eight yet, I will have one caesarean, usually for a very real and acceptable reason – placenta praevia, bleeding, very high BP, or sometimes due to induction under pressure after 14 days post dates or breech presentation where there is no skilled birthing attendant. There will be three who are blissed out and can't believe they had the birth they had dreamed of and one or two who will have a beautiful birth simply because some women do.

All hypnobirthing teachers will tell you the same, although they are not as amazed as me because, unlike me, they haven't been teaching the wrong stuff for so long and they always believed this would be the case. Hypnobirth has to be offered free to all women and if the section rate went down then the available monies for future investment and effective antenatal preparation could go up.

Let's put all that extraordinary energy that we have used forever into something which works. Let's have positive stories, let's write about and promote positive thoughts. It will take time, but not that much time. Hypnosis has changed the lives of so many women at home and in hospital for a good few years now and it will continue to do so ... backed up by good note taking, good statistical information, good midwifery training and good will.

What have we got to lose?

Christine Hall

Targets for Better Maternity Care

Healthcare Commission Conference, Sept 2006

The recommendations for this conference were:

- Women see midwives as the first point of contact
- Every woman will have one midwife caring for her in labour
- 10% of births will take place at home
- 50% of births will take place in a midwifery unit
- Every area has a stand-alone midwifery unit
- Every woman will be visited up to 10 days postnatally
- 80% of women will be breastfeeding at one month
- 60% of women will have a normal birth
- The caesarean section rate will not exceed 10%

By 2008 every Trust:

- will establish a community midwifery team which will not be 'on-call' for a hospital birth
- will have case-load midwifery
- will be required to produce information leaflets on choice.

We are still a long way from achieving this across the UK, but we know there are some areas of excellence and other places could learn from the experiences of those who have improved care to meet these standards, or who have been working that way since before 2006!

AIMS would love to hear about those units which are achieving, or even surpassing, these targets, and about those places where women are campaigning for their local maternity units to offer better care.

Please contact the AIMS committee or editor@aims.org.uk with your stories.

Our Bodies, Our Choice

Holly Lyne reports on the Airedale Mums support and campaigns

I'm looking at a bizarre sight. Just under a dozen women in an old church hall, now the Delius Arts and Cultural Centre in Bradford city centre. One woman is in a hospital gown, chained to a hospital bed, another is wearing a white coat and is looking at her huge alarm clock. Around them are numerous hand painted and printed signs declaring that 'Home birth is not a crime' and other such motivational slogans. Next to them is a birth pool filled with roses and two smiling babies. My own young son is running around the room with a toy train, apparently unfazed by the odd surroundings. There is the usual networking and the chatter that comes when a group of mums come together, but there is a sombre tone to the surroundings, a serious message to convey.

It's part art installation, part protest. The women are Airedale Mums.

We were founded just over a year ago when a group of new mums and mums-to-be came together to discuss their hopes for a home birth and the inability of the local hospital to provide that service. Complaints had been made but the women felt their voices were being ignored. So the decision was made to group together in the hope that one united voice would be more powerful. In a way we were right: although individual complaints were never fully resolved, the group has changed things, our voices are being heard loud and clear and the bigger picture is changing.

Since its inception the group has evolved and grown significantly. Our remit is pretty simple – we want three basic things: true choice of where and how women give birth, continuity of care, and respect. So many women are being denied a choice, both locally and nationally. Airedale Mums has been working hard to educate women of their rights and choices available to them. We advocate the caseloading model of care and domino care, both of which provide women with continuity during pregnancy and birth. We know that there are midwives who want to be able to offer what we're demanding, but they are trapped within a system that does not respect the birth process and does not empower women to make their own decisions. We want the system to allow for that respect and for all healthcare providers to respect women and their choices.

Our campaign began with talking to the press; we were interviewed for BBC Radio Leeds, Look North and various local newspapers. We have met with politicians to discuss our concerns and have regular representation at our local Maternity Services Liaison Committee. We've been meeting with senior midwives from both of our local hospitals in an effort to begin working together to achieve our mutual goals and are being included in the development plans for the new midwife-led unit at Bradford Royal Infirmary.

Airedale Mums is not just a campaign group. We're also a support group. We offer a safe environment for women and their families to talk through their experiences, to share the good and the bad and to find support for their choices going forward. For those who choose to remain with the group and contribute to the campaign the experience can be truly cathartic. Speaking from my own experience, my work with Airedale Mums has enabled me to do a great deal of healing after my own traumatic birth.

We're no longer just a regional group. Since the coalition government came into power with their promises of cuts and NHS restructuring, Airedale Mums has had its ear close to the ground to keep on top of the changes that will affect maternity services across the UK.

My own personal passion has always lain with demonstration. Last March a number of us went to London to join in the Reclaiming Birth march with Albany Mums and their supporters. It is a day I won't soon forget: what an exciting exhibition of families standing up for what they believe in and to see so many people turning up to march to the Department of Health was very inspiring.

When the plight of Dr Ágnes Geréb came to our attention we knew that we had to make some noise about it. Without a physical place or person to focus our demonstration on, short of travelling to London to the Hungarian Embassy, we decided on an art installation instead. We had contributions from American birth artist Amy Swagman, whose mandalas were a powerful addition to our display. We wanted to make the point that in Hungary, as well as closer to home here in the UK and Ireland, women are metaphorically tied to the system and have their choices taken away from them. Midwives, too, are not always free to provide the kind of care that women want and deserve. Dr Geréb was imprisoned for fighting that system, for attending births at home without the licence required by Hungarian law. The events leading to her arrest were scandalous, as she had already refused to provide the birthing woman with a home birth service due to certain risk factors, but when the woman arrived at an antenatal class already in established labour it would have been negligent for Dr Geréb to not assist her.

So on 15th December 2010 an Airedale Mum finds herself chained to a hospital bed, we take photographs and document the event ourselves. It's a far cry from our bright and cheerful Teddy Bears' Picnic last summer, but in a way just another day in the Airedale Mums calendar. Since our demonstration Dr Geréb has been released from jail and is under house arrest thanks to the efforts of so many people around the world.

Working with the organisers of the international Free Ágnes Geréb campaign has been a stimulating experience,

with ideas exchanged and support going both ways across Europe. It is our hope that we can continue supporting one another as the campaign continues. It is bigger than Ágnes Geréb – it comes down to the fundamental right of women to be able to choose where to give birth and to have the support they want and need.

We've seen the same sort of problems developing in Ireland too and Airedale Mums has been inspired by the demonstrations there against the bill that threatens the ability of independent midwives to support women choosing to birth at home. Right here in the UK the indemnity insurance axe has been waiting to fall on independent midwifery, but we hope that there are solutions on the cards now that will enable midwives to continue providing their very valuable service.

In the Bradford and Airedale area independent midwives are relied upon to provide the service that the NHS here has not been able to. The majority of our Core Group members were left with no choice but to hire independent midwives after being let down badly by the NHS during pregnancy, for reasons ranging from lack of continuity of care, to very negative attitudes towards home birth in general and specifically after 41 weeks, when the pressure placed upon women to induce labour can get quite intimidating. Our next major focus, currently under discussion, is shaping up to be on getting the induction rate down. Airedale General Hospital has an induction rate of 25% and a caesarean section rate to match. We have already shown that our group can get results. In 2009 Airedale withdrew its home birth service 42 times. Since we drew attention to this fact it has managed to get this figure down to just five service withdrawals in the last year, a fantastic achievement. We are hopeful that our actions can have a similar impact on induction rates.

We are deeply concerned about the decision to hand over maternity services commissioning to GP consortia but are hoping to work closely with the right people as and when they emerge in order to ensure that the services provided in our area are in line with best practice and true woman-centred care. It is now that groups like ours can really make a difference, but because the GP consortia will be regional it will require input from groups and individuals all over the country to try and make a difference in their own areas. Last year at the Sheffield Home Birth Conference Ruth Weston, in her address, likened Albany Mums and Airedale Mums to dandelions and called for groups across the country to catch the seeds blowing their way. We're urging this point again, now it is more important than ever. The power will lie with local groups to make the right people deliver the services women and their families need in every area.

Holly Lyne
Airedale Mums
For more information please see our website

Airedale Mums campaigning for Ágnes Geréb, rights and choices

Elsa Joy

Anne Dew shares the story of her daughter's birth

Many people ask me why I went the natural route with birthing my two babies: why a birth centre with midwives and not at a hospital?

My personality is such that I never want to miss a trick even, as it turns out, when it comes to childbirth. I wanted the full experience – for better and for worse.

I figured I'd only be doing this twice in my life and if all those women before me could do it drug-free, why not me? When I'm an old lady some day, I want to look back and say, 'Yeah, I did that.' I don't want to have felt that I missed a life experience.

Of course, I could have chosen a hospital birth and then simply not taken painkillers. But, I knew that giving birth would be hard work, and I was concerned about being offered pain medication when I was most vulnerable. So that got me thinking about an out-of-hospital birth.

I did a Google search for midwives in our area (Denver) and discovered the Mountain Midwifery Center. It's a stand-alone birth centre with midwives, located across the street from a hospital in case there was an emergency. I thought, this is just the ticket! I wanted to surround myself with experts on natural birth so that I could accomplish this great goal, but also have back-up in case things didn't go as planned.

Both our son's and daughter's births went very smoothly and were both so different! Here is the story of our daughter Elsa's birth – she, by the way, is the first girl on my husband's side of the family in 150 years!

Elsa Joy – a bit of a piece of work from the start! She couldn't quite make up her mind and was not interested in being rushed. On a Friday about a week before her birth, Elsa began to stir. I woke up at 1:30am with contractions that lasted throughout the day and then settled down at sunset. Grandma (Don's mom) was not to arrive until Tuesday, so we were all a bit frantic when these stirrings began three days before our extra pair of hands was due to arrive! To make matters worse, both our back-up people who were going to watch Aidric weren't available that weekend. Being the sweet Grandma she is, she changed her flight and arrived the very next day with plans to stay for two weeks. Phew.

And what happened next? Absolutely nothing for the whole week! Grandma's reassuring presence ensured that this girl would come when she was good and ready! With our time with Grandma ticking by, we began Operation Encourage Birth.

Sunday my girlfriends planned a trip to a salon for manicures and pedicures to celebrate the coming of Miss Dew. I brought Grandma along too. People had mentioned that reflexology during a pedicure is a good way to get labour going. I told the gal to go for it – hit those pressure points! Didn't do a thing to start labour, but I loved having time with friends and picking out nail polish so that I had pretty toes to look at during labour.

Tuesday I went in for my 38-week appointment and they did a cervical sweep, which sometimes helps things along. Fingers crossed! Alas, nothing happened.

The next day, Don and I went out for spicy food at our favourite Mexican restaurant. I even ate a whole roasted jalapeno! All the spice didn't do a darn thing though.

Then I went swimming. Twice. Friday evening, after the second swimming outing, I lost the mucus plug. Hurray! But then I read that that didn't actually mean that labour would start anytime soon. Oh well.

Then Friday night came and the full moon appeared, so we were curious if that would help get labour started. No such luck.

I was tired of speculating when the baby might come. And even though everyone was really sweet and encouraging, I still felt like they were all waiting for something to happen with my body.

Feeling under pressure, I decided to get some alone time. Grandma had taken Aidric up to their second home in Winter Park on Thursday for the weekend, so it was just Don and me, sitting around and waiting.

Saturday morning came and it was sunny and warm. After working from home the whole week, Don was itching to go for a mountain bike ride but nervous about leaving me alone. I told him to go anyway, and he was out the door.

Wouldn't you know, while he was gone, I stood up to use the computer and my waters broke! My first thoughts were, yippee this baby will probably be here within the day, I'll finally get to meet my daughter and I'll no longer be pregnant! I was absolutely giddy!

I rang Don on his mobile phone, but he must have been in a poor reception area because it took three calls to reach him. Once I got the message through, he zipped home and even caught a ride from a guy in a pickup truck for part of the way home. He got home at 12:30pm and jumped into the shower and we scurried about the house making sure everything was in order.

What happened next? Absolutely nothing! Hours later, still not a single contraction. We were getting very good at sitting around and looking at each other. Uhhhg!

The birth centre wanted to see me in active labour by the 12-hour mark (midnight) otherwise we'd be pushing our luck with having our baby at the birth centre. The rule is that you need to be in active labour within 24 hours of the water breaking otherwise a trip to the hospital for medical intervention is needed. At 6pm, Sarah, the midwife on call, suggested I take a dose of castor oil to get things moving. It is a stimulant laxative

that helps induce contractions. Two hours ticked by, and still nothing happened. Sarah explained that sometimes it takes two doses, so I took the second shot at 8pm and lay down to try and get some sleep.

I was disappointed. The whole day I had been so excited thinking that I'd get to have a daytime labour/delivery and how wonderful it would be to not have to pull an all-nighter like we did with our son. But it was not to be.

Sleeping didn't happen and at 9:30 I became violently ill from the castor oil. I threw up several times and was on all fours in our bedroom unable to move. The castor oil gave me severe abdominal cramps and I was getting starter contractions at the same time, so it was all one big cramp with NO break between. Panic, fear, pain ... at this point all I wanted was an ambulance ride to hospital!

After 30 minutes of this, Sarah said to go ahead and come down to the birth centre. You didn't have to tell me twice! Meanwhile, Mother Nature decided that since it hadn't rained here since October that this would be a good night to shower the road with some nice freezing rain. So, with rain coming down and temperatures falling below freezing, Don nervously drove us the 26 miles to the birth centre, which took about 45 minutes that night. We tried not to notice the pile of cars and emergency vehicles as we pulled on to the road.

We arrived at the birth centre about 11:30pm and I made a beeline for the bathroom. I spent a good hour getting sick and then lay down to rest on the birth centre's big log bed with Don. Sarah explained that after the castor oil effects had worn off, my contractions would regulate and active labour would be underway.

Sure enough, about 12:30am I started breathing through contractions and Don was there to time them. About 1:30am, I was too uncomfortable to lay in the bed anymore so I stood up and used the hammock sling thingie suspended from the ceiling. It took a lot of the weight off and I was able to sway and breathe in rhythm during the contractions. Sweat poured out and began to roll off my face like nothing I had ever experienced before.

Things were getting intense, so Sarah checked me. I was only 6cm dilated. I was so disappointed! I thought for sure we were farther along than that. She suggested I get into the birth pool at that point.

The warm water felt good and I tried my hardest to relax during contractions. I wondered if I would be in for another marathon 18-hour birth that I had had with our son. But much to my surprise, I watched as Sarah started laying out chux pads (absorbent sheets) on the bed and a towel on the floor. 'This is for when baby is here, which will be very soon,' she exclaimed. I was in disbelief!

I then felt some pressure below, as if baby was at the gate. Was it time to push? Sarah checked with her flashlight underwater and said, 'Go ahead and push, you are fully dilated at 10cm and I can see her head!'

This was all happening so fast, how could it be? The huge holy-hell–why-am-I-doing-this contractions had arrived. I pushed a couple of times and Sarah excitedly announced that her head was out. Again I was in disbelief! Sarah explained that once baby was out, she would pass her through my legs and I could pick her up out of the water.

With that I got a nice burst of motivation – I was almost to the finish line, I could DO this! A couple more 'rrrrahhhhrrrrr pushes/contractions' and Elsa came out. Sarah passed her through my legs like a little football, and into my arms she landed. Pure joy, relief, happiness, disbelief, amazement and love! Don bowed his head, completely overwhelmed with emotion. We did it.

Kate, our nurse, wrapped Elsa in a blanket and hat while we were still in the pool. Then we stood up and shuffled our way over to the bed with umbilical cord still attached. Don was at my side on the bed and held Elsa in his arms as I delivered the placenta and dealt with after-birth pains (just like contractions) and uncontrollable body shakes. That was a bit of a raw deal – to have contractions even after birth.

It was wonderful for the three of us to lie in bed and snuggle. Don and I marvelled at how tiny her hands and feet were, how beautiful her little face was and how long her fingernails were. Our precious daughter was finally here, wow! Elsa latched on without a problem, that was nice. Don ceremoniously cut the umbilical cord and also went with Elsa to see her get weighed: a healthy 7 pounds 5 ounces. I took a herbal concoction to help with the pains and later took a herbal bath that also helps with that. Afterwards, I changed into a nightgown and got to cuddle with Elsa and Don and EAT!

Sarah said that I had only pushed for 10 minutes. The labour was 5½ hours if you count from the time the castor oil kicked in, or 2½ hours if you count from when the castor oil effects subsided and real contractions began. The only people that were there for the birth were myself, Don, Sarah, and Amy, the photographer. Kate, the nurse, arrived moments after birth. I felt completely safe and supported the whole time.

Looking into my husband's eyes and hearing his comforting and encouraging words really helped get me through. Sarah was awesome. She chose her words well, always kept me informed as to what was happening, and was just an excellent coach. It was a small group, but it was all I needed. Even Amy helped out and held my hand while the placenta came out and offered reassurance when I got Elsa latched on for the first time.

I feel so blessed to have had a beautiful, natural birth. It is truly a miraculous event that I will remember always.

Anne Dew

Editor's Note: Women and their midwives are often under great pressure to get labour going and to progress towards birth efficiently if, for example, the woman's waters break without labour starting quickly, if she is more than 41-42 weeks into her pregnancy or if her labour stops or slows down. Readers might like to read our Induction booklet on when induction may and may not be necessary.

Dear Doctor

Alexandra Orchard shares how she got a VBA2C (vaginal birth after two caesareans) in the US

With my first pregnancy, I tried to be as prepared and educated as possible. I took 12 weeks of Bradley Childbirth classes with a wonderful husband-and-wife team of instructors! I had a well-written birth plan that I gave to my doctor before my due date. I keep that plan in my daughter's scrapbook because it is comical. EVERY item on that list went out the window during labour. I was so easily made to believe that all of the things my Bradley instructors said I should avoid would actually HELP me birth my baby.

On September 11, 2001, when the world was upside down in the United States, I was 2 days past my due date and had an appointment that morning. Even though I specifically had in my file that I didn't want my membranes stripped, the doctor spent 30 minutes explaining to me that since I was past my due date, I HAD to get my membranes stripped or I would end up with pitocin [syntocinon], and if I wanted a natural labour, I didn't want pitocin. I finally agreed to this 'natural form of induction'. I went into labour that night, but it was not efficient.

My baby and I weren't ready. I went to the hospital the next night, more than 24 hours after my membranes were stripped. I thought I was in transition, but I was only 1cm. I requested to go home. The next morning, the hospital called and asked why I hadn't come in again. My husband told them there was no change. They demanded I come in to be checked. I was 3cm and they had me get into the shower to get that last cm so they could admit me. After my admittance, what followed was the 'cascade of interventions' my Bradley instructors had told us about. I progressed slowly, with a 'bulging bag of waters', so I was made to believe if my waters were broken, I would progress faster. I let them break my waters because when you are in labour, you will believe ANYTHING they tell you will get you through it faster.

My labour didn't change. Without even thinking, I allowed them to put the internal fetal monitor on my baby. Then I was told that if I had pitocin, they could get my contractions closer together, though they were so strong, you couldn't see the tops of them on the monitor. 24 hours of hard labour on my own and I gave in to pitocin, couldn't handle the increase in pain, so I asked for an epidural. The epidural didn't work. I couldn't move my legs, but I could feel every contraction. Finally, I asked them to turn off the epidural because I knew I wouldn't be able to push when it came time. After 34 hours of hard labour, I was told I was 8cm and I had one hour to dilate to a 10 or surgery would be performed. I was still strong, there were no signs of distress in the baby, so I asked my husband to go out and talk to the doctor. I said, 'Ask her "why one hour? Why not two?"' After all that time, I still had some fight in me. My husband came back from his conversation and told me he felt that the doctor was right. One hour later, when I was still 8cm, I was wheeled into the Operating Room. EXACTLY 12 hours after my water had been broken, my daughter was surgically removed from my body. I was on a clock and I didn't even realise it. I was educated enough to have foreseen all of this, but in the middle of the most vulnerable time in my life, I was easily led away from what was so important to me – a natural birth for my baby.

I couldn't complain about my recovery. My baby nursed beautifully, and two weeks after her birth, we took some friends on a drive south to see Portage Glacier. When she was three weeks old, we found out my husband would be deploying as a result of the events of 9/11 and I never once thought I wasn't strong enough to handle single parenthood.

I went home, cried and because I am a 'good mom', I booked my surgery

My second caesarean was completely different.

I worked hard to try to VBAC with my second daughter. The doctors said they would be happy 'to allow me a trial of labour,' but at the end of my pregnancy, they estimated by ultrasound that my baby was 9lbs 7oz. At that appointment, the doctor said, 'Now, you're not just risking her life with a VBAC, you'll break her collarbone when you push her out. You need to book your c-section today.' I went home, cried and because I am a 'good mom', I booked my surgery. I booked it for my due date (the latest they would allow) in the hopes that I would go into labour on my own before then, but the morning came anyway. My husband and I woke up early, drove to the hospital, walked into the hospital, and I said, 'I'm here for the birth.' I was so nervous. The thought of being cut open was so scary, but I was happy to be meeting my daughter soon. They hooked me up to an IV and shaved me. I was wheeled into the operating room and was asked to get up and lie down on the surgery bed. The bed looked like a cross. There were places for me to put my arms to have them tied down. I got into the bed and all I could think was that I was being sacrificed or crucified. They put the spinal block into my spine and I was drugged up and ready to go. They poked me a few times to see if I could feel anything and then started the surgery.

Our second daughter has her first family picture just like her big sister did... a big blue sheet and me, looking like I have no body. I was able to touch her cheek, but that is the last I saw her for FOUR HOURS. They had to sew me up, and it was hospital policy for babies to be monitored immediately after birth and then for 4 hours after every shift change. Yes, this was 2004, but it might as well have been the 1950s. I was so high on the painkillers while they were sewing me up that I actually THANKED them for the pleasant experience!!!

When my daughters met for the first time, I was so drugged, I don't remember much of their meeting. Luckily, I have the video. My recovery took 14 weeks. They severed a nerve in my right leg that still feels funny years later. My incision was infected and they had to re-open it… without anaesthesia! I brought both of the girls with me to the doctor when I was feverish and my incision was red. I couldn't figure out why I felt so terrible a month after her birth. The baby was sleeping in her car seat carrier and her sister sat in the corner, nervous about seeing a doctor. I kept telling her they were going to look at Mommy, not her, and doctors are good. The doctor took one look at my incision and had me lie down. He OPENED the incision with a Q-tip without warning me!!! I stifled a scream, keenly aware of my daughter's presence and worry. He heard my gasp and said, 'I knew it would be painful, so I didn't want to warn you.' I looked at her in the corner and she had a concerned look on her face. I said, 'It's okay honey, Mommy is okay. There is nothing to worry about.' But she had seen my face. I was just thinking I was glad it was over and I hadn't screamed when he DID IT AGAIN! I gripped his arm tightly and he actually (jokingly) said, 'Ow!'

I vowed then that I would never let anyone do this to my body or my baby again.

I vowed then that I would never let anyone do this to my body or my baby again

When I became pregnant with my third child, I immediately started looking into VBACs again. I went to the hospital for my 12-week appointment and told the doctor that I wanted to VBAC. He immediately brushed my request aside, saying, 'I'm sorry, but you have two scars on your uterus. There is no way I can let you VBAC.' He had a student with him and I didn't want to argue, so I thought I would let him know how serious I was at my next appointment.

When I went to my next appointment at 16 weeks, the nurse reading my chart said, 'I see you will be scheduling another c-section.' I was angry. This was my body and they refused to consider my request not to be cut open again! When the doctor arrived, I told him that if he wouldn't allow me to have my baby naturally there, then he would be forcing me to give birth at home. The doctor expressed his disapproval, but explained that this hospital did not have the capacity to handle my type of emergency. Strangely, they did allow a VBAC after ONE c-section.

The emergency they were so sure would happen with me could happen no matter how many scars a uterus had (although rare in any case). My research (using ACOG studies) said my risk of rupture only increased slightly. The argument wasn't valid. The doctor said he would give me a referral if I could find someone who would take me as a patient.

For two months, I looked for a doctor who would allow me a 'trial of labour'. I found only ONE, but he would be out of town and could not accept me as a client because his colleagues would not agree to help me if he wasn't there. My journey to home birth began. I found a great team of midwives and a doula. I also took Hypnobirthing classes with my husband. All of these people helped me work through the mental issues I would be dealing with when I gave birth. I knew my body could do this… I just had to believe in myself!

When I was 8 months pregnant, I received a call from the original doctor I had seen. He had somehow found out about my plan for a home birth and told me he had convinced the hospital to allow me to have my baby there. I asked him what restrictions he would put on me. He said I would have to dilate 1cm per hour. I told him I already knew from my first labour that my body would not do that, so I would fail his first condition. He said I would have to have an IV drip and an internal fetal monitor. An internal monitor meant he would break my waters immediately, which would put me 'on the clock'. I wouldn't be able to move around and help myself through this difficult process. He said if I went overdue, I would have to be induced. Rule Number 1 with VBACs: if you want a uterus to rupture, give the mom pitocin. I told him I would think about it and let him know. What follows is the letter I sent him over email:

*Dr. *** [name left out for privacy],*

I want to thank you for your concern and for your efforts to allow me to have a VBAC at the base hospital. However, I have decided to continue with my birth at home.

When you and I originally discussed my desire for a VBAC in September, I specifically mentioned that if your hospital did not allow me to VBAC there, then I would be having my baby at home. At my mention of a home birth, you expressed your disapproval, but said that the only thing you could do was give me a referral. Though I had a few promising leads, my requests were denied by each doctor, and I ended up with a choice between surgery and home birth. It truly amazes me that women can choose to have a

caesarean for no medical reason and quadruple their chance of death, increase their risk of infection, increase their risk of haemorrhage, as well as increase their baby's risk of injury, breathing problems and nursing problems, but at the same time, I could not find one doctor in Las Vegas who would give me the opportunity to have my child naturally. When faced with the choice between surgery and home birth, I chose home birth because it was the better of the two options. Today, after your much delayed offer to VBAC in your hospital, I am choosing home birth because it is the best of every option.

Your specific reasons in September for not allowing me to VBAC at the base hospital were: 1) the hospital does not have enough blood for my type of emergency, 2) the hospital does not have a NICU and 3) the nurses in your hospital would not be prepared for my type of emergency. I am honestly confused why, four months later, and only after you discovered I will be doing a home birth, the hospital's capacity to support me has changed. The tone of my email may give you the impression that I am angry with you and the base hospital, but this is not the case. I know your hands are tied in many ways because of ACOG requirements and risk of malpractice suits. However, those hospital concerns should not affect me or my baby when it comes to the best way to bring her into the world. I am thankful that in this country home birth is still an option and I hope that when my daughters have their babies, the option will still be there for them.

I feel certain that the best place for me to birth my baby is at HOME, despite the scars on my uterus. I have looked at my risks and I know that I am healthy, my baby is healthy, and our chances of a rupture are very low. I do not consider myself a 'high risk' case, as you apparently do, and my midwife agrees with me. She has attended over 1000 births, 300 of which were VBACs (some after four caesareans!) She has never seen a rupture. I am certain that she and I will know whether my baby and my body are progressing well in natural childbirth. Her equipment, her knowledge and her personal relationship with me and my baby make her well equipped to know whether either of us is in distress early enough to transport me to the hospital in a timely manner. I know I am in good hands.

I need to be surrounded by people who will be patient with my body, my baby, and our progress in a natural labour. More importantly, I need to be surrounded by people who believe in me. I know the kinds of restrictions that would be placed on me in a hospital. They were clearly outlined by you and by one off-base doctor at my initial consultation with him. ACOG requires you to order many things I cannot agree with. I know that I have the right to deny those 'requests', but I do not believe that continuous conflict with the hospital staff would provide me with the best chance for a VBAC. Even if there was another doctor in the area that would allow me a 'trial of labour', I believe there is no hospital that would give my baby and me what we need to bring her into this world naturally. I have tried to do this twice, and twice my children have been surgically removed from me unnecessarily. With my first labour, 'failure to progress' with an absence of fetal or maternal distress was no reason for a surgical birth. With my second pregnancy, my doctor would not allow me to attempt a VBAC simply because my baby appeared large. I have a strong suspicion that this birth would end the same way if I put myself in the hands of a hospital and any obstetrician 'risking his career on me' (as the midwife in your office so honestly put it).

Thank you for your efforts on my case. I know that of all of the doctors in your practice, you were the most understanding and I know you worked hard to help me in the end. I hope you meet more women like me in your future: women who are well-informed of their choices, the risks involved, and who take responsibility for their health, their births and are willing to fight for what they believe is right for their babies. When you do meet these women, I hope you and your colleagues take their convictions seriously from the very beginning. I hope you belay any personal feelings or ACOG restrictions on how women 'should' give birth to their babies, and you don't force them to fight (during pregnancy or during labour) to bring their children into the world the way they believe is best. Thank you again for your time, your efforts and your understanding.

Sincerely,

Alexandra Orchard

My third daughter was born on her due date, a date she chose for herself. My labour was 30 hours long and I pushed for 1 hour and 39 minutes. In so many ways, this labour was similar to my first labour. It took 11 hours of hard labour for my body to efface before I started dilating. I had to fight for each centimetre every step of the way. My labour stalled at 8cm; the point at which they took my first daughter from me. My midwives did so many natural things to help me get through the final stage. Even when my daughter's head was out, I was still saying, 'I can do this!' Everyone in the room would shout, 'you ARE doing this!' My husband and I pulled our daughter up out of the water ourselves and the first thing I said was 'I DID IT!' The second thing I said was 'I'm holding my baby!' I wasn't able to hold her two older sisters for some time after their births. It was amazing, it was peaceful, it was empowering, and I knew in that moment that I had to do something to change birth for women. I knew I had to do something to make sure that my three daughters could bring their children into the world the way THEY CHOSE TO.

I started my path to becoming a midwife then. When my youngest was 8 months old, I started my studies and my apprenticeship. I became active in the local chapter of the International Caesarean Awareness Network and the local Birth Year Network. I am determined to be part of the movement that is giving birth back to women and their babies. I have to be part of the fight to make sure that my daughters have a CHOICE in how they bring my grandchildren into the world.

Alexandra Orchard

Alexandra's inspiring birth film can be seen at www.youtube.com/watch?v=qw3MRQGY7Zg

Reviews

Tensions and barriers in improving maternity care: The story of a birth centre

by Ruth Deery, Deborah Hughes and Mavis Kirkham
Radcliffe Publishing 2010
ISBN-13: 978 184619 425 2

Sheila Kitzinger begins her foreword to this publication by saying: *'Here is a remarkably detailed analysis of the politics of a birth centre trapped in a medicalised system that threatened and rapidly destroyed it. It is a vivid example of how autonomous midwifery is undermined by an organisational structure in which management focuses exclusively on one model of care, namely midwifery training in obstetric emergencies and rescuing women from their inherently defective bodies, rather than safeguarding normal birth.'*

The three exemplary midwife authors of this must be read book have carefully and painstakingly sought and listened to the stories of those involved with the development, opening, running, management and closing of the birth centre, whose five-year history they followed. As the authors point out, and as we well know, birth centres, like home births, provide excellent care that can improve outcomes for women and babies (especially those experiencing disadvantages in our society), and are much preferred by families and midwives.

The sad tale told in this book provides a salutary and detailed lesson about how not to go about introducing potential improvements to maternity services. From the midwife who carried out the initial feasibility study, to the midwifery managers, the midwives running the service, and those somewhat removed from the whole fiasco, the quotations show that the birth centre was set up to fail from the moment it was first conceived. The many, fascinating, frank, passionate and often sad quotations show how the potential, the optimism and skills invested in the birth centre were gradually, but consistently, undermined every step of the way through lack of leadership, lack of confidence in birth and midwifery, lack of a shared vision and philosophy, lack of support from GPs, obstetricians and even midwifery managers, and finally by restricting opening hours of the centre and 'integrating' it so that it no longer had its own dedicated midwifery staff.

The quotations also show that the impact on individual midwives who came to the centre to their 'dream job' was extremely costly as they fought to retain some degree of autonomy, fought to keep the centre open and fought to provide the woman-focused care that was needed by the community. The stress, pain and powerlessness experienced by some of the midwives who wanted to provide the kind of care that we are told by Government needs to be provided, that we know has positive impacts on communities and that we know women want are of huge concern: they are driving away the very midwives who are most committed to providing the holistic midwifery care that most benefits families, and driving down excellence in maternity services. As the authors suggest: *'It is difficult for midwives to facilitate safety and empowerment for women if they are feeling threatened and undermined in their work setting.'* (p103).

One of the problems within midwifery (and how we are generally pitted against each other in financially driven organisations) is well described by the authors: *'The "corporatisation" of professional managers that was evident here is often difficult for front-line staff to accept, as it represents a schism in previously shared professional values and commonality of outlook and priorities. These managers may continue to have the words "midwife" or "midwifery" in their job titles, but they are expected to dampen down or constrain the aspirations and demands of their fellow midwives arising from the core values of midwifery, so that they comply with corporate strategy and financial budgets'* (p49). This schism is played out in the differences between birth centres and obstetric units where beliefs, values and practices are markedly different, and where midwifery and woman-focused care flourishes in the former but not the latter. Put simply, everything about a birth centre potentially supports women, birth physiology and midwives, whereas everything about a large obstetric institution potentially undermines women, birth physiology and midwives.

Another problem for birth centres is the context in which they are often planned. When services are centralised and maternity units closed, ensuing public outcry is unlikely to be appeased by the suggestion of a birth centre. This is seen as a reduction in services rather than an improvement. For birth centres to be a well-used, effective and stable part of maternity services, they need to be carefully planned in the context of overall services, so that we can achieve AIMS' goal of many more small, stand-alone birth centres supported by obstetric units that would be smaller than they are currently. These units would provide care for the minority of women who need technological and medical care as well as providing back-up support for women and babies birthing in the community.

The authors list the potential benefits of birth centres:

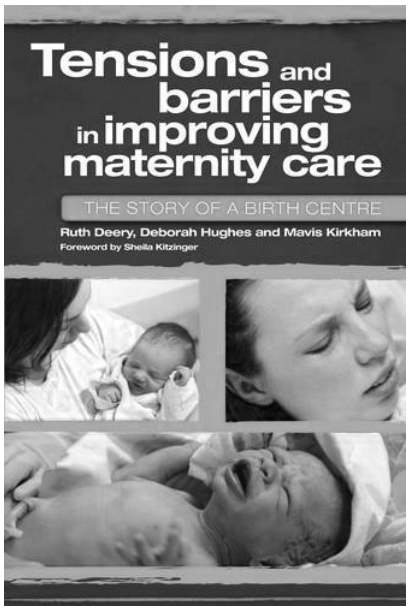
- choice
- location of birth within a community or geographical area
- homebirth-like facilities for women who are homeless or who have poor housing
- inclusion and welcoming of partners and families into the birth environment
- a place of safety and retreat from daily life
- a community hub

- a valuing of social outcomes for maternity care (p100)

Finally beware the *'changes in language of policy that repackage previously negative concepts as positive. "Reconfiguration" is a modern packaging of what were previously termed "cuts and closures". A shortage of, or reduction in, professional clinical staff is repackaged as "skill mix". Cuts in the number of antenatal and postnatal visits to women at home have been described as "individualised care", although midwives find it difficult to increase care for needy women. Similarly, "protocol-based care" is positively packaged as evidence based and managing risk, but may not respond to the needs and wishes of individual women.'*

If you want to improve maternity services, easily understand the politics of maternity care, set up birth centres in your area, protect existing ones, or fight the closure of one, this book will be an enormous help to you. It's a brilliant read too.

Nadine Edwards



Preparing for a healthy birth

by Sylvie Donna
Fresh Heart Publishing 2010
ISBN-13: 978-1906619107

Sylvie Donna became aware of birth stories when pregnant with her own children. More and more, she heard tales of traumatic, difficult birth experiences and discovered that the impact of a 'bad' birth was felt for a long time, not only by the woman herself but by the rest of her family too. The disempowerment and betrayal felt by these mothers was strong enough to impel her to write this book.

When I first opened the book, I dived straight into the middle of it. I quickly found the style to be very assertive and I could feel my barriers come up. Thankfully, I managed to override this and continue reading. The book is set out in steps rather than chapters, with plenty of anecdotal stories to illustrate points.

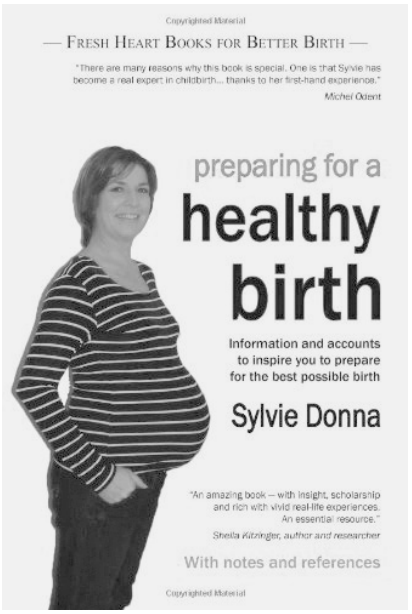
While it is, indeed, very prescriptive (What is a healthy birth? Step 1 – Understand Healthy) it is also incredibly informative and full of very good ideas. My favourite one is the underlying theme of letting nature take its course, while maintaining good health in yourself. i.e. don't mess with the process – it's very finely tuned!

The author puts forward the concept that you need to accept you have no real control over the process and each step takes you through aspects you may not have considered. For example, in Step 7 – Choose Who, she mentions the idea that the relationship between the mother and partner may be negatively affected by being present at the birth. The long-reaching implications of this change within the relationship is, in my opinion, severely under-addressed.

There are so many suggestions – ways in which the labouring woman can deal with variations from the 'norm' for example, 'What if you're told your baby's posterior', breastfeeding advice, healthy diet, what to put in your bags, what the baby will need – this book is more than just about the birth. It is an incredibly full antenatal class in one volume.

If you read this book with an open mind, there is still no promise or guarantee you will end up with the 'ideal' birth, whatever that may be, but you'll have gone a fair distance to becoming empowered and doing your best in preparing for a healthy birth.

Deborah Gilmour



Letters

Positive TV Birth

I have just watched one of the most positive television births I've ever seen – on a comedy program too! I live in Norway so am a bit behind the times and possibly you've already had comments about Nessa's birth in the series 'Gavin and Stacey' but I have only just seen it on DVD.

When one of the characters announced that Nessa's contractions had started I began to dread what sort of scenes we were in for; so often is a realistic, positive and useful depiction of birth sacrificed in the name of heightened dramatic or comic impact. However I was pleasantly surprised, and even impressed, by a number of aspects of this particular fictional birth.

Nessa's pregnancy had been fuss-free and straightforward despite the fact that she is overweight.

Her contractions started a month early but there was very little fuss made about that either.

She was shown managing her early contractions at home in a very calm way: making deep, reverberative sounds to help her cope; being entirely relaxed and 'normal' between contractions; and benefiting from the calm supportive presence of friends. I particularly liked the part where her boyfriend (not actually the father of her child) came in and, when another character commented that Nessa sounded 'like a cow', responded by saying she wasn't a cow but a fox (i.e. sexy) whereupon Nessa and he started snogging on the sofa – wonderful for the release of oxytocin!

The decision to go to hospital (no mention of a home birth option unfortunately) was made after Uncle Bryn – a middle-aged male friend – had been shown with a latex glove on announcing that Nessa was four centimetres. Whilst this was probably only put in for the comic potential, it did, for me, address an unhelpful taboo about women getting information about the state of their cervix themselves. It also put across a sensible message about when to make the transfer from home to hospital, i.e. not too soon.

Nessa's care seemed both straightforward and positive

Once at the hospital Nessa's care seemed both straightforward and positive. I was disappointed to see her lying in bed during first stage but cheered by the lovely sight of her friends gathered happily around her distracting her by singing! The midwife made sure things were quieter for the actual birth and suggested Nessa get on all fours (hurrah!) When Nessa made a ribald comment about that being a familiar position for her, the midwife responded in kind and any sort of prudery (and therefore adrenalin-inducing embarrassment) was immediately put aside!

The actual birth was in the all-fours position and noisy but powerful. On the whole a reasonably realistic but empowering birth. The fact that Nessa's friends were around her for a lot of the time, with her best (childless) friend with her for the actual birth, was reminiscent of the days when birth was an everyday fact of life and young girls as well as older women neighbours would all help out and naturally witness many aspects of the process. This is so unlike our usual pattern in the developed world today when birth is a secretive medical event and women approaching their first birth have woefully little experience or first-hand knowledge to support and reassure them.

Well done to Ruth Jones who played Nessa and also co-wrote the series.

Wendy Pagler
Childbirth Educator
Stavanger, Norway

Emancipation

I have just finished reading *Towards the Emancipation of Patients* by Charlotte Williamson, I really enjoyed it, a good recommendation. I bought it after reading the review in the excellent Anniversary Journal at our home birth group. What wonderful work AIMS has done and continues to do for women! It was really interesting to see where AIMS started and how things have and have not changed over the years. Thank you AIMS, you continue to inspire me.

Anna
Doncaster

Editor's Note: Here is the blurb from the book, for those of you who missed the review.

Despite a policy focus on involving patients in healthcare and increasing patient autonomy, much covert coercion of patients takes place in everyday healthcare. This book, by a leading patient activist, examines for the first time how the patient movement, which works to improve the quality of healthcare, can actually be considered an emancipation movement when led by its radical elements.

In this highly original book the author argues that radical patient groups and individual activists who repeatedly challenge or oppose some standards in healthcare, can be seen as working in the direction of freeing patients from coercion and from its associated injustice and inequality.

Combining new academic theory with rich empirical evidence, the book explains how looking at healthcare from an emancipatory perspective could improve its quality as patients experience it. It will appeal to health professionals, managers, patient activists, policy makers and others concerned with the quality of healthcare.

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, including 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 to birth at home. 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 and complications 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. Nicky tells us what the research says, what midwives think, what mothers want, what babies need. Every sentence is packed with interest. 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

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

What's Right for Me? by Sara Wickham: Making the right choice of maternity care. £5.00

Your Birth Rights by Pat Thomas: A practical guide to women's rights, and choices in pregnancy and childbirth. £11.50

MISCELLANEOUS

T-shirts: This is your chance to show some attitude – everyone wants to know where they stand – now you can tell them! Quality 100% white cotton T-shirts printed with ***'Don't Mess With Me! I am an AIMS Member.'*** For campaigning or for during your pregnancy. Sizes M (40" round bust and waist) L (44" round bust and waist) XXL (52" round bust and waist) £15.00 each

A Charter for Ethical Research in Maternity Care: Written by AIMS and the National Childbirth Trust, this sets out professional guidelines to help women make informed choices about participating in medical research. £1.00

AIMS Envelope Labels: Sticky labels for reusing envelopes. 100 for £2.00

Do Not Disturb: Bonding in Progress: Mothers and babies need time to get to know each other. This simple but effective sign can be hung on doors or beds to ensure others get the message. £1.00

Maternity Statistics Questionnaire: Any woman wanting information on her local maternity-unit practices can send this questionnaire to her local unit. Please then post a copy of your unit's reply to the AIMS Chair, Beverley Lawrence Beech, who will add the information to AIMS' compendium of hospital practices. £1.00

My Baby's Ultrasound Record: A form to be attached to your case notes as a record of your baby's exposure to ultrasound. £1.00

What is AIMS?: Activities of AIMS, the campaigns it has fought and its current campaigns. FREE

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Noticeboard

Labyrinth for Birth

7th September 2011

St Paul's Church Hall
Chipperfield

For pregnant women, mothers and birth professionals and anyone interested in using the labyrinth to explore and connect more deeply with the mothering journey. Meet, connect with and share wisdom with like-minded women.

Cost £75 for Birth Art Cafe Mentors, £115 for others.
hertsholistichealth.co.uk/shop/

AIMS AGM

16th July 2011
10:30am to 4:00pm

Friends Meeting House, Oxford, OX1 3LW

Guest Speakers:
Kathryn Gutteridge – Consultant Midwife, Sandwell & West Birmingham Hospitals NHS Trust
and
Caroline Broome – Lead Midwife, Blackburn Birth Centre

For more information, contact Gina Lowdon
secretary@aims.org.uk

AIMS would like to thank you for your support over the last 50 years of campaigning for improvement to the maternity services

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