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Twins and Multiples

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Association for Improvements in the Maternity Services

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Editorial

Twins and Multiples – bringing back the joy

By AIMS Journal Editor, Emma Ashworth

At the centre of a multiples pregnancy is a woman who has the same rights to make decisions about herself and her babies as any other pregnant person. As always, AIMS focus is on sharing information to ensure that parents can make informed decisions for themselves, but this is especially important with multiple babies as the whirlwind of appointments, scans and medical staff that are offered, together with well-meaning but not always positive 'advice' or comments from friends and family, mean that remaining in control of your own pregnancy and birth can be even more of a challenge.

For parents who have just discovered that they are expecting more than one baby the road ahead may look confusing and challenging, and so Mars Lord, mother of twins and doula to many twin parents, has written about some key issues which parents of multiples may wish to consider as starting points and ideas as they begin their journey.

I was particularly keen to include information about Twin-to-Twin Transfusion Syndrome (TTTS). As we all know, we don't know what we don't know and what I discovered was that TTTS is not a condition which affects all types of twins or other multiples. Many babies are simply unable to be affected by TTTS because their placentas are separate and so blood is unable to be transferred between them – something that would be very reassuring to a great number of twin parents. We are lucky to have a new contributor to the Journal explaining this condition – Rebecca Freckleton, another mother of twins.

We are hugely grateful to the midwives who have helped with this Journal, including our writing contributors, Helen Shallow and Chris Warren. Both of these experienced midwives have supported twin pregnancies with an eye towards normal physiology, and they show how with appropriate care and support, women can often have straightforward physiological births when pregnant with more than one baby.

Most of our birth stories are of twins, but mother of triplets, Rowena Hazell, took time out from her schedule of raising five children to work with Mari Greenfield to tell the story of the births of her daughter and two sons, who all share a birthday. Vaginally birthing triplets is unusual these days, and Rowena's story shows incredible strength and determination to do what was right for her. This didn't stop after her babies were born as she needed to fight for the right to provide human milk to her babies, as she has the condition IGT (insufficient glandular tissue), which means that she is unable to produce a full milk supply.

Having more than one baby means lots of preparation for life after birth as well. Nicola Lawson explains how practical carriers and slings are for twins. Babywearing doesn't need to be just for one baby.

Kathryn Stagg, IBCLC (International Board Certified Lactation Consultant) and breastfeeding counsellor, shares her knowledge and experience as a breastfeeding supporter and mother of twins. Yes, if you want to, you can still breastfeed more than one baby.

2018 saw the retirement of our long-standing President, Jean Robinson. I interviewed Jean for this edition of the AIMS Journal, but I feel that her time with AIMS, and other amazing work she's done through her life, could fill a Journal all by itself. I have rarely been so inspired and awed by a conversation and I feel that I have captured only a fraction of the enthusiasm, commitment and determination that Jean has brought to every aspect of her life supporting others. One stand-out part of my interview with Jean was when she told me about a question from an obstetrician writing to the Lancet, in response to a letter that Jean had written: "Who is this doctor hiding behind the skirts of this woman?" While we would all like to think that attitudes have changed, we all know someone who still thinks this way. Jean, you have been instrumental in huge changes that have happened in the world of birth and the rights of people using medical services, and we promise to take up your shillelagh and fight the good fight.

I have rarely been so inspired and awed by a conversation and I feel that I have captured only a fraction of the enthusiasm, commitment and determination that Jean [Robinson] has brought to every aspect of her life supporting others.

Final words of thanks go to Ruth Weston and Jo Dagustun for their summaries of the ARM Wigan Study Day and the Doula UK conference, and to Sangheetha Parthasarathy and Anna Culy for their book reviews. If anyone is interested in reading a book and reviewing it for AIMS, analysing research, writing articles, or volunteering for any other aspect of AIMS' work, please do get in touch at volunteer@aims.org.uk.

If you are pregnant with more than one baby, if you support women who are pregnant with multiples or if you are just interested in twins, triplets and more we hope that you will enjoy this Journal and find it helpful. In forthcoming issues of the AIMS Journal we plan to take a critical look at the implementation of Better Births; at infant feeding, and the gap that remains between the rhetoric of support for breastfeeding and what happens in practice; at the issues raised for the maternity services by a population of childbearing women that is being defined as increasingly "risky"; and at the impact of the maternity services on social inequality. If you are interested in any of these topics and would like to make a contribution, please email the AIMS Journal Group at journal@aims.org.uk. You will be welcomed with open arms!"

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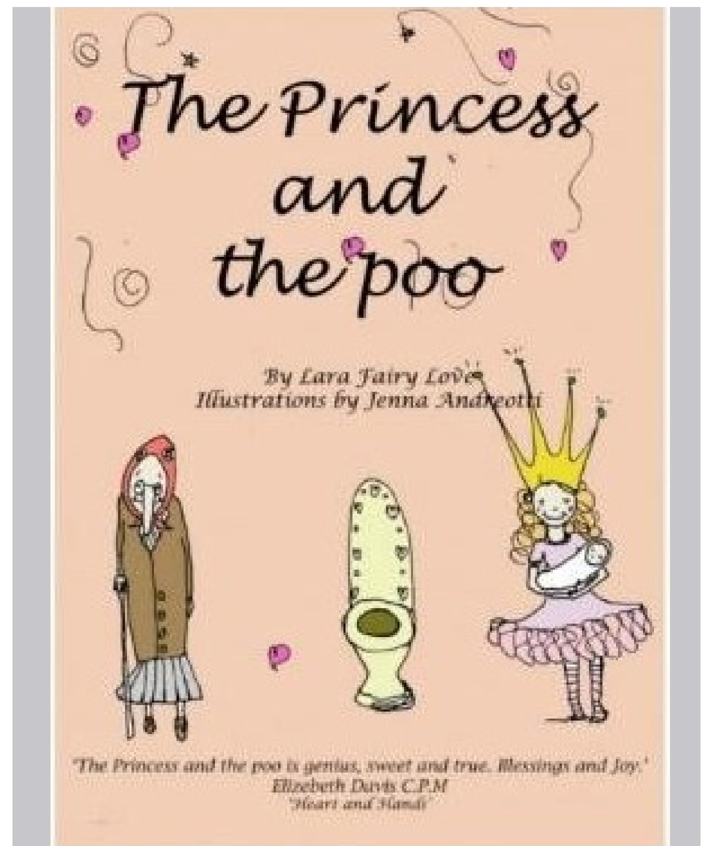

AIMS is thrilled to support the publication of The Princess and the Poo.

We came across the book a while back and thought that it's a wonderful book for children and all who read it. Lara Fairy Love, its author, wants to encourage children to think more about the way they were born in the hope of inspiring more peaceful births. She says that if more people knew it did not have to be such a scary process, more would give birth at home.

Jenna Andreotti provides the amazing illustrations.

The book is available from the AIMS Shop here: *www.aims.org.uk/shop/item/the-princess-the-poo*
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Article

Expecting Twins – and the world has changed for you!

Mars Lord, mother of twins and doula to many twin parents, writes about some key issues which parents of multiples may wish to consider

Based on my own experience as a mum of twins, and as a doula specialising in supporting mothers of twins and multiples, I offer a perspective firmly rooted in the notion that women expecting twins and multiples should not be dissuaded from considering themselves to have options, just like any other pregnant woman.

Contrary to popular belief, you will not necessarily be excessively sick when you are pregnant with twins, so this is why it often comes as a shock to arrive at the dating scan and find out that there is more than one baby. Of course, some parents already know that the chances of twins are high, due to IVF, twins in the family, etc.

One thing that we don't tend to count on, on discovering our double blessing, is the wave of negativity that fills the air. It can hit us from all sides: health care providers, family, friends, strangers in the street. Everyone knows someone, who knows someone who had twins and their life is hell. Why don't the positive ones find us first, the ones who revel in their multiples? I'm not talking about people who have no realistic view about what having twins means, but the people who love it and see it as it is... wonderful, exciting, challenging, life changing, fun! Still, forewarned is forearmed and can allow you to be more prepared and to make decisions that are right for you.

A barrage of questions

Twin mums can face a barrage of questions from day one. Questions and comments fly from all corners, even before we've met with our health care providers.

- Are they IVF?
- When's your caesarean?
- Did you know that you were having twins?
- Did you plan to have twins?
- You won't be able to breastfeed.
- You'll need a maternity nurse.
- It's going to be hell!

Small wonder that by the time we are sitting talking to a doctor and/or midwife, fear may have crept in. It's strange how much fear is put upon mothers of multiples, as though more than one baby is the scariest pregnancy prospect of all. The language that is used with multiple mums includes the word "risk". Risk is not a word that brings comfort in this situation and I prefer to use the word "consideration".

Assumptions and Decisions

There is often an automatic assumption that because you are pregnant with twins you will need to have a caesarean birth. More and more women are questioning the need to cut into their healthy bodies when twins can be born vaginally, and fortunately the medical world seems to be at last realising that surgery is not necessary for the birth of most twins. However, there may be additional decisions or more information needed when you are expecting twins.

- How will they be born?
- Where will they be born?
- How will they be fed?
- What are your choices throughout pregnancy and beyond?
- What are the considerations with a twin pregnancy?
- What will your support look like?

When will my babies be born?

Like all mothers, mothers of twins are likely to wonder when the babies will be born. Just over half of women carrying twins will have gone into labour by 37 weeks, and three quarter of those carrying triplets by 35 weeks, as early labour occurs more often with multiple births. The signs and

symptoms of preterm labour are just like those of labour at full term - regular contractions of the womb, building up in strength and frequency, the appearance of the mucous plug ('show') or waters breaking.

Contractions that do not become regular are a common occurrence in pregnancy, and these may be particularly noticeable and common with twins and triplets, but in most cases they are not a sign of preterm labour. However, it can be very difficult to determine if labour is imminent or not and if you experience these symptoms you will be advised to inform your health care provider immediately and it is likely that you will be advised to go to hospital. Although it is difficult to stop true premature labour, it can sometimes be delayed, giving time to prepare the babies for an early birth. This is where conversations about steroids and other medication to help the babies' lungs and other possible interventions and drugs come in, unless you've already had this conversation due to a history of premature birth.

Will my babies grow normally?

Most twins and triplets grow normally in the womb, although they do tend to be a little smaller than singleton babies. In all pregnancies, however, there is a chance that babies will not grow as they should, so good nutrition, along with a balance of exercise and rest, is important in giving your babies the best start possible.

You will be offered scans to determine whether your twins or multiples share placentas, and amniotic sacs, and your health care providers should explain how these things affect the growth of your babies and their births.

Although, it is important that growth restriction does not go unrecognised and that specific issues with some types of twin are monitored, you have a right to make decisions about whether, or not, to accept any tests including ultrasound scans that are offered to you.

Early delivery may be recommended if one or more of your babies is not growing well, and your health care providers should explain all your options, so you can decide what is right for you and your babies, and whether you want to accept any interventions they are offering.

Other Pregnancy Issues

There are more considerations to bear in mind when looking at and talking through options. Issues such as pre-eclampsia, gestational diabetes, anaemia occur more frequently in multiple pregnancy, but most mothers of multiples will still not experience them. However, if these considerations present themselves in pregnancy it is worth pausing and having an informed conversation with your health care provider. Seek as much further information as you need in order to make an informed decision about how, if at all, this changes your plans for your pregnancy and the birth of your babies.

Will my babies be head down?

The positions of your babies as you get close to term may determine what you decide is the best for your babies. If your babies are head down babies, or the presenting twin, the one that is in the position to born first, is head down, then health care providers are likely to be happy to support a vaginal birth. If the second baby is breech, then your health care providers are likely to talk about turning that baby or managing a breech vaginal birth. It is important to remember that you still have options and you have the right to be told what they all are, and to make an informed decision about what is right for you.

The second or subsequent babies are likely to reposition themselves after the birth of the previous twin, triplet, etc. Breech and transverse lying babies are often presumed to need caesarean births, but while transverse babies can only be born vaginally if they turn (or are turned) before they are born, breech babies, with the right support, will usually be born vaginally.

Do I have to have my babies in hospital?

Consider where you might want to birth your babies. You still have options, but depending on your local maternity services, you may have to 'fight' to birth your babies at home or in a birth centre. This may not be something that you desire and, as with all things, it's about informed consent and where you feel safe birthing your children. Most health care providers appear to try to insist on continuous monitoring of multiples in labour. But guidelines and policies are not rules; you have the right to be told the research that these are based on, if any, and to accept or decline care as you choose. The physiology of birth does not change for the birth of multiples, so you may want to ask why they think there is an issue for your babies.

What about birth plans and preferences?

These are very valuable to prepare and have. They allow you to consider and think through all the options available to you, and to research the ones that perhaps aren't offered, but might be right for you. Think about why you might want a vaginal birth and/or why you might want a caesarean birth. It you are offered the opportunity of seeing a 'twin specialist' you might want to ask what they are able to offer you that another consultant or midwife could not. You might want to know what the rate of caesarean, managed vaginal and physiological births is in order to decide whether they are the best person to support your birth preferences? Does it simply mean that all those expecting twins are under the care of this particular doctor or midwife, or does this person have a good record of supporting mums through choice and, hopefully, vaginal birth?

Despite the fact that many multiples are born early, many mother of twins find are offered induction. The AIMS book Inducing Labour: Making Informed Decisions could be a helpful resource. Talk about the reasons why your health care providers want to induce your labour. Ask what the 'considerations' are of both being induced and of not being induced. Is there clear evidence of benefits, or is it down to hospital practice? Ask what the actual statistics are when talking about the considerations of stillbirth and birth complications in multiple births. Hearing that something might double can cause us to immediately jump to imagine a high chance of something happening, rather than knowing that the percentage may still be very low, because doubling a very small number still gives a very small number. (eg. if there is a 1% chance of something happening, doubling it means there is now a 2% chance). As with all things, it is about what the considerations mean to you and whether, or not, you are happy with the advice that you are being given. Informed consent is important, but you can only make an informed decision if you know the facts and information on both sides of the coin.

After my babies are born

Immediately post birth can be very busy within a twin birthing room. The 'golden hour' is just as important for twin mums as singletons - the uninterrupted skin-to-skin and settling of the babies on the mother's chest so that bonding may begin immediately. The smallest baby regardless of their size is often immediately or frequently checked for blood sugar, as though just being a twin makes this necessary. There is an assumption that twin babies should be identical in every sense, yet, how many people do you know who birthed singleton siblings who were the same size!

There is sometimes a rush to get both babies feeding, rather than allowing mum and babies to be still together. This is a time to clear the room, if all is well with mother and babies, and allow quiet to return, especially if there has been a lot of noise around the birth.

When considering feeding twin babies, it is important to get good help and support in place from the beginning.

There are many people who do not believe that it is possible to exclusively breastfeed twins ... many, many twin mums do just this

There are many people who do not believe that it is possible to exclusively breastfeed twins although, in fact, many, many twin mums do just this. For some the breastfeeding journey is complicated by the very health care professionals that one might look to for help, whether you are feeding one or more babies. Do ask if your hospital has an IBCLC (Internationally Board Certified Lactation Consultant) that can come by to help with breastfeeding. A simple tip that I share is this, do some early feeds where you feed your babies one at a time. This should enable you to learn the latch of each baby and identify issues quickly, rather than being confused as to which is which and who is who; then progress to tandem feeding. The feeds will become more frequent and feeding them together is wonderful if it works for you. It may take time to find the right place and position to tandem feed and you may also need the support of your partner or someone else initially to get the babies in the right positions. You will also benefit from someone to bring you food and water and ensure that you are comfortable. If you are choosing combination or to bottle feed your babies, do read up on the guidelines for safely making up the milk. Our family and friends may not know these. Ask your midwife and/or health visitor about them.

There are different reasons why you may not get the birth and/or postnatal experience that you desire. One of your babies may need to go to SCBU (Special Baby Care Unit). These will be the babies who need a little support at the beginning, maybe oxygen, perhaps they need an eye kept on them for a few hours. It's worth finding out whether your hospital has a SCBU or whether this care will be provided on the ward? Some babies may need to go to NICU (Neonatal Intensive Care Unit). These will be the babies who are seriously ill and need more care. It might only be one twin that goes into it. It might be two. It is worth asking if your local hospital's NICU have double cots for babies? Both of these units will have their own rules about who can visit and when – although parents should have access at all times to their own babies. Your health care provider should be able to give you information about them.

Most women find it helps to have thought pre-birth about a 'plan' for post birth. What support will/can you put in place for your early days and weeks at home. Will you have family or friends help, or look to put in place some paid support? When deciding, think about what you might like. For most women it is about having support to enable them to focus on looking after the babies themselves, but for others it is about having someone to look after the babies. Think about the type of household you have and the type of people that you are. This should help inform your decision. You may wish to 'wear your babies' in order to be able to do other things whilst carrying one of more babies. There are resources out there to help you learn how to wear your babies simultaneously. It's good to find out about these things early so that you have them to hand in those first days and weeks at home when you may be too busy with feeding, changing and sleeping to search them out.

Sources of Support

The following may be helpful:

TAMBA
Local support groups
Online support groups
Home helps
Doulas
Sling libraries
IBCLCs (Internationally Board Certified Lactation Consultants)
Antenatal workshops specifically for multiple mums
Breastfeeding drop in groups/clinics
Birthrights
NICE Guidelines
RCOG Guidelines
SANDS
BLISS

And Enjoy

* Where possible, surround yourself with people who are confident about twin birth, or life with twins.

* Do some research early as to how you might like to birth your babies and where.

* Find out what your maternity services say.

* Read the AIMS book, *Am I Allowed?* and know your options.

* Be prepared to have a conversation with the senior consultant about your care. This includes your antenatal care.

* Find out if all your appointments need to be at the hospital.

* Think of ways to look after and nurture yourself as your body grows your babies.

This is an exciting time. Yes, you may be apprehensive as to how you will manage it all, but the support is out there. Congratulations. Welcome to the club!

Award winning doula and birth activist Mars Lord is a mother of five children, including one set of twins. She has had the privilege of working with hundreds of women, with a particular interest in multiple mums. Her work with pregnant women and their families has led her to speak at conferences and to lead workshops, namely Loving The Multiple Mamas and Cultural Competency.

Multiple Multiples

How they come about and what you might expect when you're expecting them

Rebecca Freckleton

Finding out that you are expecting multiples is a special moment and often something of a surprise. Once the fog begins to clear, questions about the type of twins you are carrying and what this might mean for the journey ahead can begin to shape your thinking and inform your choices for pregnancy and birth.

There are several different types of twins - some are very rare and scientifically fascinating, others more common but equally intriguing. The general public will **always** ask if your twins are identical and healthcare providers prioritise determining chorionicity (the number of placentae accompanying the babies) at the earliest opportunity - so everyone will have an interest in what type of twins you are having. During pregnancy, the type(s) of multiples a woman is expecting can make a big difference to her experience, so it is useful to know this information. Finding out the type of multiples you are carrying will help you know how your babies came to be, what antenatal care you might expect and want to choose, and what multiple specific experiences you could encounter during your pregnancy and birth.

The aim of this article is to define different types of multiples, the common and medical terms used to describe them and how this might impact on your pregnancy and birth decisions.

Identical or Non-Identical?

When you have young twins in your family, people will invariably ask 'are they identical?' This is more a fascination held by the general public than healthcare providers, as in itself it is not an indicator for specific health advice. Being identical or not depends on the babies' zygosity; that is how many fertilised eggs (zygotes) they develop from. A single zygote can divide to develop into two, or very rarely three, separate **monozygotic** embryos leading to identical multiples. When multiple eggs are released and fertilised separately (or implanted during fertility treatment) they lead to embryos that are **dizygotic** (from two zygotes) or **trizygotic** (from three zygotes). These multiples are referred to as fraternal and are no more 'identical' than singleton siblings.

Identical multiples

Identical multiples originate from one fertilised egg (monozygotic). The egg is fertilised by one sperm and then splits within the first couple of weeks of development. These identical babies share the same DNA from their genetic parents and so have an identical genetic make up. About 30% or 1 in 3 sets of twins are identical[1,2].

For identical twins, the point in time at which the egg cleaves or splits after fertilisation will determine whether the babies share a placenta, an amniotic sac or both. An egg which divides within the first 72 hours will result in twins each with their own placenta and amniotic sac. This accounts for around 20% – 30% of identical twins[3,4]. Division at 3 – 8 days (around 60% – 70% of identical twins) will typically result in twins sharing a placenta but each with their own amniotic sac[5]. At 8 – 12 days, an egg cleaving (splitting) will result in identical babies that will grow together in a single amniotic sac and share a placenta. Twinning occurring beyond 12 days could lead to conjoined twins, where babies share, to varying degrees, parts of their bodies. Twinning beyond 8 days is rare and represents about 1% of all twins[6].

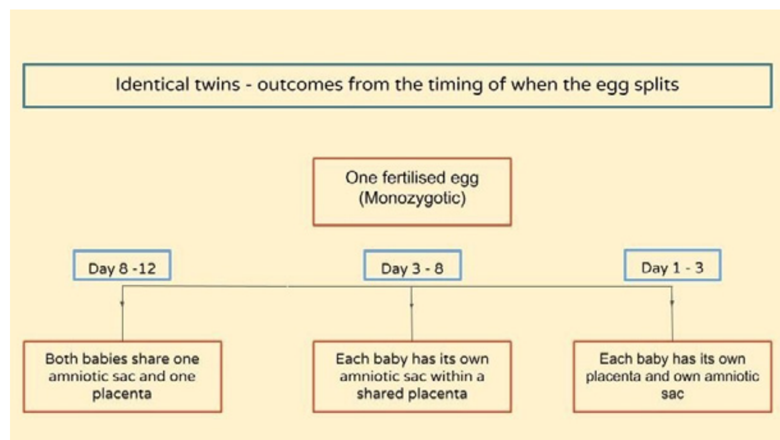

Figure 1: A flowchart showing the number of placentae and amniotic sacs identical twins will be supported by depending on the time after fertilisation at which the egg splits. The boxes in blue show the number of days after fertilisation that the egg splits.

Mirror twins are a subset of monozygotic twins, usually resulting from a zygote dividing between 9 and 12 days. They display mirrored physical attributes such as one being right-handed and one left-handed; birthmarks, dental structure and hair partings may also be in mirror image for this particular group of identical twins. In some cases internal organs may also be arranged in mirror image and this is called *situs inversus*. This is not deemed to cause any notable medical complications for those individuals with the condition, but it is useful for families and individuals to be aware so as to pass on to any services who may need to know in the future[7].

Identical twins resulting from an early egg division, which therefore have their own placentae, can only be verified as identical from a DNA test post-birth. Identical twins will share a common blood group, have the same skin, hair and eye colour, be of the same gender and look very similar. If twins seem identical but each had their own placenta it might be useful for the parents to find out about taking DNA tests for the babies if they would like verification.

Twins being of different gender is taken as clinical proof that they are not identical. Identical twins have to be of the same sex to share the same DNA. However, it can happen that monozygotic twins present as a boy / girl pair. Eggs usually carry a pair of XX chromosomes and contribute one of these to the zygote that forms, the sperm offers up the other chromosome, X or Y determining the baby's gender. In very rare instances an egg will have an extra chromosome, which can develop into a zygote with XXY chromosomes. If this zygote then divides, creating twins, different chromosomes may be dropped by each embryo, leaving an XX female embryo and an XY male embryo. Because chromosomes make up our DNA and, in this instance, these are changed during the cleaving process, these twins would not be truly identical but do come from the same egg so are monozygotic. Only a handful of these cases are known, it is extremely rare[8].

Half-identical twins

There is a theory that an egg may split before fertilisation and that two different sperm can create separate embryos. For these 'half-identical' or 'polar body twins' the DNA match would be closer to 75%, as they inherit different genes from their father but share their mother's[9].These babies would have separate placentae as the egg has already split before fertilisation. Half-identical twins would not be as similar as identical twins but share more similarities than the 'average' sibling.

Non-identical multiples

Non-identical multiples (usually referred to as fraternal) result from separate eggs and separate sperm. These babies are as genetically linked to each other as any singleton siblings (with on average a 50% DNA match), but are usually conceived at the same time and carried in-utero together. These babies will each have their own amniotic sac and placenta. These are the most common type of twin and account for around ⅔ of all twins or 7 out of 10 sets of twins [2,10].

Very occasionally, non-identical twins can be conceived at different times, either within the same menstrual cycle (superfecundation) or much more rarely as a result of an egg being released during pregnancy (superfetation). This can lead to the possibility of non-identical twins having different fathers and being half-siblings[10]. Twins conceived at different times will still be born together, but at different gestation, and therefore possibly have different medical needs.

More than two

Triplets and more can be made up solely of non-identical babies, or a combination of identical and non-identical babies, e.g. two eggs fertilised separately, one of which goes on to divide could lead to triplets including a pair of identical twins and one non-identical twin. Very rarely identical triplets can occur where the egg splits twice after fertilisation to create three separate embryos.

Chorionicity & Amnionicity

Healthcare providers will refer to twin types by their **chorionicity** and **amnionicity** and define their recommended antenatal and birthing care based on this. Chorionicity relates to the number of placentae and amnionicity to the number of amniotic sacs that will support the babies in utero. These are different qualities to zygosity.

At the earliest scan (should you choose to have them) the sonographer will be looking for the number of placentae and amniotic sacs that they can see alongside multiple babies. The placenta supplies oxygen, nutrients and hormones

to the babies and removes waste, whilst the amniotic sac protects them inside its 'waters'. Identifying chorionicity and amnionicity will help parents and healthcare providers to know what to take into account as pregnancy progresses and is likely to influence decisions in pregnancy and labour.

The **chorion** is defined by the Oxford English Living Dictionary[11] as '*the outermost membrane surrounding an embryo of a reptile, bird or mammal. In mammals it contributes to the formation of the placenta*'. The chorion develops a system of blood vessels and in association with the lining of the uterus forms the placenta. The placenta is the primary organ supporting nutrition, respiration and excretion for the baby / babies it is attached to[12].

The **amnion** is defined by the Oxford English Living Dictionary[11] as '*the innermost membrane that encloses the embryo of a mammal, bird or reptile*'. It fills with amniotic fluid to provide a protective environment for the developing fetus. This fluid is 'the waters' that surround the baby until they break at the onset of, during, or shortly after, birth.

NICE guidelines for multiples emphasise the importance of determining chorionicity at the time of identifying the twin pregnancy by ultrasound and that if chorionicity is not detectable to seek a second opinion from a senior ultrasonographer as soon as possible[13]. Ideally chorionicity will be determined by 13 or 14 weeks gestation[14,15]. So our healthcare system places great store in knowing the type of twins being carried at an early stage.

Knowing the number of chorions and amnions in a multiple pregnancy will offer insight into how the babies will be supported by their placenta and protected by their amniotic sac throughout the pregnancy. The terms used to describe types of twins by chorionicity and amnionicity are shown in Figure 2.

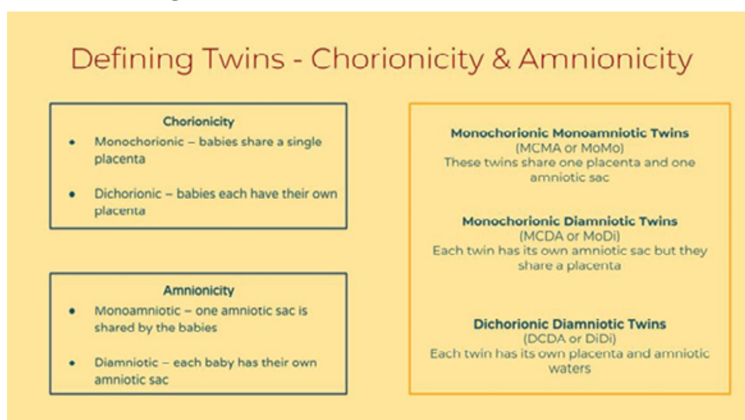

Figure 2: Possible arrangements for chorionicity and amnionicity in twins, and the terms that are used to describe them[3,16]

The relationship between chorionicity, amnionicity and zygosity is shown in Figure 3. It shows that monozygotic (identical) multiples can present with any chorionicity and amnionicity, whereas dizygotic (fraternal) twins can only be dichorionic and diamniotic. Two placentae fused together can make chorionicity hard to determine; ultrasonically it looks similar to a monochorionic diamniotic structure. If there is any doubt, healthcare providers are advised to offer care as if the pregnancy were monochorionic[13].

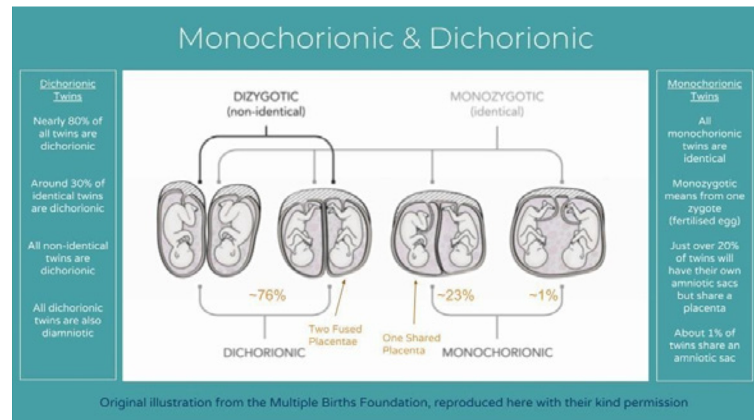

Figure 3: This diagram illustrates how monozygotic twins can present with four possible structures. Dizygotic twins will always be dichorionic. The original illustration, published with the kind permission of the Multiple Births Foundation, has been annotated with notes in orange. The figures in orange are rough calculations of the percentage of all twins that present with each particular structure[3,4].

Triplets and higher numbers of multiples may show a variety of chorionicity and amnionicity. For example triplets may be trichorionic (each baby having its own placenta), dichorionic (two babies sharing a placenta and one baby having its own, so two placentae in total) or monochorionic (all babies sharing one placenta)[17]. Triplets may also be triamniotic, diamniotic or monoamniotic depending on whether there are 1, 2 or 3 amniotic sacs present alongside the babies and their placentae.

The NICE guidelines '*draft care pathway for twin pregnancy*' outlines the antenatal care you should expect to be offered from your healthcare provider for uncomplicated twin pregnancies and how this differs for monochorionic and dichorionic twin pregnancies. The schedule of care, staff involved (with your consent) and type of care is described in brief.

Chorionicity and Amnionicity Related Conditions

With monochorionic and monoamniotic presentations there are specific conditions that can occur, or are more likely to occur, and so healthcare providers will ask to watch these multiples more closely. Guidelines from the Royal College of Obstetricians and Gynaecologists for professional '*management of monochorionic twin pregnancies*' are publicly available online. These guidelines state that, '*Clinicians and women should be aware that monochorionic twin pregnancies have higher fetal loss rates than dichorionic twin pregnancies, mainly due to second trimester loss and, overall, may have a higher risk of associated neurodevelopmental morbidity. This should form part of the parental counselling*.' This suggests that women, couples and families pregnant with monochorionic multiples might need, and should expect, a good deal of information and support from their healthcare provider.

These extra considerations to take on board come about because the placenta is shared. One function of the placenta is to provide a flow of blood to and from the baby. When there is more than one baby the blood flow can become unequal. Imbalances in blood flow can lead to specific medical conditions including: twin-to-twin transfusion syndrome (TTTS), selective growth restriction (SGR), twin anaemia-polycythaemia sequence (TAPS) and twin reversed arterial perfusion sequence (TRAPS)[15]. Conditions relating to shared blood flow are almost universally a consideration for monochorionic pregnancies, however when two placentae fuse there is a slight possibility that blood vessels between the placentae interconnect. This makes it possible for TTTS to occur in these instances but it is very rare[18].

TTTS stands for twin-twin (or twin-to-twin) transfusion syndrome. In higher order multiples the same condition may be referred to as feto-fetal transfusion syndrome (FFTS). This condition affects 10 - 15% of monochorionic twins and usually manifests itself in early pregnancy, typically before 24 weeks. TTTS happens when the blood flow is imbalanced between the multiples sharing a placenta and the 'recipient' twin receives a larger share of blood from the placenta, whilst the 'donor' twin receives a smaller share. The extra blood being passed to the 'recipient' twin can put a strain on this baby's heart and cause the heart to enlarge. The 'recipient' twin will also pass more urine which increases the volume of fluid in its amniotic sac (polyhydramnios). Conversely the 'donor' twin may have low blood pressure and become anaemic and dehydrated; its surrounding fluids will decrease (oligohydramnios). The difference in growth between twins with TTTS can become markedly discordant as shown in Figure 4.

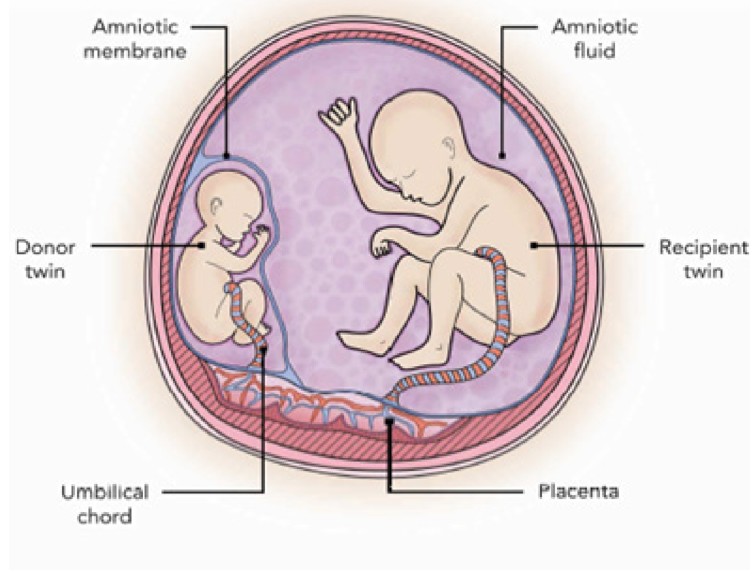

Figure 4: An illustration to show the disparity between the growth of twins and the space taken up by their amniotic sacs in TTTS. Reproduced with the kind permission of the Multiple Births Foundation.

At the onset of TTTS, sometimes the mother will notice symptoms such as: increased thirst, premature contractions, a notable tightening and swelling of the abdomen, breathlessness and palpitations. There may not be any symptoms, though, and routine and regular ultrasound scans might be the only way the condition is noticed.

Early recognition of TTTS is preferable, so extra ultrasound scans are offered in monochorionic pregnancies. These scans are usually scheduled every 2 weeks from 16 weeks until 24 weeks. TTTS can be detected by ultrasound. Doppler scans are used to observe blood flow, and ultrasound images can detect any differences in the amount of amniotic fluid around each baby, the overall size of each baby and its bladder size. If TTTS is detected, the function of the heart will also be recorded in the 'recipient' twin.

One half to two-thirds of the sets of babies with TTTS remain stable or improve but will warrant the offer of close monitoring until delivery. The remaining third or so of cases develop into severe TTTS. Currently the best treatment for TTTS is Fetoscopic Laser Ablation Therapy, with a 60% -

70% success rate for survival of both twins, and 10 - 15% for one twin to remain alive. TTTS is a condition taken very seriously by healthcare providers as in its severest form 20% - 25% of twin babies don't survive[14,19].

TAPS is a form of twin-twin transfusion in which the monochorionic twins develop markedly different levels of haemoglobin. The 'donor' twin can become anaemic, whilst the 'recipient' twin displays abnormally high levels of red blood cells which act to thicken blood and slow down its flow. TAPS is harder to identify than TTTS as the levels of amniotic fluid stay balanced, but it can be diagnosed antenatally by Doppler scans and affects between 1% and 6% of monochorionic twins when it occurs spontaneously. TAPS can also occur as a result of fetoscopic laser surgery. Laser surgery is offered to address TTTS, in 16% of laser treated TTTS cases post-laser TAPS occurs. Antenatally, TAPS may be actively managed by laser surgery, intrauterine blood transfusion or if appropriate, early birth through induction or caesarean[20, 21, 22, 23]. After birth, a newborn TAPS anaemic twin may require a blood transfusion, whereas the 'recipient' with higher Hb levels may be offered a partial exchange transfusion(PET) to redress the imbalance. The PET process is described by MedlinePlus[24] as when '*a specific amount of the child's blood is removed and replaced with a normal saline solution, plasma (the clear liquid part of blood), or albumin (a solution of blood proteins). This decreases the total number of red blood cells in the body and makes it easier for blood to flow through the body*.'

TRAPS is a condition where one twin has a non-functioning heart (called the "acardiac twin") and the heart of the other twin acts as a pump for both babies, causing a reversed blood flow in the acardiac twin. It is extremely rare and occurs in about 1% of monochorionic twins[25]. TRAPS can be detected by ultrasound in the first trimester as the acardiac twin is physically very different to a normal healthy baby. The acardiac twin has no chance of survival as it has no functioning heart of its own and is an abnormal fetus in many physical respects. The 'pump twin' however is usually structurally normal, but their heart comes under strain supporting a blood circulation to an extra body. The larger the acardiac twin the greater the strain on the 'pump' twin's heart. Reports of the overall survival rate of the 'pump' twin vary widely; 30% - 50%26, 80%27 and 90%[28]. Expectant management is one treatment option[27], monitoring the normal twin's heart performance, with the possibility of an elective early birth if the heart becomes significantly compromised. Laser treatment on the unborn baby may also improve survival rates slightly (to 82%), with birth being, on average, at around 37 weeks if laser treatment is received between 13 and 16 weeks[29]. Radio Frequency Ablation (described by '*The Fetal Treatment Center*') which stops the flow of blood into the acardiac twin shows survival rates of up to 90% with birth being, on average, around 35 weeks.

sGR or sIUGR is also a condition that affects multiples sharing a placenta. These acronyms stand for 'selective growth restriction' or 'selective intrauterine growth restriction'. In around 40% of monochorionic pregnancies the placenta is shared disproportionally, which can result in one twin growing slowly whilst the other twin grows at a normal rate. sGR is detected by ultrasound and occurs in 10% - 15% of monochorionic pregnancies. It is defined when there is a weight difference of 25% or more between the twins. There is no way to share the placenta more evenly so currently there is no treatment for sGR. Early delivery of affected multiples is the preferred approach by healthcare providers, with best outcomes for babies born beyond 32 weeks[14,19].

In monoamniotic pregnancies, when babies are sharing one placenta **and** one amniotic sac (1% of all twin pregnancies), there is a likelihood that the umbilical cords become entangled, limiting or cutting off essential supplies to one or both twins[15]. Women with pregnancies involving a shared amnion should be offered individualised care from healthcare providers with expertise in this area[13].

Multiple pregnancies can be physically demanding on mother and babies, and for the immediate and extended families waiting to welcome the babies a great variety of feelings from many different parts of the emotional spectrum are likely to be experienced along the way. Although for some multiple pregnancies, choices may seem more limited because of their complexities, all decisions are still yours to make. Guidelines suggest at least two appointments with a specialist obstetrician for **all** women carrying twins, plus there are specialist twin midwives within the NHS and independently. These are valuable chances to receive medical information, gain professional support and

ask for expert advice about your individual case[13]. Of course, who you choose to invite to support your pregnancy is up to you, and knowing more about your type of multiples can help you to decide what type of care is right for you. Being pregnant with two or more babies may draw a certain amount of medical attention, but amidst the medical terminology, machinery and specialist professionals on offer you may need to remind yourself and others that it is your body and your pregnancy, and that ultimately you make the decisions for you and your babies.

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Three's a crowd: vaginally born triplets

By Rowena Hazell

I had two children, and very much wanted a third child to complete my family. When I finally became pregnant, I started bleeding at about 6 weeks. The bleeding continued, and at 7 weeks I was sent for a scan. I was feeling very sick, which I thought might be a good sign, but the midwife said it might not be. She carefully prepared me that this might be a miscarriage. The sonographer told me that if I was 6 weeks pregnant, we might not see a heartbeat, but that if I was sure of my dates, we should do.

I lay on the bed staring hard at the sonographer's face, looking for clues. Why was the scan taking so long? Why was the assistant leaving the room? Then the sonographer turned to me and said, 'I didn't see just one heartbeat. I didn't see two heartbeats. I saw three heartbeats.'

I was stunned. I thought so many things … There goes my home waterbirth … I can't even breastfeed one myself, how am I going to breastfeed three? (I have a condition called insufficient glandular tissue, which limits the amount of milk I can produce) … How are triplets even born, is it one baby then one placenta, or all three babies and then the placentas?

The assistant who had left the scan room had gone to let everyone know the results. On my way out I saw the triage midwife and said to her, 'I told you I felt REALLY sick!'

How are triplets even born, is it one baby then one placenta, or all three babies and then the placentas?

When I got home, very bizarrely, on the top of my Facebook newsfeed was a photo of an American mum, breastfeeding her triplets. I reposted the photo without comment, sat and stared at my scan photos, and tried to imagine how this might change things, compared to the single pregnancy I had been hoping for and expecting.

At my first appointment with the multiples specialist, it had sunk in a bit. There was so much information to take in. I was told about survival rates and percentages of babies born at different gestations who would have disabilities. The doctor discussed 'selective reduction' (abortion of one or two foetuses) with me, and pushed me to seriously consider this. Even though this was upsetting, I felt it was actually right for the doctor to push me to think about these things because carrying more than two babies makes premature labour – with all the risks for the babies – highly probable. So you do have to consider whether one baby on its own would have a better chance for a good outcome.

Maybe I might have felt differently if I had 'done something' to conceive triplets, if I'd had IVF for example. But in my head, my body had got pregnant with three babies naturally, so after consideration, it felt like the right choice was to let nature take its course, and continue the pregnancy with all three babies. However, I worried about whether I would be as pressured at all appointments, so I took a friend who was a student midwife with me to the next appointment to tell the specialist my decision. I was pleasantly surprised to find that the pressure had simply been to consider the issues, and that my decision was accepted and supported.

Planning three births

My birth plan caused more controversy though. The hospital had quite a lot of experience of caring for women who vaginally birthed their twins, which gave me some confidence. But conceiving triplets is rare, and birthing them vaginally is even rarer. I arranged a birth planning meeting with the Head of Midwifery, because the multiples specialist told me that although he would 'support' my choice to birth vaginally, he himself does not cover the Labour Ward, and so could not be involved at all really with the delivery.

The Head of Midwifery arranged for a Labour Ward obstetrician to come to our meeting also. They began by discussing external holding – this is where the second baby in a twin birth is held in a head-down position by a midwife with her hands on the woman's tummy after the birth of the first twin. They said that they were not sure whether this was a good idea with a triplet birth, so they had Googled it, and found some information from Australia, which said this was

not helpful for the birth of the second baby in a triplet birth. The fact they had had to Google it amused me.

The Multiples Consultant had strongly advised me that I should have a 'just-in-case' epidural. A big concern with the birth of multiples is that once the first baby is out there is a lot of room for the others to get into different positions. This is why they do the external holding – but with a triplet birth this may be less safe, because you don't know which baby is going to be born next, and it is less clear which limbs belong to which baby. If the next baby does get in the wrong position, for example a transverse position, then an internal version would be needed. This literally involves the obstetrician putting their hand inside the womb to turn the baby. It is very painful, hence the argument for the just-in-case epidural. That was quite a scary decision – 'What happens if the next baby does get in the wrong position?' I asked. They told me they would use a hand-held Doppler scanner to check the second and third babies' positions, so it wouldn't be undiagnosed, but an internal version would be needed immediately. I asked the obstetrician if she had ever performed an internal version (it sounded so strange). She said she had, most of them with epidurals in place, and once without, which was more difficult but still doable. That was reassuring. When I got home, I found someone online who had had an internal version without an epidural. She said it was very painful, but it was very fast. The internal bruising lasted much longer, and was more significant, and of course once the epidural wore off I would feel that anyway. I decided that I would not have a 'just-in-case' epidural, and would take my chances and deal with an internal version if it was needed.

From breastfeeding my previous two children, I know that I have a rare condition called insufficient glandular tissue (IGT), where my breasts literally cannot make enough milk for my baby. Three babies were definitely going to need more milk than I could produce, but I wanted that milk to be breastmilk. This was especially important to me as my babies were very likely to be premature, and breastmilk can save the lives of premature babies.

I had managed to start collecting donor milk, together with antenatal blood tests, from the women who had donated their milk to me. I knew that, despite the antenatal screenings (as close as possible to UK Association of Milk Banks' standards), it would be problematic to get the hospital to agree to using donor milk, and if I refused formula for my babies, it could result in a swiftly obtained court order giving the hospital shared Parental Responsibility, and then they would give them formula anyway. I discussed this with the Head of Midwifery. She got a Neonatal Intensive Care Unit (NICU) nurse to call me at around 20 weeks to discuss a plan. The NICU nurse was not helpful. She refused to make a plan with me, and disbelieved that I had IGT. She told me that I was upsetting myself over nothing, and that if I gave birth prematurely it would be my fault for upsetting myself about nothing. I did more research and found:

* Milk Banks in Norway have used and distributed unpasteurised milk for many years, without incidence of infection.
* Medical papers describing how premature babies who are given formula are at much higher risk from necrotising enterocolitis – a condition which is often fatal.
* A study published in the Lancet, for babies given pasteurised and unpasteurised human milk. In the group with mixed formula and pasteurised human milk, the infection rate was 33%. For the group given only pasteurised human milk, the infection rate was 14%. The group given mixed formula and unpasteurised human milk had an infection rate of only 16%. And for the group given unpasteurised milk, it was only 11%.
* In the Czech Republic, mothers with excess milk are encouraged to donate directly to mothers who need milk, and are talked through the benefits and risks. They sign a form to attest to this.

I emailed all this information (and more) to the Patient Advice and Liaison Service (PALS), who sent replies from the Trust Solicitor, refusing to allow me to use unpasteurised privately sourced donor milk. I offered to sign a disclaimer, and pointed out that the antenatal screening the women had had was in line with the UK Association of Milk Banks policy for donor milk. I also offered to pay for pasteurised donor milk from a Milk Bank. The reply was still no.

Eventually the Head of Midwifery stepped in to help me make a plan. She was happy to use pasteurised donor milk from a Milk Bank, and told me that they had reserved some milk especially for my triplets, which I was delighted about.

There were also difficulties with my birth plan because I felt strongly about delayed cord clamping. Because my babies were likely to be premature and therefore low birth weight, I felt they needed every drop of their blood. However, when multiple babies share a common placenta, there is a risk of 'twin-to-twin transfusion' – where the baby (or babies) still inside the womb receive too much blood from the baby who has been born. This can be very damaging and even fatal to the baby who receives too much blood. The Multiples Specialist said that for this reason, current hospital policy was to 'not allow' delayed cord clamping, because they had had one case of twin-to-twin transfusion syndrome occur suddenly at birth. Scans showed that my triplets each had separate placentas (trichorionic), but the Multiples Specialist said that there was a 10% chance of the scans misdiagnosing the placentas as being separate. Therefore I could not have delayed cord clamping, because there was still a tiny chance it might harm the babies.

In the UK, all decisions are the mother's until the baby is born because the baby is not considered a separate entity until the moment of birth. This means a hospital cannot overrule any decisions a woman makes about her body before a baby is born. However, as soon as a baby is born, a hospital has a duty of care to that baby. In a multiple birth, decisions about a baby who is born can affect a baby who is not, and vice versa.

The Trust Solicitor was contacted again, this time by the Multiples Specialist. He eventually confirmed that I had the right to insist on delayed cord clamping, but only because the potential harm is to the baby or babies still in the womb. Therefore I was legally allowed to make a decision about the baby who was born, that was potentially harmful to the unborn babies, because the Trust's duty of care was only to the baby who was already born. It sounded slightly ridiculous to me that I was allowed to potentially cause harm to my unborn babies. But actually, sudden onset at birth twin-to-twin transfusion syndrome is quite rare even in twins who do share a placenta, and the Multiples Specialist calculated that even with the 10% chance of every scan being wrong, the actual risks were around .001%, and so I was quite confident this was a decision that was in my babies' best interests, rather than one that would harm them. [AIMS note: TTTS in pregnancy is discussed in "Multiple Multiples" on page 10 but in this case, Rowena is referring to TTTS during birth. More information on this is available from TAMBA (*https://www.tamba.org.uk/file/TTTS-Guide.pdf)*.]

At the meeting, both the Head of Midwifery and the Labour Ward Obstetrician supported my decision not to have continuous monitoring. With a triplet birth, I would have had bands around me for two babies, and one for my contractions, and then a scalp monitor for the third baby. In previous labours I had found any clothes really distracting and uncomfortable, so the thought of several bands round my tummy, and a scalp monitor, was not appealing. Cardiotocography (CTG) monitoring is also notorious for raising false alarms, leading to unnecessary interventions. The Head of Midwifery fully documented my birth choices, including no 'just-in–case' epidural, that I was not having CTG monitoring, and that I wanted to be in water for the first stage of labour, so I didn't really need to write a birth plan. This then ensured that whichever midwives and obstetricians were on shift when I went into labour would know that my choices were informed choices, and would be less twitchy about them. My friend later told me that the Head of Midwifery had previously been an independent midwife with experience of twin homebirth. I felt lucky – she was the perfect person to be supporting me. It now felt like my plans were all in place, and I could enjoy the last few months of pregnancy.

One labour

The last few months turned out to be only the last few weeks of pregnancy. I had a few false starts of labour. At 29 weeks I went into pre-term labour and went into hospital. I was given a steroid injection to help my babies' lungs mature. The UK policy for pre-term labour is that, if pre-term labour happens, it is taken as an indication that there must be a problem, and it is assumed that the babies would be better off in an incubator than in a womb. Therefore they usually only give 24 hours of the Atosiban drip (a drug that stops labour), to give the steroid injection time to work.

After that, they will not try to prevent labour continuing. I understand this policy, but think that it is not necessarily appropriate for multiples pregnancies. I felt my pre-term labour might not have indicated a problem, but might have been just because there was so little room inside for the babies. In the USA, hospitals are willing to prescribe many drugs to try to stop pre-term labours in multiples pregnancies – I wish they would do that here too.

I asked the Multiples Consultant about this, and he did agree to give me a second 24 hours of Atosiban (because NICE guidelines say 'up to 48 hours'), but after that nature would have to take its course. After this I was moved to a different ward. Because of the move, I missed a meal. In the new ward, the contractions started again. I quickly ate a sandwich, aware that I would need my energy, and labour stopped. I then woke up at 5am with a few contractions; I ate two biscuits, and labour stopped again! When I got home, I searched online for this and found that low blood sugar can precipitate labour. So from then on, every time I had contractions, I ate something. When I got up to go to the loo in the middle of the night, I made sure I ate a substantial snack – a banana, a biscuit and a glass of milk. I think this really helped to keep my babies in.

At 32 weeks I had a really horrendous scan. The sonographer tried to make me lie on my back, but by now my tummy was so huge that I couldn't breathe if I lay on my back. The sonographer was truly awful, really prodding and poking me, and the scan was not just uncomfortable, it was very painful. I was very distressed during the scan and after. My friend who is a doula came with me, and she later described it as an assault. I wished one of us had spoken up during the appointment, not just talked about it afterwards. The scan had shown my babies were in the same position they had been throughout, lined up like three dominos, ready for birth.

I had a really uncomfortable night, and at an appointment with the Multiples Specialist the next day I discovered that my two boys were now transverse. I think the painful prodding was so rough that it had made them move, and with my babies in this position there was less room for them, which made my tummy much more uncomfortable.

That evening, I had more contractions, and they weren't going away. At 10pm I realised this was definitely it, and went into hospital in early labour. I arrived at 11pm, at 32 weeks and 2 days pregnant. Everyone writing in my notes kept putting 32+2, though after I had been there an hour I kept saying 'it's 32+3 actually', as it was now after midnight. The extra day felt important to me. Every day matters when your baby is premature.

I had been given pethidine in my first labour and had an awful time. I had also tried gas and air, and didn't like that, so I just wanted to use water for pain relief (but understood actually giving birth in water would never be recommended because the babies would be premature). As the pool in the Labour Ward is rarely used, I hoped I would be able to use it. However, when I arrived, someone else was in it, much to my disappointment. Someone from NICU then appeared in the room, to give me a presentation about NICU care. This seemed very surreal to me, but it is what they do for all women arriving in premature labour. A few days later, I discovered a glossy brochure with pictures of shiny incubators in it, though I have no memory of having been given it. It must be very traumatic for women who were not expecting their babies to need NICU care and whose premature labour was unexpected. At least I had had time before labour to think about it and come to terms with it.

After I had been in hospital an hour, the Head of Midwifery came in. She must have asked to be called when I came in, and she cared for me during my labour. Otherwise I would just have been cared for by the duty obstetrician, who might or might not have had experience of multiple births before. I was glad to see the Head of Midwifery. She cared for me very respectfully.

I tried to find music I wanted, but I couldn't. Vocalising had helped in my previous labour, but this time it felt like it used up too much energy. I spent most of my labour draped over a beanbag on the bed. The room was dimly lit, and the Head of Midwifery and the Obstetrician were very quiet. The Head of Midwifery would catch my eye when she thought I was having a contraction, and I would just nod slightly at her, so she didn't have to ask me, which was wonderful.

… three babies, born

Finally, I was told the pool was vacant, cleaned, refilled and waiting for me. That was wonderful news, but as I was being wheeled along the corridor I knew that if I got in, I wouldn't be getting out. I think I was probably in transition, and I didn't want to tell them that because I wanted to get in the pool. In the corridor I told my doula 'I think I need a poo' and I was suddenly wheeled at high speed into the pool room, as everyone realised I was about to give birth. My daughter, Bee, was born just a few minutes later and was handed to me for just a precious few moments while they let her cord pulse.

If I had had a Caesarean birth, the theatre would have been so full of people – as well as the usual doctors, midwife and anaesthetist for me, there would have been a midwife and a neonatal doctor for each of my three babies, because they would all have been born within minutes of each other. However, because I was giving birth vaginally, only one baby was born at a time. The Head of Midwifery made sure only the midwife and neonatal doctor relevant to the baby currently being born were in the room – the rest waited elsewhere. This kept the number of people in the room to a minimum, and really protected my privacy.

Bee stayed on my chest for a few moments before her cord was clamped and cut, and she was whisked away for checks. I had wanted a longer delay for clamping for my babies, but had agreed to 90 seconds, by which time most of the blood would be transferred. Shortly after this, Bee was taken by the midwife and neonatal doctor to NICU. It felt strange when they took her, even though I had been expecting it.

After Bee was born, labour just seemed to stop. Nothing happened for an hour and a half. I think this was because there was now more room in my uterus, and everything was comfortable again. The waters around my boys were intact, and had I been really in control of all the decisions, I might have liked to just carry on being pregnant with them, until labour restarted by itself. I have read that this has sometimes taken days or even weeks for other people. However, I didn't feel strongly enough about this to want to debate it then. I was encouraged to move, but contractions didn't restart. After an hour or so, everyone in the room was glancing at the clock. Eventually the Head of Midwifery suggested breaking my waters. I didn't really want this, but I trusted her, so I agreed, and it worked. I wouldn't have changed this decision. The Head of Midwifery then did some internal holding, and the Obstetrician did some external holding, as it was now clear that the second baby was in the right position. The Head of Midwifery then guided me in pushing, which I did need at this point (unlike with Bee, because this time I did not have any natural urge to push). So my son Alexis was born. Again I held him, though on my tummy not chest as his cord was so short. We waited before clamping and cutting the cord, and then he too was taken to NICU.

Thirty minutes later my third triplet, Lenny, was born, with similar holding and guided pushing. I found this helpful, as my body was a bit like 'we've got the baby out, let's go to sleep', not seeming to realise there was still another baby to give birth to. Again, when he was born I held him for a few minutes. My doula managed to take some wonderful (and quite discreet) photos of my babies being born, which I love. The pictures surprise me a little, because everything is so brightly lit. My memory of the birth is that everything was quite dark and dim, but maybe that is because my eyes were mostly closed.

Although I had had physiological third stages for my previous births, I had agreed to Syntometrine to deliver the placenta to minimise bleeding, which seemed reasonable to me. Everyone else in the room was fascinated by this giant fused triple placenta! It weighed the same amount as one whole baby.

When all my babies had been taken away, and the placenta had been examined, they said I might as well get into the pool. It was lovely wallowing in such a huge bath after giving birth, and I felt euphoric … but strange, because my babies had disappeared.

NICU

As I tried to get back out of the pool, I had a weird sensation of not being able to breathe, as if all my body was suddenly too heavy. That was odd. On the postnatal ward I couldn't sit up or stand for more than five minutes without finding breathing difficult. I was having to be wheeled across to NICU in a wheelchair because I couldn't walk far. The

midwives didn't know why, didn't take it seriously, and looked at me quite oddly when I said I needed to use a wheelchair. One of the other mums I met had brought a corset in, because she said that she had had severe *diastasis recti* before. This is when the stomach muscles have separated so much that for a while after birth they simply don't hold your organs properly in the right place. The mum described it to me as your diaphragm not holding everything in, so it falls out of the bottom of your tummy. This was exactly what it felt like was happening to me! The midwives on the ward didn't seem to have heard of this, but they did send a physio to see me. The physio made a corset out of a double layer of their largest Tubigrip, and immediately I could breathe, sit up, and walk again with ease.

My birth had been a great experience, but NICU was sadly not. The plan the Head of Midwifery had put in place to reserve donor milk for my triplets was overruled by the NICU paediatrician, on the grounds that my babies were not premature enough to qualify for it, and they had already used most of the Milk Bank milk that the Head of Midwifery had understood was reserved for my babies. I was trying to express colostrum, but apart from an initial few drops there was literally nothing at all for about five days. My babies needed milk. The paediatrician suggested pre-term formula, but I was very reluctant. I wanted to use donor milk from my friends, if the Milk Bank milk wasn't available to them, but the paediatrician said the hospital would not allow this. Eventually they agreed to allow Milk Bank milk to be used for one week, while the issue was debated and resolved.

The Head of Midwifery and one of the neonatologists eventually came up with a plan. They would agree to my babies having one milk donor, as long as she was screened by the hospital, and came to express at the hospital under their controlled conditions. Her milk and my milk could be given to my babies whilst they were in NICU. When I took my babies home, I could feed them however I chose, so I could then use my donor milk for them without the hospital feeling liable. I was extremely lucky to know one good friend who had such oversupply that she was able to express an extra litre per day in addition to feeding her own baby, and she happened to live very close to the hospital.

And home

In the end, my babies had no formula. I found donors amongst friends and via Human Milk for Human Babies. They had only human milk for around eight months. I am so grateful to the women who donated their milk to my babies. By the time they were a few weeks old, they were needing an extra 1.5 litres of milk per day in addition to mine. I fed them myself as frequently as I could, sometimes almost constantly rotating them, tandem-feeding two at the same time as bottle-feeding the third.

When you register the birth of multiple babies, they record their times of birth, not just the date, so that it is recorded who is the oldest. Here is my babies' birth information for you:

	Time of Birth	Apgar	Weight
Beatrix (Bee)	5.34 am	8 9 8	3lb 14.5oz
Alexis	7.16am	9 10 -	4lb 5oz
Valentin (Lenny)	7.47am	8 9 10	4lb 3oz

From left to right: Beatrix, Valentin and Alexis at three months old.

With thanks to Mari Greenfield for her contribution to the writing of this article

Breastfeeding Twins – and more!

Kathryn Stagg, breastfeeding counsellor and mother of twins, offers her tips on breastfeeding multiple babies

So you're off to your first scan now that you're pregnant. Such an exciting time! And then the sonographer says: 'How many babies can you see in there?' This is how I embarked on my journey to twin motherhood. Shock is an understatement!

Lots of mums of multiples find out this way, and others have an idea that it could be a possibility due to family history or fertility treatment. But it's still a shock. Then, once it sinks in, the emotions vary from joy to anxiety, or even grief for a 'normal' pregnancy. Will they be OK? Will they come early? But how will I cope? How will I breastfeed? Will I ever sleep again? Unfortunately the comments from friends and family often do not help the anxiety. The number of times we have all heard 'double trouble' or 'You'll have your hands full', 'You're expecting twins? Oh I'm so sorry', 'Twins would be my worst nightmare!' It gets very wearing after a while. What about just a simple 'Congratulations!'? Or 'How wonderful!'

Breastfeeding is important to many mothers of twin babies, and being well prepared and informed can make a huge difference to how breastfeeding goes for mothers of multiples.

The language used by Health Care Professionals can either support or undermine parents of multiples. For example, a lot of parents are not reassured that it is possible to breastfeed more than one baby. These are some things said to mums expecting twins by health care providers:

> *'It's logistically unfeasible to breastfeed two babies.'*
>
> *'The body is not designed to feed twins.'*
>
> *'It's impossible to exclusively breastfeed twins.'*
>
> *'It's much easier to express as you can see what they're getting.'*

What we actually need to hear is, 'Oh that's fantastic that you are going to breastfeed your babies and give them such a great start. You can do this! Lots of mums breastfeed twins. Here's lots of information.'

During pregnancy, it is very important that midwives fully discuss feeding options with women, supporting them to prepare for breastfeeding should they wish to. Wouldn't it be helpful if there were a specific multiple birth antenatal clinic with specialised consultants and midwives who have experience of all types of multiple birth? It's great if twin and triplet mums who are breastfeeding or have breastfed can either help to run it or be invited to take part. Links with the local twins club can facilitate this. It is vital to discuss the implications of birth and pain relief on feeding, and ways to mitigate the effects of pharmaceutical pain relief on breastfeeding initiation. For instance, opiates such as pethidine and diamorphine can make babies sleepy, and they can find it much harder to feed after birth.

How birth goes can influence how easy breastfeeding is to initiate, and with twins there is a much higher chance of a medicalised birth, which can impact on breastfeeding initiation. Interventions, drugs, early or premature birth and instrumental or caesarean birth can lead to a higher chance of babies being sleepy, slower to feed, having an under-developed sucking pattern, being more prone to jaundice, more prone to low blood sugar, weight loss and therefore a greater need for top-ups in the early days. All of these situations can be supported, but knowing in advance what can make a positive difference can really help.

Antenatal Expressing of Colostrum

Some mothers may choose to express their colostrum towards the end of pregnancy. The resulting colostrum can be used as an 'insurance policy' to support the babies after birth if they have trouble latching on or if their blood sugar is low. The mother is provided with some small syringes to collect and store the colostrum and is taught how to hand express. More information on this technique can be found on the ABM website *(click here)*.

Active Birth

As the tradition for the last generation or so has been to manage twin birth in a highly medicalised fashion, it can sometimes be challenging to arrange support for a more intervention-free labour and birth. However, the links between a drug-free, low-tech birth and easy initiation of breastfeeding are well established and therefore mothers who are anxious to breastfeed may consider ways to stay upright and active in labour and explore alternatives to pharmaceutical pain relief. To find information on the benefits of upright, active birth, *click here.*

Early Skin-to-Skin/Kangaroo Care

Once the babies are born, holding the babies in skin-to-skin contact has a number of benefits. From regulating the babies' temperature, heart rate and respiration to stimulating the neonatal reflexes that result in the initiation of feeding, the power of this close contact is unparalleled. Staff need to be flexible with hospital routines to support as much time with each baby skin-to-skin as the parents want. Skin-to-skin helps to increase milk supply by triggering breastfeeding hormones, and depending on the age and gestation of the baby, can really help to encourage initiation and continuance of breastfeeding[1].

Biliblankets

Jaundice in more likely in premature babies, and therefore something to be aware of if your twins are born early. When bilirubin levels reach a certain point, phototherapy will be recommended. Whilst supplementation with formula is often advised, breastfeeding does not need to be interrupted and, in fact, breastmilk can speed up recovery. If the hospital has biliblankets, skin-to-skin need not be interrupted and the babies can be encouraged to feed frequently. If the babies have to be in a cot, regular breaks for feeds and cuddles should be encouraged and skilled breastfeeding support given. The NICE guidance is clear that jaundice is rarely a reason for formula supplementation[2].

Feeding Frequently And As Much As They Need

Breastfeeding twins or more is undeniably quite an undertaking in the early days; it can feel as though just as one baby finishes, the next wakes and wants to feed. It can seem that the only chance of any respite is to put the babies on a strict feeding routine. However, it is helpful for parents to understand that unrestricted time at the breast in the early days builds milk supply, ensures optimal weight gain and guards against breastfeeding problems such as blocked ducts and mastitis. Mothers need consistent, positive support through the sleep deprivation and lots of practical domestic support so that all she has to worry about it feeding the babies and getting as much rest as possible.

Born Too Soon

Prematurity can be a massive barrier to breastfeeding, but it can also be a positive. I have met mums who were not going to breastfeed at all but because their babies came early and they were informed of how important breast milk is for preterm infants, they began expressing. 40% of multiple births need special care and in some situations mothers will not be able to be with their babies as much as they would like to, for instance if the mother is herself unwell or when there are other children or family members needing care. In this case, hand expressing as soon as possible after birth, and encouraging the feeding of every drop of colostrum, will help babies to be as well as they can be.

Once milk volume starts to increase, probably around day 3 or 4, a hospital grade breast pump with a double pump setting may be more efficient and effective for mums who are not able to breastfeed directly for whatever reason, or for mums who are partially breastfeeding and partially providing milk through other means. Every drop of breastmilk is immensely valuable, and breastmilk helps to protect premature babies from serious illnesses such as necrotizing enterocolitis (NEC)[3].

For mums who are unable to supply enough milk for their babies to start with, screened, processed donor breastmilk from an NHS milk bank should be available for these infants. Parents have the right to choose to request that the hospital provides this to their babies rather than formula.

Learning how to increase milk supply can be important with multiples due to the larger volumes of milk that will be needed. The more milk that is taken from the breasts, the more milk is made.

When expressing, support to find the correct flange size for each woman is important, and can make a difference to the amount of milk which can be pumped, as can

supporting her to pump at least 8 times a day, including at least once at night. Mothers often benefit from skilled support to position and attach their babies and to recognise good milk transfer. The use of nipple shields is also sometimes useful, helping premature babies with small mouths to latch on, but these should be used with specialist support and ideally weaned off as soon as possible as they can lead to lowered milk supply in the longer term. Teaching breast compressions can increase milk transfer and staff can also really help mums by arranging or signposting to hospital grade pump hire when the mother is discharged.

When babies are tube fed it's important that the nursing care is mindful of the need to try each baby on the breast. One mum was told, 'We have just fed your babies, they won't need you now' when she came back from lunch. This was obviously very upsetting. Care needs to be taken that babies have the opportunity to practise at the breast when they are not full from a tube feed or conversely too hungry to latch easily.

The transition from highly structured routines in NNU with sleepy premature babies to taking home alert, frequently-feeding babies can feel scary and overwhelming. Staff need to discuss cluster feeding, tandem feeding, unsettled behaviour and developmental leaps so that parents understand normal newborn behaviour. It is also important to reassure parents that it is OK to ask for help, especially as many babies are discharged from NNU on the absolutely exhausting 'breastfeed, express and top up' cycle. Parents need support with how to manage this, and reassurance that it is temporary, as well as skilled guidance on when to start moving towards exclusive breastfeeding if that is what the mother wants.

NNU can be an immense support, with parents being able to access breastfeeding support for a lot longer than those on the ordinary the postnatal ward. However, rooming-in before discharge can feel a bit like a test, with some parents feeling like the staff are judging whether they are capable of looking after their babies alone. But it can also be a positive time with more freedom to parent with the continued support of staff.

Parking costs can be a real issue when babies have a long stay in hospital. It can prevent mums from seeing their babies every day and therefore spend less time establishing feeding. Some hospitals will provide a free parking permit for parents whose children are in hospital – just ask the ward staff.

Term Babies

For full-term babies, getting a good start is even more important because their stay in hospital, if they are born at home, will be a lot shorter. Skin-to-skin and early feeds are just as important, especially after a cesarean birth, and can make a big difference to breastfeeding success. Sometimes parents may be advised to top up their babies with formula – perhaps for low blood sugar, or weight loss. In this situation, babies must be treated as the individuals that they are and "because they're twins" is not a valid reason for this to be suggested. Many parents report that their babies are often topped up with artificial milk for no reason, and some parents even feel threatened if they do not agree to supplementary feeds. One mum was told, 'We will remove your babies from your care if you do not consent to give top ups.' This is coercion – and in most cases unlawful.

And, of course, there is more than one baby to care for. Balancing the needs of two or three very demanding individuals with differing needs can be challenging. Babies don't always learn to feed at the same time. Often one will get it before the other. Mothers often need a lot of reassurance that the second baby will get there in the end.

Midwives and Health Visitors need to understand smaller or premature babies' weight gain, and how to plot percentiles with adjustment for prematurity, and know how to support tandem feeding. Many parents will also need support to work out how and when to top up with expressed breastmilk or formula if that has been necessary, and how and when to move on to exclusive breastfeeding. Unfortunately, not all midwives and health visitors will have detailed training in these areas, and it might be necessary for parents to approach breastfeeding counsellors or IBCLCs for additional support.

Everyone involved in the care of the babies also needs to make sure that the babies are treated as individuals and not compared, especially for weight gain but also for developmental milestones. Health Visitors offering as

many home visits as they possibly can make an enormous difference as it is very difficult to get out to appointments with more than one baby, and mothers often need to find a friend or family member to help.

Peer Support

Signposting to specific breastfeeding support, both face-to-face and online, can help with the technicalities of breastfeeding. Peer to peer support is often absolutely vital for mums of multiples. The reality is that nobody truly understands what it is like to have twins or triplets unless they have done it themselves and this is where twins clubs can play a large part. There are also excellent online support groups like the Breastfeeding Twins and Triplets UK Facebook group.

All mothers deserve to have support in establishing breastfeeding but it is especially important for mothers of multiples. There are some very simple steps which could improve outcomes, both in hospital and the community. Breastfeeding my twins was by far the most challenging and intense thing I have ever done, but it was also the most rewarding. And once I got over the first few weeks it was just so easy. I cannot imagine having to get out of bed to do night feeds, to wash and sterilize 16 bottles a day, to spend over £1000 on infant formula or to have to go home because I had not taken enough milk out with me. It's so important to me to be able to offer support to other mums the chance to have the same fulfilling experience.

Kathryn Stagg

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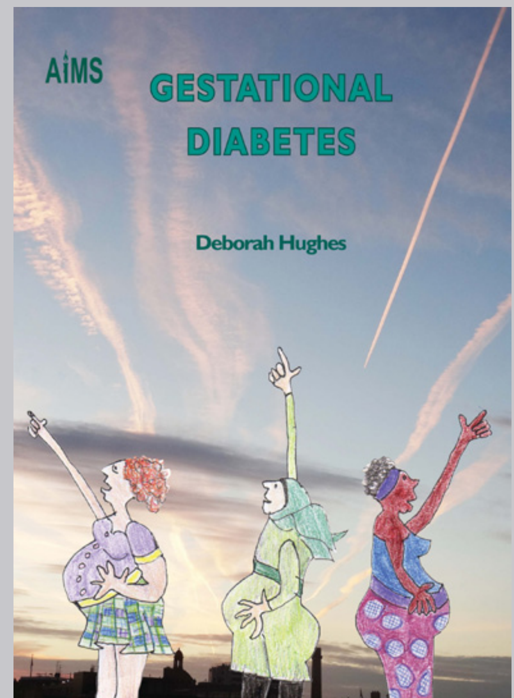

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When mothers know best - the birth of twins

Helen Shallow reviews the birth stories of two mothers who she supported as a consultant midwife

Introduction

My experience of twin births spans thirty years and, looking back, I see how increasing medical 'management' of twin births has become more focussed on risk and early intervention, and how this has shaped mothers' decision making and experiences.

I do not consider myself an expert in twin births and suspect my hands-on experience is fairly average, as twin births do not happen every day in maternity units. Notwithstanding, I have witnessed the birth of unexpected twins, surrogate twins, identical twins, premature twins, caesarean born twins, induced labour twins, post-date born twins, and precipitate term-birth identical twins. Where my area of skill and knowledge comes to the fore is in enabling, advocating for and supporting mothers who make birth choices that don't fit with current guidance or practice. In the spirit of the midwives' oral tradition (Gould, 2017) I would like to share two twin birth stories that occurred in the last five years, before I left the maternity unit to complete my own research journey in 2014.

I have used pseudonyms to protect the mothers' identities, and they gave their permission for their stories to be shared. I write from my perspective as a then-practising consultant midwife. To be clear, I do not take my professional responsibilities lightly. The safety of women and their babies is paramount, and my practice reflects that. A straightforward vaginal birth (if this is the woman's desire) is self-evidently the safest option, but of course I have yet to meet a mother who would not be grateful for and accept the advice of a health care provider if she or her baby were identifiably at risk. Safety means reducing interventions which are not required, while recognising those which are, and this works best when there is trust between everyone involved. These two stories are about two mothers who, in essence, wanted to birth their babies themselves, in their own time, and without interventions, unless there was a clear indication otherwise, and with our support. How simple could that be?

Anzu

Anzu is Japanese and lives with her husband and three healthy children. Her first birth was straightforward without complications, and labour was not induced. Expecting twins in her second pregnancy, Anzu expressed the desire not to be induced at 37 weeks. She wanted to birth her babies actively and without interventions. Her midwife referred her to my clinic. As most mothers carrying twins are under consultant obstetrician care, I rarely met mothers expecting twins in my midwife consultant role. In Anzu's case, her twins were identical and it was evident she was undergoing close observation for any signs of twin-to-twin transfusion (RCOG, 2016). Anzu talked with confidence about her mothers' twin births and her grandmothers' twin birth and I realised that her motivation was inextricably linked to her cultural-familial heritage. Her family history engendered in her a deeply held confidence and belief in herself, which in effect was translated in to a simple desire to birth her babies herself, unless there was a clear reason to intervene.

My own confidence was bolstered by her self-assured determination. She wanted the opportunity, she wanted our/my support, which was, after all, a simple request.

I met Anzu and her husband several times in the following weeks. In between visits she continued to attend her hospital appointments and had several more scans. On each occasion we were assured that all was well. The babies' growth was parallel and consistent, and Anzu remained healthy on all counts. I set about compiling a birth plan with Anzu and for this I sought guidance from other consultant midwives who had supported mothers successfully toward low intervention twin births.

Knowing the opposition we faced, I was determined that the multidisciplinary team, including supervisors of midwives, should be aware of Anzu's plans for her labour. The simplicity of a 'do it yourself twin birth' is complicated by the possible 'what if' scenarios. Therefore in discussion with Anzu we talked through the possible scenarios in order to have a clear plan a, b and c in place. For example she did

not want an IV infusion 'just in case' but accepted it might be needed. So I suggested and she agreed that an infusion would be set up, out of site and easily available. The same applied to a scan for the second twin. The scanner and the doctor were not to be in the birth room, but available, should there be any doubt as to the presentation of the second twin. She wanted to be active and mobile and declined the use of electronic monitoring. In short, each standard recommendation for managed twin birth was put aside, put on standby, and became a safety net, only to be used if needed. Is that not how it should be for all mothers?

Anzu's obstetrician tried to dissuade her, intimating that her birth plan put her babies at risk, but could not say how she was increasing the risks to her babies. Anzu was resolute in her request to give birth unaided, but with support, and this, she argued would not increase the risk to her babies. Anzu's birth plan was communicated to all concerned and we waited in anticipation.

Twin births and best-laid plans

At around 38 weeks Anzu arrived at the maternity unit in advanced labour and gave birth to her first baby in the admission bay. Amidst chaos and panic, the obstetrician was summoned and Anzu's plans for her second twin went unmet as plans were immediately made to transfer Anzu to theatre in case a caesarean was needed for twin 2.

"Hold on", the midwife said, "I don't think we have time"

"Nonsense," retorted the obstetrician, standing with her back to Anzu,

... as Anzu quietly birthed her second baby into the hands of her husband.

Kelly

I met Kelly in my clinic, again at around 30 weeks, after she expressed a wish to avoid interventions for her twins' births unless they were shown to be necessary. Her added wish was to use the pool. Kelly had one son whose birth was assisted with forceps. Kelly's twins were non-identical and in a good position for normal births. Both twins were head down and growing well. Bolstered with recent experience of supporting Anzu, I felt more confident on this journey, though her request for water birth added a new dimension and challenge.

I was disappointed by the obstetrician's outbursts of indignation and fury at Kelly's 'irresponsible decision-making'. Many midwives also expressed unease. Kelly had undergone assisted conception with both of her pregnancies. For this reason she was considered 'high risk', even though we could not elicit a clear explanation of exactly how this increased her risk, when all her parameters remained normal. When countered with the known risks of induction of labour, this was dismissed as irrelevant. The obstetrician 'washed her hands' of Kelly, even though she was reminded she had a duty of care to all her 'patients'. Therein lies the power struggle between women's agency and medical *hegemony*. In effect, Kelly's pregnancy from that point became midwife-led, with myself as the named consultant.

Kelly agreed to a detailed plan of care that we compiled collaboratively, and which included her request to labour and birth in the pool. The plan was communicated to all concerned, so that no one could say they had not been informed. I went on call for Kelly. At the time I lived a two-hour drive away and Kelly was aware I might not make it in time. My colleague, also a consultant midwife, was on standby. There was a clear understanding that one of us would be there to support not only Kelly, but also the midwives. Although they were experienced in facilitating normal births it was clear they needed someone present with the confidence and skill to facilitate twin births in water 'against hospital advice'.

As with all planned hospital twin births, there are two midwives in attendance, one for each baby and invariably the labour ward co-ordinator provides support when the birth is imminent. Also present at a medically managed twin birth, would be the obstetric registrar, the trainee doctor and a neonatologist for the babies. Theatre would be alerted and ready to receive the mother when the births became imminent. At Kelly's birth there were just the midwives and her husband, even though preparations for interventions were discreetly readied in the background and out of sight.

Kelly's water births

Mothers have the ability to let go and give birth at the right time for them, when circumstances allow, which sadly is less evident in modern maternity care. Kelly was 40 weeks when I visited her. She was enormous, tired and unwieldy. I could

sense her resolve weakening. She brightened when I told her that, "tonight is a good time to have babies". Her husband would be home after his week of night shifts, and I was on call and staying close to the hospital. Kelly called me at 2am in the morning to say she thought labour was starting. She sounded relaxed and calm. I told her I would meet her at the hospital. When I arrived soon after, she was already in the pool room wanting to push, leaning on the arms of the two attending midwives. The pool was almost full so we helped Kelly settle in to the warm water.

Kelly's son was born soon after and handed straight to her. Joy filled the room as we waited quietly for the onset of more contractions. As Kelly gave her son his first feed, her contractions resumed. The midwives looked nervous, so I offered to examine Kelly and sure enough her daughter's head was just waiting to emerge. Kelly's daughter slipped into the water and I leaned over and passed her through and up into Kelly's arms. Kelly's daughter was slower to respond, so the midwife passed her to her colleague where, after minimal stimulation, she was reunited with her parents and her brother in the warm pool.

The labour ward was busy that night, and I noted the relief on the registrar's face when we shared the news with her. There was no triumphalism, but there was elation and joy and exhilaration that reverberated round the unit for some time to come.

Conclusion

Why is it, that when women want to birth their babies with our support, with a safety net in place, but without intervention unless it is clearly indicated, why is it so hard to achieve? We are all conspirators. As modern women, as mothers and health professionals, we have unwittingly imbibed the medical risk discourse, that is so hard to shake off, particularly in the labour ward 'just in case' setting. When mothers and midwives work together in partnership and the mother leads the way, we can with confidence support them on their journey. If, as midwives still are, the professional experts for normal pregnancy, labour and birth, midwives can and should support mothers with their requests for a normal birth of twins irrespective of guidelines and protocols. Thank goodness we have them when we need them, but when we do not, let us use our knowledge and skills and respect and trust the mother's judgement that she does know best.

Kelly's Perspective

I became pregnant with my twins following a failed FET and IVF cycle, so began the pregnancy with the knowledge that I would probably never have another. After a fairly traumatic first birth, I knew that I wanted to avoid a second medicalised birth if at all possible. From the outset, I made my wishes clear to the consultancy team at the hospital. At each visit, I would be given the standard information on NICE guidelines for twin births, and I would wearily repeat my preference to avoid unnecessary induction and intervention, to give birth naturally and in the pool. My decision was an informed decision. I read the NICE guidelines for patients and for clinicians. I read medical journals and articles, and heard stories from independent midwives. I spent six years and many thousands of pounds to have a family, and that struggle colours every decision and thought throughout pregnancy - it is never taken for granted and I was hyper-aware of things that could go wrong. So, to be dismissed time and again by the obstetric team providing my care was more than dispiriting. Even with Helen's unwavering support, I still had to fight for the birth I wanted, right up to meeting with the clinical director of the hospital to defend my decision. I'm sure many people would have given up by then, cowed by the system that supposedly exists to care for them. In the event, I gave birth to two extremely healthy babies, on my due date, and returned home the same day as a complete family. My beautiful, positive birth experience is testament to the fact that no women should be subject to a "one size fits all" approach to labour and birth, discounting the instincts and experience of midwives and mothers.

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[1] Identical twins otherwise known as monozygotic twins are distinct from non identical twins in that they have developed from the same egg. Monochorionic, also identical twins, may share the same amniotic sac and placenta and this increases the risk of twin-to-twin transfusion, which can be life threatening for one of the twins who may fail to thrive.

Protecting Twin Physiology

Birthing twins – encouraging normal physiology

By Chris Warrren

'*You need a maternal-fetal specialist, an obstetrician, who has received specialist training and put it to use in the management of high risk pregnancies*' (Luke and Eberlein 2004[1]).

This strongly worded advice to parents expecting more than one baby reflects the view of most prospective parents and healthcare providers, but not all. Women expecting twins and who book with independent midwives disagree. Women pregnant with multiples are no more a homogenous group than women who book for independent care but who are carrying one baby. They have different reasons for choosing an independent midwife, but most want to minimise medicalisation and avoid 'routine' interventions during their pregnancy and births. This article is based around the births of four sets of twins supported by Yorkshire Storks, but a couple of others have crept in. All of the women's names are pseudonyms, unless they have expressed a desire to own their own name, and all have given their permission for their stories to be included.

Jessica booked with us at 28 weeks after being told by the community midwifery manager that she could not have a home birth as she was expecting a big baby and her midwives were scared of having to deal with a shoulder dystocia. Two weeks later I realised Jessica was carrying twins. I had missed them the first time I palpated her abdomen. She still wanted her home birth.

Nora knew from an early scan that she was expecting twins. She was happy to access the hospital for scans and initially she felt comfortable seeing the obstetrician, but wanted the convenience of antenatal care at home at times convenient to her work commitments. She knew that she did not want to be 'messed about with'. She wanted to avoid vaginal examinations, induction, continuous monitoring and imposed time limits and wanted ideally to birth at home. She wanted to minimise interventions.

Lindsey does not like being told what to do and not being listened to and she quickly realised during her antenatal care that she wanted and needed to be supported in her informed decisions and therefore booked with us. She is not a nurse but works for the NHS.

Hayley wanted a home birth with her IVF twins, had had a traumatic birth with her first baby, and a home birth with NHS midwives for her second but had not felt well-supported. She knew that her community midwives would not be comfortable at a home birth with twins. She is a nurse working within the NHS. One of her friends had booked with us to minimise medical interactions as she was considered high risk for other reasons – so we came personally recommended.

These four women were expecting diamniotic-dichorionic (di-di) twin babies: each baby had their own placenta and amniotic sac and was not at risk of having a twin-to-twin transfusion – a potential risk when the babies share a placenta, where one twin thrives at the expense of the other[See *Rebecca Freckleton's article* in this journal issue]. All the women were offered, and some took up the offer of, regular growth scans, a good way of picking up this problem, despite it not being a reality for any of them. Jessica had decided not to have any scans but accepted one to 'confirm' my findings that there were two babies, and to find out what 'sort of twins' she was carrying. This would influence the discussion we would have about the likelihood of problems occurring. Nora had fourteen scans and found them reassuring despite the babies sometimes measuring 'too big or too small'. Lindsey had five scans and declined several. My client notes state '*does not want a scan as then she will have to see the consultant who will go over everything again*'.

It is difficult to get good evidence of the likelihood of problems as the research tends to consider all sorts of twins together, but there is acknowledgement that di-di twins are the most straightforward. NICE (2011) in its Twins and Triplets Guideline[2] says that '*The evidence relating to such pregnancies was very limited in quantity and quality*'. The Guideline does list many increased problems for those expecting multiples but also acknowledges that '*An awareness of the increased risks may also have a significant psychosocial and economic impact on women and their families because this*

might increase anxiety in the women, resulting in an increased need for psychological support'.

This increased anxiety increases the likelihood of the women accepting an unwanted intervention as their confidence in themselves and belief in the ability of their bodies to birth their babies have been seriously undermined. These interventions could have unexpected consequences and increase harms.

The chance of a woman carrying twins developing pre-eclampsia, obstetric cholestasis or going into pre-term labour is higher, but how much higher is difficult to ascertain. None of 15 sets of twins that have booked with us have been born before 37 weeks, with most going to 39+ weeks and Hester's babies being born at 41 weeks and 3 days. One of our twin clients had signs of pre-eclampsia and possible obstetric cholestasis at 38+ weeks and had reluctantly agreed to go in for an induction, but, the night before, went into labour and birthed her babies spontaneously and straightforwardly in hospital. The second twin was born after a 4-hour gap just before the consultant who had tried to bully our client was due to make her ward round.

Another factor frequently given as a reason for home being less safe than hospital for birthing twins is the increased chance of the woman having a significantly heavy bleed after the babies are born. The logic for this is that there is a bigger placental area to bleed from and that the uterus has been overstretched and therefore will not work so well after the birth. This has not been an issue for us where the labours have been spontaneous and the births straightforward. The physiology of the control of bleeding from the placental site is that when the uterus is empty and contracts to become smaller, the muscle fibres of the uterus act as 'living ligatures' to squeeze and (mostly) close the blood vessels. This seems to work well when labour and the immediate post birth time is not disturbed. Active management of the third stage of labour, the birth of the placenta and membranes, after giving an intramuscular injection of a synthetic oxytocic drug, is advised by NICE and all the NHS policies I have seen, but in my experience as long as the atmosphere is calm the placentas will birth spontaneously without interference. Eight out of ten top tips for a physiological third stage focus on maintaining the quiet, peaceful atmosphere, the baby nuzzling at the breast and no interruptions[3].

Independent midwives working in Yorkshire benefit from collaboration with Airedale NHS Trust and are legally able to provide birth care for our clients. We now share the Airedale guidelines with our clients, even though there are several pages of risks to mother and baby that are not contextualised or explained in the best way. The guidelines allow for clinical judgement but make it clear that deviating from the guideline must be explained and documented.

Risk is a contentious issue and those involved in making decisions on where and how to birth their twins need to be aware of the medical concerns, the evidence, the robustness (or otherwise) of the quoted 'facts' and that these figures come from population studies and need to be individualised and put into context for each woman. The language used to express risk carries emphasis and value judgements and supports the idea that pregnancy inherently needs medical help. The term 'risk' '*evokes feelings and concerns to such an extent that it is accepted in a critical way that helps determine the delivery of maternity care*' (Thompson 2002[4]) and '*Women are subject to a litany of risks regarding birth [even with a singleton – my insertion], resulting in perceptions of risks that are not always rational*' (Healy et al. 2016[5]).

Our twin clients who choose to birth at home do so in the well-researched belief that this is the safest and best option for their babies. They reject the medical model of birth and the medicalisation of pregnancy and birth, and do not necessarily accept all medical opinions, especially when these differ from information they have found for themselves. They are affected by 'shroud waving' and negative medical opinion, especially when it is said time and time again. They often feel that they have to justify their decisions to each new healthcare provider (even though in fact they do not need to justify their decisions to anyone), they face disbelief, the information they have found is dismissed and fears are raised without references or acceptable justification. Repeated discussions focussing on what can or will go wrong may have a nocebo effect of increasing the likelihood of problems occurring (Symon et al. 2015[6]). Once we find a consultant midwife or obstetrician who understands informed decision-making, we stick with them like glue. All of our clients willingly accept medical help when it is necessary for them or their babies' well-being.

Many of our clients are affected by the 'climate of fear' within maternity care and we need to help them unpick the issues and see risks in context to themselves. Jessica's waters released at 34+ weeks and we found she had Group B Streptococcus (GBS) colonising her vagina. About a third of women harbour GBS at any one time and only rarely does it cause complications, but when it does the consequences can be severe and in rare cases can result in the baby or babies dying. Jessica did a lot of reading about the subject, and took her temperature as suggested. After seeing her consultant – a very reasonable doctor who understands not to coerce women – she then only saw us and birthed her twins at home, 37+ weeks and before her partner could fill the pool. She reports her experiences in more depth in this AIMS journal, Vol 21, No 3 (Hind 2009[7]).

Nora decided after seeing her consultant a couple of times not to see him again, but just to have the scans. This caused her local Trust concerns and we spent a lot of time liaising with the Supervisor of Midwives to reassure everyone that Nora was making reasonable choices that were safe for her and her babies and that she was accessing midwifery care. Lindsey, likewise, minimised her interactions with consultants after seeing them twice and receiving a perceived aggressive letter rejecting her decisions, but she did access the maternity unit on several occasions when she became concerned about her babies' movements. She did not reject the whole NHS system, but just the aspects that she did not find helpful.

Lee *et al.* (as in reference 8) found that women had different strategies to avoid confrontation with obstetricians or midwives who gave advice or information they perceived as biased or unhelpful. The article found that, sometimes, women decide to disengage or to lie. The authors suggest time during consultations should be used '*to explore women's feelings and beliefs to gain better understanding of their motives and choices*'. At a 'Policing Pregnancy' conference looking at risk and choice in maternal autonomy, the speakers agreed that we need to trust women and that they will nearly always act in their babies' best interest and '*it may be counterproductive for policies to tell them how to do so*' (Murphy 2016[9]). Our clients booked with independent midwives to have more time, to be listened to, to be respected, to be sensitively challenged and then supported in their decisions. There is also, usually, an overlap of shared philosophies around birth, a belief that given the right circumstances women's bodies nearly always work well to birth their babies.

Risk assessment was introduced to target those women considered to be more likely to have problems and to need interventions to keep them and their baby safe, but it has led to '*pregnancies fraught with worry, an ever increasing fear of labour and birth, and a reluctance of women to make choices that reflect putting risk in perspective and deciding for themselves what an "acceptable" risk is*' (Lothian 2012[10]). The author of this paper, a childbirth educator, goes on to say, '*It is important that we spend time discussing the differences between risk and safety and making it clear that the current maternity care system increases risk and makes birth less safe for mothers and babies*'.

For our clients, avoiding medicalisation of birth includes accessing certain aspects of care provided and saying 'No, thank you' to others. Many healthcare providers have difficulties with this, probably because they feel threatened when women disagree with their view or the policy. This may be because they feel responsible and don't understand autonomy in childbirth (Prochaska 2013[11]). Equally, working within a system where blame culture is endemic and there is a high fear of litigation, it is not '*surprising that risk-based care takes precedence over considerate individual care*' (Healy et al. 2016[5]).

Hayley was lucky enough to meet an obstetrician who said that he respected her choices and understood that as long as she had capacity, and he could see from the information she provided him with that she did, she was within her rights to choose her place of birth. That interaction was positive enough to make transferring in with the second twin when we had concerns over his rising heart rate far more acceptable than if all the hospital interactions had been negative and adversarial. The second twin was born spontaneously after an ARM as the staff were preparing for a caesarean due to their concerns over the time elapsed since the first babe was born – about four hours. Both are thriving.

Informed decision-making results when the women (and families) have access to reliable information, and they can explore how this impacts on them and they feel supported.

Women should not have to fight to avoid medicalisation and unwarranted interventions. Even with the support of a senior, very experienced midwife, Karen still felt she had to fight the system. (*See* "When mothers know best - the birth of twins" on page 26 [12].)

There is good evidence that fear adversely affects the physiology of birth and it follows that interventions aimed at the 'just in case' scenario can influence what happens. Also, the usual hospital 'management' of twins may well contribute to the problems that then occur. For instance, an epidural is advised in case an urgent caesarean is needed if the second twin becomes lodged in a transverse position after the first is born, despite the fact that this leaves the woman on her back (unless supported to be upright) and this can itself cause the baby to lie transversely. When the woman is actively labouring, and upright after the birth of the first baby, gravity is likely to help the second baby to a longitudinal position, head or bottom first, minimising the need for a caesarean. But if a woman is supine, it is more likely that the second twin will assume a transverse position and then need help to exit the womb. Jo Whistler (2011)[13], writing for this journal, eloquently explores further the ways the NHS proposed management of the birth of her twins could increase the likelihood of complications. She chose independent care and birthed her twins in water on her canal boat.

The NHS's strict time limits with regard to when the second twin should be born just don't fit with our lived experience, and seem illogical. I believe vaginal examination should never be offered as routine but only if the clinical situation suggests that the findings could be useful to help decide on the next course of action, for instance if palpation or just observation of the uterus indicates that the second baby appears to be in a transverse position. During my very first experience of twins born in water, the mum suckled her new born and had lunch, we topped up the pool, she suckled her toddler and then her new born again, and then her contractions restarted. It was so normal and straightforward. She had no vaginal examinations but we did listen in to the baby's heart rate. She suckled both and then got out to birth the placentas. I learnt a lot from that woman. She did it her way in her own time and listened to her body and responded. She did feel supported – it was a long time ago and I knew no better than I should support the woman in her informed decision-making – I had no fear so did not communicate that.

Respect for physiology is important in the way independent midwives (and those NHS midwives striving to maintain and promote normal/natural/ physiological birth) support women. Foureur (2008)[14], writing about creating safe spaces to promote and enable undisturbed births to unfold, explains that reducing stress and creating a calm environment allows the oxytocin mediation of the neural-hormonal system to work properly. This needs psychological and social awareness of the woman and family from the midwife as well as awareness of optimal birthing environments. Knowing your midwife, her knowing you, feeling cared for and supported are as important as the environmental factors: calm, quiet (or the woman's choice of loud music), low lighting and no intrusive tests or examinations. The more we learn of the physiology of labour and birth and how the emotions and hormones interact, the better we can support instinctive birthing. 'Ensuring women maximise the limbic brain connection is about supporting them to "disconnect" with others during labour whilst also maintaining the usual physical and emotional midwifery care' (Dixon et al. 2013[15]).

In a series on 'Midwifery' in the Lancet, which took a global view of midwifery care, the core characteristics of midwifery were identified as '*optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families*' (Renfrew *et al.* 2014[16]). The current organisation of maternity care prevents midwives from fulfilling this role. The medical model has all but taken over. There is increasing concern that while childbirth has never been safer, fear of litigation is driving care towards routine interventions that potentially result in harms to women and babies.

With our four sets of twins, the babies were born 3 minutes apart, 5 days apart [!], 30 minutes apart and 5 hours apart and sometimes the placentas took their time. And it was OK. In two cases the second twin was born in

hospital, one spontaneously vaginally after an ARM and the other by Caesarean, and all were well.

Reflections

Renfrew et al. (2014)16 consider consider "*there is global concern about the over use of treatments that were originally designed to manage complications, with the consequence that many healthy women and newborns in high-income, middle-income and low-income countries are being exposed to the adverse effects of unnecessary interventions being used routinely*". I agree, and this applies even more to twins than to singletons. I agree, and this applies even more to twins than to singletons.

We need to know more to ensure we 'do no harm' to both mother and baby/babies. Being quietly in the background, making tea, topping up the pool, ensuring phones are on silent can be positive things we do. It makes sense not to intervene unless we and the woman can weigh up the potential benefits and harms of the intervention. Listening to women, learning from them and respecting their decisions are equally positive contributions to creating a safe birthing environment.

This article is written from my point of view and I have worked independently since my daughter Jess was born (at home with the NHS) 28 years ago, but I would work in the NHS again if it fully supported continuity of carer and women's choice. I have been lucky to have had the opportunity to learn from the women I have supported and from their belief in their abilities to birth their babies. This has allowed my belief in psychophysiology to develop.

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Babywearing Twins and Multiples

Nicola Lawson shares her knowledge on carrying one - two - three babies!

The idea of transporting two babies at once can be daunting, and thoughts often turn quite quickly to the practicalities of having two. Parents of twins often feel like they are ruled out from using slings and carriers for their children, worrying that carrying two would be too heavy or cumbersome – and twin-specific carriers too complicated or expensive. Happily, this doesn't have to be the case. The question isn't how do you manage to carry both babies, but how on earth do you manage without carrying one or both babies?

So, here's the deal – we all carry our children, whether we use a carrying aid or not. A sling, carrier or carrying aid is designed to make that process easier – to distribute weight well, to meet your child's needs to be held, and to free your hands. There are hundreds of carrying options out there, and the happy news is that having two babies means you have twice as many options for carrying.

Carrying One

Let's start where parents of singletons start – with carrying one. In the first instance, using a well-fitted carrier for one of your babies can open up lots of options for you. When you are out and about, carrying one and pushing one gives you lots of practical configurations. If you have another adult with you, each of you carrying a baby gives lots of off-roading possibilities.

Placing one baby in an easy-to-use and well-fitted carrier can free your hands up to carry the other on your hip or shoulder, ideal for unloading babies on short trips at the pre-walking stage. When they are mobile, a carrier can become an essential piece of safety kit, holding one still whilst you concentrate on the other.

Carrying Two

It's absolutely possible, and can be comfortable for all of you. We know at the newborn stage babies have high touch needs, and that being close to an adult helps them to regulate their own body rhythms, as well as providing warmth and reassurance.

When your babies are very new, there are plenty of soft carriers which can be adapted to carry two infants safely, upright on the front, on the adult's chest. It can be a learning curve to get them in, but practice at handling babies is one thing you won't be short of with two around. A well-fitted carrier will distribute the weight of your babies around your body, making their weight feel like it is a part of yours.

Carrying two babies on one adult can give you a 'Take on the World' type of feeling, and there is no need to give that up as they grow. When babies are too big to be carried alongside each other on the front, you can switch to either carrying one on each hip, or carrying one on your front and one on your back – again, spreading the weight effectively. There are many carriers out there which can be used effectively on the front or on the back, as babies grow, and a well-chosen combination of carriers can be worn two at once without overloading your frame. Selecting carriers which work well together means that you can also expand your choices by carrying just one of your children, or having one each on two adults. There are lots of options out there.

Twin-Specific Carriers

You might like the idea of a carrier designed for twins, and they can be brilliant tools, with all kinds of features such as built-in storage. Some will carry children of different ages, for example siblings close in age, and some are twin-specific. When choosing your twin carrier, consider if you are able to use it to carry a single baby safely, and if it splits to allow the 'two babies on two adults' configuration, for maximum flexibility.

Types of Carrier

Different carriers will suit different people, preferences and budgets. There are plenty of guides to different types out there online, but how does that apply when adapting a carrier for use for two babies?

- Stretchy wraps are long pieces of stretchy material that, with guidance, can be used for very young babies and adapted for twins upright on the chest. It's also possible to use two stretchy wraps on one adult – giving you two independent pockets for your little ones who can be moved, fed and changed without disturbing the other.
- Woven wraps are also long pieces of material but we no longer rely on the stretch of the cloth to accommodate the baby, but on tightening the cloth around the child. Woven wraps can be adapted for use in all configurations of carrying two babies – two on the front, one on each hip, or front and back, as they grow.
- Ring slings are a fabric pouch for a baby, which tightens safely to fit using a ring mechanism. They can be exceptionally simple carriers to use and are ideal for carrying one baby on the hip or chest, and are suitable well past toddler age to keep them safe. Because they only use one shoulder, it can work well to use two ring slings at once, to carry your twins.
- Buckle carriers should have an adaptable panel for your babies, allowing them to have optimum support as they grow, supporting their heads to the back of the neck and legs all the way to the back of each knee. Some buckle carriers are very structured, meaning it's tough going to fit two carriers on one adult, but many offer lightweight and comfortable carrying solutions. They are ideal for carrying your twins front and back, or on one adult per baby – but you will need to wear two buckle carriers at once; they won't adapt to carry two babies in a single carrier.

There are more carriers out there than we can do justice to here, from meh dais to onbuhimo, framed backpacks to adjustable pouches. If you get a chance to try carriers on, take it. There is a network of sling and carrier help across the UK which offers support with slings and carriers, and many are free or low-cost to access. Personalised help and support is available at every stage – many areas have a local sling library, consultant or carrying educator who can help to get you started, keeping you comfortable and hands-free.

Further Reading:

West Yorkshire Sling Library: http://wyslinglibrary.com
Site for finding sling libraries: http://www.slingpages.co.uk/
Safety: http://babyslingsafety.co.uk/
Adventures in twin slings: http://peekabooslings.co.uk/adventures-in-twinwearing
Twin wrapping: https://wrapyourbaby.com/wrapping-twins/

Nicola is the founder of the West Yorkshire Sling Library, one of the largest independent sling and carrier resources in the UK. She offers carrier training for peer supporters, parent support and health workers, and works with thousands of families each year.

Doula UK Conference (2018) Report

By Jo Dagustun

Wow – what another great conference put on by the team at Doula UK! I was keen to get to this annual conference again, having been highly impressed by their conference in Manchester last year. And it surely lived up to my expectations. From founder member Hilary Lewin's opening welcome to her closing address, this was a day jam-packed with brilliant speakers, a lovely 'bazaar' to browse (including a popular stall run by AIMS volunteers), and a fantastic space for networking. Indeed, the professionalism and care (and catering planning) that had gone into the event epitomises for me the very best care and support that doulas can offer.

Seventeen years ago, Doula UK was founded by a group of women who had recently completed doula training by Michel Odent. Doula UK now has around 700 members, and provides an important role in supporting its member doulas to, in turn, provide support to women and families. As an important part of their mission, Doula UK has provided free doula care to families in emotional or financial hardship for over ten years, and the Access Fund (previously the Hardship Fund) is now being transformed into a standalone charity, so that it can support even more families. The organisation's latest annual conference left participants in no doubt about the maturity of the organisation, and the fantastic contribution that excellent doulas can make to the care of women, babies and families. A screening of a short but fascinating film (from Emma Arran), exploring the difference that doulas can make worldwide for women in particularly challenging circumstances (e.g. where their own social support networks are weak or absent), for me really grounded the day; for at heart, doulaing is all about women delivering justice to other women, achieved by walking by her side: justice for women who would otherwise be left unsupported by mainstream services.

This year, the theme of the conference was how doulas (and others) can support women who have previously experienced trauma and abuse. To open a discussion of this theme, experienced doula Kicki Hansard gave a very comprehensive presentation about the issues that doulas should be aware of around this topic, including signs to look out for and practical tips about supporting such women through the challenges that they can face when pregnant, giving birth and in the postnatal period. I hope that all relevant healthcare professionals receive such detailed briefing on this issue: I can imagine that the topic is well-covered in initial training, but I wonder how well the issue is addressed in ongoing professional development.

More excellent and informative presentations followed. I would highlight in particular Bridget Supple's wonderful presentation which was wide-ranging and research-based, at the same time as being incredibly clear and highly engaging; if any AIMS members haven't yet seen Bridget in action, do look out for an opportunity. Bridget has many areas of interest (including her work on the microbiome), but her focus for this presentation was the impact of women's stress in pregnancy and the postnatal period, exploring in particular how this affects the development of the baby's brain, and making clear the key importance of this as a public health issue and for the maternity care system. If Better Births is successful in introducing a fundamental shift towards a relational model of care for all women, it is possible to see how the NHS could support all women effectively in this area. But while we are waiting for that, Bridget rightly highlighted the role of doulas in providing such support for women, where local NHS maternity services are either too fragmented or too pressed for time to provide the (variable) level of support that each woman needs, according to her individual circumstances.

Another highlight for me was Maddie McMahon's thought-provoking presentation on breastfeeding. Maddie suggested that we need a paradigm-shift, to focus not on how women can best endure breastfeeding but to think about how a woman might sustain – and even exalt in – a successful breastfeeding relationship with her baby: an approach to breastfeeding in which mother, baby and family thrives, rather than simply survives. In light of this suggested

approach, the UK's traditional measures of breastfeeding success (rates of women initiating breastfeeding and then continuing to breastfeed at 6–8 weeks) look feeble indeed, and unlikely to drive the huge improvement necessary in postnatal support. This has parallels with discussions around birth measures, of course, where technical outcome measures focussed on spontaneous vaginal birth (or normal birth) tell us very little about the quality of women's birth experiences and the impact these have on short- and longer-term physical and mental health outcomes for mother and baby.

There was so much else to this very well-organised conference. Members of Doula UK should be proud indeed of their organisation, and all UK birth activists would be well-advised to see what a future Doula UK conference could offer them. Reduced conference rates are available to Friends of Doula UK!

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Wigan ARM 2018 Study Day

A review by Ruth Weston

The Wigan ARM Study Day is fast becoming my Number One go-to event of the year for the quality of speakers, topics and discussion. This year was no exception, with a line-up of powerful and provocative speakers as well as some fantastic questions and input from the floor. Kicking off the day was superhero and RCM President Kathryn Gutteridge. Amongst many important messages her key message was 'stronger together'. To build up the midwifery profession and face down the challenges we currently face we need to avoid fragmenting our community, to avoid splitting NHS from independent midwives, ARM from RCM, community from labour ward midwives and to work together for the good of the whole but also for each area of the profession.

Next up was Claire Mathews, Deputy Head of Midwifery (HOM) for NHS England who took us through her regular presentation on the implementation of Better Births across England. A highlight was the definitive short-term target of Delivering Continuity of Midwifery Care to 20% of women, the advice to trusts being to start with the low-hanging fruit – staff who are willing to have a go. In the questions, Deborah Hughes asked if NHS England would put a moratorium on the closure of midwife-led units whilst the strategy and implementation of Better Births (which includes the setting up of MLUs) was being agreed. Claire simply referred us back to the presentation without giving any further comment. This I found immensely infuriating and stood up to say so! We need more accountability for the recent MLU closures rather than avoiding the question and referring back to the plan!

To talk about the rest of the day would take too long but here are some more speakers:-

Jo Dagustun's excellent presentation took us through the findings of her PhD looking at women's experiences and perceptions of the birth system – and it is well worth looking out for her presentations on this subject. It was an illuminating and sometimes difficult listen. Talking to women about their experiences and what they wanted, Jo found that women were less concerned about continuity *per se* and more interested in being shown kindness. The lesson women were learning from their birth experiences was to shut up, shut down and choose the best way to protect their emotional and physical safety within what was felt to be an unfriendly environment, and for many women this meant taking the medical route for birth. Finally, with skill and sensitivity, Jo used a recent example of how some health service providers had handled a woman's query about current practice on social media – to illustrate the relevance of her findings to midwifery practice right now. She asked, 'But why is it so hard for providers to perceive issues first and foremost from the perspective of the woman and her family's wellbeing?'

The amazing Soo Downe took the microphone and energised us with her enthusiasm and optimism, while overwhelming us with relevant data and research! The stand-out stats for me were how little difference induction of labour for postdates makes to outcomes for the baby. It leaves us reflecting on the impact of the iatrogenic effects on mothers of this policy. Another important point she
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made was that medical research is usually about solving problems: someone has a health problem – how can we solve it? This does not work well for physiological birth where our research is about enabling health and wellbeing rather than solving a medical issue.

There were some fantastic workshops on the new 'not supervision' system, on continuity of carer, on Airedale Hospital Trust's system to enable independent midwives to carry on working (a win–win–WIN for parents, Trust and IMs!), to mention just a few. It was good to see One to One represented, Aquabirths and Margaret Jowitt with her Hi-Lo/Osborne birthing system, but most of all to see the fundraising stall for Haven – a new support group set up for midwives being disciplined or referred to the NMC. And as always the conversation and mutual support shared between us during the day was immensely warming and inspiring.

Finally Katherine Hales, ARM's national coordinator, updated everyone on the campaign for better midwifery regulation, but in her own inimitable fashion also reminded us of who we are and where we are going. After doing some research I am now clear that what midwifery needs is its own professional body, like physiotherapists, rather than being combined with nursing. We were all pleased to have the RCM representative present stand up afterwards and show public support for the work being done here. As Kathryn Gutteridge said, 'Working together we are stronger'.

Ruth Weston is an AIMS and ARM member, owner of Aquabirths, mother

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AIMS was founded in 1960 by Sally Willington to support women and families to achieve the birth that they wanted.

Since the 1960s we have campaigned tirelessly for improvements to the UK's maternity services, as well as supporting women and families directly through our helpline, and sharing information to pregnant people and health carers with our hugely informative books, Journal and website resources.

AIMS works towards better births for all by campaigning and information sharing, protecting human rights in childbirth and helping women to know their rights, whatever birth they want, and wherever they want it.

Our candle image which has been the AIMS logo since the late 60s; it represents our commitment to change, no matter how large or small changes may be. "*It is better to light a single candle than to curse the darkness.*"

In 2014 we became a registered charirty and we adopted the slogan There for your mother. Here for you. Help us to be there for your daughters.

In 2017 we agreed that our mission is "*We support all maternity service users to navigate the system as it exists, and campaign for a system which truly meets the needs of all.*"

An Interview with Jean Robinson

Emma Ashworth (EA) interviews Jean Robinson (JR) about the years of support that she's given to AIMS, and to women and families. Jean retired as AIMS' Honorary President in 2018. We join the many thousands of families whose lives Jean has touched in thanking her for her work, her passion and her inspiration.

EA: When did you get involved in birth issues, and why?

JR: When I was Chair of the Patients Association in the early 1970s, I started getting horrifying letters and phone calls about induced labour. I decided that I needed to learn about normal labour! I found a local midwife, the great Chloe Fisher, who became my reference point, and for the first time I decided to read medical journals to find out about induction. At the time, the Patients Association was the only voice of patients in healthcare. I took over from Helen Hodgson, who had founded and run the Association with a tiny grant and a staff of one part-timer.

When I took over, it became a full time, unpaid job for the next three years! But I learnt so much from it – not least from the 100s of complaints that we received every week.

Letters about birth leapt off the page, with comparisons of induced labours against non-induced labours; this being at a time when maybe 60% of women were being induced! Gestational dates were less clear as there was no ultrasound at the time, and there was not a wide use of epidurals. Moreover, there were, as yet, no prostaglandins so women were struggling with oxytocin-induced labours and non-physiological contractions against an unripe cervix.

I was living in Oxford, and the local professor of OBS/GYN had done some early research on artificial oxytocin induction and he asked me to do a talk at the local maternity hospital about induction, and how women felt about induced labours. The room was filled with midwives and obstetricians! I talked about the hundreds of letters I had studied from women about their traumatic experience of induced labour, and mentioned a case study of a woman who had one straightforward, spontaneous birth and healthy baby and then her second baby was born following induction and an overdose of artificial oxytocin, following which the mother ended up suicidal. She spoke movingly about how she felt differently about her two girls. With her second daughter, her instincts were muffled and she had to consciously react to comfort the child if, for instance, she fell over, rather than it being a reflex action as it had been with her first first.

I felt – listening to these women – that the hospitals were taking away something crucial. I couldn't define it; there were no papers on it. I just went back and forth between the helpline and the scientific papers such as they were, and they were worlds apart.

I was then asked by Woman's Hour on BBC Radio 4 to do a piece on women's health. This was just a general piece, not just on pregnancy and birth, but at that time many women's health problems were thought to be psychosomatic. I found that Women's Hour were getting letters on induction as well!

Following this, I contacted the agony aunt Claire Rayner. It turned out that she was anything but an ally. As a former nurse she strongly felt that "doctors must decide" and she berated me for suggesting that women should make up their own minds. However, she was also receiving hundreds of letters on induction which she passed to me. I read every one, and then I wrote to the Lancet, saying that the paper that they had published did not prove that induction reduced stillbirth, as they were claiming. An Obstetrician in the south of England replied. "*Who is this doctor hiding behind the skirts of the woman writing this letter, since no layperson would have known enough to write it?*"

I started to read medical journals at the local library – medical dictionary in one hand, and medical journals in the other! I wrote back to the Lancet to say that no doctor had written it for me. All I needed was a Bodleian readers card and hundreds of letters from women who had been induced.

I think that this is a woman's way of working - listening to women and believing that what they said was true, was valid and it mattered. For their mental health, for their children and for their family.

I went on to speak to husbands who couldn't understand why their wives were in the state they were in – but I know now that they had Post Traumatic Stress Disorder (PTSD). There was nothing in the research at the time, but their letters reminded me of World War 1 Shell Shock. So, I went back to the library and found that work had been done on mental health in the military since then, following the Vietnam war. That was where the term PTSD came from. Then I read about similar conditions in police and ambulance crews, and I realised that all the research was being done on men! Women's descriptions of their feelings around their birth stories were closer to descriptions of rape - different to male PTSD.

I have since thought about it a lot. I feel that the birth letters were different to other forms of trauma, such as from surgery, misdiagnosis, mistreatment, and the difference was that women are particularly sensitive around the time of birth and shortly afterwards due to their raised oxytocin levels. This makes them intuitive – they sense whether the midwives and doctors around them are being kind and helpful and mean well, or are antagonistic. Research shows that memories of birth, both good and bad, are very long lasting, detailed and exceptionally durable. What happens in birth is so important. We need to drill into every student that increased hormonal levels can increase psychiatric damage.

EA: Did your personal experience of maternity care affect your involvement with AIMS?

JR: No. For many years I was sub-fertile, so we adopted a baby boy and four years later I had a daughter. I needed all the obstetric intervention available, but this did not prevent me from learning about the importance of normal birth from listening to AIMS helpline callers. I have always loved babies, but I was with AIMS for women's rights. I want people to start their family life on a good footing. Transitioning from being a couple to a family when you have your first child is such a challenge, and men and women should be given all the help they can. But not from officialdom! *"Do not do unto others as you would be done by – their tastes may not be the same"*. G Bernard Shaw

EA: How did you get involved with AIMS?

JR: At the Patients' Association I used to suss out any special support groups which existed for people with problems. I explored AIMS and the NCT but I preferred AIMS! NCT is much more orthodox and I'm not orthodox! After I left the Patients' Association in 1973, I joined AIMS and I became the honorary research officer, monitoring the obstetric journals in the library and trying to explain things in more accessible language for AIMS readers. My husband subsidised my AIMS work and was wonderfully supportive. Later, he became unwell and needed more care and I had to give up the journal study, then later, when our founder, Sally Willington died, I became president. I'm not a title person, but it's been a tremendous honour and I liked writing official letters to tweak the minds of people at the Department of Health and similar! I consider myself to be politely irritating to officialdom! It takes me until the 3rd or 4th draft to get it polite enough, though…

EA: Can you tell me about some of AIMS' achievements whilst you were involved?

JR: The one thing I am personally pleased about was (after many years of trying) finally persuading the Department of Health to look at suicide as a cause of maternal death, since I spoke to so many suicidal women on the phone. Finally, we had a woman medical officer in charge of the Confidential Enquiries, Dr Gwyneth Lewis, and she listened. When the first study including psychiatric deaths was produced, suicide proved to be the largest cause of maternal death. Also, Beverley Beech and I wrote a letter to the British Journal of Psychiatry about nightmares after childbirth, and this is credited in the medical literature as being the first identification of post-natal PTSD. It was phone calls to the help line which taught us about this.

I was constantly asking "what is the evidence base for what you are doing" and often there wasn't one. I knew that no one would listen to a lay person without evidence so I went to Ann Cartwright, who was a well- known sociologist who worked on medical issues, and I persuaded her to do a study on how women felt about induction. Ann published a book which showed that women didn't like induction, but obstetricians did. So then we had got something published in the literature that we could quote.

Through helpline calls I suspected that women were concealing Post Natal Depression through fear of referrals to Social Services. I went to talk to my GP, who was a researcher, who then did some research into this – found

that it was true – and published it. This gave us some more research to work with!

We were constantly challenging things like routine episiotomies, and I wrote a column in the Birth Journal of Midwifery for 10 years where I talked about what women were complaining about, and what could be improved, in a way that midwives would read.

EA: What changes have you seen in maternity care - for the better or worse?

JR: The recognition – at last – of the importance of normal birth and the gradual erosion of standard practices in maternity hospitals which prevented it (e.g. routine episiotomies, denial of food and drink, the stranded beetle position for birth, etc.).

EA: How has AIMS evolved over your time?

JR: We have always depended on a surprisingly small number of hard-working volunteers. It is listening to women on our confidential helpline that has provided changes of direction, because they tell us about how things are changing on the ground in different areas. But, our greatest strength has always been the same – listening – and a willingness to be changed by what we hear.

EA: What is the biggest challenge for AIMS going forward?

JR: The shortage of money in the NHS which will prevent changes we would like going forward.

EA: What do you hope for the future of AIMS?

JR: That we shall go on listening to women and representing their different voices. We will continue to succeed by perpetually challenging obstetricians for their evidence.

EA: What has been your biggest frustration?

JR: The failure of the population to recognize the potential harm of ultrasound, and the dishonesty of obstetricians in claiming it was safe.I'll not be happy until we are routinely measuring mental health outcomes in wider research. We know that there is lots of evidence on how poor maternal mental health is bad for the baby, not just for the woman! If you look after the women properly, the mums and dads, you don't have to worry about the kids! How can you not do that? I get so upset and indignant and I should be past that but I shall die with my shillelagh in my hand!

How you can help

Join AIMS

AIMS became a Charity in 2014. It still has no paid staff – our committee and volunteers give their time freely.
All monies raised go towards providing women with support and information.
If you are not already a member, please join.

Annual Individual Membership £26
(£25 if setting up a standing order)

You will be invited to join the AIMS discussion group and get involved with AIMS activities. We send you regular newsletters with updates about the AIMS Journals, campaigns and other information.

Annual Organisation or Group Subscription £32
(£30 if setting up a standing order)

You will be sent information about each AIMS Journal by email which you can distribute to your group or organisation.

Book Reviews

Trust your Body,Trust your Baby: How learning to listen changes everything

Rosie Newman

Published by Pinter and Martin, 2017
RRP: 11.99

When you are pregnant, you are bombarded with information. Well-meaning friends and family will give you all sorts of advice, including recommendations for a plethora of birth books.

Most advice falls into one of two camps: that the medical world knows best or that your body was designed to give birth. And whilst people often say 'trust your instinct', a newly pregnant woman is then left to wonder what that actually means. How are you supposed to know? Isn't that what doctors go to university for? And this idea of trust in your body and in your baby then reaches beyond the process of birth, into early years parenting and the many decisions you are faced with as a parent, giving rise to a whole slew of parenting books.

In this gem of a book, Rosie has managed to skilfully unpick and explore the idea of trusting your body and baby, in an immensely readable text which consolidates evidence, interviews, case studies and the lived experiences of families. While I'd heard the notion of trusting your body when I was pregnant, this book would have been really useful to give me confidence and ideas of how to go about it. The book also goes beyond birth and tackles some of the key parenting conundrums of the modern age.

Rosie's writing style is warm. I felt as though she was sitting opposite to me in a café, like old friends catching up on our pregnant years rather than offering an encyclopaedia of information. This style definitely makes the content sink in.

The chapters of the book are laid out logically: First the pregnancy, then the birth itself, then the immediate postpartum period. It next tackles beautifully important aspects of early years parenting - including early attachment, sleep, milestones and potty training. (*Ed: never before have I found the rather specialist topic of elimination communication slipped into a parenting text so engagingly, reaching audiences that would never pick up a book on the topic itself. Very clever!*)

Throughout the book, the message to trust your body, baby and nature is like a golden thread: To let pregnancy, birth and early childhood play out without trying to control them, but rather letting them wash over and change you. As a parent, we have all heard many of the terms Rosie talks about, such as attachment parenting or the sphincter law. However, what is beautiful about this book is how she talks about them in the context of her own experiences, thereby interpreting how these textbook concepts that the reader may wish to explore might work in real-life – without judgement or fear. This to me makes this book very powerful for new parents.

There are many, many books which go into every aspect of the contents of this book, but in far greater detail and backed up with facts and figures. This book doesn't claim to be one of those books, and that is precisely what makes this book powerful: it is instead an easy to read for an expectant/new parent, without an over-reliance on jargon.

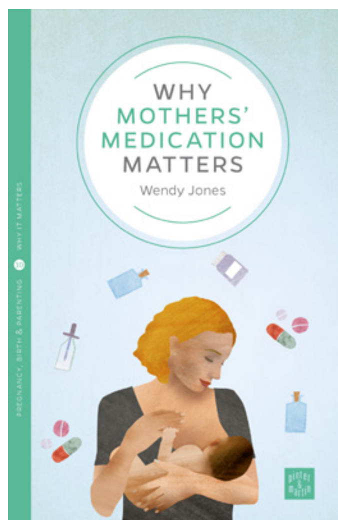
I would recommend this book as a great introduction for any parent/pregnant couple interested a physiological birth and/or natural parenting, or even for someone who is plain curious about how we got to where we are as a species. And as Rosie says, trusting yourself begins with this book: it's quite easy to pick and choose the concepts that appeal to you and let go of the rest.

Sangheetha Parthasarathy

Why Mothers' Medication Matters

Wendy Jones

Published by Pinter and Martin, 2017



As a breastfeeding mother, finding evidence-based advice on what medications I could take whilst breastfeeding has been a source of anxiety, with wide-ranging and conflicting information available all over the internet and from healthcare professionals. Even as a pharmacist myself, I have found it difficult to pull together the evidence to help me make decisions about taking medicines, so I can only imagine what it is like for mothers who don't have pharmacy training.

As part of Pinter and Martin's popular 'Why it matters' series, Wendy has produced a priceless, comprehensive resource with this little book. It covers all of the important information that mothers need to know about breastfeeding while taking medications. The chapters are carefully organised for easy reference, starting with general issues about prescribing for mothers and ending with a fantastic chapter comparing breastmilk with formula. All information is evidence based, with a comprehensive reference list, and written in an engaging friendly style.

The introductory chapter is wonderfully reassuring in busting myths around taking medications while breastfeeding, highlighting the lack of clinical data and limited information available from manufacturers in their patient information leaflets (so commonly used by healthcare professionals to advise mothers on the use of medications in breastfeeding). It also highlights the general lack of healthcare professional training in this area, and therefore the importance of seeking out the best evidence to allow mothers to make informed decisions about taking medicines in pregnancy and while breastfeeding, related to their particular situation.

The book has a strong emphasis on medication and breastfeeding, although it also covers the use of medicines in pregnancy, labour and birth. It carefully reinforces the idea that in most cases breastfeeding can continue, and provides advice for commonly used medicines, whilst making it clear where there are exceptions. Wendy's passion for breastfeeding and maintaining the breastfeeding relationship if desired is evident throughout. I found this wonderfully reassuring to read as a mother. It also makes some obvious points that are not often taken into account, for example highlighting that there are risks of stopping breastfeeding (to baby and mother). When a mother is advised to stop feeding in order to take a medicine, therefore, Wendy advises that these risks should be balanced against the need to take a medicine and the small risks associated with medicine transfer through breastmilk. Information on the management of mastitis, thrush and engorgement is also included, along with other common problems encountered during breastfeeding.

On a practical level, the book is very well indexed, so readers can access the specific information they need without reading the full text if required – very helpful for a busy healthcare professional or mother. The text is very heavy in places, with some jargon that may prove confusing for non-healthcare professional readers, but this is balanced carefully against the use of appropriate medical terminology, making it accessible to all. Please note, however, that if you are looking for advice on herbal medicines, this book provides limited information.

I could go on and on about this fabulous book, which I will certainly be returning to many times over the coming years both as a pharmacist and as a mother. It is an excellent resource which has boosted my confidence in the use of medicines in breastfeeding. It is also lovely to find support for breastfeeding at a time when, as a mother, I am in the minority for how I choose to feed my babies.

Anna Culy

GDPR and Data privacy

You are probably aware by now of the new General Data Protection Regulation (GDPR) which comes into force on 25th May 2018. We have updated our privacy policy in line with this and you can read the latest version on our website here *www.aims.org.uk/privacy* . This explains what data we hold on our members, how we use it and how we protect it. You can at any time request a copy of this personal information, ask for it to be amended or deleted by emailing datacontroller@aims.org.uk.

We use MailChimp as our emailing platform. Their servers are based in the USA, but they state that they have implemented "strong privacy protections that mean we're handling your contacts' data appropriately and in line with EU legal requirements." *https://mailchimp.com/legal/privacy/*.

You can ask to be unsubscribed from our mailing list at any time by clicking the "Unsubscribe" button at the bottom of our emails, or by emailing datacontroller@aims.org.uk.

Please be aware that if we do not have a current email address for you, or if you ask to be unsubscribed, we will not be able to send you further issues of this quarterly Newsletter, or notifications of AIMS events and activities. You will continue to receive an annual newsletter and annual set of AIMS Journal abstracts by post.

AIMS Journal on ISSUU

We are gradually putting copies of the AIMS Journal on ISSUU, an online platform for journals and magazines. Please go to *https://issuu.com/aims1* and take a look. By using this medium we will be able to reach far greater numbers we have in the past. Please bear with us whilst we develop our presence in this media; it is time consuming to get it organised. Current Journals will be available to subscribe to on ISSUU, which we hope will be useful for libraries and organisations. Older edition are available free of charge. You will find that the Journal looks far more like our previous ones, albeit on a screen. You can download these Journals to make it easier for you to read and share, as well as purchasing printed copies. If you have any experience of ISSUU and have time to help us use it to its fullest potential - with apps and social media links - we would love to hear from you.

AIMS meetings

Details of AIMS meeting can be found on the events page of the new AIMS website so you can easily check out whether there is a meeting near you *www.aims.org.uk/events*

The **AIMS AGM** is on **Saturday 22nd Sept, at the Carrs Lane Conference Centre, The Church at Carrs Lane, Carrs Lane, Birmingham, B4 7SX**.

Please email secretary@aims.org.uk if you plan to attend or wish to send apologies.