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Where will the baby come out?
Birthplace dreams, instincts and lived experience

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Birthplace dreams, instincts and lived experience

by Alex Smith

Welcome to the June issue of the AIMS journal. The theme for this quarter is birthplace.

Just for a moment I invite you to imagine this - imagine it even if, for a zillion reasons, it is just not possible - imagine that you are about to give birth to a baby. Everything feels just right. You feel warm, safe, and calm. You feel strong, grounded and capable. Everything is as you would wish. You could close your eyes now, just for that moment, and notice where you are. Where is this good place? What can you see, hear, touch, smell or taste? What are you doing? Is anyone with you? If so, what are they doing?

The images and feelings that emerge in that moment are important. They tell us something about the natural conditions for human birth. They speak of our primal mammalian instincts, and, despite all of our cultural conditioning and the deeply entrenched medical paradigm of birth, those instincts creep into our hopes and dreams regardless. As the birth approaches many women, even (and perhaps especially) those who have not consciously questioned the appropriateness of giving birth in a hospital, begin to feel an undefined sense of disquiet and may express this by saying that they just wish they could hide away somewhere until after the birth. Sometimes women have very clear images of nature that come to mind when they have this feeling. One mother who spoke to me described with real poignancy her longing to give birth surrounded by the safety and tranquillity of her childhood garden.

> "I am gently wading through long grass which discreetly peaks at eye level. I am surrounded by the sounds of buzzing bees, flitting cabbage whites and red admirals and the occasional chirrup from the robin. I envisage myself in this serene and secure existence and I would naturally be at one with the land and bring forth life."

Another mother, Deborah Maw, writing in this issue, felt this pull so strongly that she bought a car and, with only a month to go, drove to friends in West Cork, where, on one warm summer afternoon (the garden was 'lush'), she gave birth to her first baby.

> "...using tree trunks to pull against as I pushed... just after midday, my daughter was born, beneath a tree."

Other women have an instinct to move more closely to their mother at this time; they experience a strong 'homing instinct'. My own daughter had no sense of 'rightness' when she considered the birthplace options for her first baby, not until she was in labour, and then she packed a bag and came to my house. After her baby was born, she said that she knew that everything was all right because she could hear her father watering the tomatoes on the coal bunker - a sound of her childhood. Another woman I met told me that, quite early in her pregnancy, she had relocated from England to Wales to be near her mother as this was the only arrangement that gave her a sense of safety.

Sometimes the homing instinct is more related to the geographical place of the woman's own birth or childhood. In the Welsh language the word 'hiraeth' describes the sense of longing and yearning a Welsh person may have for their homeland[1] - a longing to be where your spirit lives - but nuanced with a sense of irretrievable loss and grief.

Cornwall (hireth), Brittany (hiraezh) and Ireland (síreacht) have similar words - all roughly conveying a deep and sad longing for home. I feel certain that the deep instinctive pull towards a place of familiarity and safety that women approaching birth describe, is related to hiraeth, especially when it is accompanied by a feeling that, for whatever reason, this possibility has been lost to them. It puts me in mind of the way that salmon travel thousands of miles using their acute sense of smell to return to their own birth-river when they are ready to spawn. Perhaps the smell of home in human birth is more important than we realise, and that if her 'river' is blocked, it can stir deep, unfathomable emotions in a woman approaching her time. This is certainly true for many women who approach the AIMS helpline. In this issue of the journal, Katherine Revell explains that when a Trust suspends their home birth service it leaves women feeling angry, let down and scared, but doula Sue Boughton describes how she proved to be an alternative place of safety for a massage client who couldn't 'swim home'. While some women who have spoken with me describe a longed-for birthplace in rich detail, others only experience fleeting moments of wanting to hide away - so fleeting that they are gone before clear mental images of the 'hideout' can be formed.

Commonly, a sense of being alone and private and undisturbed is expressed, but this 'confession' is often followed by a dismissive explanation that they are being daft or suffering from 'anxiety' or 'hormones'. These feelings should not be dismissed too quickly as unsafe fantasies. In her two-part article Kathryn Kelly (part 1, part 2) revisits the research showing that birth outside of the hospital can be safe for most mothers and babies, and that planning for such reduces the rate of medical intervention. Indeed, bringing birthplace dreams out into the light and paying respectful attention to them may help shape the birth experience in positive ways. The results of a recent study[2] found that:

"The birth-related mindset assessed during pregnancy predicted labour and birth: Women with a more natural mindset had a higher probability of having a low-intervention birth. This in turn had a positive effect on the birth experience, which led to greater general emotional and physical well-being in the first 6 weeks after birth. Breastfeeding and the well-being and (perceived) behaviour of the infant were also positively affected. These short-term positive effects in turn predicted longer-term psychological well-being up to 6 months after the birth, operationalized as [reduction in] postpartum depression, post-traumatic stress symptoms, and [better]bonding with the infant."

In another recent study[3] aiming to explore both mothers' and fathers' lived experiences of the birth environment, three main themes emerged from the data: 'the home–hospital gap', 'midwifery care' and 'movement in labour'. While both partners shared many views and regarded the midwife as being more important than the physical environment, the researchers found that:
"Mothers and fathers felt differently about personalizing the birth space. This was more important and achievable for mothers, while fathers felt that the space was more about functionality."
"Mothers and fathers differed in that fathers observed closely how the midwives worked, which put them at ease. On the other hand, for mothers it was more about how the midwife made them feel, in what was considered to be a sacred time for the mother as she focused on her labor and trusted her midwife."

This shows that it may only be the person who is actually giving birth that experiences the need for a birth 'den' or 'nest' that aligns with their instinctive sense of comfort and safety. For anyone else, the away-from-home setting is seen as a place where midwives are carrying out *their* work. However, some midwives also describe a strong calling that is only fully satisfied through practice in the home setting. In our June issue, James Bourton remembers that as a child he would dream about being in the birthing space of

women even before he knew how babies were born. He is now a Midwifery Team lead and clinical midwife who specialises in home birth.

Even though some fantastic work is going into the design of hospital birth environments with results confirming the importance of a calm atmosphere, greater intimacy, a spacious and adaptable birth room, clarity of service points, clarity in finding midwives, sufficient space for labour, noise and privacy,[4,5] birth outcomes in modified hospital birth rooms compared with the standard hospital rooms are often little different. One study from Sweden[6] compared an 'Institutional' room, where birth was approached as a critical event, designating birthing women as passive with a 'Personal' room, where birth was approached as a physiological event in which women's agency was facilitated.

They found that behaviours were similar in both rooms[7], concluding that:
"Institutional authority permeated the atmosphere within the birth environment, irrespective of the design of the room. A power imbalance between institutional demands and birthing women's needs was identified, emphasising the vital role the birth philosophy plays in creating safe birth environments that increase women's sense of agency."

> "Most midwives did not regard themselves as autonomous decision-makers and sought permission to implement a physiological approach. They were predominantly observed not to challenge routine clinical intervention use."

This very much echoes the research findings of Florence Darling, writing in this issue. In her PhD study, in which midwives were primed to offer a physiological approach to care in an obstetric unit, Florence observed that:
When institutional authority 'permeates the atmosphere' and when midwives are unable or unwilling to challenge it, it can be traumatising; traumatising for the mothers and their supporters *and* also for the midwives themselves. Doulas Grace Hall and Shellie Poulter each address the effects of stress and trauma in the birthplace in this issue of the journal.

There are many complex reasons why a woman's own home may not be where she wants to give birth, and why she may not be able to 'swim home' to her mother instead. Away-from-home birth settings should provide a safe alternative. One mother I met told me of her dream since childhood that one beautiful day she would give birth to a baby in a hospital. In her dream she was surrounded by radiant angel-like midwives all attending her with gentleness and kindness. Sadly, her lived experience was bitterly

disappointing. Every woman in today's world should be able to expect to feel safe and private and respected throughout their labour in hospital - to be attended with gentleness and kindness. They should certainly not feel that the likelihood of experiencing a smooth and safe physiological birth is sabotaged the moment that they walk through the doors. This is why AIMS is campaigning for physiology-Informed maternity services.[8] In the meantime, Anne Glover, opens this issue by setting out AIMS position on choice of birthplace, and our belief that it should indeed be a genuine choice.

[1] Editor's note: Homeland, in relation to hiraeth, can be a real, an imagined or a 'felt' place.

[2] Hoffmann, L., Hilger, N., & Banse, R. (2023). The mindset of birth predicts birth outcomes: Evidence from a prospective longitudinal study. *European Journal of Social Psychology*, 00, 1– 15.

[3] Mizzi, R., and Pace Parascandalo, R. (2022). First-time couples' shared experiences of the birth environment. *European Journal of Midwifery*, 6(October), pp.1-9.

[4]Setola N, Iannuzzi L, Santini M, Cocina GG, Naldi E, Branchini L, Morano S, Escuriet Peiró R, Downe S. Optimal settings for childbirth. Minerva Ginecol. 2018 Dec;70(6):687-699. doi: 10.23736/S0026-4784.18.04327-7. Epub 2018 Oct 5. PMID: 30299042. http://clok.uclan.ac.uk/24584/1/Minerva%20Ginecol-4327_Bozza%20in%20PDF_V1_2018-10-11%20nicoletta%20optimal%20settings.pdf

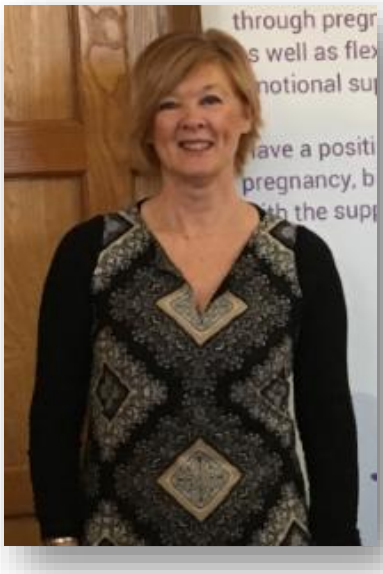
[5]Nicoletta S, Eletta N, Cardinali P, Migliorini L. A Broad Study to Develop Maternity Units Design Knowledge Combining Spatial Analysis and Mothers' and Midwives' Perception of the Birth Environment. *HERD: Health Environments Research & Design Journal*. 2022;15(4):204-232.

[6]Goldkuhl L, Dellenborg L, Berg M, Wijk H, Nilsson C. The influence and meaning of the birth environment for nulliparous women at a hospital-based labour ward in Sweden: An ethnographic study. Women Birth. 2022 Jul;35(4):e337-e347. doi: 10.1016/j.wombi.2021.07.005. Epub 2021 Jul 26. PMID: 34321183.

[7]"It [behaviour] was dependent on the care providers' permissive approach that enabled the women's agency as well as the women's readiness to take ownership over the room…the care providers shaped the environment regardless of the room's spatial design."

[8]AIMS (2023) Physiology-informed Maternity Services https://www.aims.org.uk/assets/media/730/aims-position-paper-physiology-informed-maternity-care.pdf

Choice of Birthplace *by Anne Glover*



Author Bio: Anne is a well-known doula in Northern Ireland and is forever going on about maternity choices to anyone who will listen! She has recently been lobbying for all four birthing options to be available to all families in Northern Ireland.

AIMS has a position paper on Choice of Birthplace which states that choice of place of birth is a fundamental human right protected under Article 8 of the European Convention on Human Rights Act, 'the principle of autonomy'.

AIMS believes that every pregnant woman and person should be made aware of all their choices and respectfully supported by their care providers when making an informed decision on where to birth their baby. Choice is the key word here, and to be able to make choices, you need to know all your options.

AIMS does not promote any particular birthplace as being better than another, recognising that different birthplaces will be appropriate for different people depending on their circumstances, preferences and clinical needs. However, AIMS believes that everyone has the right to access any of the four birthplace options, no matter where they live, what Trust or Board they come under and whatever the current staff situation. This means that all Trusts/Boards should be making all the options available:

- Home setting
- Freestanding birth centre/midwife-led unit
- Alongside birth centre/midwife-led unit
- Obstetric unit/delivery suite

However, as the recent pandemic has demonstrated, even where options exist, restrictions can be placed at short notice leaving people with very limited choices. Even

now, our Helpline continues to hear from people planning a home birth who have been told that the local home birth team has been suspended, due, for example, to staff sickness.

So we will continue to campaign and lobby for everyone to have the right to all four options throughout the UK. We ask you to share our position paper with maternity service users and MVP/MSLC[1] user representatives, to check your Trust/Boards' policy on access to birth centres and support for homebirths, and to lobby for improvements. This way, everyone is made aware of their options and can confidently choose where to birth their baby.
If you are interested in joining our campaigning work, please drop us a line at campaigns@aims.org.uk

[1] Maternity Voices Partnership (MVP) and Maternity Services Liaison Committees (MSLCs)

Safety and place of birth: part one

by Kathryn Kelly

Kathryn Kelly has been a self-employed NCT Antenatal practitioner since 2009, and also works for NCT creating and curating CPD for practitioners. She has a particular interest in learning and writing about perinatal informed decision-making.

Introduction

Until relatively recently, women[1] gave birth at home as the norm and only used a 'maternity home' or hospital if they had social or medical needs or could afford the private fee. In 1946, 46% of births in England and Wales were at home, with the balance in a maternity home or hospital. [2]By 1970 birth at home was down to 13%, and in GP units 12%. By 1990 home birth was at 1%, and GP Units 1.6%.[2] In her seminal statistical analysis of birth data, Tew describes the "almost universal misunderstanding" of what the evidence showed, that "birth is the safer, the less its process is interfered with".[2]

Data for 2021 shows that 97% of parents in England and Wales gave birth in an NHS establishment,[3] with a home birth rate of 2.5%,[3] but despite this wholesale move to a perceived place of safety, anecdotally anxiety about birth appears to be rising alongside the intervention rate.

The National Institute of Health and Care Excellence (NICE) states that women should have access to four planned places of birth: Home, Freestanding Midwife-Led Unit (FMLU), Alongside Midwife-Led Unit (AMLU), and Obstetric Unit (OU). While NICE considers that women at low risk of complications are free to decide on place of birth, it suggests that those with certain risk factors should be given information about those risks before being supported in their decision. It states that personal views or judgements of the healthcare provider should not be shared.[4]

When we talk about safety in childbirth, most people think of a 'healthy baby', with 'healthy' as a euphemism for 'live', and perhaps as an afterthought a 'healthy mother'. Parents I speak with who have already given birth are more likely to prioritise factors such as psychological safety, cultural safety, and a sense of control.

In this article I intend to explore what research tells us about place of birth and safety for babies and mothers. I will also consider the wider factors involved, as well as what makes birth unsafe and who are we keeping safe.

Definitions and statistics – for the baby

Let's start with some definitions and, because all definitions are situated within time and place, context.

Table 1. Definitions and statistics of stillbirth and infant mortality in the UK in 2023. [3],[5],[6],[7],[8]

Term	Term	Definition	Rate	More information	
Stillbirth		Born after 24 weeks, never takes a breath	3.8/1,000	Of all live and stillbirths	
Of which...	Late stillbirth	Born after 28 weeks, never takes a breath	2.9/1,000	Vs 1.3-8.8/1,000 in high-income countries	Also known as 'Extended perinatal death'
Neonatal mortality		Born breathing, dies up to 28 days	2.8/1,000	Of all live births	
Of which...	Early neonatal death	Born breathing, dies up to 7 days		Accounts for over half of all neonatal mortality	
Infant mortality		Born breathing, dies up to one year	3.8/1,000	Of all live births	

MBRRACE-UK shows the causes of stillbirth to be relatively consistent over the period 2016-2020:[7]

- Unknown causes are reducing, but still over 30% of all stillbirths
- Related to the placenta (over 30%)
- Congenital anomalies (under 10%)
- Other conditions: fetal, cord, infection, maternal (each around 5%)
- Intrapartum (around 2% of all stillbirths)

Intrapartum death is a tiny component of the 'safety' dimension

An intrapartum death describes the rare situations when the baby was assessed as alive at the onset of labour, but dead at birth. Even if we add intrapartum stillbirths and neonatal deaths due to intrapartum causes, we still arrive at a rate of less than 0.1 per 1,000 live and still births.[7] While acknowledging that every death is a huge and painful loss, we can also see that there is a very rare chance of it happening.

For the mother

As Winnicott identified, maternal wellbeing is critical to the baby as they adjust to life outside the womb.[10]

Table 2: Maternal mortality in the UK, 2018-2020.[11]

When mothers died		Number	Rate	Of all women who died
During or up to six weeks after the end of pregnancy		229	10.9 per 100,000	14% during pregnancy; 32% up to six weeks
	Died from Covid	9		
	Covid deaths removed	220	10.5 per 100,000	
	Black women		34 per 100,000	
	Asian women		16 per 100,000	
Between six weeks and a year		289	13.8 per 100,000	54% six weeks to 12 months

The MBRRACE review of maternal mortality in 2018-2020 includes a table of place of birth.[11] This shows that 5 (4%) of the women who died had given birth at home, and only one of those had died of 'direct causes' (a wide definition which includes thrombosis, suicide, sepsis, and haemorrhage).[12] The remainder gave birth either in hospital, the emergency department, or an ambulance. This data is not shown by 'intended' place of birth, so we should acknowledge that more of the deaths could be associated with place of birth, though the variety of 'direct causes' might suggest that a good quality and well supported out-of-hospital birth service would not be a contributing factor.

What about the safety of the health professional?

Protecting midwives is sometimes given as the reason for withdrawing the home birth service when the maternity or ambulance services are compromised. Understandably, a Director of Midwifery doesn't want to put their staff in a situation without good backup. There is also enormous pressure for documented adherence to guidelines, to protect both individual healthcare workers and the service provider from the fear of withdrawal of employment or litigation.

With the harm of long-term exposure to Entonox in the news this year, 'safety' takes on another perspective. Midwives may be working in older hospitals without adequate scavenging systems that remove harmful gases.[13] For them, a home or midwife-led unit with windows providing fresh air could be protective.

What reduces or mediates safety?

Most stillbirths occur in pregnancies without established risk factors.[8] So what reduces that safety, and what protects it?

Routine antenatal care looks for the key factors associated with poor outcomes for the mother or baby. Early scans and blood tests look for congenital abnormality, and monitoring of the baby's growth checks whether that slows or stops. Monitoring of the mother's blood pressure and urine check for pre-eclampsia. In the event of any

concern, or when labour starts before 37 weeks, it's recommended that care is provided on the obstetric unit, and parents can accept or decline that increased level of medical care.

We know that previous birth experiences have a significant impact, both on risk status and the perception of safety.[14] A first-time mother or pregnant person is known as nulliparous (nullip), and someone who has given birth before is multiparous (multip). Even with a more complicated pregnancy, a multip (except by caesarean) is less likely to have a complicated birth in a subsequent pregnancy, while a woman who has had a previous caesarean is considered to have the same risk status as a nullip.

For the unexpected outcomes we can ask why place of birth would have an impact? The resources at home and midwife-led units are identical. An analysis of intrapartum deaths at home and in MLUs found that risk assessment in pregnancy or early labour could be improved, along with a better standard of monitoring, resuscitation, and timely transfer.[15] So, while staff at different locations should have the same skills - and they routinely conduct 'skills drills' to practise for emergency situations - there is scope for improvement. But the most significant factor is time and distance from speedy intervention if it's needed, which I will explore later.

While the planned place of birth is captured in the raw data, it is not currently shown as a risk factor for infants. What we do know is that stillbirth has been rising since 2010 for the poorest families, while it falls for the more advantaged. "The stillbirth rate in the 10% most deprived areas in England was 5.6 stillbirths per 1,000 births in 2021; in contrast, the stillbirth rate was lower in the 10% least deprived areas in England at 2.7 stillbirths per 1,000 births".[3] The UK has a high level of inequality (when compared with economically similar countries) and lower socioeconomic groups are less likely to access antenatal care promptly, more likely to smoke and to be obese.[6] There is also an association between deprivation, stress, domestic abuse, and small or premature babies and late stillbirth.[16],[17]

Ethnicity is a significant factor: "Babies from the Black ethnic group continued to have the highest stillbirth rate at 6.9 stillbirths per 1,000 births in 2021".[3] Since the MBRRACE-UK report published in 2020 there has been a spotlight on the need to address ethnic disparities (which were already present but not highlighted). While this is partly laid down to socioeconomic deprivation, that doesn't fully explain it. For example, research with migrant women illustrated the need for clear and consistent protective messages.[18]

Just as with babies, mothers with severe disadvantages are over-represented in the data, and 20% of women who died were "known to social services".[3] These were known

vulnerabilities, which makes this even more unacceptable. Black, Asian, and mixed-ethnicity women are over-represented in the numbers, and while there is intersection with other vulnerabilities, this doesn't explain it all. Ina May Gaskin points out that women's bodies are not "inadequate" to birth, and this remains true of Black and Asian women and babies, so we need to understand how weathering[19] and gendered racism are leading to these worse outcomes.[20]

Social disparities are not only more difficult to resolve, they are also public health issues outside the remit of maternity services. So, while Continuity of Care (CoC) teams may be established to focus on providing holistic support to groups with identified medical or social needs, healthcare providers tend to focus on more easily measured factors, such as smoking, obesity, and high blood pressure. However, "target driven care can be actively harmful".[21]

What's the best source of information about place and safety?

'Birthplace in England' was a large and robust study that looked at where women had planned to give birth and what the outcomes were.[22] While it may feel to parents that a report published in 2011 is 'old', there has been no update and it remains the 'go-to' source for this specific information. By analysing outcomes by 'planned' place of birth it showed all outcomes, wherever birth finally took place, which makes it an interesting resource. When we compare newer research, we have to bear that point in mind.

There were several analyses of the data collected. In the report, 'perinatal and maternal outcomes by planned place of birth for healthy women with low-risk pregnancies', four planned places of birth were included: Home, FMLU, AMLU (in the same building as the OU, though sometimes not on the same floor), and OU (commonly known as 'Labour Ward'). The OU is the only place doctors will be found, though most of the care is still undertaken by midwives.

Table 3: Summary of Birthplace findings for women with 'low risk pregnancies' [23], [24]

Report and link	Focus	Findings
Birthplace in England Collaborative Group, 2011[22]	Women at low risk, home, freestanding MLU, alongside MLU, Obstetric Unit (OU)	Very safe in all locations. Small increase in perinatal adverse outcomes in first time mothers at home (from 5.3/1,000 to 9.3/1,000). Likelihood of birth without intervention decreased with proximity to OU (92.8% home, 76.4% OU) High rates of transfer to OU for first time mothers from all settings (36%-45%), vs 9.4%-12.5% for multips.
Rowe et al, 2012[23]	Transfers from freestanding MLU, alongside MLU	Transfer in labour or immediately after birth is common; "only a minority of transfers take place as a response to an unequivocal emergency". Both proximity to OU and parity have an effect.
Hollowell et al, 2017[24]	Secondary analysis comparing outcomes in freestanding and alongside MLUs	No difference for babies, or in chance of caesarean birth. Instrumental birth lower in freestanding MLU.

The top line from the first published study was that "giving birth is generally very safe".[25] This explored the experience of women with 'low risk' pregnancies, and a primary outcome of "perinatal mortality and specific neonatal morbidities: stillbirth after the start of care in labour, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus, and fractured clavicle".[22] This composite was designed to capture outcomes that might be related to quality of intrapartum care, and includes those factors which could potentially have a long-lasting impact on the baby and family.
The study found that for multips there was no difference in adverse outcomes across all four places of planned birth. For nullips there was a small but significant increase in adverse outcomes for the baby if birth was planned at home (4 in 1,000 babies).[22]

For the secondary outcome of "neonatal and maternal morbidities, maternal interventions, and mode of birth" the finding was that women who planned births off the

obstetric unit were much less likely to experience "an instrumental or operative delivery or to receive medical interventions such as augmentation, epidural or spinal analgesia, general anaesthesia, or episiotomy".[22] I find it's often necessary to remind parents at this point that all the women started with the same 'low risk' factors, so those on the obstetric unit were not having these procedures because they 'needed' them at the start of labour.
A useful decision aid for birth workers and parents is Dr Kirstie Coxon's graphic, which illustrates both primary and secondary outcomes.[26]

I mentioned earlier that time and distance from emergency care could be considered the only point when place of birth might have a safety dimension. For context, the top three reasons for transfer from either FMLU or AMLU are not for emergencies but a cautious response to a slower than expected labour or meconium staining, or for access to epidural pain relief (especially in AMLU).[23] Much less common were reasons such as fetal distress in the first stage (4 or 6 in the list), or postpartum haemorrhage (9 or 10 in the list). First time mothers (especially older nullips) were more likely to transfer, and the authors theorise that this may have been down to care-provider caution.
For women considering the difference between freestanding MLU and alongside MLU, a secondary analysis showed no significant difference in adverse outcomes for babies, or chance of caesarean birth.[24] Instrumental birth (forceps or ventouse) was lower in freestanding settings.

Let's talk about 'low risk'
Much like the fact that most medical research is conducted on men because they don't have pesky hormonal cycles that might muddy the waters, most place of birth research looks at women with 'low risk' pregnancies. The Birthplace study used the NICE definition to identify women with conditions that may lead to higher risk status.[4]

A 2014 study found that 45% of women would have been considered low risk using these definitions, so even then, any guidance aimed at 'low risk' women already applied to less than half the birthing population.[27] Since then, we've had a pandemic which resulted in a dramatic reconfiguration of maternity services, and an increase in poverty and social disparities. Research has not yet been published that would address how these changes might affect risk. Nor has there been a recent exploration of whether these definitions of higher risk remain valid.
In the next article I discuss the majority who are regarded as not having a low-risk pregnancy, and look at other factors we need to consider.

[1] This article is based on research and other sources that refer only to 'women'.

[2] Tew M (1998) Safer Childbirth?: a critical history of maternity care. (2nd Edition). London. Free Association Books Ltd.

[3] Office for National Statistics (ONS), released 19 January 2023, ONS website, statistical bulletin, Birth characteristics in England and Wales: 2021. Worksheets 1 and 17. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthcharacteristicsinenglandandwales

[4] NICE (2014) Intrapartum care for healthy women and babies [CG190]. www.nice.org.uk/guidance/cg190

[5] Morris J (2018) Understanding the health of babies and expectant mothers. Nuffield Trust. www.nuffieldtrust.org.uk/resource/understanding-the-health-of-babies-and-expectant-mothers#how-do-stillbirth-and-infant-mortality-rates-compare-internationally

[6] Draper ES, Gallimore ID, Smith LK, Matthews RJ, Fenton AC, Kurinczuk JJ, Smith PW, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2020. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2022 www.npeu.ox.ac.uk/mbrrace-uk/reports

[7] Nuffield Trust (2023) Stillbirths and neonatal and infant mortality. www.nuffieldtrust.org.uk/resource/infant-and-neonatal-mortality#background

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Two birth stories I love *by Sue Boughton*

Sue Boughton is a longstanding AIMS member and is a massage practitioner and doula from the North-East of England now living in London.

A massage client gave birth in my home

This is one of my favourite birth stories. It is written with the permission of the mother who I will call N.

When N came to see me for a pregnancy massage at the Active Birth Centre therapy clinic a few years ago, she was 40 weeks pregnant with her 2nd baby. She knew exactly what she needed and that was to relax so that she could give birth. N told me that she wanted a homebirth but as they were having major building work done in their home it wasn't going to be possible. She was upset about this as she had given birth to her first baby at home, and she also mentioned that she wasn't getting on very well with her partner. This was hardly surprising given the stresses of being heavily pregnant whilst living in a building site!

At the end of her massage N asked me if she could come for another massage in a couple of days time if she hadn't gone into labour. I said, yes of course, and then I added something that I've never said to anyone before, I said, "I don t think you'll need to, your body is so ready for labour, I'm sure you'll have given birth by the end of the weekend". This was Friday evening.

N called me the next day and asked if she could book another massage. She had started to have surges[1] after the first massage, but had gone to her mother-in-law's that evening, was stressed by the visit and her surges had stopped, so we arranged for her to come to my home for a massage on Sunday evening.

N drove herself to my house but didn't tell me until afterwards that she'd had a few surges as she was driving over. She had a few more surges during her massage and half way through she went to the bathroom and had a big surge on the way downstairs. I suggested that she call her partner to come and pick her up as I wasn't going to let her drive herself home or even to the birth centre, which was in Islington, so not far from my home. I simply thought, well, this is good, she's in early labour now so she can go straight to the birth centre after her massage.

N asked me to continue her massage and said that she would call her partner afterwards. I asked my husband to go and get her phone as she had left it in her car. N's waters broke while she was still on the massage couch after calling her partner! She shouted, "take my pants off, take my pants off!", as of course they were wet. So I helped her take them off and at that point it dawned on me that she was about to give birth and there would be no time to get her to the birth centre after all. She called her partner back to ask him to hurry up and then I called 999 just in case we needed help. I am totally confident in a woman's ability to give birth and I know that if a baby is coming quickly, at term, that it's not a problem, but I do feel nervous after the baby is born in case the baby has any trouble breathing. I am not trained in resuscitating newborn babies, so calling the paramedics is for this reason. The woman I was speaking to asked me all sorts of strange and sometimes hilarious questions: "How old is the mother? "Is the mother breathing?" How she couldn't hear the N groaning and yelling, "catch my baby, catch my baby" I will never know!

"Catch my Baby, catch my baby"

So I tried to get N back on the couch and into the knee/chest position to slow things down but she wasn't going to move anywhere; she was standing and leaning over the couch so I pulled some of the towels off the couch onto the floor in between her feet. I knew how hot and slippery a baby is from a previous BBA[2] and I think I was worried about dropping her baby. Crazy thoughts go through your head in these moments. N literally gave two grunting pushes and you could see some of her baby's head, so I suggested that she breathed slowly and her baby's head was born a few minutes later. Then she shouted, "catch my baby" and her baby boy was born, amazingly hot and very wet. I managed not to drop him and I passed him to her through her legs as she sat down. I wrapped a big towel around her shoulders and covered her baby with other towels to keep them both warm. Luckily, as she'd been having a massage, the room was warm and dark and there were plenty of towels to hand!

The paramedics arrived and I managed to get the second paramedic and their student to wait in the kitchen while one of them came in to check that the mother and baby were ok. I wanted the least disturbance possible as her placenta hadn't come yet.[3] The paramedic wanted to cut the cord but N asked him not to as she wanted to wait for her placenta to come first. He was surprised by this and not very comfortable, so I gave him a brief explanation as to why optimum cord clamping is a good idea[4] and then he was happy to wait. Amazingly, N didn't bleed at all. It was the 'cleanest' birth I'd ever seen. About ten minutes later her partner turned up. He was a bit in shock that he had missed the birth, but he was happy to meet his son.

N looked at her baby and then looked up at me and apologised for giving birth in my house. I certainly didn't need an apology; I thought it was amazing, a complete blessing and the most exciting thing to have happened in our home for years!

It was interesting to find out how the emergency services work in this situation. They stayed on the phone until the ambulance arrived, then the paramedics stayed until the midwife arrived. So N was actually booked for a homebirth after all and luckily we live in the same borough so one of the Islington community midwives came to see her and helped her birth her placenta - into my salad bowl, which I let them keep...

The reason I love this birth story is that it shows perfectly how the environment and the atmosphere are so important. N was very relaxed as she was having a massage; the room was warm and cosy; candles and fairy lights were on; calm, relaxing music was playing; and, even though we didn't know each other well, N knew I was a birth doula and must have felt safe enough to let go. She also reminded me very much of a good friend, so I felt like I already knew her, and this may have helped too. N was like a cat looking for a warm, dark, safe place in which to give birth. A few days later she said that my massage room felt 'womb like'. It does have one soft, dark red wall and red fairy lights in it, but I'd never thought of it that way before.

Mum, Dad and baby left our house a few hours later, healthy and happy (with the placenta in the salad bowl), and we sat down and had a glass of wine!

Holding out for the birth centre

I love this next birth story too, as it shows how lovely and relaxed a first birth can be and not what anyone expects. It is shared with the parent's permission.

This was H and A's first baby and they were planning to use a local hospital birth centre. H noticed some of her 'show' one evening and later that night she felt her surges beginning. Her husband calls me around 2 am; the surges are irregular but already between three and six mins apart and H is feeling nervous. I suggest she has a bath or sees if moving around helps. Everyone expects a first time mum to have hours and hours of pre-labour while the body gets prepared and for the hormones to build up before labour really gets going, but it doesn't always take a long time.

A calls me again at 3.30 am. H's surges are three mins apart and very regular now so they ask me to come over. H is coping really well, breathing calmly whilst leaning over the birth ball in their candle-lit front room. She's listening to a Hypnobirthing App that handily doubles as a contraction/surge timer. Very soon the surges are building and getting stronger, I give H some Aconite (a homoeopathic remedy for fear/worry)[5] and I run her another bath. H is quiet and focused in the bathroom with her partner for about half an hour. Her surges are now much longer and stronger, so A calls the birth centre around 5.30 am. He is told that the birth centre is dealing with an emergency and that they should either go to the labour ward or stay at home for longer. They decide to stay at home when I reassure them that we have plenty of time.

Around 7am they say that they want to go in and I agree that it's probably a good idea as her labour is now looking pretty strong and appears to be moving quickly. I don't want to end up with a stressful rush to the hospital in rush hour traffic. We arrive at the birth centre (which is in the hospital) to find it deserted, no staff and no labouring women! I make various phone calls to try and find out what's going on. Clearly it's a busy night for births in North London. H is calm and focused with her headphones (listening to the hypnobirthing app) and with her eye mask on.

I find them a comfortable place to wait with H sitting on a birth ball while I go upstairs to the labour ward to find out what's going on as no-one is answering the phone. After speaking to the midwife in charge of the labour ward and finding that the labour ward is full (though I don't tell H and A that as I don't want them to worry), we go to the antenatal ward to wait for the birth centre to open. We're hoping that the day midwives will come in at 8 am.

A midwife listens to their baby's heart rate and we get settled into a cubicle on the antenatal ward. It's quiet at least and there are midwives there if we need them. Apparently, today there are staff shortages and no midwives are available for the birth centre, so we wait, with fingers, toes and legs crossed, hoping that more midwives will be found and the birth centre will open soon.

H is coping really well considering this quite major hiccup in the proceedings. She accepts the offer of a VE and the result is that she's in active labour - well we knew that! - and the baby is in a good position, his/her heart rate is perfect and so all is well. H repeatedly changes from standing and leaning on a table to kneeling on the bed, walking to the toilet and back to standing - the typical restlessness of a woman in labour. No-one suggests this, but she very wisely and instinctively keeps her headphones and eye mask on. It's daytime now, we can't make the cubicle dark, and it's not quiet anymore on the ward. At 10.40 am H is feeling a little pressure and is beginning to make little grunting noises. I keep checking with the midwives for updates on the birth centre. We have been told that it should be open again in an hour but that was a while ago. Now they say that a midwife is taking a mum and her baby from the labour ward to the postnatal ward and then she's coming to take us to the birth centre.

A is concerned that we are running out of time and the midwives suggest that we go to the labour ward if they can't or don't want to wait. We discuss it and I say that I think they have some time to go yet as H isn't really pushing or groaning yet and that the birth centre will be lovely and quiet, so they decide to wait. Finally at 11.35 am our lovely midwife comes and quickly takes us down to the birth centre. She listens to the baby's heart rate and does a visual check (not a VE) as H is clearly getting close to giving birth. The birth centre midwives start to run the pool as soon as we got there so H gets up and takes off her T-shirt and pants before getting in the pool.

As she starts walking towards the pool she says, "Sue, it's stinging down there", so I bend down to check what's happening and part of the baby's head is visible! The midwives and myself remind her to try not to push but the baby's head comes as we guide H back onto the bed on all fours. There wasn't time for her to get into the pool before the baby's head was born. The shoulders come slowly and their baby is born at midday. The midwife passes the baby in between her legs and we help her to lie down and hold her baby skin to skin. H is in shock and cries with wonder and surprise, as does her partner, A. I look at the midwives, we are surprised that their baby came so smoothly and quickly. We all thought that there was time for her to get into the pool. Well, you just never know do you!

Their baby's birth was a really lovely surprise for everyone and she was perfect - a good sized, gorgeous baby girl.

1 Surges is another term for contractions.
2 BBA stands for Born Before Arrival (of the midwife)
3 Editor's note: The safe and timely separation and birth of the placenta is achieved by further uterine contractions, and these depend on continued high levels of oxytocin. Therefore it is important to maintain the warm, calm and quiet environment that increases oxytocin, so that this process is not disturbed.
4 Guideline: Delayed Umbilical Cord Clamping for Improved Maternal and Infant Health and Nutrition Outcomes. Geneva: World Health Organization; 2014. Background. Available from: https://www.ncbi.nlm.nih.gov/books/NBK310514/
5 College of Natural Health and Homoeopathy (2021) Homeopathy for Pregnancy, Birth and Beyond https://cnhh.ac.nz/homeopathy-for-pregnancy-birth-and-beyond/

Safety and place of birth: part two

By Kathryn Kelly

In the first article I explored evidence around mother and infant mortality for low-risk pregnancies and place of birth. Now I move on to consider the majority of women and pregnant people[1], and the other factors we might encompass with the term 'safety'.

What about the 55% who are not 'low risk'?

We know that most women are now directed to give birth in an Obstetric Unit (OU), despite Tew's finding that "obstetric intervention only rarely improves the natural processes".[2] The Birthplace study[3] conducted various secondary analyses to explore different risk factors for women with 'higher risk' pregnancies (See Table 2).

Table 1: Summary of Birthplace on women with 'higher risk pregnancies [4,5,6,7]

Report and link	Focus	Findings
Hollowell et al, 2014 [3]	Effect of obesity (otherwise low risk)	"Modest" increase of chance of intervention and some adverse outcomes for mother. Lower for multips.
Li et al, 2014 [4]	Effect of maternal age in women (otherwise low risk)	Absolute chance of interventions lower in all non-OU settings, at all ages, for both primips and multips. Adverse outcomes for both mothers and babies increase with maternal age. Older first-time mothers birthing outside OU more likely to experience interventions (augmentation). For babies, no difference in adverse outcomes until woman over 40 and giving birth on OU.
Li et al, 2015 [5]	Women at higher risk, home or obstetric unit.	Lower incidence of mortality, morbidity, and neonatal admission in planned home births. Maternal interventions are also lower.
Rowe et al, 2015 [6]	Women planning VBAC, home or obstetric unit	Similar adverse outcomes for both mother and baby in both locations. Chance of vaginal birth higher at home. Transfer rates high, particularly in women with only one previous birth (56.7% vs 24.6%)

Analysis of the effect of obesity[3] showed a modest increase of risk of intervention and some adverse maternal outcomes. However, otherwise healthy women who have already given birth (multips) were at lower risk of intervention than first-time mothers (nullips). The conclusion was that birth in non-obstetric settings could be a positive option for healthy women who already had a baby.

Secondary analysis of the effect of maternal age (otherwise low risk)[4] showed that adverse outcomes for both mothers and babies increased with maternal age, but without a specific age (i.e. 40) when risk increased. The absolute chance of interventions was lower in all non-OU settings, at all ages, for both multips and nullips. However, older nullips planning birth off the OU were more likely to experience interventions, particularly of augmentation with syntocinon (which could only take place after transfer to the OU). For the baby, the risks showed no difference unless the woman was having her first baby over 40 and giving birth on the OU, when the chance of neonatal unit admission or perinatal death increased. There is an interesting discussion of possible reasons for the disparities in the 'comparison with the existing literature', which includes the potential impact of labelling women.

A comparison of outcomes for women at 'higher risk' of complications planning birth at home or in the OU found the home birth group had a lower incidence of mortality, morbidity, and longer neonatal admission.[5] This echoes Tew's work in the 1980s which found that only those at the very highest risk had lower infant mortality in hospital compared with home or GP unit.[1] Maternal interventions were also lower in this group. The team qualified their findings around neonatal care by saying that while more babies born in the OU were admitted to neonatal care, it was "unclear if this reflects a real difference in morbidity".[5] Which is to say that, if the neonatal unit is next door, you may be more likely to send the baby there than if it required an ambulance transfer.

Potentially this mirrors the 'next door' effect of a higher rate of women transferring from AMLU to OU for an epidural, though we also need to recognise that women with additional risk factors may have negotiated to labour on the AMLU, knowing transfer would be easy if necessary.

Another higher risk group is women planning vaginal birth after caesarean (VBAC), and a further study looked at planned birth at home or in the OU.[6] While mother and baby experienced similar risks of adverse outcomes in both locations, the chance of having a vaginal birth was significantly better at home. However, transfer rates were high, particularly for women who had only one previous birth (56.7% vs 24.6%).

While we're thinking about safety, a fascinating insight came from the one piece of qualitative research that formed part of Birthplace.[8] This small study of 58 'low risk' postnatal women found that 30 women reported 'speaking up', defined as "insistent and vehement communication when faced with failure by staff to listen and respond".[7] This highlighted that women may be trying to self-advocate for their safety in the face of the failure of staff to listen. The presence of a lay supporter (i.e. partner, relative or doula) helped the women speak up. With such a small study, even though researchers looked at birth planned in different locations, place cannot be identified as a factor.

Follow-on study

Further analysis of the Birthplace data addressed five areas in more depth.[9] Their conclusions state that further centralisation of services in larger units should be done thoughtfully, monitored and evaluated, because intervention rates are lower in out-of-hospital birth. For example, more support for home birth for multips is recommended. It also highlights that "non-clinical factors may be leading to an 'excess' use of epidurals and augmentation in women labouring during 'office hours'" and suggests a review of these practices.[8] And it highlights the "marked age-related increases" in interventions, and "prolonged" neonatal unit admission as meriting further investigation.[8] Better data recording, and information for women to support decision-making were also suggested

'Risk' is conditional and flexible

Any of us who work with pregnant women know that risk isn't a fixed concept, and that "very few women are absolutely always either low- or high risk and neither definition may hold true at all times during the childbirth experience".[10] Health conditions (which may or may not be pregnancy-related) emerge, and "complicating conditions",[2] such as prolonged rupture of membranes or meconium in the waters, may appear at the start of labour.

Parents are usually aware that, as in life, the assessment of risk might change, with consequent impacts on their plans. This is not a reason not to plan a birth in a specific location, but a reminder that decisions are always contextual and have implications. The identification of risk factors is intended to ensure a woman and baby get appropriate care. However, they are only predictive tools, and not guarantees. More recent thinking highlights a need for research to better understand any specific risk factors associated with place of birth so that parents can be given evidence-based information on which to base a decision.[11]

Other pressures on choosing place of birth

The pandemic brought about rapid service reconfigurations such as remote consultations and telephone triage, to protect women and their carers from infection. Many of these services have remained in place as the time saved can be attractive to both parents and staff. However, the HSIB (Healthcare Safety Investigation Branch) report of intrapartum stillbirth during that period recommends that those services should be reviewed for safety and effectiveness, as in-person contact can improve diagnosis.[12] The report also suggested the definition of a minimum standard for use of interpretation services, along with other structural improvements such as data recording that can be more easily shared between stakeholders and across geographical boundaries, improving speedy and effective transfer.

We know that a woman or pregnant person might be interested in exploring different places of birth, but experiencing pressure to labour on an obstetric unit, either from healthcare professionals or their partner. Some women say they can't make what might be viewed as a 'riskier' decision because 'it's his baby too'; alternatively, they may feel they would be safer away from an abusive partner. Being cared for by health professionals, away from home, could also be attractive to a woman overwhelmed by the demands of her family.

Even if she's healthy and not under pressure, the uncertainties of low staffing and an overstretched ambulance service, with some MLUs having restricted opening hours, or the potential for home birth support to be withdrawn at short notice, can feel too risky

an emotional load to cope with. As a nation we are moving from more, smaller units to fewer, larger units, which is likely to have a negative impact on extended outcomes – a lose-lose scenario where first time mothers either take the slightly increased risk and stay at home, or move to the OU with the strong likelihood of more intervention. As a result, many women now seem to be making 'least-worst' decisions and choosing what feels to them a predictable intervention over the unpredictable unfolding of labour and birth. My local Trust are alarmed at the rate of maternal-request elective caesareans, but who can blame the women for wanting the only form of control they seem able to grasp, especially when told how 'safe' it is.

As birth workers we can help parents explore their feelings around minute but potentially catastrophic risks, versus a higher chance of interventions that may feel less immediately daunting but can have potentially life changing repercussions. Because, despite the good intentions of healthcare staff, there is not good evidence for many interventions.[13]

Research since Birthplace

In the Netherlands, where the home birth rate is around 20% versus 2.5% in England and Wales, research found no difference in adverse outcomes for babies of nullips birthing at home or in hospital. The authors concluded that midwives' greater experience of home birth was at the root of this difference.[14]

Systematic review and meta-analysis bring together multiple studies. Two recent reviews have found that for 'low-risk' pregnancies place of birth had no statistically significant impact on infant mortality, and a lower chance of morbidity and interventions for mothers. [15,16] For both reviews the studies included may not have been large enough to detect rare outcomes, and even in well-resourced countries maternity systems differ, so we must be cautious about interpretation.

During the 2020 Coronavirus pandemic it was highlighted that for women who didn't require obstetric care it would have made more sense to birth outside hospital.[17] This would have protected women from hospital acquired infection and reduced the stress on maternity units. However, the increased anxiety from hospital Trusts in England saw a dramatic and military entrenchment, and, in many areas, a withdrawal of out-of-hospital care in any form. This did lead to more women considering freebirth,[18] and a hasty briefing sheet from an anxious Royal College of Midwives.[19]

What else do we need to consider?

Research is conducted on populations and is generalisable only to the extent that we are represented by that population. So, increased risks for women and pregnant people

over 40 will include those with multiple health, social and economic issues, as well as the fit, healthy, and well supported. Population data will also be more representative of the majority ethnic groups, and, "In all reviews that aim to draw conclusions about population health needs, it is vital that explicit consideration is given to ethnic minority communities", yet coding data about ethnicity is often inconsistent or missing, muddying our understanding of the issues.[20] So, while population data is necessary for the configuration of services, it may not apply well to an individual.

In research looking at what people value when selecting care there was an almost universal desire for a local service with a known midwife, and a sense of control in decision-making.[21] However, while some prefer easy access to doctors and a range of pain relief, others had different priorities.[19] Safety and psychological wellbeing were equally valued by birthing women as part of a positive experience.[22]

Despite NICE guidance, planning a place of birth is often a process of negotiation and compromise. Middle settings such as Freestanding MLUs may be perceived by midwives as less suitable for women with higher risk status, while there can be more flexibility around use of the Alongside MLU (especially if it is literally through a set of doors rather than on another floor). Some women will request home birth as an initial step to negotiate MLU care, or will accept 'lesser' interventions such as a managed third stage to calm midwife anxieties about home birth.

Sometimes women and birthing people choose not to give birth in hospital because they have experienced trauma and find the systems and attitudes insufficiently flexible to meet their needs.[23,24] When women have experienced both hospital and home birth, their experience of birthing at home was more positive than hospital.[25] These researchers concluded a need for genuine choice, and the "importance of care which is respectful and responsive to divergent ideologies about birth".[23] This echoes work showing that ethnic and social inequalities are reflected in the options offered to women.[26]

In evidence to the Health and Social Care Committee, Birthrights stated that they were "concerned by the ongoing risk that focusing on too narrow a definition of "safety" – one governed solely by policies, procedures, checklists, monitoring and equipment leads to the sort of inhuman, conveyor belt maternity care described by women in the Better Births report".[27]

When adverse events occur, we must be thoughtful about assuming that the later identified risk factors should have excluded a woman from a particular care setting. Perhaps the initial risk assessment was inaccurate, and the woman was not given

correct information on which to base her decision. Perhaps the risk factors were not shared with other members of the care team, or acted upon, to provide the best care. Was the care continuously monitored and reviewed as labour progressed, with adaptations made to the care plan as risk status changed, and were communications between teams and locations effective?

Women used to experience a lying-in period, with traditions of sister or neighbour care, often the same people who supported them during labour. Now, most will experience care within the NHS establishment, and will be encouraged to return home promptly to a family who can theoretically provide better support than they will get on the postnatal ward. But 'well enough to go home' is often understood as 'well' which, given that maternal mortality is greater after birth than before or during, puts women at greater risk.

For the infant, we know that breastfeeding is positively affected by birth at home,[28] and potentially

protective against longer-term health conditions.[29] Where partners are actively involved, which may be more likely in an out-of-hospital setting, their experience of birth is also more positive.[30]

What about the cost?

Some people feel that the individualised care at a home birth, for example, would be more expensive than in hospital, and that it is 'selfish' of women to ask for such personalised care. It is useful to know that around the world birth in hospital is known to be more expensive for the service, as well as physically and psychologically costly for the women.[31,32] Maternity services should "re-orientate themselves to provide choice of place of birth", because "while the cost savings would be attractive to planners, the central driver of service redesign should be to safely meet the woman's physical, social, and emotional needs".[33]

Perspectives on risk

Our values and attitudes to risk matter too. People who choose an out of hospital setting, with either low or high-risk factors, and with or without midwifery care, may be making a more active and informed decision than those who opt for hospital and may have a mindset that leads them to be better prepared physically and emotionally for the challenges of labour and birth. Fear based choices do not protect, and for these people, choosing a place of birth can be a composite of balancing physical and emotional risks, and encompassing cultural safety in addition to what works best logistically for the family.[34] Excessive talk about 'risk' can be considered coercive, and lead to women disengaging from maternity services, bringing its own set of new risks.[35]

What next?

An exciting development is this year's Cochrane review comparing low risk home and hospital birth.[36] The authors identify that there is not enough evidence from Randomised Controlled Trials (RCTs) to draw conclusions - most women are not willing to be randomised to a place of birth, and studies would need to be very large to address the rare adverse events. They further conclude that as, "there is strong evidence that out-of-hospital birth supported by a registered midwife is safe, equipoise may no longer exist".[34]

Equipoise means that nobody can state with certainty which option is better, and is the necessary starting point for an RCT, because it would be unethical to randomise someone to a pathway known to be inferior in any way. They suggest that Cochrane will move to using well conducted observational studies in future updates of this regular review of place of birth.

For practice, their recommendations refer to "a planned home birth attended by a midwife backed up by a modern hospital system (in case a transfer should turn out to be necessary)".[34] Our problem in 2023 is that with NHS services under significant strain, the well-organised integration of out-of-hospital birth suffers, sometimes because of pressure on ambulance services. It feels bizarre that a service could not only cause more iatrogenic harm, but also cost more, because it does not act on a well-founded evidence-base.

Conclusion

The public understanding of childbirth is poor, and it is understandable that expectant parents focus on the negatives. Yet the absolute risks are very small, and "perinatal mortality rates are now so low that they are a crude measure of safety".[37] Therefore, differences between birth place locations remain very small, though this may not be how they're framed to parents.[38] Moving to the more technological obstetric environment may 'feel' safer for some parents and healthcare professionals, but it doesn't remove risk.

Even in her 1989 preface to the first edition, Tew identified that "action to reduce losses in childbirth still further would have to concentrate on improving the health of the neediest mothers",[2] and poorer outcomes in the UK remain more likely to be a result of social inequalities than either ill health or inadequate care. When women choose to birth outside the system it is often the result of trauma experienced (around 4-5% of women who have given birth)[39] or anticipated in hospital, and their need to feel a safety that goes beyond 'a healthy baby'. Integral to safety is listening to women, birthing

people and their families, meeting their psycho-social and cultural needs as well as their health needs.

While risk can change during labour, quality care will accommodate that. Well integrated services - where out-of-hospital birth is supported by skilled and experienced midwives and excellent ambulance services - are known to be safer. However, UK services were sub-optimal before Covid, and have been hard hit by staffing and organisational issues since. We don't yet know what impact this is having on safety, nor the effect of the Integrated Care Boards established in England during 2022 to replace Clinical Commissioning Groups.[40]

Dahlen states that rather than asking if home birth is safe, we should be asking if birth in hospital is safe.[10] Safety not just as an element of birth but part of a woman's reproductive life and human rights, and she states, "we need to change the embedded narrative, to embrace a definition of safety that women instinctively understand and strive for, including physical, psychological, social, cultural and spiritual safety".[10] Yes, future research needs to explore what increases risks out-of-hospital, but it should also address the financial and environmental aspects of place of birth. We can campaign for what we know is protective: well-integrated care; skilled, supported and culturally competent health professionals providing respectful relational continuity of care;[41] and adequate resources including places of birth that meet the parents' needs.

Ultimately, I'd argue that place of birth is less relevant to safety than care, and good and poor care can arise in any location. So, let's be brave, and challenge the choice architecture, which ignores individual needs and restricts access. Let's assure mothers that their care will be excellent in any location, and then make that a reality. After all, if more women were encouraged to birth out-of-hospital, what difference would that make to the stories we hear and share?

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Homebirths suspended and under review *by Katherine Revell*

Author Bio: Katherine Revell became passionate about childbirth when pregnant for the first time, back in 1994. Her first homebirth was a deeply empowering experience and led her to train and work as an active birth teacher and doula, which she did for over twenty years. She no longer works in the birthing world but keeps her passion alive by working as a Helpline Volunteer for AIMS. Please visit ninjagranny.org to find out more about Katherine's work as a Tai chi, Qigong and Somatics teacher.

During the covid pandemic home birth services were suspended in many Trusts and Boards throughout the UK. Some areas were more badly affected than others. As a consequence, the AIMS Helpline saw a big increase in enquiries from people who had just been told they couldn't have a home birth. This was devastating news. It's hard to gauge how many women were affected. We know that most people don't contact AIMS - we only hear from a small fraction of the population. For the people who did contact us our strategy was to support them to argue their case in advance for a homebirth, citing their particular needs and experiences, and to stick to their guns when the time came. Often Trusts went out of their way to provide a service, so for many this was a successful strategy. However, there were incidents when only an

ambulance crew showed up, leaving birthing women in a difficult situation – should they go into hospital in the ambulance or stay home and give birth without a midwife?

Since the pandemic the situation has eased a little in terms of the number of enquiries, but now instead of homebirths being suspended, they're "under review", due to serious midwife shortages. This is even more unsettling for women planning a homebirth, as they cannot plan. It's pot luck whether there's a midwife available on the day. Over the past few months, the emphasis seems to have changed from "we'll try our utmost to support you in your home birth" to "we can't guarantee anything."

This leaves women feeling angry, let down and scared. Most people will probably just give in and accept that they have to go to hospital. Other people will get their homebirth if they persevere and are lucky. Some will stay home, hoping for a midwife to show up and then give birth with just the ambulance crew in attendance, or not even that. A few will hire an Independent Midwife (if they can find one and if they can afford it) or a Doula. Some will actively choose to stay home and freebirth.

Here is a typical letter from the Helpline Inbox:

Dear AIMS Helpline Volunteers,
I am nearly 34 weeks pregnant and due on (_____). I have been planning to have a home birth but have just been told by my midwife that the home birth service is currently being reviewed daily due to staffing levels. Therefore, they can't say for sure that they will be able to offer me a homebirth at the time I'm due. This has left me feeling distressed and anxious.

I know that legally I have a right to birth at home and cannot be compelled to go to hospital to give birth, yet these rights are being ignored.

Due to the impact of my previous traumatic hospital birth, I have found making plans for my home birth very reassuring. I have discussed the choice with my consultant and my midwife and I am optimistic that a calm approach at home will minimise the chances of a similar traumatic outcome.

I feel that I am being denied what should be a basic right to birth in the place where I will feel most safe. I cannot afford to pay for an Independent Midwife and I am now having to consider birthing at home without medical support. This is not an option I would normally choose but feel that if midwifery care continues to be declined, I will have no alternative.

Please can you help me to negotiate with the Trust. Are there any resources that you can recommend about birthing without medical support? I want to be as informed as possible so that I can make the best decisions and hopefully make my homebirth happen.
With kind regards

And here would be a typical AIMS reply:

Dear _____
Thank you for contacting AIMS and many congratulations on your pregnancy.
The homebirth situation is very much like this around the country, and the legal side of things is complex. While you have a legal and human right to decide where you give birth, a hospital Trust has no legal duty to provide a homebirth service. At the same time, midwives are still bound by their Code of Practice to attend you at home if you call them while in labour. However, they could be in trouble with their employers (the Trust) if they did so at a point when the Trust had suspended the service.

These fact sheets may be helpful: https://www.birthrights.org.uk/factsheets/choice-of-place-of-birth/,[1] and https://www.birthrights.org.uk/2018/03/07/home-birth-what-are-a-trusts-responsibilities-towards-midwives-and-women/[2] - and this article may feel relevant too: https://www.birthrights.org.uk/2022/11/03/home-birth-series-the-realities-of-planning-a-home-birth-in-autumn-2022/[3]

The suggestion we have made in the past and still offer is two-fold:
Firstly you can consider writing to the Head of Midwifery stating that you intend to give birth at home and that you expect a midwife to attend. This gives them fair warning and therefore enough time to make suitable staffing arrangements. We have a sample letter on this AIMS information page: https://www.aims.org.uk/information/item/booking-a-home-birth.[4] Please feel free to copy AIMS into any written communications.
You could also call the hospital to make an appointment to speak to the consultant midwife. A consultant midwife has more authority to tailor care to the individual and to advocate for you. It may be a good idea to keep a record of every written communication and to ask for any verbal guidance or information you are given to be confirmed in writing. This request often helps people to focus on their legal duties more clearly.

Secondly, we used to suggest that the mother (if she wishes) holds tight to her homebirth plan and, when she is in labour, has someone else call for a midwife. If they are told that no one is available, this other person can simply repeat that the mother does not intend to leave the house and that she is expecting a midwife to attend. There

is no need for them to be drawn into a debate; it is a matter of just calmly repeating the request.

We used to find that those two things almost always resulted in a midwife attending. ***This is still worth trying.*** *Unfortunately, though, Trusts are getting wise to this tactic and sometimes women are told that they have a right to give birth at home without a midwife (free birth), and to call an ambulance if they are worried. They are correct in saying that free birth is your legal right, but it should not be something you feel forced to do.*

In terms of resources about freebirthing, these fact sheets may be of interest:
AIMS: https://www.aims.org.uk/information/item/freebirth,[5] and
Birthrights: https://www.birthrights.org.uk/factsheets/unassisted-birth/[6]
Some women are handling this uncertainty by having a contingency plan. They may hire an experienced doula to be with them at home so that if a midwife does not arrive promptly, they feel supported (https://doula.org.uk/).[7] They may also read up about free birth and talk with others who have chosen this option (https://caerphillydoula.co.uk/exploring-freebirth/).[8] And there is also Anita Evensen's book, "The Unassisted Baby",[9] which is useful for anyone planning a homebirth - midwife attended or not.

With any birth there is the possibility of the baby arriving before the midwife, or even before there is time to get in the car to travel to the hospital. Therefore, it is always useful to feel ready and relaxed to welcome your baby without the help of a midwife or doctor - whatever the plan.

We hope this is useful to you. Please let us know how you get on and if we can be of any further help.
With kind regards,

So where does all this leave us and where are we heading? The situation of midwife shortages looks set to continue, if not to deteriorate. For us on the AIMS Helpline it's no longer possible to reassure people that they will probably get their homebirth if they stick to their plans. It feels expedient to suggest they explore all of their options, including having plans to either go to hospital on their own terms, or to freebirth in a fully informed and prepared way. Then, if a midwife does not appear, the woman is still at the helm and her personal contingency plans can fall into place. However, this could be experienced by the mother as capitulation[10] and, in the bigger picture of things, not serve well in reinforcing women's rights to decide on the place of birth.

As staffing levels are always the reason given for not being able to guarantee that a midwife will attend a homebirth, how do we retain our current midwives and recruit new ones? Is this a question of money, investment, or job satisfaction? The RCM (Royal College of Midwives) is looking closely at this situation.[11] If money is the issue, homebirth is much cheaper than birth in hospital and could pay for itself in terms of increasing the number of midwives.[12] If job satisfaction is an issue in midwife retention, then changing models of practice, greater autonomy, more midwives and smaller caseloads seem to be the answer,[13] and worked well for midwives and mothers in New Zealand.[14]

How do we transform the system and how do we change the accepted view that a hospital is the normal place in which to give birth? In my mind these two things fit together: if homebirths were the norm, there would be more midwives; if there were more midwives, homebirths would be the norm.

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https://www.aims.org.uk/information/item/booking-a-home-birth
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A Mother's Instinct *by Deborah Ma*

Author Bio: Deborah believes that everyone is free to make their own decisions, to follow their inner guidance. She began her education in science; however, after gaining a PGCE and PhD in Biochemistry, she changed track, travelling for 4 years before starting a family and re-training as a complementary therapist and artist. Deborah now works with people who want more freedom in their lives, freedom to follow their dreams.

My first baby was born in Eire, although we were living in Dumfries and Galloway at the time, 20 miles from Dumfries - the nearest hospital.

I had my heart set on a homebirth; it was one of those 'knowings' that mothers get. I knew I must not be in hospital but, at about 7 months into my pregnancy, I was living alone in an isolated caravan, with no car or phone (way before the mobile-phone era), and the midwives who came to visit said, 'No'.

They persuaded me to visit the hospital where I was taken to meet a consultant in what looked to me like a boardroom. He completely ridiculed my birth plan - because I wanted to be outside - and then barricaded the door when I tried to leave in floods of tears. I went straight to a phone box and called my friend in Eire who told me to come to her.

Everything then happened at once. I was given a council house but this was still 20 miles away from the hospital and I still had no phone. I moved in, bought a car and an old flat bed pram, persuaded a friend to accompany me and at 8 months pregnant I drove down to West Cork.

It was so beautiful. Late June, the weather was hot, the garden lush, and I settled into the last weeks of pregnancy with friends and babies all around.
The weeks passed. I was about two weeks overdue when I started with medium but regular contractions - for two days. They really kicked in on the third evening, but other than being exhausted nothing had changed by the following morning. I was hanging - literally from anything that would support me - in the garden as it was a beautiful day again. I went into the second stage mid morning. Our midwife friend came over. The hospital was over two hours away in Cork and we didn't have a phone.

My waters broke - full of meconium - however it was obviously old and my baby's heartbeat was good. The midwife was using a cardboard tube pinard (stethoscope) that worked perfectly well. But nothing was happening except that I was getting more and more 'out of it', being walked around the garden and using tree trunks to pull against as I pushed.

Three hours of second stage later, just after midday, my daughter was born, beneath a tree. After a bit of suctioning she was absolutely fine despite a very temporarily misshapen skull. 7lb. I already had her name since the caravan days - Geminy, with Bridget as a second name to honour my friend and the country of her birth.
We had to go to Skibbereen to register her birth. The registrant was completely discombobulated - and when we saw the register we realised why. My daughter was the first baby born in West Cork for over 20 years as everyone now went to hospital in Cork City. We returned to the UK a month later.

Geminy, now 34, is so grateful to have dual citizenship with a British and an EU passport. Because of the latter, she has just been accepted for a Canadian working visa. For Brits without an EU passport, it's a random lottery.

I may have been running a risk, however, had I remained in 'the system' it is highly unlikely I would have been allowed to go two weeks overdue, or to be in first stage for three days, or second stage for three hours, especially after my baby had obviously been in distress at some point. As a primigravida mother (old at 31) I would have had medical intervention at some point - possibly resulting in a C-section. As it was, I hadn't even torn. This meant I was able to go on and have two more home births - both with three hour second stages - and both with much bigger babies.

I highly recommend Ina May Gaskin's book 'Spiritual Midwifery' for all mothers who want to trust their instinct and need to be fully informed.

For Geminy's 30th birthday we returned to West Cork for a cycling tour holiday of the Beara Peninsula, visiting Bridget, Ballydehob (the village of Geminy's birth), the house and the tree under which she was born.

Being on Hyper-alert: the observations of a doula *by Grace Hall*

Last month, I joined a mother for her appointment with a Consultant Midwife to discuss her suitability to have a home birth. The mother, I changed her name to Elise to honour her privacy, a highly accomplished professional, sought my support as a doula because she was concerned about all the aspects of her transition into motherhood, a journey that she and I consider as an important rite of passage.

What made me reflect about Elise is that, when I was listening to her, I could see a mental movie in my mind of all the births I have attended – including the ones of my own children. Watching this 'movie' made me wonder, yet again, about how I can facilitate this passage in the most honourable way; a way that will capacitate her to meet the challenges of becoming a mother.

Doulas are not here to solve women's inner discomforts for them. This could be undermining and may render women less able to recognise, understand and respond to personal triggers, which, in turn, could lead to lost opportunities for personal growth at this time in their lives. As birth workers we are simply meant to hold the physical, emotional and energetical space[1] for birthing people to go through their rite of passage and to transcend it in a way that will support them with all the challenges parenting brings. However, this is hard for us to do in the hospital setting.

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To emerge from the birth experience feeling it has been transcendental[2] - perhaps feeling stronger, wiser and better-equipped - a positive birthing experience (however challenging) is an important step. To achieve that, the ability to relax or to 'let go' to the natural forces at play, is vital.
Family Physician Dr Sarah Buckley and Obstetrician Michel Odent have been campaigning for decades about the importance of guarding the space of a birthing woman, just as it is for any other mammal, as any perceived threat will hinder the process of labour and birth. They explain how an unfamiliar territory and other disturbances during birth puts the mother on hyper-alert and this skews the balance between oxytocin (the hormone that fuels every single uterine movement that will birth the baby) and adrenaline (the hormone that reduces oxygen in the womb by increasing blood flow to our limbs and vital organs for the fight, flight or freeze response). This has

However, how can the mother let go if she is constantly being prodded and examined by people searching for any and every potential issue? How can she let go if she is constantly being offered old and new solutions that have not even been proven to be effective but are often just based on subjective opinion and policies shaped by the medical mindset?

the effect of slowing, and at times, stopping labour all together.

So, how can doulas help guard the birth space in a way that enables the mother to let go?? This is a question I asked myself as I saw that very fast mental movie and as I listened to the Consultant Midwife explain to Elise the risks of having a homebirth with low haemoglobin levels. During the explanation very few benefits of giving birth at hospital or at home were given. There was a fixation on the risks.

This is what I see every time; a fixation on the risks. The mother is worried into a state of hyper-alertness but left without clear evidence-based information about the advantages of any proposed action. For example, I heard a homebirth mother being told in the transition stage of labour, when she was almost ready to birth her baby, that her baby had opened his bowels and it was important to transfer to hospital '*now*'. This was despite the mother's and baby's vital signs showing they were both in great condition. This mother had a major haemorrhage after the birth, very probably because she was in a state of hyper-alertness.[3]

I see this too often. I witnessed a black mother being told that she should make the 40 minute journey into hospital sooner than she had wished, because her contractions

were coming every five minutes and she might not get there on time otherwise. She left the safety and calm of her home only to be told that, according to hospital policy, she was not dilated enough to be admitted. This mother panicked and went into the hyper-alert state birthing her baby not long afterwards, standing up by the door. This led to complications that required her to have major life saving surgery immediately after the birth of her baby.

I feel there is a commonality here whereby many of the procedures and policies that are meant to guard and protect the mother and her baby are actually causing these complications.[4] The continuous monitoring that puts mothers into the hyper-alert state every time they move and baby's heart rate is not picked up by CTG machines; the induction for postdates without any other clinical indication but *just in case* (with about half of these procedures ending up in instrumental birth or caesarean section); the sweeps; the prophylactic antibiotics; and the active management of each and every step of labour; all of these have implications that quite often lead the mother further and further away from the peaceful, calm birth they had imagined.

These procedures, these modern but often unproven 'rites of protection', can indeed save lives when there is time to know the pregnant person and understand their health and emotional particularities in advance. I have seen appropriate medical support working so well. Mothers birthing in hospital, birthing centres and at home, being listened to and heard. Birthing practitioners collaborating with birthing people to provide tailored solutions for health issues that could impact labour, birth or the health of mothers and babies. But medical procedures applied routinely by people the mother is meeting for the first time, especially when fear is used to gain compliance, take her out of her calm birthing zone and even further down the medical route.

By contrast, I remember a homebirth mother whose placenta was not born until three hours after the birth of the baby. The midwives called the hospital and then explained to the mother that their shift had just finished and that they could not continue to support her at home. They said that she would need to be transferred to hospital for the birth of the placenta. Instead, the mother and I went into the bathroom and closed the door. Unwatched and private, able to relax and let go in her bathroom with the familiar aromas, warmth, silence and physical contact with her baby and partner, the placenta came away immediately.

I wish you could hear about the home birth mother I supported recently. She was so deeply into her zone that there was not even enough time to call me. I have seen a few of these now. Women who simply trust the natural rhythms of their body; the natural rhythms of labour.

They talk to their babies and I imagine the babies listening to their mother's voices

Without any conscious thought, they allow their instinctive movements to make extra room for the babies as they travel from the womb out into the world.

humming through the uterine waves. When the mother's birth space is adequately protected, mothers simply get on with it. They wait, they walk, they cry and laugh, they lose hope and they find their second wind. Then they give birth to their babies and feel elated. Birth is beautiful when women feel completely supported and are able to make space for themselves and their babies.

Working with many women over the last few years, I have also had to face my own challenges. Challenges of the romanticisation of motherhood and of taking total responsibility for looking after myself before seeking external answers. I had to come to understand that a medical practitioner's uniform does not automatically equal compassion, common sense, competence or integrative knowledge. Medical practitioners may know about medicine, but labour and birth goes beyond that – it digs into the depths of the mother in places she never imagined. Undisturbed birth is truly magnificent to see.

I also see, and I feel on my skin, both sides of the perception of medical practitioners and of the families that I supported.

Many midwives and doctors welcome the presence of a doula as an advocate, space holder and pregnant person's support. They cheer us, and appear to sometimes even wish that they could share our role and our experience - that they could share in using the encouraging words that we say, the dim lights, projectors, smells and visual prompts that change the environment to a safe haven - that they had time to offer massage and drinks and to never ever move away from the birthing person's side. Conversely, there are other midwives and doctors who feel undermined even before we doulas open our mouths. Now they feel that there are keen eyes looking at what they are

doing, and at how or if consent is being gained. When questions to the midwife or doctor are not answered clearly or objectively, parents seek contact with our eyes to understand what they are being told. We are their continuity of carer; they turn to us. Sometimes parents tell me after the birth that they felt too scared to even put their questions to the midwife or doctor, and then ashamed that they did not. This atmosphere of mutual unease and distrust leaves the mother in that state of hyper-alertness that is so bad for her.

I feel that supporting other mothers like me is my life-mission, but when they start their labour from this place of hyper-alertness, things often end in a way they would have hoped to avoid.

For me as the doula, I am bound to the parent's journey – always respecting their will and bringing calm to the environment.

But in the medical birth setting this is increasingly hard to do. Nevertheless, my role is to support the birthing person's autonomy as they go through their rite of passage solving their internal dilemmas independently, never alone, but with sovereignty so they can continue to do the same as parents.

[1] Editor's note: Energetical space refers to 'the vibes' being exuded into the space that people are in together. We all have the ability to 'sense the atmosphere' in a room, and this can be explained by the energy fields that are thought to surround each person being affected by their individual personality and mood. www.reiki.org/articles/science-measures-human-energy-field, and https://pubmed.ncbi.nlm.nih.gov/27881613

[2] Editor's note: *Transcendental* in the sense of acknowledging the potential of birth to take the mother beyond herself and thus for her to feel that it has been a spiritual experience - or perhaps an experience from which she has emerged able to see herself and the world through a brighter and clearer lens.

[3] Editor's note: The way that stress may increase the risk of postpartum bleeding is explained in this article about birth hormones: www.ncbi.nlm.nih.gov/pmc/articles/PMC4720867

[4] Editor's note: Grace is describing iatrogenic harm - the harm caused by medical care:
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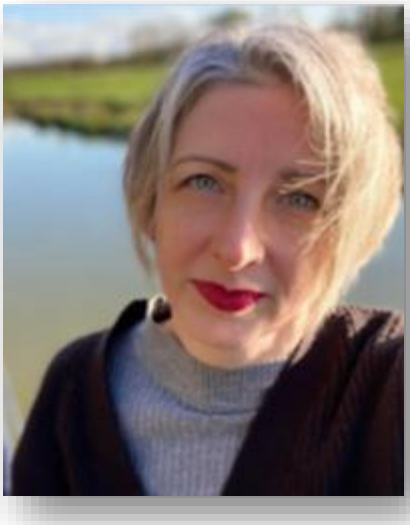
Birth Space – Supportive or Coercive? *by Shellie Poulter*



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What is important in a birth space? Low lighting, access to water and other comfort measures, a relaxing soundtrack? Or is the sanctity of a birth space about something more than the physical environment? For me, it feels of utmost importance to consider the communication and language, both verbal and non-verbal, that is used surrounding and within someone's birth space and how this may affect the birthing environment, the birthing dyad and anyone else who may have been invited in.

People speak of their birth experiences as being powerful, life changing, affirming, amazing, but they also speak of these experiences as horrific, traumatising, humiliating. How people are treated at the time of their birth is etched in their minds. The words spoken to them, and the way they were treated in the perinatal space is remembered

more vividly than the physical pain and discomfort. Were they spoken to with compassion or cruelty? With support or coercion?

Birth supporters, whatever their role, have the power to make any birth situation better through compassionate behaviour and by enabling informed consent. Likewise, we have the power to make it worse with coercion, no matter how kindly it is offered. The current system is not serving anyone. Doctors and midwives are burning out and leaving in droves; women and their babies are being caused significant iatrogenic harm.[1] [2] [3] [4] A new tub on a labour ward - that often lies empty - or some twinkling lights are nice gestures, but these gestures are not leading to long-lasting, fundamental changes in how we approach the birth space. Change that is so desperately needed for the health and wellbeing of everyone in the birth space - from babies and parents to doctors and midwives.

How people within a birthing space interact with the person birthing and their companions, is of vital importance, not just in that moment, but for the family as it is developing. Our communication and language, both verbal and non-verbal; our care to ensure true informed consent; and our capacity to provide genuine and compassionate care - all are crucial for the short and long-term well-being of all involved. In the seventeen years I have been in birthing spaces, I have witnessed genuine and compassionate care, but I have also witnessed gaslighting, coercive control, and obstetric violence. When I have questioned these behaviours or highlighted them, I have often been met with aggressive defence, attack, or denial. It is essential that we find a way as a community to reflect on how we can improve women's experiences. There currently exists a belief within the healthcare system that women have unrealistic expectations of birth – and that it is these unrealistic expectations that are leading to high rates of post-traumatic stress disorder (PTSD).[5]

However, PTSD is more likely to occur following events which are perceived to have been intentionally perpetrated rather than those following accidents,[6] which is particularly pertinent in the context of childbirth.[7] Research shows that women are more likely to be traumatised when the level of care - rather than the events of birth - do not meet their expectations.[8] The difference between birthing people's expectations of their level of care and their actual experience has shown to be predictive of PTSD.[9] There is substantial research demonstrating that support during labour and birth improves both physical and psychological outcomes for the birthing dyad.[10] Women who are traumatised often describe interactions with staff that left them feeling rushed, bullied, judged, ignored, or that access to pain relief was actively withheld or delayed when requested. The Journal of Perinatal Education cited that up to 45% of new mothers report experiencing birth trauma.[11] Research also shows that many maternity

staff are suffering secondary trauma.[12] This is not acceptable for families, and it is not acceptable for maternity staff.

At the same time, with many midwives and doctors suffering secondary trauma, their language is frequently aimed – not to communicate and form connections - but to control and coerce people to choose the path that feels safest to them (the doctor or midwife).

We are innately programmed to be compassionate and work as a team for our survival.[13] There are reward mechanisms in our physiology, whereby it *feels* good to help people. We are also programmed to protect ourselves from danger. When we experience trauma or sense danger, even unconsciously[14], our higher brain function shuts down and our fight, flight, freeze, fawn response kicks in. The danger does not need to be overt; it can simply be hidden in the words used to gain the mother's compliance. Even the label of 'high risk' is sufficient to trigger a response. It is an automatic response taken care of by the autonomic nervous system. One understanding of this, Stephen Porge's Polyvagal Theory,[15] may be helpful when considering interactions within the birth space.

Polyvagal theory describes a three-part hierarchical system that has evolved over millions of years. The Parasympathetic Dorsal Vagal system – playing dead or dissociating – is the most primitive form of defence. The sympathetic nervous system - enabling the fight, flight, fawn responses - gives protection through action. And the ventral vagal system - connecting, interacting and communicating - enables the most developed responses for remaining safe.

The Fawn response[16] is particularly interesting in terms of understanding behaviours in the birth space, as the response is heightened in a high oxytocin state, indicating that birthing people may be more susceptible to coercion.

This lack of connection is a further self-protective behaviour, associated with compassion fatigue and burnout, which are at elevated levels in maternity care.[17] Although there is widespread agreement that it is unethical to perform medical procedures without informed consent (or by using undue pressure or coercion to gain consent), there is widespread evidence that it occurs across the world. In a recent Dutch study, 7% of women reported unconsented vaginal examinations, 36-38% unconsented foetal monitoring and 42% unconsented episiotomies.[18] Women both in the Netherlands and the UK report minimal information provision and lack of choice regarding procedures such as episiotomies, which can be experienced as distressing

and can play a significant role in self-reported negative and traumatic birth experiences. [19,20] Informed consent means that the person must be given all of the information about what the treatment or procedure involves, including the benefits and risks. Reasonable alternatives should be discussed, as should the likely repercussions (if any) of declining the procedure. It should be made clear to the birthing person that participation is voluntary and that their consent, if given, can be withdrawn at any time, without giving a reason and without cost.[21] In the UK informed consent is a legal requirement for any medical procedure and is reinforced by professional guidelines. Treating without valid consent may be considered an assault or battery and a case can be made for civil or criminal proceedings. Yet I was recently told the following by a former midwife: "I always remember my colleagues looking confused as to why I would go into such detail explaining the true risks and benefits of vaginal exams to women.

What does informed consent look like?

Here are two different examples of how maternity staff might use language in the same situation.

Example 1. Using language to coerce
"We need to know where you are in your labour in order to admit you. It is hospital policy that you need to be four centimetres dilated; just so you know before we start, there is a very small risk of infection, or accidentally breaking your waters. So if you're ok to just hop up on the bed and we can do a little vaginal exam? Don't worry I can close the curtain."

Example 2. Gaining informed consent
"I don't see a preference here regarding vaginal examinations (VEs) in your notes. Is it okay for me to speak with you about them now? If you need me to pause at any time, just let me know. You can decline for any reason and at any time and I will support you in your decision. I would like to offer some information for you to make the decision that feels right for you. You are welcome to ask questions or ask me to stop at any time.
It is an expectation of my role to offer you a VE every four hours under the hospital policy and guidelines; however it is not evidence-based to assess labour progress in this way. Current evidence shows that the understanding of labour progress patterns on which the policies are based is not correct,[22] but this form of monitoring is still widely used under NHS guidelines.

There is no evidence that vaginal exams can accurately assess labour progress or outcomes for you and your baby.[23] There is evidence that they may negatively influence your labour progress and that the risk of infection to your baby is increased with each

subsequent examination.[24] *Some people like to know an estimate of the dilation of their cervix, even though it doesn't give an accurate indication of how long the labour will take from here, and most report being 'satisfied' with their VE experience.*[25] *Others find it painful and or embarrassing,*[26]*and for a few, a VE is associated with PTSD.*[27] *So, it is completely up to you.*

What the cervix is doing at the moment of a VE does not indicate what the cervix is going to do in the future. Therefore, the findings cannot effectively inform decisions about pain medication or other interventions. The measurements are subjective and inconsistent between practitioners: The accuracy between practitioners is less than 50%.[28] *A VE can result in accidental rupturing of the membranes: It is not uncommon to accidentally break the amniotic sac and this alters the birth process and increases risk for the baby.*

If you decide to go ahead, I would like you to understand that you can remove your consent at any time and for any reason, you can tell me to stop or signal to me to stop and I will immediately remove my hand and that is absolutely fine. There are other signs of labour progress that we can look out for that do not involve a VE. Do you have any questions or want me to explain anything further? I can give you some time to see what feels right for you."

A BioMed Central (BMC) pregnancy and childbirth paper explored women's descriptions of childbirth trauma relating to care provider actions and interactions.[29] Four themes were identified in the data: 'prioritising the care provider's agenda'; 'disregarding embodied knowledge'; 'lies and threats'; and 'violation'. Women felt that care providers prioritised their own agendas over the needs of the woman. In some cases, women became learning resources for hospital staff to observe or practise on. Women's own embodied knowledge about labour progress and fetal well-being were disregarded in favour of care providers' clinical assessments. Care providers used lies and threats to coerce women into complying with procedures, in particular, the lies and threats related to the well-being of the baby. Actions were also described as abusive and violent and for some triggered memories of sexual assault.

According to the perceptions and experiences of fathers, there was a significant lack of communication between birthing teams and fathers. Fathers experienced a sense of marginalisation before, during and after traumatic childbirth.[30]

It is important that we shine a light on the abusive and disrespectful 'care' that some people experience. We need to see and acknowledge that midwives and doctors are doing this. In my experience, many interactions with hospital staff feel akin to that of an

abusive relationship; rather than there being informed consent, there is coercive control. How can we recognise the difference? Defined by Women's Aid Federation of England, coercive control is 'an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'.[31] Examples of this in maternity care may include the following.

1. Isolating you from friends & family: "*Your partner must wait outside whilst you are in triage*."
2. Closely monitoring your activity: "*We need to monitor x, y, z or your baby might become distressed or die*."
3. Denying your freedom: "*You have to wait until the doctor has spoken with you*", or "*You can only have a home birth if it is signed off by the consultant*."
4. Gaslighting (claiming it's your fault your baby might die): "*Look at that monitor, you can see when you are pushing you are hurting your baby, you need to stop pushing*." (said to a mother on a synthetic oxytocin drip)
5. Constantly criticising you, putting you down: "*If you think it's bad now, wait until it really gets going; you are only 2cm dilated*."
6. Forcing you to live by their rules: "*You cannot get in the pool until you are 4cm*."
7. Parental alienation, turning your baby against you: "*Your baby is getting tired now, you need to let us cut you, it is in your baby's best interest*."
8. Policing your lifestyle/choices: "*Your BMI (body mass index) is rather high, you won't be allowed a water birth*."
9. Making jealous accusations: "Well, we'd all like a natural birth but…"
10. Depriving you of access to help/support: "*We need to do a vaginal exam before I let you have gas and air to make sure we don't run out*."
11. Regulating your bodily autonomy: "*No drinking or eating in case you need a caesarean*."
12. Making violent threats: "*We'll cut you if you don't get your baby out on the next push.*"
13. Blackmailing you (pretending to be trustworthy to get information to use against you): "*Was your birth really a BBA (born before arrival) or was it an intended free birth?*"

I have either witnessed these points first-hand while with my clients, or they are things that were said to me by clients relaying past traumatic birth experiences. The trauma in a birth space is felt by everyone there, including mothers, birthing people, partners, babies, doulas, doctors and midwives. Many people don't want to acknowledge that this is happening - or even to think about it - because it feels so awful and it is happening to such a great extent.[32] If we can't talk about it, how can we change it?

As a doula I work with people from different ethnic and socio-economic backgrounds, both privately and with charities.

The disparity between how middle-class white families and other ethnic communities are treated within the birthing space (even with a white middle class doula present) is obvious and chilling.

If English is not the first language, this disparity, in my experience, is exacerbated. These are a few examples of interactions I have witnessed whilst supporting women who have a first language other than English:

"This woman [your doula and birth partner] needs to leave and you need to birth alone." [Midwife to mother as the midwife entered the room for the first time.]
"I am assuming this child has a different father to the last one." [Midwife to mother during the initial stages of admittance for induction.]
"I am going to cut her; it is in her best interest." [Midwife to colleagues in mother's hearing as midwife approached the mother's perineum with episiotomy scissors without any attempt to consult with the mother before approaching.]

In the birthing population, 26% of women say they felt they were not always involved in decisions about their care during labour and birth.[33] However, when women seeking asylum in the UK were surveyed,[34] 77% said they were not involved in decisions about their care and 87.5% had outstanding questions about their care. When the same cohort received doula support, only 25% said they did not understand everything about their care and only 27% had outstanding questions.

What does compassionate care in the birth environment look like? It requires an individualised approach, as we all have different values and place importance on different things. I believe it benefits from good antenatal education, where there has been time for exploration of birth, of what medical care may be offered and the implications of this, and of alternative approaches to care (although this was shown not to be essential in the Happy Baby Pilot Study)[21]. During the birth itself, there should be introductions when appropriate and a deeply held awareness that we are in the birth space by invitation and not by right. Our purpose is to help people feel comfortable, safe, and supported and we are to remain in the background unless needed. We are to

hold space lovingly and respectfully and offer information and support. The choices that feel right for the birthing person should be respected and honoured.

With the release of catecholamines at key points during labour, attention and alertness are heightened synergistically. How someone is treated during their perinatal period is therefore strongly imprinted in their memory. Childbirth experience has the potential to strengthen self-confidence and trust in others or lead to deep-rooted feelings of failure and distrust. In marginalised communities, treatment around birth has great potential for helping to begin healing discriminatory-related trauma or it has the potential to deeply compound it for the next generation.

How do you want to be remembered?
Because you will be.

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[14] Editor's note: The ability to unconsciously sense danger is referred to as neuroception. It is explained in this article by Stephen Porge. Porges SW (2022) Polyvagal Theory: A Science of Safety. *Front. Integr. Neurosci.* 16:871227. doi: 10.3389/fnint.2022.871227

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[16] Editor's note: In this context, fawning is a trauma response where a person develops people-pleasing behaviours to avoid conflict and establish a sense of safety.

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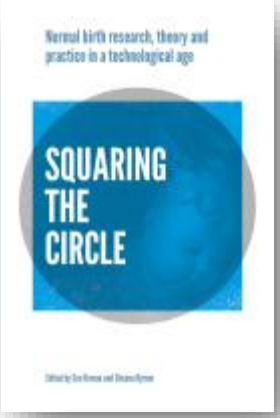
Squaring the Circle: Normal birth research, theory and practice in a technological age

Reviewed for AIMS by Mary Nolan



Squaring the Circle: Normal birth research, theory and practice in a technological age
Edited by Soo Downe and Sheena Byrom
Pinter & Martin; 352 pages
ISBN-13: 978-1780664408
Paperback, 352 pages
At time of writing, this book is £13.79 on Amazon

Any book edited by Soo Downe and Sheena Byrom is likely to appeal to birth activists, childbirth educators, midwives and women – yet members of all these groups might think that we don't need another (lengthy) contribution to the normal birth[1] debate. However, this book is exceptional in so many ways:- in the breadth and depth of its

scholarship, the profundity of its wisdom and the nuanced examination it provides of contentious issues around the nature and context of normal birth.

The book contains 27 brief chapters varying in length from seven to ten pages. This means that not only have the editors been able to include 66 contributors and many famous and well-respected names – e.g. Sarah Buckley, Hannah Dahlen, Cary L. Cooper, Lesley Page, Christine McCourt, Mary Renfrew and Jane Sandall – but they have also been able to insist on succinct, carefully written and impactful content. While it doesn't take long to read a chapter, there is so much food for thought in each one that the time spent reflecting afterwards is likely to be much longer.

The book is divided into five sections covering: The Nature and Context of Normal Birth; Philosophies and Theories; The Interconnectivity of Psychological, Emotional and Physiological States; Environment and Architectures; and Making Change Happen. It is worth reading from cover to cover. There was certainly no chapter which didn't extend my knowledge, deepen my understanding or challenge my preconceptions. Especially fascinating for me were contributions on human rights in maternity care (Nicola Philbin and Rebecca Schiller); the 'trusting communion' of a positive birth (Gillian Thomson and Claire Feeley); approaches to pain in labour (Nicky Leap, Elizabeth Newnham and Sigfríður Inga Karlsdóttir); the space and place of birth (Neel Shah and Nicoletta Setola), and a global perspective on respectful maternity care (Nicholas Rubashkin and Elena Ateva).

My only quibble with the book is its title. The editors explain in their introduction that they set themselves the task of 'squaring the circle of our multiple perspectives, beliefs and experiences' with 'our' referring to four 'scientific groups': obstetrics, midwifery, medicine and neurosciences; biomechanics and engineering; psychology, sociology and public health, and philosophy and activism. A diagram which I don't find especially helpful, illustrates this 'squaring the circle' concept. It takes a subtitle (which unfortunately is in a much smaller font than the title) to indicate what is 'in the can', i.e. 'normal birth research, theory and practice in a technological age'. A title as uninformative as 'squaring the circle' may lead to the book being dismissed by the busy potential reader from academe, practice or activism without further investigation. I strongly hope that this is not the case because if every person walking beside childbearing women and people read and acted on this book, the experience of bringing a baby into the world would unquestionably be transformed for the better.

Dr Mary L Nolan, Emerita Professor of Perinatal Education, University of Worcester

[1] Editor's note: At the present time normal birth is often referred to as physiological birth.

The Lancet Series on Breastfeeding 2023 *by Laura Scarlett*

Author Bio: Laura is a birth and postnatal doula, maternity support worker and breastfeeding counsellor in training. She is a mother of two and passionate about supporting women through their transformation into motherhood. All views are her own.

"Breastfeeding is not the sole responsibility of women and requires collective societal approaches that take gender inequities into consideration." The Lancet Series on Breastfeeding, 2023.

The World Health Organisation (WHO) has an ambitious target: for 70% of mothers to exclusively breastfeed for the first 6 months of life by 2030[1]. Currently, in the UK, less than 1% achieve this goal, despite an initiation rate of over 80%. Eight out of ten women stop breastfeeding before they are ready[2], self-reporting insufficient milk supply as the most common reason for cessation. This is reflective of breastfeeding results from around the world, and, with some urgency, The Lancet Series on Breastfeeding 2023,[3] explores the forces that influence these low rates.

The series, released in February 2023, is a collection of three papers: global systematic studies of data released between 2016-2023, which highlight the benefits of breastfeeding; a review of the social and structural barriers which prevent these benefits from being realised; and an examination of the predatory and manipulative strategies used by commercial milk formula (CMF) companies to circumvent and often violate the WHO Code of Marketing Breastmilk Substitutes 1981[4] (known as The Code), in order to undermine and compete commercially against the physiological process of breastfeeding.

The series, particularly the third paper, crucially explores the neo-liberal ideals of individualism rather than collectivism,[5] and how they have penetrated the family unit,

leading to social isolation and an unfair pressure on mothers to "succeed" at breastfeeding, rather than an emphasis on the collective social responsibility to support breastfeeding mothers. These factors, coupled with a chronic lack of recognition for and remuneration of women's unpaid work, have huge implications for the sustainability of breastfeeding. The failure to recognise the benefits of breastfeeding and provide the structural and social support required to facilitate higher rates of breastfeeding, has impacted the human rights of women and children, the motherhood pay penalty[6], and global and environmental health.

In its 2016 series on breastfeeding,[7] on which this series is built, The Lancet estimated that exclusive breastfeeding would prevent 823,000 annual deaths in children younger than five years worldwide, as well as 20,000 annual maternal deaths from breast can cer[8].

Yet fewer than half of newborns are put to the breast within the first hour of life, with 1 in 3 receiving pre-lactal (foods given to newborns before breastfeeding) feeds. This practice leads to an increased risk of cessation of breastfeeding and poor health outcomes.

The Lancet does not blame mothers or children for this shortfall, but instead the commercial milk formula companies and their rapacious commercial practices, which have captured women, families, communities, health practitioners and governments at a global level.

Over decades, since 1865, these companies have exploited women's insecurities about their ability to feed and satisfy their babies, by pathologising normal infant behaviour such as crying and needing regular feeds, and by portraying "…breastfeeding, and thereby women's bodies, as inherently difficult, unreliable, and inconvenient."[9] Commercial milk formula, presented as the magic bullet solution to a range of normal infant behaviours (which don't need fixing), capitalises on parental uncertainty to exploit "…emotions, aspirations, and scientific information with the aim of reshaping individual, societal, and medical norms and values."[9]

The series examines how CMF (commercial milk formula) marketing practices are in direct violation of The Code, the only food marketing regulation in the world, as well as at least three of the human rights of women and children, including: the right to access impartial and truthful information; a child's right to health; and a child's right to life, survival and development. Over the years, CMF marketing tactics have embedded a

distrust of breastfeeding within communities and even health care systems, increasing reliance on CMF and causing profits to soar.

Indeed, the Lancet draws meaningful attention to sales of CMF which have grown by over $50 billion USD in four decades. With profits so large, the CMF industry wealth is equivalent to the 62nd largest economy in the world.

The CMF marketing spend is huge, and growing, accounting for 16.7% of net sales, approximately $627 million USD per year. There are just six CMF companies that dominate the CMF market, with one other huge competitor: breast milk.

While these companies fight for their "share of the stomach" by undermining breastfeeding and falsely presenting CMF as a helpful and equivalent alternative, they also serve to obscure the real barriers to breastfeeding faced by many mothers, which tend to be structural, rather than, as CMF marketing suggests, individual. This message is compounded by neo-liberal public health messaging that, "frames breastfeeding as a matter of individual responsibility and, in particular, women's responsibility alone." But how can it be an individual responsibility when breastfeeding has such a meaningful impact on the economy and global health? The Lancet estimates that not breastfeeding contributes to economic losses of US$341.3 billion annually from, "increased health-care costs, reduced cognition of children who are not breastfed, and reduced workforce productivity associated with not breastfeeding." UNICEF estimates that in the UK alone, the unrealised social and economic benefits of breastfeeding could save the NHS up to £50 million per year.[10]

And that's not all: the environmental benefits of breastfeeding are huge, with 6 months of exclusive breastfeeding, saving 95-153kg of C02 per baby compared with formula. According to a study at Imperial College London, if all UK mothers were supported to breastfeed, C02 savings would equate to taking between 50,000 and 77,500 cars off the road each year. [11]

With such staggering benefits, The Lancet calls for recognition of the unpaid reproductive labour of women, and meaningful collective action within communities, health systems and governments to protect breastfeeding and breastfeeding mothers. It rejects the idea that breastfeeding is a free or costless activity or lifestyle choice for women, but instead recognises the unpaid labour of women in producing a meaningful, life-saving, food production and nurture and care system, which is beyond replication.

The third paper reports that breast milk production, if monetised, would have a commercial value of $3.6 trillion USD per year, while estimating that if the unpaid work of women were included when measuring national economic performance, it would equate to 20-40% GDP worldwide. It argues that reform is needed to factor these unpaid work burdens into policy making and recommends structural changes to relieve pressure on mothers, including fair maternity leave and pay, to adequately remunerate women for the work they do. This requires meaningful global recognition of the financial, health and environmental benefits of breastfeeding and commitment from governments to promote gender equality and safeguard the rights of women and children. It also calls for countries to implement The Code in meaningful ways to curtail, regulate or even eliminate CMF marketing strategies, while providing funding for health care providers to ensure robust breastfeeding support is prioritised and implemented within healthcare settings and communities.

The series is an unapologetic exposé on the barriers to breastfeeding, with practical recommendations[12] to support breastfeeding mothers and improve global breastfeeding rates for a healthier and fairer world.

While this is by no means the first time a light has been shone on the unethical practices of CMF companies, or the unpaid work of mothers, it is powerful to see it argued so persuasively across three robust, engaging, international papers.

However, for many health care workers and breastfeeding specialists, working at the coal face of perinatal services which have been the victims of swingeing austerity measures and cost-cutting service limitations over the past decade and more, it is hard not to wonder how realistic these series recommendations are. While it's essential to understand the inner workings of CMF marketing strategies and to consider the unpaid care work of women, including how much breast milk production is worth, it is difficult to see how this insight can reverse the generational damage caused by the collective and systematic betrayal of mothers in the global failure to support breastfeeding.

There are few more emotive topics than how a mother feeds her baby and the feelings of failure and guilt caused by the early cessation of breastfeeding can make any criticism of CMF feel like a personal attack. No loving mother wants to harm her baby; in fact CMF is often deployed to avoid that risk, and in some cases, rightly so. But for those who have been undermined and misinformed by CMF marketing tactics, the reality can be (understandably) hard to accept. However, this series isn't about the individual

women who are navigating the difficult cultural and pragmatic issues surrounding how to feed their babies. It's about how breastfeeding is prevented by the prioritisation of profit over health and a collective societal and governmental failure to defend the rights of mothers and babies and health of global populations.

The series ultimately looks towards a world where parents and families are supported in the care of their infants, where breastfeeding is robustly promoted, supported and protected at all levels, and in which predatory CMF marketing practices and the systematic undermining of women and children become a memory of the past.

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Environmental cost of formula milk should be a matter of global concern | BMJ
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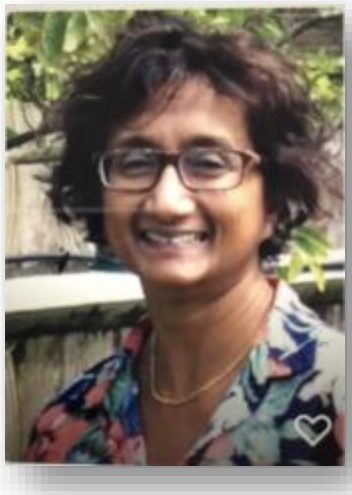
Facilitators and barriers to the implementation of a physiological approach to care in labour

Editor's note: In this article, PhD student Florence Darling shares the findings of her study that looks at the facilitators and barriers to the implementation of a physiological approach to care in labour. Florence presented these findings at the international labour and birth research conference in April this year and is now completing her thesis.



Author bio: Florence is a semi-retired midwife and PhD Student. She has a BSc in Midwifery (First), an MSc in Public Health and an MSc in Clinical Research Methods. Her PhD research was supervised by Professor Christine McCourt and Dr. Martin Cartwright and was funded by The Worshipful Company of Saddlers, City University of London.

No blades of steel,
No pulls nor tugs,
It comes when the time is right,
I bring it forth from me,
Time, time, endless as it may seem,
Time is all I need.
By Florence Darling

Introduction

The AIMS position paper on a physiology informed maternity services states that a failure to recognise the link between safe care and an understanding of physiology can result in ways of working that routinely disrupt, rather than protect, physiology. Practices may include inappropriate medical tests, interventions, and treatments with little consideration of the iatrogenic harm,[1] both physical and emotional, that these can cause.

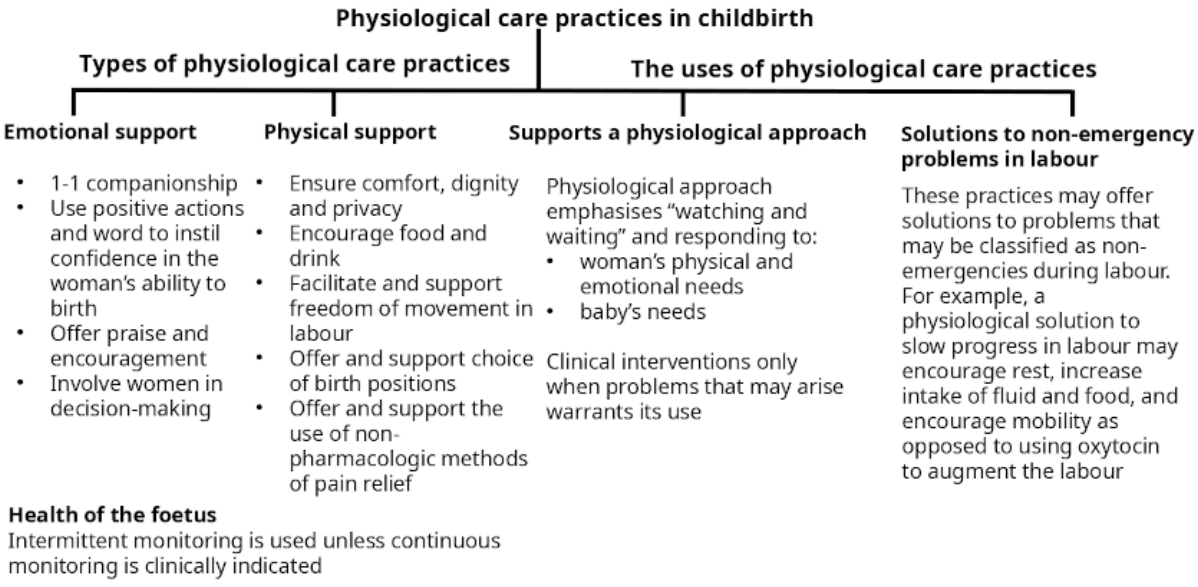
Whilst recognising the importance of providing "timely, safe and effective medical treatment when this is beneficial and wanted", the AIMS statement reflects deepening concerns about the increasingly routine use of clinical interventions in childbirth. Despite evidence of iatrogenic harm to women and babies, an interventionist approach

using routine risk surveillance and clinical interventions to actively manage labour is entrenched and difficult to shift (Miller et al., 2016).[2] A physiological approach, recommended to address this problem, is also identified as varied in implementation (McFarlane et al., 2015).[3] In a physiological approach, care practices during labour use expectant management of watchful attendance, responding to the woman's and her baby's needs; informing and using interventions only when there is a clinical indication (De Jonge et al., 2021).[4]
This article describes my PH.D. research that speaks directly to this issue.

The research
The two aims of my research were:

1. To assess midwives' use of and competence in physiological care practices
2. To explore and understand how facilitators and barriers at an organisational leadership, professional group (midwives and obstetricians) and individual (women) level influenced the implementation of a physiological approach.

This research took place in two obstetric units (OUs) at a merged London NHS Trust. The researcher observed twelve labours and undertook familiarisation of guidelines to support decision-making during labour. Interviews included: two consultant midwives and two consultant obstetricians who collaborated to drive implementation of a physiological approach at an organisational level; 16 midwives engaged in implementing physiological care practices; and 12 women and their birth partners about their experience of labour care. Observations also included one mandatory training session for midwives in developing competence in a physiological approach.



This was followed by an analysis of quantitative and qualitative data before integrating and comparing across datasets to generate findings.

Findings

Organisational leadership:

Facilitators

The committed leadership of consultant midwives (CMWs) who collaborated with two consultant obstetricians (COBs) was evident in ongoing work to resource and implement midwife-led models of care, for example: the continuity of carer model; training to develop a skilled autonomous midwifery workforce; and providing opportunities for women to develop personalised care plans. However, their ability to prioritise, resource and upscale this work was described as difficult; and their interactions to implement a physiological approach in practice were met with resistance from midwives and obstetricians.

Barriers

Resourcing decisions that prioritised an obstetric framework of care were described as a barrier.

> **"We need to move away from obstetricians do high risk and the midwives do physiological birth. We do need to get rid of midwifery units and change the way we think about birth – we should be able to have one unit where women can come in without this divide" (Consultant**

"Organisational priorities were orientated towards allocating resources to obstetric specialisms and research aimed at reducing stillbirths, pre-term births, [and] admission to neonatal units. They do not recognise that a social model of midwifery could also achieve these outcomes" (Consultant Midwife)

In practice, learning in risk management was more widely resourced than learning in a physiological approach.

Time allocated by the consultant midwives to provide clinical support in practice to develop competence in a physiological approach was limited by their responsibilities at organisational leadership level.

Consultant obstetricians described engaging in role modelling a physiological approach; and were supportive of implementing continuity of carer models. However, one described midwifery units (MUs) as creating a divide:
Consultants described a preference for collaborative working and caring for all women on the OUs. However, one stated that obstetricians were, “the experts in intrapartum care;” and the other stated that a centralised approach to risk surveillance was necessary to ensure safe care. Their views suggest a supervisory rather than a collaborative model. In contrast, based on their experiences of interactions to implement a physiological approach, the consultant midwives emphasised that midwifery units and care in the community were needed to remove women from the ‘obstetric gaze,’ with obstetric care accessed only when deviations from the norm occurred.

Both consultant midwives described implementation in the OU as varied:
“Depending on the leadership in those areas, midwives who want to make change, support different behaviours or practices can either feel empowered or disempowered. The leadership changes on a day to day basis and depending on who your Labour Ward (L/W) coordinator is you either feel empowered or disabled” (Consultant Midwife).
Most labour ward coordinators were observed and described as embedding an interventionist approach:

“You are newly qualified, and you are asking for advice and even then they do not nurture you to make your own decisions – they make the decisions for you and that is the decision that is made” (Midwife)
“I wouldn’t imagine any of them, if they were looking after a woman, using a birth stool or upright positions. That will help you to imagine how it’s hard for us as new midwives to come and say, 'let’s do this and this and this'” (Midwife)

Observations showed a lack of implementation and competence in several physiological care practices, for example, provision of labour support, protecting the labour space from unnecessary intrusion, use of upright positions, optimal cord clamping and facilitating skin to skin, advocating on women’s behalf and discussing informed consent for clinical intervention use. Centralised surveillance increased the routine involvement of OU coordinators and obstetricians in the care of all women.

What was observed was an approach where midwives routinely escalated the woman’s progress in labour, even when there were no concerns, to the team in charge of the OUs, and implemented decisions the team made, rather than working autonomously as lead carers of women.

Professional Groups (Midwives and Obstetricians):

Facilitators

Midwives described opportunities to work in birth settings apart from the OUs as useful in developing their competence. Midwives who chose to work rotationally across all birth settings were observed to use a higher number of physiological care practices and were rated as more competent in using these practices.

Barriers

Despite the facilitating influences of rotational working, the preference amongst most midwives was to practise in one birth setting. The consultant midwives described having "to win hearts and minds" to encourage midwives to adopt different ways of working.

In OUs, midwives described hierarchical decision-making and use of centralised surveillance as institutionalising them in an interventionist approach.

> **"You come into work, women are on the bed, on epidurals and doctors give you a plan, rather than you make your own plan. If you spend 99% of your working life here it's extremely easy to become a part of that culture."**

"Practices are deeply ingrained, they are just habitual – you end up doing things – how often do you have women on intermittent auscultation on L/W? – hardly ever, you do it automatically, put them on a CTG." (Midwife)

"They [L/W coordinator and obstetrician] were watching the CTG outside and wanted to do a ventouse. She was beginning to push well but once they were in the room it was too late. I felt they could have given her more time but once they were in the room, there was little I could do." (Midwife)

The implementation of an interventionist approach was engendered by daily dilemmas of managing large workloads; risk preoccupations; and a lack of skills amongst L/W coordinators to support a physiological approach. However, this norm was also observed and experienced by most midwives as a preference; some described it as a "more efficient" way of working.

Most midwives were observed to acquiesce, citing fear of blame if things went wrong; not wanting to feel isolated and not receiving clinical support; and being respectful of labour ward coordinators. Rationalisation by midwives to manage cognitive dissonance[5] that arose from having to implement an interventionist approach that they disagreed with included, for example, wanting to work in a collegial manner, "we do not

wait on the OU, we need to be seen to be progressing labour," and describing practices like lithotomy positions as useful in hastening birth. Time and resourcing for learning activities in classrooms and clinical practice was limited; and group appraisals to reflect on practices were absent.

Women and Partners:

Facilitators

All 12 women described plans to experience a physiological labour and birth. During labour, their actions demonstrated their resolve with the support of their partners to achieve a physiological birth.

For example, in one labour I observed a birth partner negotiating a longer wait when contractions slowed after an epidural insertion, rather than agreeing to immediate intravenous syntocinon. This was despite opposition from the obstetrician.
Obstetrician: "What are you expecting in 2 hours? Do you want an infection?"
Partner- standing his ground: "I do not think we will lose anything by waiting two hours."
Obstetrician: Bleep sounds - she leaves the room.
Partner (head in his hand): "I am so against interfering in a normal process." He worries about what will happen if nothing happens in 2 hours.

In another example a woman told me that the only thing she did not want was an episiotomy. In my observations, during her labour, the obstetrician stood at the end of the bed, gloved up with a ventouse trolley by his side. The woman was pushing in a recumbent position. The midwife held a pair of scissors, baby's heartbeat was slowing down (baby's head was at the perineum and advancing):
Midwife: "I am sorry, but I need to do a small cut."
Woman: "No! No! No!" And during her interview recounting the experience she said, "I was like - no way. I will push my baby out."
Women were not observed to present barriers but rather to be facing them at organisational and professional group levels.

Barriers at organisational and professional group level to women's experiences of care

Women and their partners described not having time to discuss their plans for birth with midwives in antenatal clinics. Antenatal education was described as, "being talked at." Most women developed their plans through conversations with friends, relatives and research on the internet.

The women said they understood why MUs were recommended for their birth, but the main reason given for choosing the OUs was:
"Lots of the people we know have had complications. It would be better for us to be on the labour ward in case there were problems. The level of care should be the same wherever you go, instead of 'why are you here? You should be going to the birth centre'." (Woman)

Midwives were observed to continue to encourage women in labour and during its progress to move to the MUs. However, those who opted to stay in the OUs were not always supported to use a physiological approach, for example pharmacological pain relief options were routinely offered instead of options like the use of water that was available on the OUs. One woman said:
Midwives made assumptions that most women who used OUs were open to clinical interventions. Noting that most women will want an epidural at some point during their labour, one midwife said:
"Quite often, if women do not want an epidural, they will tell you if they want to stand up and be walking around. But I don't think she [woman whose labour was observed] would have done that."

"I did not want the epidural, and it seemed I had no choice. I could only use the OU if I used the epidural." (Woman)

This was also given as a reason for not moving the bed away from the CTG monitor to create space and encourage mobility because women on epidurals will need to be continuously monitored.
However, only two out of the 12 women wanted to use an epidural.

Other aspects of care, for example, support in labour, were described as the partner's responsibility and most midwives were mainly observed to engage in technical tasks.
"They forget how reassuring it can be, especially for someone who is doing it for the first time to have someone there, instead [you have] someone who is focused on admin work, leaving you on your own" (Birth partner)
"In terms of supporting the woman's needs in labour, this was not there. If I had not received support [from my husband] I would have gone for the epidural or something" (Woman)

These women's involvement in decision-making was also observed to be limited by centralised surveillance because discussions about their care frequently took place outside their room next to the white board and centralised CTG monitors:
"The midwife kept leaving the room to talk to doctors. They had updates happening outside the room. They should come to the room to discuss our care" (Partner)

Women expressed surprise at the involvement of other professionals in their labour and when informed of decisions to intervene.
"Up until now you have not taken me seriously [referring to the little support she received on coming to the labour ward], and now I have all these wires and bits hanging off me. You have got a ventouse out and you are cutting me [episiotomy]." (Woman)
"It was OK until the doctors came. Wow! How serious is this? Then more people came, whether they were required or not I do not know but that was the last stage of labour, were they there for support? I don't know." (Partner)

Frequently, women were informed by professionals that, "you need help" or "your baby needs help," as explanations for clinical interventions. Options were not fully explored with women and there was an observed lack of involvement and advocacy from midwives. In only 2 out of 9 labours where decisions to intervene were made, was informed consent obtained.

Conclusions
Despite a committed leadership, the resourcing and scaling up of midwife-led models of care to progress the implementation of a physiological approach is tenuous. Consultant midwives were of the view that resourcing decisions prioritised an obstetric framework of care. This is despite evidence that in midwife-led models of care, clinical interventions are reduced; care is safe and cost-effective; and in continuity of carer models, outcomes also show a reduction in stillbirths and premature births. While practice in midwife-led models of care offered midwives opportunities to develop competence in a physiological approach, in the obstetric units, an interventionist approach was progressed through hierarchical decision-making and centralised surveillance. Most midwives did not regard themselves as autonomous decision-makers and sought permission to implement a physiological approach. They were predominantly observed not to challenge routine clinical intervention use. In the current context of care, MUs and practice in other models of midwife-led care, for example, the continuity of carer models, provide an important opportunity for midwives to be supported to work autonomously, and to develop competence in using physiological care practices.

Women were of the view that they should be supported to experience physiological labour and birth in all birth settings. However, most women and their birth partners were poorly involved in decision-making, and explanations for clinical interventions used were cursory.

Midwives' lack of advocacy of women, and their lack of challenge of routine clinical intervention use, posed significant barriers to women in sustaining a physiological experience through to birth.

[1] Iatrogenic harm is harm caused by medical treatment

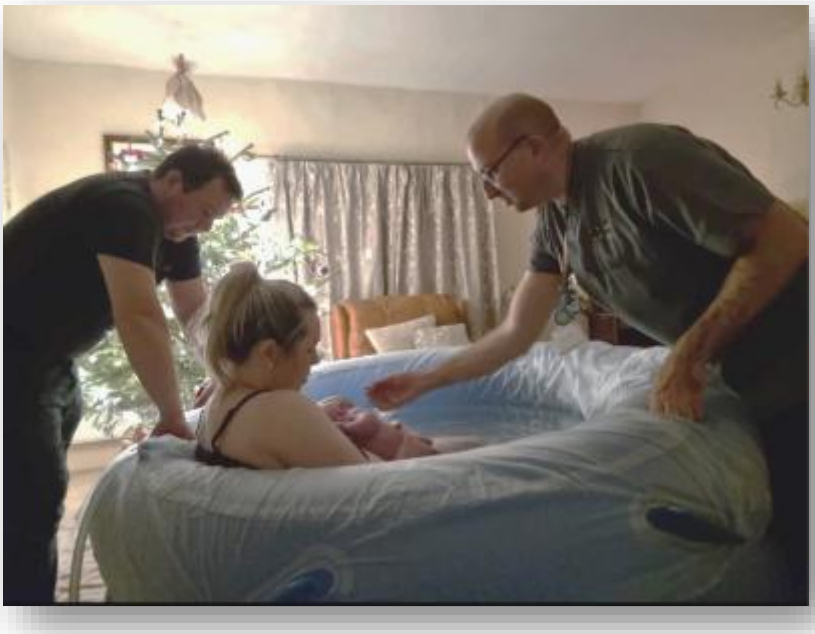
[2] Miller, S., Prof, Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., BIS, Diaz, V., Geller, S., Hanson, C., Langer, A., Manuelli, V., Millar, K., Morhason-Bello, I., Castro, C.P., Pileggi, V.N., Robinson, N., Skaer, M., Souza, J.P., Vogel, J.P and Althabe, F. (2016) 'Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide', *Lancet,* 388 (10056), doi: 10.1016/S0140-6736(16)31472-6.

[3] Macfarlane, A.J., Blondel, B., Mohangoo, A.D., Cuttini, M., Nijhuis, J., Novak, Z., Ólafsdóttir, H.S and Zeitlin, J. (2015) 'Wide differences in mode of delivery within Europe: risk-stratified analyses of aggregated routine data from the Euro-Peristat study,' *British Journal of Gynaecology*, 123 (4). doi:10.1111/1471-0528.13284

[4] De Jonge, A., Dahlen, H. and Downe, S. (2021). "Watchful attendance" during labour and birth,' *Sexual & Reproductive Healthcare*, 28, p.100617. doi: 10.1016/j.srhc.2021.100617.

[5]Festinger's (1957) cognitive dissonance theory suggests that we have an inner drive to hold all our attitudes and behaviour in harmony and avoid disharmony (or dissonance). This is known as the principle of cognitive consistency. When there is an inconsistency between attitudes or behaviours (dissonance), something must change to eliminate the dissonance.

An interview with James Bourton by Anne Glover



James Bourton is a Midwifery Team lead and clinical midwife who specialises in home birth.

Thank you for agreeing to be interviewed by AIMS, James. To begin, can you tell us what first attracted you to being a midwife, how it came about?

Midwifery is something that is part of who I am, it isn't necessarily just what I do for a living. This is a way of life for me and it sits alongside the other aspects of my daily living. I remember as a child dreaming about being in the birthing space of women even before I knew how babies were born. However I didn't immediately associate those early dreams with becoming a midwife. Of course, being a man, I didn't believe midwifery would be an option for me. When I was in my late teens, I remember travelling past the local maternity unit, looking at the building and just intuitively knowing I had to be in there. So I went in and spoke to some of the maternity staff expressing my interest in midwifery and I ended up leaving with a week's work experience. That is the beginning of my long journey into midwifery.

Can you tell us a bit about your journey and how you got to where you are today?

During my week of work experience in the late 1990's, I remember going out with a community midwife on her visits and spending some time on the postnatal ward. It was all very conventional for the time but I remember loving the experience and knowing that's what I wanted to be doing.

I became a health care assistant (HCA) in the same maternity unit. I did shifts in all areas of maternity including the labour ward. I was so lucky to be able to witness a vaginal birth and a caesarean birth on my first ever shift. It just fuelled my desire to become a midwife. Of course, looking back, I would never practise now in the way that I observed then, but prior to that, the only births I had seen were on TV drama shows, so it was exciting for me to witness birth in real life.

After about a year I was considering how to apply for a midwifery course. The Trust I was working for had sponsorship opportunities for people to apply for adult nursing and continue to be paid their HCA wage throughout the training, but not for midwifery. I ended up being accepted for sponsorship to train as an adult nurse and although this wasn't my chosen path, it was a means to an end. So, in September 2001, my nursing diploma training began. It was a long and difficult 3 years for me. Several times I nearly left nursing because my heart wasn't in it. I knew it wasn't where I wanted to be. I completed my training and luckily got a job on a women's health ward specialising in early pregnancy, gynaecology, and breast surgery.

Finally in 2006 Oxford Brookes University were offering places for nurses to enter midwifery on a 20 month BSc degree programme. I jumped at the chance and luckily I was accepted. My midwifery training began in September 2007 and I loved every minute of it. My first clinical placement was with a small team of community midwives based just outside Oxford and their base was a free-standing midwifery-led unit, (MLU). They were hot on promoting home birth and the first 3 births I witnessed as a student midwife were home births. Suddenly everything clicked into place. I had found my passion; I had finally answered my calling.

I qualified in 2009 and I spent the first six months working on a very high-risk labour ward where I had trained in Oxford. However, I found it so traumatic that it nearly ended my career due to what I was witnessing.

I eventually got a job closer to home in the same unit where I had been a HCA all those years before, so some of the staff remembered me. At that time they had no MLU so I began working a rotational post between antenatal, postnatal and labour wards. I remember being unaligned with the culture there. My views on birth differed greatly to the majority but they did respect me as a practitioner and everyone knew if they came in my room the bed would be pushed out of the way and women birthed instinctively with my very 'hands off' approach.

After a few years the Trust opened an alongside MLU and I was lucky to become one of the first midwives to work there. I felt so elated to be able to now work with women and

their families within the scope of physiological birth and the unit soon became a victim of its own success. Very quickly more midwives were needed to support the numbers of women using the facility

> However, I knew I needed to have a change when I began to burn out by literally just catching babies. Birth was becoming less 'special' because I was catching nearly 100 babies a year and not developing relationships with families either before or after. Something had to change.

Community midwifery was my next goal so off I went feeling like I could change the world and promote home birth and improve the local home birth rates that sat at around 2-3% at that time. I soon realised this was not going to happen. With a caseload of around 100 and only seeing women through a GP clinic for 15 minute appointments, trying to build any kind of relationship was near impossible and I would hardly ever see them postnatally. Being on call just twice a month also meant I would hardly ever be exposed to home birth and the few women in my caseload that did choose this option would be very unlikely to have me on call when they went into labour.

So I put myself on call more often and that increased my exposure to home birth. But it wasn't enough. I looked into becoming an Independent Midwife (IM) and undertook a course with the amazing Liz Nightingale. I knew this was my path and that I wanted to provide full continuity of carer. Then came the blow that IM's couldn't practise intrapartum care without insurance and there was no insurance package available. I was devastated!

Just when I thought all hope had been lost, an ex-colleague who had moved to Wales to live and work, had come back for a visit. She found me, sat me down and explained about their model of care and knowing my ethos, encouraged me to look at moving and applying for a job in the same health board. When I read the health boards job description and their ethos, it was a no-brainer.

So in 2015 I moved my whole life from Wiltshire, England to Powys, Wales and that is where I remain working and living.

What are you most proud of in your career to date?

This is a difficult question but I think I am most proud of the fact that I haven't allowed myself to become medicalised and I have tried to stick to my true calling, which is ultimately to be 'with woman' during pregnancy, birth and beyond. I will always put the

needs of my clients before anything else and I am not afraid to be a strong advocate for them when the need arises.

I have ensured that I am an 'expert' in physiological pregnancy and birth by constantly updating my knowledge and understanding of what that entails. Sadly physiological birth is no longer the 'norm', so I see it as the midwives' responsibility to remain competent in the skills of facilitating physiology so that women and birthing people can still have choice and that midwives do not fear physiological birth.

I fear that true, authentic midwifery is almost a lost art. The midwife of the future is now trained in a highly medicalised model where midwifery AND women's autonomy have been overridden by the mainly obstetric-led system we find ourselves in. Dare I say it, but, in my opinion, midwives are now being moulded into obstetric nurses.

James, you currently practise in an NHS continuity of carer midwifery model, covering a vast rural area in Wales. Can you tell us about your role and what you enjoy about working in this way?

So, we are a midwifery–led service covering rural mid Wales, which spans around 2,000 sq miles. We have 6 free standing birth centres across the patch and in each birth centre there is a small team of between 4- 6 midwives.

Within each team there is a band 7[1] team leader, who also has a small caseload of women, then the remainder of the team are band 6 midwives and occasionally we have newly qualified band 5 midwives. Each midwife in the team covers a certain geographical area that their birth centre caters for and those women become your caseload.

Caseloads tend to be around 35 women at any one time for a full time midwife, and less for midwives working part time. The caseload is of a mixed complexity so we provide care for women who also receive obstetric input.
As a service, we feed into around 8 different district general hospitals. Each team will normally feed into 2 different units.

We continue to work closely with our clients who receive obstetric care to ensure they are being given the correct information, based on current evidence so that they can make truly informed decisions. We remind them that they are in control of their care and what their legal rights are when it comes to pregnancy and birth choices. If women choose to birth with us 'outside of guidance,' then we ensure we support them by giving them the evidence and the 'actual risks' not 'relative risks' so that their care is

individualised to enable them to make informed choices. We then put in place a robust plan, outlining our discussions including the evidence we have used to support our conversations. This plan is given to all midwives so that if their named midwife is not available when they go into labour, the woman doesn't have to endure the same conversation.

When it comes to labour care, some women decide to use their nearest obstetric unit and will contact them directly for advice. However most units are around 30-40 miles from us, so some of these women (particularly multip's) don't make the hour's car journey and we end up catching the baby.

For women who are undecided or know they want a local birth, we will firstly 'home-assess'. This isn't a case of going in and performing observations and vaginal examinations, it's about sitting with the women, watching and waiting and making an assessment from what's going on externally. Of course, we will gently, over time, offer to perform the clinical observations to ensure fetal and maternal wellbeing. Also, most of the time the woman is seeing a known midwife, and often it's their named midwife, so we are aware of their pregnancy journey and their wishes, which means we don't have to question and disturb them while they are in labour.

It's at this point we will ask the woman where she wants to give birth, and she decides if she wants to remain at home or to move to the local birth centre. If a home birth isn't planned but she decides on the day that's where she is staying, then we are fully kitted out to be able to facilitate that choice there and then.

Postnatal care is again carried out by the named midwife or their 'buddy'. We see the women in their homes and provide an individualised approach. There is flexibility in when we offer certain screening for the new-born, so often the named midwife can work the postnatal care into their own diaries and around their own pre-planned antenatal appointments.

Midwives are encouraged to work as autonomously as they can. Planning their working hours around the needs of their caseloads and to some extent their own personal lives. Hours can be worked flexibly if that's preferred and we keep a running total of our hours in our own diaries so if we go over then we take time back or if we go under then we make the hours up when the caseload becomes busier again.

Working in this model of care is where I want to be. It's still not perfect, but close. I have covered the same patch now for 8 years so I am now the 'village midwife' and I have gotten to know many of the families in the area. I have seen many of them through 2 or 3

pregnancies and that includes the births, which gives me the most amazing job satisfaction.
I am the team leader for my team and although this gives me added responsibility, it also enables me to empower those midwives to remain autonomous and support their families in a way that is individualised and evidence based.

So tell us James, what are the practicalities of working in a continuity of carer team and how do you make it work successfully?

To work in this model of care, you have to be able to work flexibly. It really isn't a 9-5 job. Also being able to commit to 2-3 on calls per week is sometimes challenging.
It Is essential to have ownership of your own work and diary. There needs to be a trusting relationship between the management team and the staff working on the ground floor. Our management team is very supportive of our model of care and actively encourages us to work in this way.

There can also be challenges working in a small team, so communication is a must. We have monthly team meetings where we have protected time together to discuss issues about our caseloads. I provide some revision on an element of physiology of pregnancy or birth, and we also run a scenario on a specific obstetric emergency.

If we are the midwife on-call, we try to only work in the morning to ensure we have a rest break before the on-call begins. However, occasionally we can't do that if our caseload needs us. So being able to support each other is essential. In this situation, often one of the other team members will offer to triage the calls for a few hours to ensure the on-call person gets some protected time to rest.

What do you see as the advantages of the continuity of carer model of care for your clients?

Our clients are receiving a good standard of care, compared to many other areas of the UK. I think this is evidenced by the feedback we receive, which is often very positive. All women have a named midwife and have access to a team of midwives 24/7 for advice when needed. This ensures women have confidence in us and that is important when it comes to their birth.

Seeing women in their own homes and having the same midwife for each of their pregnancies, builds a robust and trusting relationship. We know this improves outcomes in maternity care and it is so rewarding for the women and the midwives.

We achieve high levels of home and MLU births, compared to the rest of the UK. Over a quarter will start their labour in our care with just under a quarter birthing with us either at home or in their local MLU. Our transfer rates are low compared to national averages and the outcomes for women and babies are not compromised by this.

We know through evidence that the CofCer[2] model improves health outcomes for both mums and babies and it leads to better birth experiences for women.[3],[4] This is important, especially as suicide is a leading cause of maternal death.[5]
We know that women who plan birth at home but then transfer to hospital are still more likely to come through birth having had a much better experience and feeling empowered and part of the decision making process.[6]

One theme of this Journal issue is place of birth. Can you share some of your experiences of this?

I class myself as a home birth midwife, even though some births are facilitated within our free standing MLU. The MLU is no closer to an obstetric unit than the woman's home, and we have nothing extra in an MLU than we have in our home birth kits, other than a fixed birthing pool, so it is basically like a home birth. Many women decide on the MLU in order to use the pool, and for no other reason.

Home is where physiological birth happens, and I am lucky to witness this time and time again. It is where I feel most comfortable in providing care to women in labour and it is where I feel most confident in my skills as a midwife providing intrapartum care. Homebirth is calm, it is raw, it is empowering. It is where women have birthed their babies for thousands of years, up until our recent history. Birth in the home works pretty well most of the time and with skilled home birth midwives, the rare deviations can be dealt with swiftly and safely in the majority of cases.

I witness the primal instinct of birthing women at every home birth I attend, and when I arrive at the homes of women who are very close to giving birth, I know exactly where they will be. In the smallest, darkest room of the house, tucked up in the corner, kneeling or forward leaning. This is physiological birth!
I have attended many births where children have either been present for the birth or they have been in another room blissfully asleep and unaware of the events that are unfolding. In my experience those children who are asleep, tend to remain asleep and often wake as the baby is born. Those children who witness a birth are never traumatised, they are instead, mesmerised and in awe of what has just unfolded before them.

The children who witness birth in this way will be empowered in the understanding that this is not a process to fear, but to embrace and see as a normal, physiological process.

AIMS continues to campaign for continuity of carer and physiology-informed maternity services in the UK. Any thoughts on how AIMS can best focus our limited resources, to help ensure improved maternity services for all?

These are challenging times for maternity services. We are deeply embedded in a culture of fear and we no longer trust birth.
The terms 'normal birth' and 'physiological birth' are now seen as threatening to some groups of people and there is a big push from government level to stamp out the perceived 'ideology of normal / physiological birth'.

We have almost lost the truly autonomous midwife; many people grow up fearing birth due to the media and television programmes depicting it as a painful, dangerous process.
AIMS has a massive challenge to combat this. My suggestion would be starting at the beginning. We need to educate our children from school age about birth and what it means to understand this as a physiological process and not fear it as something dangerous.
I fear it is too late now to turn the tide on the current maternity system, instead we need the birthing people of the future to stand up for their rights as human beings and insist on being heard.
If women and birthing people want to continue to have the option of physiological birth then they are going to need to stand up and fight for it, and equally midwives are going to need to stand up and fight for their rights to remain truly autonomous practitioners.

[1] Editor's note: Bands are related to years of experience and level of responsibility. It is explained here: www.reed.com/articles/midwife-bands-salary-uk
[2] CofCer, the abbreviation of Continuity of Carer
[3] NHS England. Continuity of carer www.england.nhs.uk/mat-transformation/implementing-better-births/continuity-of-carer
[4] Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5 www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full
[5] MBRRACE Report (2022) Saving Lives, Improving Mothers' Care www.npeu.ox.ac.uk/news/2188-new-report-highlights-persistent-inequalities-and-continued-inequitable-care-for-pregnant-women
[6] NPEU The Birthplace cohort study: key findings. www.npeu.ox.ac.uk/birthplace/results

Influencing NICE guidelines – the stakeholder role *by Nadia Higson and Debbie Chippington Derrick*

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What are NICE guidelines?

Among the roles of NICE (the National Institute for Health and Care Excellence) the best known is probably their production of guidelines to inform care. These are defined as "Evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders." In addition to this,

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it also publishes quality standards, technology appraisals that assess the clinical and cost effectiveness of new drugs or other types of treatment, and various other types of information and advice across the fields of health, public health and social care. Guidelines are drafted by a Guideline Development Group (GDG). This is a multidisciplinary group which normally includes a mix of healthcare professionals, lay members including "at least two members who have experience or knowledge of patient and carer issues", and a number of technical support people such as an information specialist to identify relevant clinical research, a systematic reviewer to summarise the evidence, a health economist and a project manager.

Although NICE guidelines can be influential, hospitals are not obliged to follow them, and neither are they rules that individual maternity service users have to accept. They are a list of recommendations about the care that should be offered in different situations. These recommendations are intended to be "based on the best available evidence", but they can only be as good as the evidence that they use or is available.

What does NICE mean by 'the best available evidence'?

NICE has a process for reviewing evidence (Identifying the evidence: literature searching and evidence submission | Developing NICE guidelines: the manual)[1] which considers the type and quality of research. This means that if there is evidence from randomised controlled trials (RCTs), evidence from Observational studies is likely not to be considered. (For an explanation of the strengths and weaknesses of these two types of research see our Birth Information page Understanding quantitative research evidence.)[2] This process also means that "When there is little or no evidence, the committee may also use expert testimony, {or} make consensus recommendations using their knowledge and experience." In other words, sometimes a recommendation is just the opinion of a small group of people.

Details of the evidence considered and an assessment of its quality can be found in the 'Evidence Review' document relating to each recommendation. However, these are technical documents and may not be easy for an ordinary reader to understand. Usually the evidence is given a rating according to the 'GRADE' system (See What is GRADE? | BMJ Best Practice)[3] which is an assessment of the 'certainty' (from 'Very Low' to 'High') that the effect estimated by the research is similar to the true effect. You may wish to check out how often recommendations are made on the basis of 'low' or 'moderate' evidence.

Initially NICE made the level of the evidence behind a recommendation very clear, but this information is now not included with the recommendations, making it very difficult to quickly judge how robust a recommendation may be. Many stakeholders, including

AIMS, objected to this change, stating how it would undermine informed decision making, but we were unsuccessful in persuading NICE to retain this information. Instead, their practice is to use standard wording which is intended to reflect the strength of a recommendation. For example 'offer/do not offer' will be used when the evidence is stronger, but 'consider' if there is "a closer balance between benefits and harms."
Sometimes there is an expandable box within a guideline to explain why a recommendation was made, which may be more informative.

Role of Stakeholders
Any 'registered stakeholder' can submit comments during the preparation of a new or updated guideline. Stakeholders can include national charities (like AIMS) who represent service users, patient or carers' organisations, organisations representing healthcare practitioners (such as the relevant Royal Colleges), providers and commissioners (such as NHS Trusts and Clinical Commissioning groups) and commercial companies with an interest in the topic. Note that there is currently no mechanism for individuals to become registered stakeholders, but many organisations, including AIMS, welcome input to their submissions to NICE.
Stakeholders are invited to give comments:

1. On the scope of the guidance

The scope sets out what the guideline will and will not include, and the key clinical issues for the GDG to address. In the case of an existing guideline, the scope identifies which sections will be updated – normally those where there is thought to be new evidence to consider.
Once a draft scope has been prepared, it is made available on the NICE website, and registered stakeholders are invited to attend a workshop to discuss the key clinical issues. They are also able to submit written comments to suggest, for example, additional issues that they think should be included. All of these comments will be considered before the scope is finalised, though they won't always be accepted. Stakeholders are sent a written response, which is also published on the NICE website.

2. On the draft guidance

Once the GDG has reviewed the evidence and written a draft of the guidance this is made available on the NICE website. This means that anyone can review the draft, but only registered stakeholders are able to submit comments.
Comments from stakeholders are considered by NICE to be "a vital part of the quality-assurance and peer-review processes." In AIMS experience they are taken seriously, and

can have a powerful influence on the wording of the final guidance. This means that the final guidance can differ substantially from the draft. All stakeholders receive a copy of all the comments made and the GDG's response to them, and this is subsequently published on the NICE website.

What AIMS tries to do as a stakeholder

AIMS is a registered stakeholder for guidelines relating to the maternity services and over the years has contributed comments to many of these, subject to having the volunteer time available. Our preferred method of working is for a group of volunteers to review the draft guideline and then get together to discuss their individual comments and agree on the wording of the AIMS submission.

Our submissions may include a variety of types of comments. We've illustrated these with some of our comments on the update to the Induction of Labour guideline, published in November 2021, together with the GDG's response to them. We submitted 65 comments, most of which were accepted. For a summary of the influence we were able to have see www.aims.org.uk/campaigning/item/nice-iol-comments.[4] The full set of stakeholder comments is here NICE comments table.[5]

Comments are more likely to be acted on if multiple stakeholders make the same point (though preferably not in identical words). For this reason we try to publish our comments on the AIMS website before the end of the consultation period, in the hope we will be able to raise awareness of our concerns with draft recommendations, enabling others to comment on similar lines if they share our concerns.

AIMS has volunteers who have been involved in providing stakeholder feedback for many years, and also some who have been involved with guideline development as members of GDG. This experience has enabled AIMS to provide feedback which is constructive and based on the way that NICE Guidelines are developed. We actively work with new volunteers to help them understand NICE processes and to be able to put together constructive feedback. We review draft guidelines to make sure they reflect the evidence and support informed decision making. We explain carefully why we feel the recommendation is problematic. Often we will make suggested wording changes that better reflect the evidence. We will also suggest wording that makes it clear that treatments and interventions are an offer, and it's up to the individual whether to accept or decline the offer. We have had many cases where our carefully considered suggested wording change, or something similar, actually appears in final guidance.

Comments to make language supportive of autonomy and informed decision-making

AIMS Comment: We are pleased to see that the Guideline Development Group has taken some care in their language to make it clear that it is the woman who is the decision-maker, but unfortunately this has not been done throughout. We would ask that all wording is reviewed to recognise the principle of autonomy and make clear that the carer's role is to provide the information to support the individual's informed decision making, NOT to make the decision for them.

GDG response: We have added an additional recommendation to the information and decision-making section of the guideline to clarify that whether to have labour induced or not is a woman's decision, and that this decision must be respected. We have reiterated this message at several other points in the guideline.

Wording in the final guideline: "recognise that women can decide to proceed with, delay, decline or stop an induction. Respect the woman's decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given. Record the woman's decision in her notes."

Requests for fuller information provided including statistics, actual risks and quality of evidence

AIMS comment: We feel that in any discussion of 'risks' women should be told what the actual risk is in different circumstances rather simply that something 'increases' the risk. Without this information they cannot make an informed decision. Baseline risks should be given for comparison, and risks should be stated in a consistent format as the actual rather than the relative risk.

GDG response: We have amended the recommendations on timing of induction for prolonged pregnancy to make the focus a discussion with the woman about the risks of earlier or later induction. We have included tables of absolute risk and details of some of the limitations of the evidence upon which these tables are based.
(These tables are in Appendix A[6] which includes the important comments that "this should not be taken as definitive evidence based on the limitations of the included studies" and "the absolute risk remains low.")
Comments questioning recommendations that are not evidence based

The draft guideline recommended offering early induction purely on the basis of race, age, BMI or conception through IVF – a recommendation which was not only discriminatory but also likely to impact a substantial number of people without any evidence of benefit. Many people objected vociferously to this on grounds of racism.

AIMS took a more measured and we hoped more effective tone, focusing on the lack of evidence to support the recommendation.

AIMS comment: We are concerned that the recommendation to consider induction from 39 weeks for women at a higher risk of complications is not evidence-based and could lead to large numbers of women having unwanted inductions purely because they fall into one of these 'higher risk' categories.

GDG Response: Based on stakeholder feedback we have replaced the recommendation on earlier induction for groups of women who may be at higher risk with the information from the most recent MBRRACE report, and there is therefore no longer a recommendation to consider earlier induction in women from these groups.

Wording in the final guideline: "Be aware that, according to the 2020 MBRRACE-UK report on perinatal mortality, women from some minority ethnic backgrounds or who live in deprived areas have an increased risk of stillbirth and may benefit from closer monitoring and additional support." Note that they have also quietly removed any mention of age, BMI or IVF as indications for induction!

Comments requesting that wording is clarified
In the original draft, the recommendations for information to be explained to women included "some methods of induction can cause the uterus to contract too frequently, called hyperstimulation, and that these too-frequent contractions can lead to changes in fetal heart rate and result in concerns about fetal wellbeing." We felt that this underplayed the potential risk to the baby's wellbeing, and that it was unhelpful to say "some methods" without explaining which ones might have this effect.

AIMS comment: We would like to see the wording "concerns about fetal wellbeing" strengthened to make it clear that hyperstimulation can cause actual fetal compromise and in some cases the need for an unplanned caesarean. It is not clear whether 'some methods' includes the use of an oxytocin drip, and we feel that the methods which have this potential effect should be stated.

GDG Response: We have amended the wording of this recommendation to state that hyperstimulation can lead to changes in fetal heart rate and result in fetal compromise {and} to make it clear that this just refers to pharmacological methods of induction (which would include oxytocin).

Wording in the final guideline: "pharmacological methods of induction can cause hyperstimulation – this is when the uterus contracts too frequently or contractions last too long, which can lead to changes in fetal heart rate and result in fetal compromise."

Get involved

If you are a member of a relevant organisation you might want to encourage them to become a registered stakeholder for any new guidelines or updates that are of interest to you. The more stakeholder organisations that comment, the more likely the GDG is to listen.

Alternatively, anyone - whether or not you are an AIMS volunteer or member – is welcome to help us review draft guidelines and compile our submission. Please check our members newsletter or join our mailing list here www.aims.org.uk/join-us to hear about these or other opportunities to get involved, or contact enquiries@aims.org.uk to let us know you are interested in getting involved.

[1]NICE (2014 - updated 2022) Identifying the evidence: literature searching and evidence submission | Developing NICE guidelines: the manual. www.nice.org.uk/process/pmg20/chapter/identifying-the-evidence-literature-searching-and-evidence-submission

[2]AIMS, Higson N. (2020) Understanding quantitative research evidence www.aims.org.uk/information/item/quantitative-research

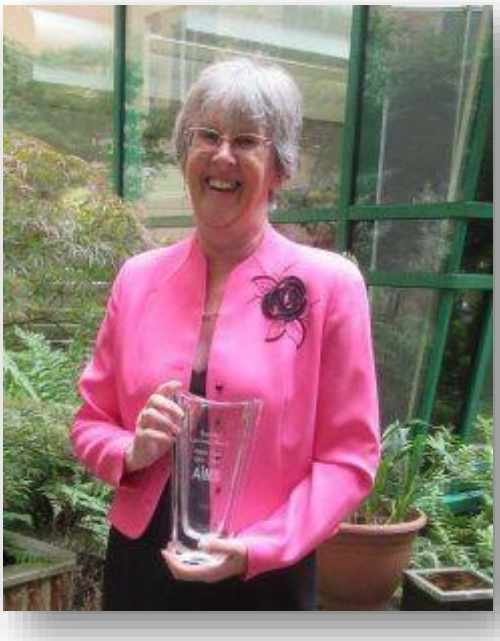
[3] BMJ Siemieniuk R., Guyatt G. (No date) BMJ Best Practice-Evidence-based medicine (EBM) toolkit-Learn EBM-What is GRADE? bestpractice.bmj.com/info/toolkit/learn-ebm/what-is-grade/

[4] AIMS (2021) NICE Inducing Labour Guideline - Consultation on Draft July 2021 www.aims.org.uk/campaigning/item/nice-iol-comments

[5] NICE (2021) Inducing labour (update)Consultation on draft guideline - Stakeholder comments table 25 May – 06 July 2021 www.nice.org.uk/guidance/ng207/documents/guidance-consultation-comments-and-response

[6] NICE (2021) Appendix A: Risks associated with different induction of labour timing strategies www.nice.org.uk/guidance/ng207/resources/appendices-a-b-and-c-10883967373/chapter/Appendix-A-Risks-associated-with-different-induction-of-labour-timing-strategies

Beverley Lawrence Beech - 12 November 1944 - 25 February 2023



Beverley joined AIMS in 1976 and was elected Chair of the AIMS Committee at the AGM the following year on 23rd April 1977. She held this role until she retired as an AIMS Volunteer in September 2017, but continued to be an AIMS member until her death.
Beverley was a women's maternity rights campaigner, a second-wave feminist and a birth activist. Her voice on issues was challenging for many, but always came from a perspective of women's human rights.
She would listen to what women and families were saying and actually hear what they had said. Then she would stand up for their rights in any way that she could: helping them personally to find ways to assert their rights, speaking out about the injustices anywhere that she could get a platform and challenging the systems which were creating such injustices.
This was the basis of the work she carried out with other AIMS volunteers over the years, and the basis of the work of AIMS today, including the AIMS Helpline, the AIMS Journal, AIMS publications and AIMS Campaigning.
She came to this work before computers or the internet were available and when everything had to be done on paper, by phone or in person. There were long periods of time where AIMS Helpline calls were all going to Beverley's phone number and letters to

her address. Beverley and AIMS were keen early adopters of these technologies as they became available and Beverley was always keen to try things that would enable her to be able to do more.

Beverley was actively involved with the AIMS Journal; not just writing the Journal articles which bear her name, but commissioning, editing and peer reviewing articles, helping the AIMS Journal to be the platform for debate of maternity issues which it has been for decades. She would also get involved with the production and distribution of the Journal, and use it to highlight issues to those who were in a position to make improvements in maternity services. Again, this was initially without the aid of computers or the internet, but adapting and making use of technologies as they emerged.

Beverley had developed an understanding of book production from having written books such as "Whose Having your Baby?" and knew how valuable such books were in sharing information. That book later became the AIMS book "Am I Allowed" when at the end of the 1990s AIMS gained lottery funding to enable the publication of a series of AIMS books. The funding and production of this initial set of books put AIMS in a position to be able to continue to produce new books.

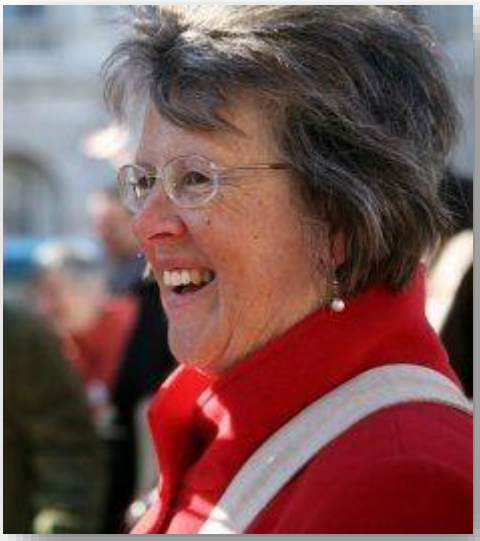
AIMS has a habit of picking up on issues within the maternity service before others, often because people reach out to the AIMS Helpline when they have not found their answers elsewhere. This led to some particular issues with which Beverley and AIMS became involved. Three that stand out are the shackling of labouring women prisoners, the use of social service referrals or the threat of referral to coerce compliance, and birth trauma, PTSD and suicide after birth.

Beverley and others in AIMS got involved in supporting and campaigning on these issues, raising the profile until they were accepted by others as issues which needed action. Since then all three of these issues have been taken up by other organisations who have been able to focus on them in detail. For example, Birth Companions (www.birthcompanions.org.uk) now focuses on the issue of women prisoners during pregnancy, birth and early motherhood (see AIMS Article on this). NPEU was encouraged by AIMS to extend their data collection to include death due to suicide and this helped to raise the profile of Birth Trauma and mental health issues, issues that are now considered mainstream. Other organisations such as the Family Rights Group [https://frg.org.uk/get-help-and-advice] provide support for those being referred to Child Services. Although all these issues are still a concern to AIMS, with the AIMS Helpline often still supporting women dealing with threats of referral as a means of coercion, I would hope that by listening to women and birthing people we can continue to be a voice on issues where there is no other specific support - yet.

I wrote very soon after she died my personal reflections of Beverley which can be found here. I have since reached out to others who knew her to hear their reflections and memories, and that piece can be found here.

We were very pleased to see the Guardian recognise her with the following obituary https://www.theguardian.com/society/2023/apr/05/beverley-lawrence-beech-obituary.
And one of our ENCA partners have published a blog "When I grow up I want to be like Beverley" https://www.elpartoesnuestro.es/blog/2023/03/01/de-mayor-quiero-ser-como-beverley (and in the English translation).
I am also pleased to see that she now has a Wikepedia Page https://en.wikipedia.org/wiki/Beverley_Lawrence_Beech
Beverley has been an inspiration to many birth activists. So, in the spirit of the saying “"It is better to light a single candle than to curse the darkness.” which AIMS adopted and has been using in the AIMS logo since the late 60s, I am sure Beverley would want her legacy to be the lighting of candles everywhere we can.

Memories of Beverley



Debbie Chippington Derrick, AIMS Volunteer who worked closely with Beverley from 2005 when she joined the AIMS Committee, through to 2017 when Beverley stepped down from AIMS, shares memories of Beverley from people who knew her through her AIMS work.

Beverley’s involvement in trying to improve maternity services had a very wide reach and there were so many threads to it, as the voices of people who knew her testify. Her ability to cut through the bullshit and say it as it was brought many up sharp and often forced them to reevaluate what they understood or believed. She made very strong personal relationships with people, hearing what they needed, and providing it or helping them be able to find it; again this comes through clearly in the memories included here.

She did like a good fight and found it difficult to walk away from what she saw as an injustice. She always wanted to be able to do something, and that also comes through strongly in many of the personal accounts included here.

Supporting women

The core of Beverley work at AIMS was supporting individuals to make informed decisions about what was right for them, but even more so it was about helping them to have those decisions respected. At one time she single-handedly ran the AIMS Helpline, answering phone calls, letters and then later emails. This is still the work of the AIMS

Helpline today. It is common for people to find AIMS when they know what they want and they are struggling to have respected and supported what they already know is right for them.

Davina Ramshaw wanted a VBAC and Beverley helped her to find a way to achieve that.

I was so sad to learn of Beverley's passing. She was the first person from AIMS I spoke to, and she gave me time and attention when I was in despair after a caesarean birth. She told me about Peter Huntingford who later helped me achieve a vaginal birth. That experience greatly enriched my life, and I have never forgotten that it was Beverley who set me on that path. I am sure there are many families who owe a similar debt to her work and endeavours. She truly cared and worked so hard for so many years . I did meet her at an AIMS conference and she made sure I felt welcome amongst a crowd of confident women where I felt a bit out of my depth. Please extend my family's condolences to her family and let them know that all over this land there will be women like me, who will never forget her and her influence on the world of maternity services. There will be thousands of parents who owe Beverley the same debt of gratitude and whose lives have been changed because she was able to help them find a path to what they knew was right for them. Sometimes this led to those she had supported taking up the mantle themselves.

And creating a new birth activists in the process

Sandar Warshal, who spoke to Beverley then became actively involved in the work of AIMS and was AIMS Secretary for 15 years.

I rang BB in 1983 in a panic. I had a bad high-tech birth in 1980 and was being threatened with an induction for the next child. I told her my very long story and she asked, "What do you want?"

I was startled by her question and galvanised to think about the answer. I wanted to ignore the advice I had been given re. the health of my baby and proceed in having a natural birth. When I said this, she was completely supportive but remarked -You must take responsibility for your decision- which was what I wanted. I trusted my own instincts and distrusted the medical advice I had been given.

After the normal birth of my healthy baby, I went along to an AIMS meeting to see who this amazing person was. I foolishly offered to staple some papers together and was instantly drafted on to the AIMS committee. I spent 15 happy years as Secretary. Working with BB was inspiring. She listened to people patiently. She assumed they were as bright as she and that they were capable. She encouraged us to take on a task and complete it without overseeing it herself.

BB was a very collegiate leader. She listened to her fellow activists and let us get on with the job. If children or work commitments made it hard to do a project, she was always understanding and flexible. It was certainly better to be working with her than against. She was withering in her judgements of people who did not support women or respect their wishes.

She supported and encouraged frightened and overwhelmed people. Her passion for justice never faltered.

One day BB decided we should put on a Water Birth conference-at Wembley! She named high profile speakers and told me to invite them to our event. They all said yes! This was before water birth was mainstream and, on the day, it was thrilling to see hundreds of midwives, professionals and women flooding into the conference centre. The same was true of the Home Birth conference -again a ground-breaking event which was oversubscribed.

BB saw trends before many others. She warned us that midwife units would be closed and that we must prepare to fight for them. She contributed to Parliamentary investigations working tirelessly for change. She submitted papers and evidence in support of an enlightened Maternity Service. When it was obvious that many of her ideas were largely ignored, I could tell her that all 5 of my grandchildren were born in water, tended only by midwives in hospital.

When I visited her a few weeks before her death, she said with an evil chuckle, her only regret was that she couldn't pursue her claims against a health authority which had closed a valuable birth centre.

The list is endless of her progressive ideas and commitment to change. I am certain that her vision will be carried forward by other enlightened feminists. The grandchildren who hear of their safe and happy births will want no less for their children. Women the world over are changing their view of what is acceptable about control over their bodies.

I am honoured to have spent so many years working with such a determined and effective campaigner. I will miss her very much.

Emma Barker, who made contact with AIMS and Beverley when trying to plan the right birth for her twins, then went on to edit the AIMS Journal and write a book on birthing twins.

It was with a howl, akin to childbirth fittingly, that I read the sad news about the sudden demise of one of the most powerful voices in women's rights and childbirth. Having worked with Beverley Beech as editor of AIMS journal for a couple of years, I came to admire her more and more as a force of nature. Along with the brilliant committee that stood around her, she single handedly made it possible for more women in this country to have more rights in their birth than they can ever know. Only recently, the "Am I Allowed?" book was mentioned with my god-daughter who after a successful homebirth last month, said that that was the phrase the women in her NCT group still asked her about a home birth.

I came to Beverley when I was ringing around for the birth of my twins, where she was the first person to speak to me as a human being as I explained that I did not want to have a C-section and a normal birth at the same time - what was being proposed at the local Chelsea & Westminster hospital, as well as giving birth in an operating theatre with 12 people present. "We won't be exactly being selling tickets during labour... but..."

joked the Doctor, and I didn't see the funny side. Nobody cared until after two weeks of ringing around, I finally got Beverley Beech on the phone. Like the starfish analogy so beautifully described by Debbie Chippington Derrick in the AIMS journal, Beverley took up my case, put me in touch with the late great Mary Cronk midwife, and the independent midwives - and helped me achieve the crowning glory of a brilliant birth. So brilliant I wrote a book about how brilliant birth can be: "Stand and Deliver - and other brilliant ways to give birth". It was all down to Beverley taking that call on the AIMS Helpline.

Nobody can ever underestimate how Beverley and AIMS have educated birth practice in this country and reminded women that they have autonomy over their own bodies. We all have a debt of gratitude to this woman; our daughters and our sisters will never know her transformative impact on birth practice in the UK, Europe and the world.

The battle does not stop with her death, but I will never forget how hard she fought on so many women's behalf, turning up in court, fighting the good fight every time she heard injustice was in danger of triumphing.

May she rest in peace as we all continue her good work, in the memory and inspiration she left behind us.

Annie Francis, now retired midwife, was helped by Beverley to find the support that she needed for a vaginal breech birth. Annie then went on to train as a midwife, and to be influential in midwifery practice, setting up Neighbourhood Midwives and being involved with the Better Births review.

I first met Beverley when I was pregnant with my first child 38 years ago and long before I retrained as a midwife. I had recently discovered - very late in the day - that my baby was in the breech position and I had been told by the consultant obstetrician that I should go down the caesarean route as the safest option. Beverley reminded me in her wonderfully forthright way that it was my baby and my body and that I had a say in what decisions were made about the mode of delivery. She gave me the confidence to explore other options and I ended up changing hospitals at the 11th hour and going on to have a very straightforward vaginal breech birth.

Of course I joined AIMS immediately and, after having 3 more children - all born at home - I qualified as a midwife in 1998 and often bumped into Beverley at different meetings and events. Her indefatigable campaigning for continuity of carer and for all childbearing women to be given evidence based information and to be at the centre of any decisions about their care, was inspirational to witness. She never wavered from her passionate belief that the maternity services were over medicalised and in need of urgent reform. Her courage and leadership will be sorely missed by many.

Ruth Weston was supported by Beverley when making a complaint about her maternity care. Ruth has gone on to be a very strong Birth Activist, locally and nationally and produces a regular blog focusing on issues in maternity care - we thank Ruth for allowing us to share her words which were first published in that blog.

There is a series of stories in the Judeo-Christian tradition of a prophet Elijah who was a fearless defender of his faith, who single handed faced down Kings and Queens and their henchman. Even his enemies held him in fear and respect. His apprentice and successor is heard to cry out bereft at his passing, "My Father, my Father, the Chariot of Israel and the horseman thereof."

In Beverley Beech we have lost a fearless defender of women's rights, a champion for quality maternity care, a leader who inspired others to speak out, who faced down Ministers and National NHS leaders alike. In Beverley Beech we too have lost the cavalry as we do battle in the face of falling care quality, and savage cuts to maternity.

My first encounter with Beverley was over the phone when I finally decided to make a complaint about the lack of care I received for my home waterbirth. I don't remember the advice, I do remember her being forthright and cynical of the responses I was getting. I smile now because her forthright and cynical manner and the robust response she advised and which I thought was 'over the top' at the time (although she was right) is probably exactly how women find me when asked for advice today. Twenty years listening to women talking about the poor care they have received and the poor response to their complaints does that to you, I have found. How can a service dedicated to caring for women and babies be so callous and self serving?

Our paths crossed many times after that, we gave speeches at the same conferences, or met at AIMS or other campaigning meetings. She was a kind and good mentor and opened doors to enable me to speak out, deftly cut through the flannel to the real cause of opposition I might face, and was generally a solid ally in the cause of women's rights to good maternity care. She was my hero, with her unquenchable passion for justice, her toughness and endurance, her willingness not just to stick her head above the parapet but to dance along its walls!

The last time we were together - or at least it is the last memory I wish to hold of her, was one dark February evening. We were sat in the corner of someone's living room attending an ARM meeting. I love the dynamism and nurturing of ARM meetings but they can be long! So I had brought my latest crochet project which was to put tassels along the bottom of a poncho. It would take me at least two hours. Beverley watched me for a few minutes, then took over counting out the strands ready for tying on, a Grande Dame sat on my other side quietly began cutting the lengths of yarn. We enjoyed this quiet sisterhood of industry for about 40 minutes until the poncho had its fringe. But our efficiency and industry now left us with idle hands and the rest of the meeting....

In recent years I had lost touch with Beverley as my illness confined me for some years to a small circle. Like many readers I will regret the loss of 'one more conversation'. Her final message to me was typically solicitous and accepting: if or when I felt better, to get in touch as there would always be something I could do.

In the old story, the apprentice utters his cry of despair, but then picks up Elijah's dropped cloak - his mantel. 'Taking up his mantel' in every sense of the word, Elisha

continues the work of his master. Beverley Beech, quintessential 'angry woman', Lady of the Anonymous Brown Envelope, irrepressible advocate for birthing women, our tribute is to take up your mantel and carry on your work. This we shall do.

Emma Ashworth, who has been an AIMS Trustee, AIMS Journal Editor and is the author of The AIMS Guide to Your Rights in Pregnancy and Birth which followed on from Am I Allowed. The words below were first published in the same blog as Ruth's and we are including here with Emma's permission.

It was 2012, and I had been hosting screenings of Freedom for Birth, and I'd noticed that Beverley Lawrence Beech was interviewed for the film. Beverley was the honorary chair of AIMS, a charity that I wanted to start to volunteer for, and I'd read her amazing book, "Am I Allowed?", so seeing her powerful contribution to the film pushed me into attending my first AIMS meeting.

Like most people, I was star struck on the day, but Beverley and the other AIMS volunteers made me feel so welcome, so I stuck around.

Over the next 5 years, until Beverley's resignation as Chair, I was witness to her kindness, her passion and her incredible commitment to the lives and rights of birthing women. One evening, the AIMS team was gathered at a volunteer's house and we were discussing our birth stories. Beverley shared hers - like so many of us, the reason that she went into birth work. The power of our experiences can drive our lives to places that we never expected to go, and for Beverley, it led to her changing the births for many thousands of women for the better.

Beverley taught me to be brave. She taught me that it really is ok to speak out, and to stand up to what society perceives as "authority" when we believe that something is wrong. This was the beauty of Beverley. Not only did she make incredible change herself, she assiduously supported many hundreds of others to step forward into their own power and strength.

Beverley's death is a terrible loss, and a great sadness. We step forward with her voice in our heads and her passion in our hearts.

Supporting and working with midwives

Beverley was strong in her support of good midwifery, as well as fast to condemn poor midwifery practice which failed to be truly 'with woman'. She encouraged and supported those working to support good midwifery care.

Lesley Page, Professor of Midwifery

Thinking about Beverley and the immense contribution she made to the lives of women, their babies, and families around the time of birth I am drawn into a kaleidoscope of vivid memories. I loved the many hours I shared with her on conference platforms, both in the UK-and sometimes in more exotic locations overseas. I loved it because she was so honest in her opinion and spoke from heart and head about what was needed, what went well and what went wrong. There was none of the 'diplomacy' that often obfuscates the truth.

Also, sharing travels with Beverley always added zest to work that was challenging, intense, and incredibly important. From this work with like minded communities came fun too. After a few days working 'down under' there was just time to catch a swim when we passed the beach on our way to the airport. Getting on the plane clutching damp swimsuits, with sand between our toes added delight to a wonderful visit.

In Brazil our long days were often topped up with Samba dancing or a wonderful dinner. I had to fly out of Brazil ahead of Beverley. Travelling alone I made sure I had her phone number. It was the year 2000 and the guidebooks were full of exhortations to avoid falling into the hands of police or immigration officials. Arriving at the airport I was shocked to find I had lost my exit visa. When in my panic, I phoned Beverley, she was excited that she might need to get me out of custody. When I called back to tell her it was sorted, she was, rather than relieved, disappointed that she would not be able to campaign to get me out of prison!

The thing is, that Beverley was a tireless fighter for one of the most important causes in our world. The right for women, their babies and families to have the best care around the start to life, care that will give them every chance of health, wellbeing and happiness throughout their lives. We will miss her so much -but we can always ask -what would Beverley do?

Caroline Flint, Midwife.

What a loss you are. You have been there for so long, so strong, so knowledgeable. Whenever a woman rang me to ask advice on her pregnancy or labour or her rights, I immediately either gave her your number or rang you myself, secure in the knowledge that you would have the answer. Assertive, looking at the problem in an entirely new light, aggressive and so, so funny B Beech! I shall miss you beyond measure, you were such a unique personality, and now you have tasked me with taking all these geezers to court for malfeasance in public office. While you dally in golden glades I shall be toiling away in your memory; well you deserve a lasting Legacy - this will be it!

I'm so glad that your dying was so loving and kind - you deserved it, you did so much for so many, Thank you B Beech x x x

Sheena Byrom, midwife and founder of All4Maternity.

I met Beverley many years ago at a conference where I heard her speak up and out for the rights of women and families to have respectful maternity care which included informed choice. It included the right to choose a normal physiological birth because this was becoming increasingly difficult at the time. Beverley spoke up for midwives, for students, to have the time and resources to support women's choices and for their autonomy. I remember feeling heard, feeling relieved.

Over the past decade Beverley also supported me with personal challenges. Her courage and compassion made an impression on me and gave me courage too. I will never forget her. Beverley's life and work positively impacted maternity services in the UK. RIP.

Dianne Garland, Freelance Midwife, and Beverley often found themselves speaking at the same conferences. Having been supported by Dianne at a conference myself when my forthright views on support for HBAC were under attack, I know the value that Beverley also placed on supporting others in this way.

I am fortunate to have known Beverley for many years. In writing a few words about our "encounters" I hope her calmness, kindness and patience will shine through.

I remember being with Beverley in Porto Portugal at a birth conference many years ago. We had met at the airport and flown out together. We had both done as requested, and already emailed our presentations in advance for translation. I was due to follow Beverley with my talk, but disaster struck; my slides had not arrived and were therefore not yet translated. Beverley was her usual calm and relaxed speaker, giving some extra births stories to the audience throwing the translators into disarray as she left her original slides. Needless to say when I eventually did my presentation she sat in the front row, smiling and nodding in all the right places.

We once had a terrible train journey back from the midlands after another conference. We got as far as Birmingham and the train just stopped, no sign of any journey heading south. Cool, calm and collected Beverley chatted and suggested we either got a hotel for the night (along with hundreds of other stranded passengers) or consider a taxi back to London. As the only one who had a "modern" phone she organized a taxi to take us to the start of the northern line (I think it was High Barnet). We started to leave the station and found two other passengers also stranded trying to get back to London. "Join us in our taxi " suggested Beverley. Four complete strangers bundled into a taxi with suitcases on knees for the journey. We laughed and once at the tube station said our goodbyes. We must have looked a sight, two mature ladies, a very young rugby player size gentleman and a young man who had been in Birmingham for an interview. Needless to say they knew more about Maternity and Midwifery than they did at the beginning of the journey !

Well done to Beverley for all that you did for families. I shall miss your laughter, kind, supportive words and your smile.

Denis Walsh, Retired Associate Professor in Midwifery

Beverley was fierce advocate for optimum maternity services for women. I shared a platform with her at several midwifery and maternity care conferences and meetings from 1995 to 2016 when I retired. To be blunt, she had a reputation of being 'bolshi' and difficult among obstetricians and some midwives. But in retrospect, I recognise this as a gendered trope about women of a certain age, written about so eloquently recently by Victoria Smith in her important book: 'Hags: the demonisation of middle-aged women'. Beverley's 'bolshiness' was what men act out all the time but are called 'passionate', 'committed' or 'eccentric'. Beverley was passionate and committed to the cause of women's agency in maternity care and she did not 'cow-tow' to authorities and hierarchies when engaging with others on a topic so dear to her heart. She was fearless,

unrelenting and extremely hard-working for this cause, and though Conference Chairs tried to ignore or side-line her voice from time to time, she would not be silenced.
We've lost a true social justice warrior in her passing but her legacy will live on.
Her support of good midwifery included reaching out a supportive hand to those whose support of women was being attacked. There have been quite a number of midwives who have had their practice of supporting women's informed decisions reported to the NMC, the very organisation which should have been upholding this practice. Many of these midwives were put through years of untold stress and damage, and costs.
Debs Purdue was reported to the NMC and struck off as a midwife for supporting a woman. This was later overturned by the High Court, but what she had been put through destroyed her as a midwife, and had untold consequences for her personally.
I met Beverley in Scotland about 28 years ago. She had travelled up, I think it may have been for a conference with Mary Cronk, but certainly we met at Nadine Edward's house after a conference or meeting - I forget where it was held. It may have been the beginning of the insurance issue for Independent Midwives, but I forget.
During my Independent Midwifery career, Beverley supported me with 'offloading' stories, and during my NMC hearing in London. We talked infrequently and I liked her enormously - her sense of humour, her loyalty and her support.
It wasn't until Mary Cronk's funeral that I got to know Beverley much better. Various midwifery friends and Beverley stayed with me in Iwerne Minster over a few days, hot-bedding - I think Helen Shallow and she shared a double bed! Not proud 'our Beverley' of mucking in - but she was a sailor! She stayed on for an extra night at our invitation.
She assisted my husband and I financially, with a loan to secure a house that we had lost because sale had fallen through.. From then, she visited us about twice year and we were able to thank her and got to know her. We never made it to London, to see her at her home, until she was near the end of her life. She joined us though, in the City for 'Proud' Cabaret to see our daughter strutting her thing, and on another occasion to just play.
In early December Beverley came to stay for 3 nights and we were, at last, able to take her to Rick Stein's in Poole to thank her formally for her support, friendship and generosity. We were able to take her to the Royal Steam Yacht Club for a drink first, as we have friends who are members. We had a lovely evening. Sadly, she broke the news of her illness two weeks later and we were privileged and grateful to see her on 23rd February to talk, and say goodbye.
Best wishes and love to her family.
Beverley, thank you for being my friend.
Love Debs (and Basil)
Beverley went beyond the UK in supporting those providing good midwifery care who came under attack. There are many articles detailing the saga of the cases brought against Agnes Gereb, her imprisonment and fight for justice in the AIMS Journal

including Hungarian State Injustice, The latest from Ágnes and Dr Ágnes Geréb Update (August 2018).

Agnes Gereb, obstetrician and homebirth midwife, Hungary

Beverley has always stood up for women. When I got into trouble - perhaps because I stood up for women - she stood by me personally and on behalf of AIMS. In her own outspoken style, she made her point to Hungarian society.

Supporting and working with obstetricians

Beverley understood the value of good Obstetric care, care which was there when women needed or wanted it, and which supported midwives to truly support women. Again when this came under attack Beverley stepped in to take action.

Wendy Savage, Obstetrician who came under attack for her respectful care of women which was enabling them to make informed decisions about their births [a review of the book about what happened can be found here).

I met Beverley in 1985 after I was suddenly suspended from my post as senior Lecturer and Honorary Consultant in Obstetrics and Gynaecology at the Royal London Hospital. She along with the late Sheila Kitzinger and Luke Zander, a GP in Lambeth doing home births and giving women their own Antenatal notes, joined with the two support groups started by women and GPs in Tower Hamlets to organise my defence which was ultimately successful.

Beverley was a fearless and creative campaigner and indefatigable in seeking out justice for women trapped in an often seemingly unresponsive system. She helped women who wanted to have their babies at home fight the system and was not afraid to confront Social Services. I heard her speak persuasively at several international conferences at the end of the last century. We, with the late Dr Marsden Warner, did a gruelling Australian Tour speaking in 5 cities in 6 days about the unnecessary rise in the caesarean section rate. Recently Beverley accompanied me to a showing of a film about the damage being done to the NHS being shown in South London by a Keep Our NHS Public group and I had hoped of getting her involved in that campaign, but things were dashed when I heard of her diagnosis just before Christmas last year. We will miss her, but AIMS will continue.

Susan Bewley, Obstetrician

I can't think of a time that I didn't know Beverley although as a junior doctor (who thought she was a feminist and on the side of women) I still remember being very frightened of this formidable woman who challenged everything I was taught and held dear! Funnily enough, although I held her in great regard and would keep seeing her over the decades throughout my career and small amount of out-of-work activism, I don't think I had anywhere near enough of an idea of the extent of her (and your, and AIMS') activism until the latter years. I remember (pre-covid) being at a meeting where she was furious about how a disenfranchised and marginalised pregnant woman was being mistreated by social services, where AIMS was clearly putting much more effort into

individual casework than other organisations manage. She was a touchstone for what was right, not what was expedient.

Networking and working with other organisations

Beverley built relationships, and influenced people working in other organisations. She worked with organisations within the UK and beyond. She was a founding member of ENCA as Elisabeth Geisel explains and was involved in the development of the RSM (Royal Society of Medicine) Maternity and the Newborn Forum.

Liz Thomas, Policy and Research Manager, AvMA, talks about the association between AvMA and AIMS, and Beverley's influence.

I wanted to say how very sorry we were to learn of the death of Beverley Beech. AvMA and AIMS have had a very long association over many decades. Beverley was a veritable titan in the battle to empower women and reverse the medicalisation of childbirth. I am sure she will be greatly missed but have no doubt that the legacy she built through AIMS will continue. On behalf of Paul Whiteing CEO, our Trustees, and my colleagues at AvMA, I would like to extend our condolences to Beverley's family and friends and the team at AIMS. Our thoughts are with you all.

Belinda Phipps, former CEO NCT

Beverley was queen of the killer question. Countless times when there was a debate about how a birth room should be arranged or how a mother should be treated Beverly would cut across this and remind everyone we should ask the mother and listen to and act on her answer. My favourite moments were when an obstetrician was putting forward his views and the simple idea that you should ask the woman and trust her answer was a jaw dropping moment for them.

Elizabeth Duff, Senior Policy Advisor, NCT

Beverley used to represent AIMS at meetings of the Maternity Care Working Party, originally established to enquire into the sharply rising rate of caesarean births, and chaired by the NCT president. The remit of the MCWP also included providing informed advice to MPs and peers on the All-Party Parliamentary Group on Maternity. Beverley's voice at meetings was, as ever, assertive, well-informed and passionate in speaking for women who had experienced poor treatment during pregnancy and birth.

A particular memory was of Beverley sharply taking issue with another member who referred to 'shared decision making'. Beverley said: 'It is the woman's decision, and - if she wishes - her partner's. It is they who will be taking that baby home and caring for it'.

Mary Newburn, former Head of Policy and Researcher at NCT

I worked alongside Beverley when I was with NCT. We collaborated on several projects, The Charter for Ethical Research in Maternity Care, and The Normal Birth Consensus Statement, are two examples. We were both advisers to researchers and professional bodies and sometimes joked about doing a 'good cop, bad cop' double act. Once Beverley had lambasted a group for being out of touch and implicitly for their paternalism, I seemed like a pussycat. Campaigners need to work together, sharing

policy insights, human rights knowledge, and key aspects of emerging - and changing - evidence, and we did.

Beverley represented the UK on ENCA for many years, The European Network of Childbirth Associations. I attended one of the annual meetings with her in Utrecht. As well as knowing about differences from literature, it was invaluable to begin to have more direct conversations across Europe, with activists and potential influencers. It brought alive an understanding of variations between our cultures and histories of childbirth. We learned more about the varying roles of midwives, access to home birth, the size of maternity hospitals, funding of public services, and the treatment of women.

Beverley was on the RSM Forum for maternity and Newborn Forum committee. The group was and continues to be a mix of health professionals and consumers, and the forum continues to provide a place where a wide range of maternity issues can be explored and debated.

Jane Sandall, research midwife, worked with Beverley on this forum.

I guess for me I worked with Beverley on the RSM Forum for maternity and newborn committee and what a stellar group that was, with Luke Zander, Beverley, Roxanne, Wendy Savage. What did we achieve? We gave a space for events on place of birth, politics of maternity care, always debates on evidence and always lively. There is nothing new under the sun about having a group of health professionals and advocacy groups working together to improve reproductive rights, and choices.

Luke Zander, GP also worked with Beverley on this forum, but was also involved with AIMS and others when the Albany Midwifery Practice was so abruptly closed.

As a General Practitioner with a particular interest and involvement in the development of community based Maternity Care, I had many opportunities to experience and greatly value the significant role that Beverley played in protecting and furthering women's interests in the care the maternity services provided.

In the multidisciplinary Forum on Maternity and the Newborn at the RSM, she was a powerful and influential voice, and in our shared engagement in the Albany Midwifery Practice saga I was able to witness the strength and purposeful dedication she brought to many of the issues of concern.

She has left a legacy that will be widely remembered and much appreciated.

ENCA - European Network of Childbirth Association

Elisabeth Geisel, Hon. Chair of GfG (Gesellschaft für Geburtsvorbereitung e.V.), Germany

In April 1993, almost exactly 30 years ago, the German association of childbirth education GfG, organized a European meeting in Frankfurt for the weekend; guests arrived at the airport from Western and Eastern Europe. I was in charge to find participants from 15 different countries (mind you, this is without pictures or cell phones) and improvised a literal shuttle service. Agnès arrived from Hungary, Annia from Poland, Pierra from Italy, two from Russia, etc... But where was Beverley, the

representative for the UK? What a relief to finally find a lady seated on a trolley, holding a journal high in the air in which she was calmly reading: The AIMS Journal -- brought along not only to while away the hours, but also to draw attention to her and AIMS. These women were themselves representatives of local Childbirth associations, and came together to share about the necessity of developing common strategies to improve conditions in pregnancy and birth. At the end of the weekend, we had not only overcome the language difficulties, but launched a new network, and had a name for it: ENCA, European Network of Childbirth Associations. Beverley as an English native speaker played a decisive role in developing the first steps of ENCA and volunteered to host a second meeting in London in the fall 1993.

Over the next several decades Beverley and I met not only at the yearly ENCA meeting, but also to give talks somewhere in Europe. She always carried heavy suitcases full of AIMS-material which she displayed on an improvised AIMS-table. We travelled together, shared rooms, ideas, fun, and concerns. I learned the word "appalling" from her; we had so many reasons to be appalled. I appreciated a lot her patience, her sense of humour, her quick wittedness, and her knowledge of scientific evidence. That she was a great speaker goes without saying. Most impressive was her way of retaining her sovereignty and superior knowledge in the face of the arrogant chief obstetricians whether in Warsaw or in Athens or in Budapest… or anywhere! She was a Grande Dame – a Grand Lady!

Thea van Tuyl and **Hannie Oor** first met Beverley at an early ENCA meeting in 2001

Thinking about Beverley, she was a great, powerful woman who never missed a moment to be 'a pain in the ass ' of many so called 'pretend to be' care-takers who were nòt woman-centred. She would stand up in the middle of a congress to ask for evidence if a doctor, obstetrician or gynaecologist made a statement that was wrong in her opinion. We met Beverley in 2001 when we first visited an ENCA meeting. Since then we have seen her almost every year at the ENCA meetings. She was the most perfect activist of our ENCA-members. During these meetings she always wrote the minutes and she was very to the point with her explanations about our discussions and actions. She never felt this as a heavy task,… more a logical thing because her native language was English. Which for most ENCA members it is not. She always kept her note block and later her laptop ready to make the notes. The press releases she made were always sharp and assertive about the statements ENCA wanted to make after the meetings.

Personal memory of **Thea**:

In 2002 she stayed at my home during the ENCA meeting in the Netherlands and I found out how she enjoyed the garden, the birds and nature. We also had a lot of fun, especially during the free moments around ENCA meetings. We tried to find the same hotel and spend a lot of time together.

Personal memory of **Hannie**:

Beside our passion for woman centred care around birth, we had a connection with the ocean… She, as a sailor, me as a diver. I do remember our encounter in the Netherlands where I had the privilege to sail a day with her on a ship which she had to sail from England to the Netherlands. Just one skipper and her to cross the north sea!! Sailing with her across the Frisian lakes to Leeuwarden was a delight on a beautifully warm summer day. A precious memory!! Her humour, together with her specific high English pronunciation of what she said, was for me so lovely to hear and we always joked about that.

We will remember her most of all for her passion and will to fight for the right things for pregnant women and young mothers. She was the voice of AIMS and she meant that her voice was heard in the UK, but also far over the borders. We loved her and she will be missed.

Lucie Ryntová, Czech Republic

I had been meeting Beverley for over twenty years at ENCA meetings in many countries and will always be grateful for every minute I spent in her presence. It's impossible to sum up briefly 20 years of memories so I´ll just close my eyes and recall a few images.

- *I can see her standing behind the desk offering the great AIMS journals and publications that have inspired us so much.*
- *I see her brilliantly leading our internal discussions and speaking accurately and courageously in the public panel discussions we often held in different countries.*
- *I see her commenting sharply and wittily on activist topics, always defending rights of women and children.*
- *I see her patiently taking down and editing our meeting minutes as none of us was better at English than her*
- *I see her bravely discussing with doctors on excursions to hospitals in many countries where we had meetings.*
- *I see her laughing and being able to make light of difficult topics.*
- *I recall in details her active involvement at both ENCA meetings we hosted in Prague, in 2002 and 2014.*

Beverley, I´d like to thank you on behalf of Czech women and chidren, for helping to change Czech maternity care for the better. Please continue to watch over ENCA from above and over all the people who are trying to create a better world for children and families.

Maria Andreoulaki, activist from Greece

I was heartbroken with the news of Beverley's passing; only slightly soothed by the fact that we were in contact until a few days before. I feel so lucky and blessed to have been around her.

There is a lot written about her tremendous contribution to the world. I don't need to add to that, so I thought I would share some personal moments with her, as I remember our times together.

I met her through AIMS more than 25 years ago, when, as a traumatized cesarean mother, I had written to her for guidance. She had sent me book gifts all the way to Greece, without knowing me and I would cry and cry reading the invaluable information that I found there. We got to corresponding and finally met through ENCA.
For some years we shared rooms in ENCA conferences. There was an ease about our co-existence - who's taking which bed, when lights should go off, alternating shower times, yawning away loudly, chitchat into the night and early morning. Then it was natural that I would invite her to Greece several times, where she put some fire in people's minds with her talks and actions. Having her in my home was a pleasure and honour. One time, as I was setting the table, she loved my linen tablecloth and imagined how good it would look in her new home, so it was hers! She sent me a beautiful flower dress when she got back home as a thank you, along with a photo of the tablecloth on her dinner table. She would visit sometimes outside birth work events, combining the trip with her sailing adventures. I was in awe to hear all about them!
As I age, I have decided that I will take no insults to my person anymore, as a woman, as a professional, as a citizen. Here is an anecdote to demonstrate Beverley's contribution to my decision (background information: in Greek we do not pronounce differently the ee to i sounds).
[in Beverley's words]: Once I was picked up from the airport by someone who asked me 'Are you Beverley Bich'? And I proudly answer right back at him: 'You're right, I am a bitch!'
Love knows no space and time limits, so I keep her with me and hold her in my mind and heart for guidance, for her passion in the joys of life, human rights, the open sea, daring, standing up against irrationality, supporting unconditionally and being assertive and fearless, all qualities that I keep practising with her as my teacher.
Ana Maita
A tireless crusader for human rights in childbirth, Beverley's spirited presence made a strong impression on anyone who ever met her. As a rookie activist coming from a former communist country I was in awe of her vast knowledge of Romanian womens' plight during the forced reproduction policy under the dictator Ceausescu. Although many decades my senior, our origin stories in birth activism were eerily similar, both having had sons along with a deeply transformative experience brought on by childbirth. We also shared a fiery temper which we kept in check as best we could to bring the change we felt was needed without conflict. I loved her big presence and her loud energy. No one filled a room like Beverley! With her staunch work ethic and her loyalty to women's wellbeing during childbirth as one of the most intense rites of passage in human experience, Beverley's memory will remain a boundless well of energy and inspiration for every HRIC activist who had the joy and privilege to know her. She will be sorely missed!
Patricia Pineda, El Parto Es Nuestro (Childbirth is Ours!), Spain

I cannot feel more lucky for having been able to hear her speak in public on several occasions. She filled the stage with her presence. When she spoke, the audience fell silent because the power she radiated was amazing. You couldn't do anything but listen, admire yourself and learn.

I feel really grateful for having met her in my life and having shared meetings and meals and conversations with her. I don't think she was aware of the amazing impression that being with her and sharing with her caused. She left a bright mark on me and I will never forget her.

We will miss her so much.

Lucie Ambrožová, Action for Motherhood, Czech Republic

I've met Beverley just online - during COVID years. But even through the screen I could feel the lovely, kind and strong spirit Beverly had. It was a pleasure to meet her, organise and cooperate with her activities within our European network of childbirth associations. She readily shared her knowledge and experiences with us - new members. I will be always grateful for every moment spent in her (online) presence.

Working with policy makers

Beverley got involved in fighting for changes at the highest level. She was frequently bending the ear or writing to people of influence. I have attended meetings with her to speak to people in many organisations including the Department of Health. Beverley worked hard to make sure that the voices of women were heard by those 'in power'. She was involved with the World Health Organisation (WHO), involved in the development of the consensus statement on caesareans, and made relationships with people such as the late Marsden Wagner [https://www.aims.org.uk/journal/item/marsden-grigg-wagner].

She was involved in getting women's voices heard for three maternity reviews - Winterton, Changing Childbirth, Better Births, and was on the Maternity Transformation Stakeholder council until 2017.

Julia Cumberlege, Chair of both the Changing Childbirth and the Better Birth reviews knew she could rely on a Beverley for a clear communications of the issues in the maternity service

When I first got involved in Maternity Services the person 'to go to' was Beverley - rather she usually got to me first. For years quite simply she was AIMS. Supportive, but that did not blunt her questioning, her research and if well founded her stringent criticism of what was wanting in maternity services. She was an effective campaigner for women and their babies and when we met I never took her comments, her ideas, her questioning as anything trivial or insincere as they were well founded and rang true. She is greatly missed.

AIMS

Those involved in the work of AIMS will do our best to continue her legacy. Whether we knew her personally or only heard or read her words, her influence will remain with us.

Nadia Higson, NCT Antenatal Educator and current AIMS Coordinator, only became involved with AIMS shortly before Beverley stood down.

I knew of Beverley many years before I met her, as a dauntless campaigner whose name almost always appeared in any discussion or new story relating to the maternity services. I also knew her as an inspiring author, both of the seminal book "Am I Allowed" and many AIMS Journal articles. Her writing always felt like a breath of fresh air - she was never afraid to "tell it like it is."

It's a source of regret that my time as an active AIMS volunteer only briefly overlapped with hers, but we did work together on the two 'Celebrating Continuity' conferences which AIMS co-organised, in London and Leeds. I had the privilege of sharing a hotel room with her in Leeds, and still remember a wonderful evening enjoying a curry and her stimulating conversation.

I hope that AIMS can continue to embody her fighting spirit for generations to come.

Jo Dagustun. AIMS Campaigns Team

I remember the day of that beautiful photo well. It was at an AIMS AGM: it so happened that I was stepping up as an AIMS Volunteer just as Beverley was stepping down, having done her time and excited to keep up her focus on maternity service improvement with a change in energy and in pastures new.

Sitting next to Beverley during the formal meeting, I suggested an amendment to her final statement, which she graciously accepted. In a small way, I am hopeful that my AIMS volunteering honours the work of Beverly and the work that all other AIMS volunteers have done - generally unsung - over the past 60+ years.

Thank you, Beverley. And here's to the continuation of an ongoing thriving dynamic, diverse and collaborative maternity improvement community, in your - and in all women's - honour. Creating the conditions of support for women throughout their maternity journeys, to be the best they can be, for them and their families.

I have already written about a few memories of Beverley in the last Journal here, but I could go on for pages. There was never a dull moment with Beverley and travelling with her was always an adventure, even when her knees were playing her up and I had to wheel both our suitcases. When travelling on trains l began to want reassurance she did actually have the right ticket to travel on the same train and I even started to play it safe and arrange to buy both our tickets. I think there were at least two occasions when she did not have the right ticket and got thrown off; but the idea of not travelling together just because we had booked different trains would have been intolerable. But that carried over into much of the work that she did, especially within AIMS, doing work together with those who were available to travel with her.

Thank you Beverley for the shared journeys.

Debbie

What has the AIMS Campaigns Team been up to this quarter?

by the AIMS Campaigns Team

Written outputs:

- Letter to Peter May, Permanent Secretary at the Department of Health in Northern Ireland about the likely impact of the withdrawal of regional guidelines on homebirth and midwife-led care in the maternity services
- Joint authorship of article discussing public support for midwifery continuity of carer in The Practising Midwife, March 2023

Conferences and meetings attended:

- 2nd February Westminster Health Forum conference - Priorities for delivering long-term progress in the NHS (online)
- 6th February GOLD Midwifery Online Conference keynote presentation Shoulder Dystocia: Prediction, Prevention, and Appropriate Response
- 7th February London Maternity & Midwifery Festival (online)
- 7th February and 13th March NHS England Maternity Transformation Programme: Stakeholder Council meetings (online) to discuss the Single Delivery Plan
- 7th February Webinar Pregnancy in prison: What midwives can do by Level Up
- 8th February Inaugural NHS England National Maternity research strategy conference (online)
- 10th February and 21st April Maternity Continuity Network meeting (online)
- 14th February NMC webinar on Updated standards for pre-registration midwifery programmes
- 3rd March and 10th March launch of new content by Safer Beginnings (a joint programme of work by Best Beginnings and the White Ribbon Alliance UK) in the Baby Buddy app, that is aimed to enable, educate and support people on maternity journeys
- 7th March NIHR webinar, Reflections on impact & evaluation of public involvement: Who, Why, & What?
- 8th March Online book launch 'Supporting Physiological Birth Choices in Midwifery Practice'

- 13th March Research seminar The influences of facilitators and barriers on the implementation of a physiological approach: in two obstetric units in England - City University of London
- 20th-21st March - NHS England Maternity and Neonatal Summit, Leeds
- 24th-26th March - Doula UK Conference
- 30th March - RCM Shared Voices project co-production session
- 30th March - NHS England Board meeting (online, observer)
- 18th April - Midwifery Continuity of Carer implementation evaluation stakeholder event, City University of London
- 18th April All Ireland 2023 Maternity & Midwifery Festival
- 24th-26th April International Normal Labour and Birth Conference, by the Research in Childbirth and Health (REACH) Group, University of Central Lancashire
- Throughout the period: ongoing meetings with other stakeholders about Continuity of Carer implementation
- Throughout the period: attendance at Maternity and Midwifery Hour (online) - every Wednesday, 7-8pm (usually live, sometimes on catch up)

Who we have been corresponding with:

- NHS England and other stakeholders on the withdrawal of entonox in some Trusts in England and on next steps for the Maternity Transformation Programme's Stakeholder Council
- Lobbying Members of the Legislative Assembly (MLA) in a call to action on the Maternity Services in Northern Ireland

What we've been reading:

- NICE Quality Standard on antenatal care updated on 14 February 2023
- 'I kept begging for pain relief': the women forced to give birth without gas and air - The Guardian
- Healthwatch England survey on experiences of 6-week postnatal mental health checks: Six-week postnatal checks are failing many new mothers
- Maternal Health and Care in London - Report of the London Assembly Health Committee April 2023
- Black maternal health (parliament.uk) report by the House of Commons Women and Equalities Committee March 2023
- Draft update of NICE Guideline Intrapartum care for healthy women and babies published 25th April 2023

What we've been watching:

- The launch of the 2023 Lancet series on breastfeeding

Thanks to all the AIMS campaigns Volunteers who have made this work possible. We are very keen to expand our campaigns team work, so please do get in touch with campaigns@aims.org.uk if you'd like to help!