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Mixed Feelings

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Mixed Feelings

by Alex Smith

Paintings by Andrea Mantegna and Harry Morley

Welcome to the December issue of the AIMS journal, which this quarter has the theme of perinatal emotional and mental well being.

That the experience of early parenthood is likely to include 'mixed feelings', is an understatement, and by all accounts, it has always been that way.1 In 1984 I had my fourth baby and my first dog at around about the same time. Nestling my newborn under my coat, and with three other small children in tow, I walked along to the post office to buy the dog licence - (we didn't need one for the baby). The post office lady, who was older than me, leant forward to admire the baby and gave me some motherly advice. She told me not to be surprised if I woke up every morning for the next six months wondering what I had done; wondering whether I had made a huge mistake; and more tired than ever before with the additional responsibility. She said that this was absolutely normal. Then she said that I would wake up one day soon afterwards feeling as if the dog had always been part of our family and wondering how we could ever live without him - (I assume she thought I would take the baby in my stride). This was when I learned that post-dog depression was a thing, and this was the point when I started to reconfigure the idea of postnatal depression as being more than the temporary chemical imbalance I imagined it to be.2 Might a period of altered mood be common after any big life change?

Some years later I was standing in the hall reading an article. I was standing because if I sat down to read in those days, a dog and four children tried to sit on top of me.
The article was written by a woman who had experienced a period of severe depression after having her baby daughter. She wrote about her feelings and her sadness with such poignancy that tears rolled down my cheeks and onto the paper. The article was entitled, My Experience of Postnatal *Expression*, and in that lay her point; she felt that her feelings were probably normal in the circumstances and that she had a right to express them without the label of mental illness. She believed that if society 'listened' to what women and new parents were expressing in their altered mood, we could learn to 'do birth' and the transition to parenthood differently. In this way, her mood was a 'signal' that the birth and new parenting environments were not meeting her needs - it had a purpose. More recently I read another interesting article.[3] Exploring cross-cultural literature the author, an anthropologist, also proposed an evolutionary explanation for postpartum depression as 'having a purpose'. Whilst thought-provoking, it was a challenging read on many levels.

The idea of postnatal *expression* further developed the way I was learning to understand the experience of postnatal *depression*. It stirred within me a sense of political and feminist disquiet.

Much has been written about the way in which the medical model of birth views the woman as a 'defective machine',[4] as inherently 'faulty'[5] Women supposedly cannot 'do pregnancy' without medical surveillance, with those labelled as high risk in pregnancy carrying feelings of shock, fear, frustration, grief, isolation and loneliness, anger, sadness, and guilt that spill beyond the birth.[6] Women supposedly cannot 'do labour and birth' without a high chance of medical intervention being required or imposed, with increasing rates of intervention and poor care, both associated with increasing experiences of postnatal distress;[7,8,9] and quite possibly women will not 'do breastfeeding' in the way or to the extent that they had expected, with 80% of women stopping breastfeeding before they would have hoped,[10] often experiencing a deep sense of grief when they do.[11] Yet when they express their very reasonable feelings about all of this, plus their feelings of isolation, loss of identity, loss of income, loss of sleep, insecure housing and more[12] - for a little bit longer than is considered normal - they are diagnosed as having a mood *disorder*. How disorderly of them!

The discomfort we feel (as a society) about the expression of 'the wrong' feelings is echoed throughout history and is particularly (but not solely) targeted at women. Hysterectomy was performed as a treatment for the common diagnosis of *hysteria* in the 18th, 19th and early 20th centuries; 'wayward' girls were sent for punishing stints in asylums or homes, well into living memory; frontal lobotomy for treating 'mental illness' in the 1940s and 1950s (and beyond), was predominantly used on women;[13] and the equally controversial use of Electroconvulsive Therapy (ECT) to treat depression is still being used on twice as many women as men without addressing the social issues behind why more women than men appear to have depression.[14] It is described by one researcher as being "part of the over-medicalisation of human distress".[15,16] This controversy is also found in the pathologising of extended grief, where psychologists and psychiatrists argue as to whether human emotions should be classified as illness, with one specialist saying that "grief warrants strong social support and compassionate connection, not medicalisation". [17] What the woman who wrote about postnatal expression was saying is exactly the same - that what she needed was strong social support and compassionate connection, not medicalisation, and study after study finds that this is true for other new mothers too.[18]

For some new parents, especially those with complex lives and those with increasingly worrying symptoms (see the next article in this journal), the timely support of some specialist help may be welcomed and can even be life-saving. Thank goodness that these days there should be no shame in admitting to feeling mentally and emotionally out of sorts.

But shame exists, not for the struggling parent but for a society that finds so many struggling. It is a shame that the social structures, cultural traditions and rituals that once 'held' people during times of transition or incapacity have largely broken down; broken down because we didn't and still don't value them as we should.[19] As a consequence, some parents *have* to be diagnosed with an illness by a doctor in order to get the time and support they need to adapt to their new role. It is also a very real shame that strategies known to reduce the incidence and severity of mental and emotional unhappiness both before and after a birth (including: continuity of carer;[20] labour and birth care that supports the physiological process;[21] and home visits from people who listen and care;[22]) are ignored in favour of increased but under-resourced medical surveillance and treatment,[23]often with long waits to see an NHS specialist[24] and with limited evidence regarding the effectiveness and safety of antidepressants.[25] If the

expression of postpartum distress is indeed a signal, a fire alarm if you like, then is it not the fire - the lack of strong social support and compassionate connection in maternity care and in life in general - that we should be addressing?

This December issue of the AIMS journal looks at the range of emotional and mental health challenges that people may encounter as they become parents. Using the weather as a metaphor, I start by outlining the different manifestations of the changeable and occasionally tempestuous feelings experienced during the postnatal period, and this is followed by Katharine Handel's three Christmas wishes that, if granted, would transform the perinatal experience for everyone. While most episodes of postnatal emotional and mental health concerns are mild, a few are not.

Lizzy Lister shares a powerful and heartbreaking glimpse into the experience of postnatal illness in the form of a short story, and, given the terrible toll that postnatal depression or on-going symptoms of trauma can take, Mary Nolan puts forward a strong case for offering support to would-be parents before they become pregnant. AIMS quite often hears from people who are considering giving birth without the presence of a midwife or doctor, and one of the reasons they sometimes give is the belief that being in control in this way will protect their mental health. [26]

While mental health is not her focus, Mariamni Plested's research study, in which she interviewed ten women who gave birth without a health professional in attendance, makes for a very interesting read. It is noteworthy that, "the experience and sensation of birth was described by all participants in a wholly positive way". Sadly, this is not what we often hear about hospitalised birth, and especially not when labour has been induced. From listening to women we understand that the experience of induction can be particularly challenging to postnatal emotional and mental well being. With the rate of induction on the rise, Jo Dagustun's account of nearly having an induction asks the question, "how many of us are induced just before a healthy straightforward spontaneous onset would have anyway occurred". To round off the themed section of this issue, we have an interview with Dr. Rebecca Moore about her organisation, Make Birth Better.

Moving away from a direct focus on perinatal mental wellbeing, but still intrinsically relevant, Charlotte Edun reports on the recent King's Fund event, 'Putting a spotlight on women's health', where she spoke on behalf of AIMS.

Next, we have Jo Dagustun who describes one shocking incident of censorship where she could only conclude that the Maternity Services do not want to listen. This is followed by Jude Field and Jenny Cunningham who want to let you know about an exciting new major project which they are undertaking to identify the top 10 priorities for midwifery and maternity research, based upon the perspectives voiced by midwives, student midwives, maternity support workers, and women and pregnant people. AIMS is very pleased to be involved in this project. For all of you birth activists, the AIMS Campaigns team runs through the recent updates to the NICE guideline on Intrapartum Care, and as ever, we conclude with the AIMS Campaigns team telling us what they have been up to in the last three months.

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The Emotional Weather of Postnatal Life

by Alex Smith

Author Bio: Alex is an editor for the AIMS journal, a grandmother and great grandmother, and witness to some truly wonderful physiological births. She has close to half a century's experience as a childbirth educator.

I often hear new parents saying that they wish they had known what life with a new baby was really like, that they wish they had been prepared. As an antenatal teacher who tries to help parents prepare and equip themselves for 'the most challenging new job ever', for this 'uncertain adventure', for this 'seismic shift in their lives', I sometimes feel I am being accused of glossing over the realities, or worse still, not even addressing them. I have come to two realisations. One is that it is almost impossible to describe a colour to someone who has never seen it (or a similar one) before. The other is that the ability to block out the potential reality of what is to come, may be a biological necessity and, in a way, an expression of perennial courage and hope. Whatever strategies we use to help parents prepare, we must take care not to undermine courage and hope but to focus instead on resourcefulness and resilience. Using the medium of story and metaphor may help. What follows is a run through some of the different manifestations of emotional and mental upheaval that can be experienced during the perinatal period, using the weather as a metaphor.[1]

Third day blues

About three days after a baby is born, many women have a day of 'light showers'; of feeling very tearful. This is a normal response to a sudden drop in levels of endorphins. All that is required is kindness, cocoa and plenty of tissues! The early weeks of parenthood can feel a bit like a strange and endless blur, but soon enough things come into focus and the rhythm of the day starts to take shape.

Emotional ups and downs

It is normal for new mothers and fathers to experience emotional ups and downs as they adjust to their new life.

The emotional weather is naturally changeable with darker days and brighter days. This may be more intense at first, but as the weeks and months go by, the weather changes from wintry patterns, through spring, and then to summer, when it is still normal to have occasional blustery spells but generally it feels warm and pleasant. Use all the strategies you have available to lower stress levels during this time - for you, your partner and for the baby. Try everything that you normally find relaxing: warm showers; music; singing; dancing; phone calls with old friends; a meet-up with new baby friends; light reading; knitting; a brisk or gentle walk; a nap; a warm drink; funny TV; some yoga stretches; a massage; calm breathing. Things that can be fitted around the unpredictability of a baby, or even better, done *with* the baby are helpful. A gentle but flexible routine with even just two or three very simple pleasures that can be fitted into a few minutes here and another few there *every* day, makes all the difference. Many parents find it helps to 'tag-team' to ensure that both get 30 minutes to themselves each day, and people who live at a distance from friends and family may consider engaging the support of a postnatal doula in the early weeks.[2]

Depression and anxiety

It is also normal for new parents to feel down in the dumps occasionally. Mild depression that comes and goes, like grey clouds floating overhead, can serve to prevent a new parent from taking on extra commitments when they are already fully occupied with navigating the huge changes that come with the arrival of a baby. Some parents feel anxious rather than depressed, and similarly, waves of mild anxiety can serve to keep the novice parent alert and attentive to the needs of the baby. In this way, depression and anxiety, like waves of labour pain, can be reframed as having a positive purpose - *at least for a while*. Regard and prioritise the stress-reducing practices in the section above as important 'treatment' that is effective when taken regularly. Be kind and patient with yourself and with each other.

It is not usual for the postnatal-life barometer to be set to gloomy or stormy all of the time.

If days and weeks go by without any calm and sunny spells, or if these are becoming fewer and fewer, this could be a sign of clinical depression or anxiety. If all of the joy and pleasure of life seems to have disappeared behind a constant threatening cloud, this is when extra support or treatment of some kind or another could be very helpful. The first

port of call is usually the health visitor, GP or practice nurse, but other people may prefer to approach their homoeopath or a private therapist.

Puerperal psychosis and Post Traumatic Stress Disorder
Neither of these two different conditions are depression. This distinction is important.

Puerperal psychosis is very uncommon but very serious and needs prompt recognition and treatment - usually in hospital or, ideally, in a mother and baby unit.[3] It often starts within a few days of the birth with the mother suddenly starting to behave very oddly. She may find it hard to sleep and will be saying very strange things. It is scary for her loved ones. This is the only time you call the doctor behind her back.

If the situation feels desperate, call 111, or even 999.

PTSD symptoms that persist beyond a couple of months after a birth are increasingly common. This expression of postnatal distress is often related to having felt neglected, unheard, disbelieved, disrespected, and trapped within a system where one or other parent felt they had no control. The mother or father (or other person present) may have bad dreams or flashbacks and cannot stop thinking about what happened. They feel stuck in the events as if they were still happening and may be edgy and on hyper alert all or most of the time. Talking about things, and being treated for depression, can make the symptoms worse. Many people suffering from symptoms of PTSD find Eye Movement Desensitization and Reprocessing treatment (EMDR), or Rewind Therapy, very helpful.

The long-range weather forecast

It is reassuring to know that with appropriate treatment and support people make a full recovery from postnatal distress and illness.

Seeking support and treatment as soon as you realise that the situation is not within the range of the normal ups and downs of life with a new baby, is helpful.

In the meantime, ensure that the baby has plenty of loving and responsive support as well.

It takes a village to raise a child and utilising the support of friends and family is great for everyone involved.

Notes:

[1] Note: I am not alone in the use of a meteorological metaphor in connection with mental illness. Sulis W. The Continuum Between Temperament and Mental Illness as Dynamical Phases and Transitions. Front Psychiatry. 2021 Jan 18;11:614982. doi: 10.3389/fpsyt.2020.614982. PMID: 33536952; PMCID: PMC7848037.

[2] Editor's note: It is sometimes possible to apply for funding for the support of a doula: https://doula.org.uk/doula-access-fund

[3] Editor's note: There are no mother and baby units in Northern Ireland.

Three Christmas Wishes

by Katharine Handel

Author Bio: Katharine Handel is a former editor of the AIMS journal. She is one of the coordinators of The Motherkind Café, an Oxford-based postnatal peer support group for women who are concerned about their mental health. She lives in Oxfordshire with her husband and children.

Christmas is traditionally a time for wishes. It's also, somewhat more mundanely, a time for lists. I've got several lists going at the moment, but I'm going to let myself make one more. This one doesn't have things I need to do on it, or things that other people would like; instead, it's a list both for myself and for all women, a list of things I'd like to see in perinatal care and society more broadly based on my five years of experience of supporting new mothers in the transition to motherhood.

I've been part of The Motherkind Café since it launched in 2019, during which time I've met hundreds of mothers who are adjusting to motherhood. The café is an Oxford-based peer support group which provides a space for mothers who are concerned about their mental health. Our peer supporters are local mums who have experience of struggling with some aspect of motherhood or mental health themselves and have come out the other side. Five years since its founding, it's still going strong, and last month we trained a new group of peer supporters so we can go on supporting women in our local area. Through talking with the mums who visit us, I've had many opportunities

to consider what I might change to make the transition to motherhood easier. So here's my personal wish list for what I'd like to see in all perinatal care, if a pantomime fairy godmother were to appear and grant me three magic wishes...

Honesty

Honesty is a vital component of perinatal mental and emotional wellbeing, and it is necessary both for the mother and for those who are supporting her. Medical professionals need to be honest with women about their options at all stages of pregnancy and birth, setting realistic expectations without enforcing a particular care pathway. Family, friends and the wider community need to be honest about their own experiences of parenthood, offering a contrast to the idealised view of motherhood on social media or popular culture and also to the often denigrated role to which mothers are often relegated. Additionally, new parents need to be honest about the support they need and about what they're finding difficult, and they also need people to be honest with.1 There needs to be a culture of open, candid conversations in the perinatal period, and this can be helped by reducing social isolation and increasing connections between new parents. At The Motherkind Café, we try to bring mothers together and create a non-judgemental, confidential space where nothing is taboo and mothers can say how they're really feeling, sometimes for the first time.

Respect

Respect is another important factor in perinatal wellbeing. One of the things that comes up in our conversations at the café is that how a woman feels about her birth experience is more influenced by how much control and choice she had rather than specific details of the experience, something that is supported by academic research.2 Medical professionals can play a vital role in mediating birth trauma, as it has been shown that if they are respectful and supportive, this can help to improve how a woman views her birth experience.3,4 Respect includes an awareness of and sensitivity to a woman's medical, cultural and personal history in perinatal care, taking all of these factors into account so that a woman is seen as an individual in need of individual care. It also includes validating a woman's feelings about her perinatal experience rather than attempting to impose a narrative on it.

Dignity

It's often said that you have to 'leave your dignity at the door' when giving birth, in a range of tones that include disparagement, pity and well-meaning advice. While pregnancy and birth certainly can involve being confronted by your body behaving in ways that it has never done before, a loss of dignity shouldn't be a given. Discussing birth in these terms is disempowering and encourages women to feel a sense of resignation and helplessness, to accept poor care or care pathways they do not want

instead of advocating for themselves. Another phrase that I would like to abandon forever is 'nothing matters as long as you have a healthy baby.' Of course the baby's health is important, but the mother's health matters too, and the idea that she can and should put up with anything as long as the baby is all right is often used to justify or downplay a mother's negative experiences. At The Motherkind Café, we try to take a more holistic approach, encouraging mothers to value their own wellbeing and empowering them to seek further help and support when they need it.

So there you have it, my three wishes. When I was first asked to write this article, it was suggested to me that I compose it as a letter of wishes for my daughter, who was born last year, and that was how I started off. But as I was writing it, I realised that I don't want these wishes to be granted so far in the future. Ideally, I'd like them to come true instantaneously! Is this asking too much? Perhaps. However, to quote a very wise editor, this list might feel 'entirely like wishful thinking, but there is no change without imagination.' So, I'm hoping that this might one day come true, sooner rather than later, perhaps with the help of more spaces like The Motherkind Café.

1 Editor's note: These are Christmas wishes and as such Katharine is wishing for the very best. Until her wishes are granted, the idea of honesty rang some alarm bells for our peer reviewer. She commented that it's very difficult to be honest in the current climate, because health visitors are not just there to support women but they also have the power to report and refer them to social services. This makes being honest with them risky. The Motherkind Cafe clearly provides an alternative safe space that any new mother would wish for.

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Postpartum: A short story

by Lizzie Lister

Editor's note: *This is a fictional account of the state of mind of a mother suffering postnatal illness. As such, it is a powerful and disturbing piece which some people could find triggering, so please consider its likely impact on you before deciding whether to read it. The following are sources of support for anyone affected by postnatal illness: Home – PANDAS Foundation UK, APNI - Association for Post-Natal Illness \| Post Natal Depression*

Author Bio: Lizzy Lister is a poet, musician, artist, gardener, mother, eco-warrior, cyclist and sea swimmer who lives with her family in a railway station beside the Cornish mainline and for a hobby adds live soundtracks to silent films with the band Wurlitza.

I know you're reading this Gracie, you nosy cow. I am melting the ice caps on Greenland for you Gracie. Your house will be underwater in no time. Yes Gracie, I'm doing this for you. Watch that sea rising. Just you wait.

I don't know why I hate her so much. Maybe I blame her. Or maybe it's because she represents control.

The forces of control, the forces of control are gathering… around our heads. That's going in the book. It's an Au-Pairs lyric, one from my inner juke-box. They're tapping our phones, tapping our phones, you can be sure that… they've seen us.

Write all your thoughts in the book, says Gracie, it will be just for you. No-one else will read it. Like I'd believe that.

Sometimes I write things specially in the book for Gracie. I take a scalpel and peel away the lemon curd of her eyelids. It pleases me to imagine her sneakily looking and shuddering as she reads. Power to the people.

Because let's face it, there's not much power otherwise. Except there is for me. I control the world.

*

July 13th. The day I discovered my gift. I'd burned my hand, held it over a gas ring. It smarted satisfactorily. I rubbed it with Vaseline and tea-tree oil, giving it a ruby gloss. I was admiring the result when Gav comes in with his phone. "It's sixty degrees in Spain" he says. "Look, here's the thermal satellite image. See that little white spot. That's Madrid."

That map. Why is it so familiar? I look down at my burned palm; the contours, the lines, in the centre a little blister; Madrid on the map. A burning blister, tiny and white. I grab a pin, try to pop it. It doesn't work. A blob of blood rises, lava-like. I wipe it off, compare my hand against his phone. Definitely the same.

"Are you okay?" Gav asks. "What have you done to your hand?" I don't know. Am I okay?

Gav hasn't been the same since the incident. We don't talk about that. Just outside things; Ukraine, train strikes, the cost of pears in Lidl.

Am I okay? I don't know. "I need the toilet." A sudden urge to retch.

I sit in the bathroom for a while. I don't want to come out. I don't know what to say. I pretend it isn't happening, like it's not really me that made the heatwave. Like it's something else, something out of my jurisdiction.

When I was little, I had a host of tiny workers inside me. They organised everything; moving my jaw, sorting my thoughts into neatly laundered piles, pushing food about with tiny spades, whisking eggs in my grumbling tummy. Tiny bearded men in little leather aprons and green felt caps.

They came back again after Fay was born. They came back with thick book-binding thread to tie my insides back together. It was like heavy rope to them. They pulled so hard I had to bite my lip, stay silent, wait for it to be over.

It's been hard for Gav. I don't know why he stays. He bangs on the bathroom door.

"Pip are you okay?"
"I'm fine. Leave me alone."

I will be fine. I just need to think. I wash my hands. The water runs clear, stinging the burn. A notification pings on my phone. Thirty-six die in small boats crossing the channel. Thirty-six bodies floating down the plug hole, into sewers, into the sea.

I should have seen it coming; in the bucket, after the birth, that great pool of bloody urine lit up like a burning sunset. All the while clouds of smoke smothering France, Siberia, Scotland, Canada. I was oblivious to it all.

Oblivious. I don't know why. Exhausted I guess. The perfect home-birth, all nineteen hours, so much gas and air the midwives couldn't keep up. Hallucinating she'd been born; kaleidoscopes of greens and browns, a voice saying would you like some honey? Gav, pleading Can't someone do something?

It keeps me awake at night. My power over the world. Silent power. I can't tell anyone. They already think I'm mad.

*

Sometimes Gav looks at me like he can see everything.
"I just wish I knew how to make things better."
It's not him. It's me.

After the incident everyone avoided us. None of my friends called. No-one knew what to say. Congratulations. A baby girl… My parents responded with radio silence. Only my sister Kate insisted on visiting. I pushed her away but she kept coming. Held onto my flailing arms. Whispered "It's okay. It'll be alright. It'll all work out. It'll be okay."

I don't know why she still calls, but she does. "I was just passing." It's hardly on her way from work. I think she comes to see Gav. I hear them whispering in the kitchen. I know they are talking about me.

*

Gav is going to work. His blue overalls stink of engine oil. I recoil from him. I don't want his pollution near me, tarnishing everything. He looks hurt. "I'll call at lunchtime to make sure you're okay. Don't forget Gracie is coming in today."

There are too many people in the world. I get a pin. Every jab will be one less. Jab jab jab; aids, hepatitis, ebola. It's easy to kill people you don't know. I can do two hundred a minute. A big patch of stinging red is forming on my thigh. I make it into the shape of Africa.

My wrist is aching and my thigh gloriously sore when the doorbell goes. I slip my skirt down over the raw patch. Don't want Nosy Parker asking questions. That's one good thing about NHS cuts. Less visits. Suits me.

"How are you feeling today?" Blah blah blah. What if she had to talk for a change? Her perfect life must be so boring.

I stare at her wedding ring. Her knuckles are swollen with arthritis. How old is she? Fifty-five? Sixty? Her ankles are thick above navy brogues, her brown curls flecked with grey. I wonder if she is someone's mother.

"Come on Pip. Give me an answer. How are you feeling today?"
"Fine."
"No more self harming?"
"No."
"Have you been keeping your journal?"
"Yes."
"Is there anything you would like to share?"

Would I like to share? Yes. Today I killed four-thousand six-hundred people in Africa, then I created a tsunami in Japan by brushing my teeth. Later I intend to drown more innocent people seeking a better life, then as a diversion am considering starting a wildfire in Italy.

"No."

I hear Gracie sigh. I know she is trying to hide her frustration from me. Trying her best to Be Professional.

"Pip, we do need you to help yourself."
"I am."

Another sigh.
“Have you eaten?”
“Yes.”

Yesterday Gav made risotto. Mouthfuls of paddy fields drowning in rising seas, Bangladesh under water. I try not to swallow but I know he is looking at me. He is watching with that worried look he wears. I stretch each mouthful for as long as I can. Try not to cry. Apologise over and over in my head. I’m sorry. I’m sorry. My throat is unyielding. I force myself to swallow. Under the table I curl and uncurl my toes.

“Yes, I have.”

I twist the skin of my wrists. Every twist makes a tank in Israel. It’s a game I like to play with Gracie. My secret. She thinks we are innocently talking, while I am making war. Twist, another tank, twist, another tank. Little bruises moving through the desert, wiping out everything in their wake.

I know when Gracie leaves she’ll get into her car and light a fag. Turn on the radio. Move on to the next visit. Probably open a bottle of wine when she gets home. I hope she does. I hope I stress her out.

*

Gav has returned. I hear him clanking around but I pretend he is not there. I am hiding under the duvet. I feel so tired. Killing people is hard work.

“I’m just making a cheese sandwich; would you like one?” he calls. He is whistling. I stay silent. If he thinks I’m asleep he might not disturb me.

He still insists on sharing our bed. Even though I shrink from him. Even though he knows what I am capable of. We do not talk about it. I hum a song to keep him away. It grows into a curtain of semiquavers and minims.

He is still there, persistent.

“Come on Pip. I know you’re awake. You need to eat. You’ve got to come out of this sometime.”

*

It wasn't like they said it would be. After the birth you will have a rush of endorphins, filling you with love. All I felt was exhaustion. They put her to my breasts. I didn't know what to do, how to feel. Just watched her, flailing her arms about.

They gave me a dose of oxytocin to reduce the bleeding. Then they filled in paperwork, quietly dismantled the baby resuscitation apparatus they'd set up. Just as a precaution. It's been a long tough labour for both of you. It had been a long day for them too. Placenta delivered. Tick. Vital checks. Tick. I was glad when they left. Finally I could go to bed. Gav's Mum was last to go. She leaned over. Kissed my forehead.

"Well done, Pip. You've made a little miracle. Make sure you get plenty of rest and Gav looks after you. You hear that Gav. Make sure Pip is well looked after."

I think Gav was as relieved as I was that we were alone. A family at last. Gav doesn't show much, but as he held Fay I could tell he was fighting back tears. We'd waited long enough for her. It had certainly been a journey.

A few minutes after they all left I collapsed. Gav carried me back to bed, brought over a bucket. All night the need to pass water was overwhelming, Water flushed with blood. Gallons of it. Gav slumbering in the chair, Fay nuzzling into his elbows.

They were busy in the days after. The little men. Pumping breastmilk all over my clothes. Sticking pins and needles into my flesh. Turning my breasts hard as pears. The feeding wasn't working. My breasts were sore and my tummy covered in a red-raw rash. The Doctor said it might be scabies. I should stop feeding Fay, smear my body in a anti-parasitic lotion. Avoid holding her for twenty-four hours afterwards.

The midwife was furious. It doesn't look anything like scabies. How ridiculous. It's a postpartum rash.

After four days Gav went back to work. His Mum offered to come and help, but I didn't want to put her out.

*

The moths are back again. They are whispering in my ear. Since I stopped doing housework they have been carving labyrinths in our carpet. I trace my hand along the hessian underlay. Round and round the garden, like a teddy bear.

I run a lighter across the hairs on the back of my arm. I like the smell. Keratin. Today I am burning forests to the accompaniment of Manuel De Falla's Ritual Fire Dance on Spotify. I hum along as the music gathers pace; clarinet trills, dense strings, soaring piano, pounding timpani. My hair frizzes, crumbles into dust. After forest fires the land grows back a chartreuse green. Some plants thrive on burnt soil. Pioneer plants. It's all part of a natural cycle.

Natural cycle. Birth, marriage, death. Death. I no longer have any fear of it. It liberates me. I could do anything. It wouldn't bother me any more. I could die now. Quite happily.

Gav would be better off without me. He and my sister Kate. They'd be good together.

*

On the morning of the incident my mother phoned.

"How are you? Sorry I haven't called, but I'm flat out with parish council stuff. I'll try and get over next week, all being well. Did you get the flowers I sent? I was expecting a call to say they'd arrived."

"I did. Thank you. They're beautiful."

Actually I found the scent of lilies cloying. There were so many smells, it was one too many. The midwifes gave Fay a quick wipe-down after she was born, but I still hadn't managed to give her a bath. Her scalp was sticky. I buried my head into her downy crown. She had her own special aroma, sort of salty, like wet clothing left too long in the machine. Cracked waxy scales of cradle-cap were forming. I carefully picked them off. She was tiny in my arms.

Everything I do and say to her now will form who she becomes. Everything. I hear my mother's voice. It's up to you not to screw it up.

I was desperate for a cup of tea, but didn't want to risk scalding Fay. My stomach itched, my breasts ached and a sore was forming on my right nipple that was getting more and more painful. Fay wouldn't stop crying. I tried to get her to latch on, but it wasn't working. Spikes of pain with each futile effort. Breast is Best. Radio 2 was playing in the background. Climate change. Jeremy Vine. A woman on the end of the line passionately advocating turning to Jesus. God, I so wanted to sleep.

Fay was still wailing when I picked her up and went into the kitchen. I sat at the table, ineffectively attempting to feed her. Why does breastfeeding make you so thirsty? Awkwardly clasping her to my shoulder I grabbed my empty glass and shuffled to the sink.

What will happen to her? What happens when war in Ukraine spreads? When food supplies collapse? When fires burn, reservoirs run dry? How could we bring a child into This?

Gav had been pretty good looking after me, but domestic chores weren't really his thing. Unwashed plates languished carelessly in the sink, and on the top lay a black-handled knife, a Kitchen Devil, remnants of cucumber flecking the blade's edge.

A sharp knife. A Kitchen Devil.
I don't know why. I don't know why it happened. It was calling.

Now! Use me! Now!
She won't suffer.
Quick! Quick!
Close your eyes
It's what she needs.
What she needs.
Strike!
Strike!
Strike!

When Gav returned three hours later she was still screaming, lying on her back in the Moses basket, the washed knife hidden in a drawer. He was shouting my name. "Pip!" Pip!" Louder and louder, closer and closer, his voice slow and stretched like he was swimming through thick, jellied water, empty boxes of paracetamol and fluoxetine littering the carpet with their promise of sleep, blissful, dreamless sleep.

*

Gav is putting his foot down. He's not used to it; he always relied on me making the decisions. Poor, easy-going Gav. Not so easy-going for him of late.

"Come on Pip. I know it's been tough, but we can't continue like this. It's been nearly three months. And we can't let our tenth pass without any kind of celebration. I've asked

Kate so you've got some support. Just a couple of days. We could both do with a break. It's a beautiful lodge, right on the beach. Please don't resist Pip."

I let him do the packing. Sit watching from the arm of the settee. Decisions are all made for me these days. He packs my pills, the box helpfully printed with days of the week. Monday Tuesday Wednesday. A card To My Darling Wife On Our Anniversary.

*

Kate is burying me in sand. I am holding my breath, rigid with fear, attempting to save the world. In Syria, Afghanistan, Egypt, Libya, sand-storms are rising, eyes smarting, lungs thick, mouths crammed with grit. In my head I am singing a protection charm. I close my eyes. Try not to scream. Sand-hoppers jump in and out of my hair. Tickle my scalp. I hear Kate laughing.

"Look Pip. The sea is almost at your toes."

I don't want them to, but they lever me out of my sand grave, straddle an arm over each shoulder, rush me into the sea before I have time to scream.

This is it. This is the moment it ends. Our watery death.

The surf is cool. The shock of the cold water catching my breath. Gav and Kate are laughing. Go Pip. I can't speak, my whole body is shaking. A swell lifts my feet off the ground. I try to sink, finish it all. But I can't. I'm floating.

A jellyfish drifts past, a gigantic bloodshot eye, watching me. My foot scrapes against sharp rock teeth. Sunlight is playing tricks. Towards the cliff the sea shimmers like glass, to the harbour, nothing but grey.

Kate has picked up a piece of long thin seaweed.

"Look. Spaghetti. You can eat it."

She puts a piece in her mouth. She is far away, in another world. I tread water. Pockets of sun-warmed thermals melt the chill of deeper currents. I am an iceberg, slowly thawing.

I'm pushing back to shore, but as I get there the undertow catches me, drags me under, spits me out like a floundering sprat.

I wait for the tide to rise, to drown us, but nothing happens. The cliffs above. The village beyond. Nothing.

I'm laughing. I'm laughing so hard I can't stop, my whole body shakes. Then I'm crying, crying all the pain, the suffering, the drowning, the burning, the famine, the wars, Gav and Kate taking me by my arms and rushing me off the beach.

I must have slept for hours because when I wake it is dark. Gav is beside me, holding my hand. I do not shake him off. He strokes my forehead. I let him.

*

"You can stay in the car if you want. But as we're passing it would be rude not to call. They'd be hurt if we didn't."

Gav. Making decisions again. We pull up outside his parent's house. I'm not ready. I say. You go.

There's a tap on the window. Gav's Mum is there. She's holding a bundle of blankets. I screw my eyes shut. Pretend to sleep.

"Oh Pip. I can't let you be so close without seeing your daughter. Isn't she beautiful." It's too late. She's opening the door. Should have locked it.

"Look Fay. Here's Mummy. Look Pip. She's smiling at you."

I open my eyes a little. She is beautiful. Not red and screwed up and screaming any more. Her skin is pink and soft. She's looking at me, smiling. Making gurgling noises.

"I'm not going to make you hold her Pip, but just put out your finger. Feel her grip. She's getting lovely and strong."

Fay takes my finger, bobs it up and down. She is looking at me curiously, trying to catch my hair with her other hand. Gav's Mum is squatting beside me. She whispers "Yes, sweetie. It's your Mummy." I can feel the tears welling again. I am a failure. Gav's Mum hasn't finished.

“Pip you mustn’t be hard on yourself. It was our fault for not insisting we came over to help. I know it frightened you, thinking you were going to hurt Fay, but you didn’t, did you? You made sure she was safe. And she is safe. Look at her.”

She wipes a tear from my cheek with her thumb.

“Pip we’re delighted to have her. She can stay as long as it takes, but she’s your daughter. Don’t be a stranger. You know where we are. And then when you’re ready…”

She tails off. I know she doesn’t want to push it. I uncurl Fay’s fingers. She goes to pull my hair again. She’s blurred, but I sense she’s still smiling.

*

Gav stands in the door. His overalls are freshly laundered, smell of lemons. Before he leaves he squeezes my shoulders. “I’ll call at lunchtime. Don’t forget Gracie.”

Gracie arrives just after eleven. The journal is on my lap; I’m writing Leonard Cohen lyrics. The birds they sang at the break of day. Start again, they seem to say.

She looks tired. Her last visit must have been a tough one. I don’t know why, but I suddenly feel sorry for her. It’s not her fault her job is shit.

“Hello Pip. Can I come in? How are you feeling today?”
I don’t know. How am I feeling today?

“I think I feel okay.” I feel nervous, like I’m welcoming a playdate without really knowing how to entertain them. She follows me into the kitchen.

“Would you like a cup of tea?” I ask.

I’m surprised to notice Gracie is fighting back tears. I feel an overwhelming urge to put my arm around her, but stop myself just in time. She gives me her best professional-front smile.

“Yes please. Thank you Pip. That would be lovely.”

END

Perinatal mental health: A preventative approach

By Mary Nolan

Author Bio: Mary Nolan worked as a birth and early parenting educator for 28 years before spending 13 years as Professor of Perinatal Education at the University of Worcester. She has published extensively in academic journals on birth-related issues and is the author of eight books. The most recent, 'Birth and Parent Education for the Critical 1000 Days', was published in 2020.

Some Inconvenient Truths

Here are some uncomfortable facts that you may well be familiar with:
In the UK, in any given week,

- *8 in 100 people are living with mixed anxiety and depression*
- *4 in 100 people are living with post-traumatic stress disorder (PTSD)*
- *3 in 100 people are living with depression*[1]
-

If we look at statistics for Black or Black British people, we find that:
23% of Black or Black British people will experience a common mental health problem in any given week. This compares to 17% of White British people.[2]

Statistics specifically for young women are as follows:
Over a quarter (26%) of young women aged between 16–24 years old report having a common mental health problem in any given week.[2]

This figure is likely to be higher in 2023 than in 2016 given the impact of COVID on mental health, and especially on young people's. In a 2021 survey of 12,000 adults across England and Wales, MIND[3] found that around a third of adults and young people reported that their mental health has got much worse since March 2020, the start of Lockdown 1.

If we turn to statistics for perinatal mental illness, we find that antenatal and/or postnatal depression, anxiety, obsessive compulsive disorder, postpartum psychosis, eating disorders and post-traumatic stress disorder (PTSD) affect up to 27% of new and expectant mums.[4]

Data for fathers' perinatal mental health is neither as robust or as available as for mothers, but in 2017, the Born and Bred in Yorkshire (BaBY) team[5] reported that: *The prevalence of fathers' depression and anxiety in the perinatal period (i.e. from conception to 1 year after birth) is approximately 5–10%, and 5–15%, respectively.* (Abstract)

What can we deduce from these figures?

Well, we can certainly say that mental health problems are widespread among the British population. In particular, young people and Black or Black British people are too often struggling with loneliness, depression, anxiety and suicidal thoughts. If you are a young woman, you are more likely to be living with mental ill health than if you are an older woman, and if you are a young Black woman, you are even more likely to be living with mental distress. All of this equates to a huge amount of human suffering, and an enormous burden on the NHS.

A significant proportion of people living with mental illness are in the group of those likely to become parents for the first time or to add to their existing family. That is, they are the future mothers and fathers of the next generation of citizens. Parents who are depressed before they become pregnant are likely to be depressed during and after pregnancy. And this matters hugely because their mental health will significantly affect the wellbeing of their babies:

If parents experience mental health problems in pregnancy or the first year of a baby's life, this can affect the way they are able to bond with and care for their child. This can have an impact on the child's intellectual, emotional, social and psychological development.[6]

Maternal mental health difficulties can have serious and lasting effects on the health and wellbeing of their baby.[7]

Interestingly, and importantly, Public Health England[8] acknowledged that parental perinatal mental health affects children beyond babyhood when it named its 2015 Report, 'Mental health in pregnancy, the postnatal period and babies *and toddlers*'.

All of us working in the field of the transition to parenthood would agree that our aim is to ensure that every baby has the best possible start in life. To achieve this, I think that we have to adjust our sights to *before* pregnancy and explore what can be done to ensure that future mothers and fathers are as prepared as possible, in body and mind, to embark on their parenthood journey.

Pre-conception health, education and care

In 2018, researchers[9] found that, worldwide, up to 50% of pregnancies are unplanned. That is, there has been no opportunity to address lifestyle factors such as smoking, overweight, relationship and mental health problems which increase the risk of adverse perinatal outcomes for mother and baby, including traumatic birth experiences and less likelihood of initiating breastfeeding.[10]

Many of the women and childbearing people who are depressed and anxious during pregnancy have a history of mental ill health *prior* to pregnancy as is evident from the figures quoted in the introduction to this article. In a study from the Institute of Psychiatry in London,[11] the authors examined how to improve outcomes for mothers and babies and concluded that the *preconception* window is the golden opportunity to address the physical and mental health of women thinking of having a baby, and of their partners, and that by so doing, health outcomes could be improved 'across the whole life course' for babies.

Spending money to address serious problems once pregnancy has occurred may well be a case of bolting the proverbial stable door..... Perhaps antenatal classes come far too late in the day; what we should be doing is running pre-pregnancy 'Preparation for Parenthood' courses and making it mandatory for every person between the ages of 16 and 25 who has not yet had a baby to attend (and, yes, I did say *mandatory*. Please send your comments via social media or email; I'd love to hear).

The Netherlands

I should be clear that the idea of a preconception programme is *not* my idea! Other countries such as the USA (some states) and The Netherlands have already thought about this. The Netherlands started its 'Ready for a Baby' program in 2008 and now has two online preconception programmes - ZwangerWijzer (Preparing for Pregnancy) and 'Smarter Pregnancy' which is a six months' programme tailored to the needs of prospective parents who are finding it difficult to conceive. Zwangerwijzer invites prospective parents to assess their readiness for pregnancy. The home page[12] asks: *Do you want to get pregnant?*

Then it is important to prepare well..... It helps to give your child a healthy start. Sometimes also to get pregnant faster. With Zwangerwijzer you can test whether there are risks for the pregnancy and your baby.
Completing the questionnaire takes approximately 15 minutes. If you have a partner, you can complete it together with him or her.
If there are risks, you will receive immediate information and advice. At the end you will get an overview of all your answers. You can take it with you to your doctor or midwife. At the end of the questionnaire, you will also receive information about a coaching program to improve your lifestyle.

These online programmes are part of a nationwide targeted programme called 'Solid Start' which was initiated in 2018 and aims to ensure that more vulnerable parents-to-be are well prepared when they start their pregnancy, and that fewer unplanned and unintended pregnancies occur. Solid Start has been described as 'social obstetrics' which moves maternal mental health beyond the medical sphere and places it at the centre of a complex of issues - poor housing, debt, job insecurity, domestic violence and substance abuse - which require the attention and cooperation of multiple groups because the challenges prospective parents face cannot be dealt with by one agency or professional group alone. A cross-sectoral approach is the most appropriate, involving local coalitions of medical and social professionals, including debt assistance services, youth healthcare services, social welfare teams, general practitioners and midwives.

The United States

In the United States, Michele Stranger Hunter has devised the One Key Question® approach to pre-pregnancy education, health and care. The idea is that every occasion on which a woman or childbearing person presents for medical care, or visits the pharmacist, or sees the occupational health nurse at work, is an opportunity for preconception advice and counselling. The 'key question' is, 'Are you thinking of becoming pregnant in the next year?' Researchers[13] have noted that:
Asking about people's reproductive goals and desires can be a powerful tool to learn more about the context of their lives and build a stronger relationship between practitioner and patient/client.

Women and childbearing people may answer the one key question with 'yes', 'no', 'I'm not sure' or 'I don't mind'. If they answer 'no', they are asked whether they are happy with their current contraception or would like to review it. If they give any of the other possible answers, they are offered information, advice and services to help them embark on a future pregnancy in the best possible mental and physical health.

Running a preconception course

Preconception courses could be run by antenatal teachers, midwives, health visitors, social workers or family support workers, and might cover:

- When is the right time for me to have a baby?
- What lifestyle issues do I need to address before conceiving a baby? (Thinking about diet, exercise, alcohol, smoking, drugs - prescribed, non-prescribed and illegal)
- Do I need some help with my mental health? Where can I get help?
- Are the key relationships in my life supportive?
- What special measures do I need to take before trying to conceive a baby (e.g. starting folic acid supplements)
- Where will my support come from if I have a baby?
- How much does it cost to have a baby? Where can I find financial support?
- Do I have the right contraception in place if I don't want to have a baby in the immediate future?
-

Where might such courses be delivered? Should they be delivered online or face-to-face?

During the COVID pandemic, many prospective parents were grateful to be able to access antenatal education online, but in the post COVID era, I am regularly told by midwives and health visitors, and by pregnant parents themselves, that they would ideally prefer for antenatal classes to be face to face. It seems to me that the obvious place to offer preconception health, care and education in the UK is in Children's Centres. Unfortunately, the number of these has declined steeply from the heady days of the late 1990s when the Sure Start programme was launched to target parents and children living in the most disadvantaged areas. The worth of Children's Centres as a locus of education, counselling, advice and support was quickly recognised and Children's Centres spread across the country to serve all parents, whatever their circumstances. However, in recent years, more than 1000 Centres have been closed. While there are plans to replace some of these with Family Hubs, it is not clear what exactly these hubs will provide and for whom. Writing only a few months ago, Sally Hogg,[14] Senior Policy Fellow at the University of Cambridge, argued that the new Hubs and Family Centres appear to be 'very different from the 'welcoming, non-stigmatising progressive universal provision which is key to improving outcomes for all children in the earliest years'.

There is also scope for running 'Preparation for Parenthood' courses at colleges and universities, and in the workplace. Let's not forget that another opportunity to maximise

positive outcomes occurs *between* pregnancies – before the next baby is conceived. Such an inter-conception programme would enable women, birthing people and couples to reflect on their birth experience and on their experience of caring for a young child. Birth trauma resolution which many NHS Trusts now offer[15] could be incorporated into or added onto a more general 'Preparation for the Next Pregnancy' programme.

A Broad Preventive Focus to Improve Parental Mental Health and Outcomes for Babies

The NHS Long Term Plan,[16] which built on the Five Year Forward View for Mental Health, aimed to transform specialist perinatal mental health services across England so that by 2023/24, at least 66,000 women with moderate to severe difficulties would be able to access care and support in the community. This was an admirable aspiration and specialised mental health services for severely mentally ill childbearing people have improved in many areas.[17] However, there is still very little for women and childbearing people with mental health issues which are sub-clinical or mild to moderate and these are the majority of parents who are struggling. There will never be enough money to fund services for all of these and while waiting for services, or being considered not sufficiently unwell to receive any, babies' well-being is at stake. How much better – for parents and babies - if we could support people before they start a family.

Reviewing progress in perinatal mental health in 2020 and the challenges facing us, an article[17] in 'World Psychiatry' argues for:

An extension of generic psychiatric services to include preconception care, and further investment into public health interventions, in addition to perinatal mental health services, potentially for women and men, to reduce maternal and child morbidity and mortality (p313).

For many years, those of us working in the early years were arguing for government and services to see 'early years' as commencing *before* children reached the age of three and started attending pre-school or nursery. Now the effort must be to push the moment of intervention back further and recognise that if we are to have an impact on children in the early years, we need to start by supporting the people who are planning on becoming their parents.

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Just 'birth': the phenomenon of birth without a healthcare professional

by Mariamni Plested

Editor's note: AIMS is honoured to present Mariamni's research study in which she interviews 10 women who gave birth without a healthcare professional in attendance.

Author Bio: Mariamni Plested studied Theology at Pembroke College, Oxford followed by Midwifery at Oxford Brookes. After working as a midwife and midwife researcher in the UK she now lives in the US where she is a PhD candidate in Philosophy at Marquette University.

Abstract

***Purpose*:** The purpose of this study was to examine the meaning and experience of the phenomenon of birth without a healthcare professional in the United Kingdom.

***Research Design*:** Reflective Lifeworld Research, a phenomenological approach, was used in this study based on the philosophical writings of Husserl, Merleau-Ponty and Gadamer (Dahlberg et al, 2008). 10 in-depth interviews were conducted with women who had birthed without a midwife or other healthcare professional present, interviews were transcribed and hermeneutically analysed.

***Findings*:** A preliminary paper from this research project was published in 2016 and described the themes of fear and risk discourse between study participants and healthcare professionals. This paper presents the broader findings of the study and describes the meaning and experience of freebirth through four further themes, 1)

naming the phenomenon, 2) the sensation of birth, 3) choice, inclusion, and exclusion, 4) the birthing self.

***Key conclusions*:** While the phenomenon of freebirth may well show up systemic failings and health service issues, taking those issues as the limit and framework for investigation into this phenomenon is problematic and does not provide a sufficient account of freebirthing experiences. The birth practices of the participants of this study are better described as resistance to the biopolitics of public birth systems than intentional birth choices. The experience and sensation of birth was described by all participants in a wholly positive way. Participants revealed a knowledge of birth grounded in personal first-hand experience as the responsible agent and actor of birth which opens up new possibilities for the way we talk about and understand what birth is.

Implications for practice: The disciplines of nursing, midwifery, and medical science would greatly benefit from interdisciplinary collaboration with the fields of philosophy and theology to deepen epistemological frameworks and understandings of the meaning of birth beyond the dominant healthcare discourses.

***Key words*:** unassisted birth, freebirth, phenomenology, physiological birth

Introduction

This study explores and describes the experience of ten women who gave birth in their homes in the United Kingdom without a midwife or other healthcare professional present at the moment of birth, and the phenomenon of birth in these circumstances.

The title of this paper 'just birth' seeks to articulate, describe, and refresh the nomenclature of the phenomenon of this study. The terms often used to name this phenomenon are 'birthing outside the system', 'freebirth', 'birthing alone', 'unassisted birth' (with an ambiguous double meaning either without the assistance of a healthcare professional, or without the assistance of delivery technology such as forceps or ventouse, depending on context, culture, and country).
These terms do not adequately capture the meaning or experience described by the participants in this study. While a previous paper from this research project (Plested & Kirkham, 2016) focused on the specific issue of risk-discourse which took place between study participants and healthcare professionals, this paper describes the main findings of the study, and seeks to surface meanings and describe the phenomenon of birth as experienced by the study participants.

A recent meta-narrative review of freebirth across diverse research traditions described it as 'a clandestine practice whereby women intentionally give birth without healthcare professionals in countries where there are medical facilities available to assist them' (McKenzie G, Robert G, Montgomery E, 2020).[1] The media keeps freebirth in the public eye with regular features and often uses language which contributes to a sensationalist perception of freebirth (Summers, 2020).[2] While the literature examining freebirth has grown considerably in the last decade, any actual quantitative data remains elusive, with no reliable statistics available on the numbers of women birthing in this way.

Methodology

See: Plested M, Kirkham M (2016) Risk and fear in the lived experience of birth without a midwife. *Midwifery* 38: 29-34
[The methodology can also be viewed here.]

Results

A preliminary paper from this research project was published in 2016 and described the themes of fear and risk discourse between study participants and healthcare professionals. This paper presents the broader findings of the study and describes the meaning and experience of freebirth through four further themes, 1) naming the phenomenon, 2) the sensation of birth, 3) choice, inclusion, and exclusion, 4) the birthing self.

Naming the phenomenon

The participants in this study met the inclusion criteria for 'freebirth' in very different ways, there was wide variety in the timing of their intention to freebirth from early pregnancy planning to in-labour decisions. Not all participants identified with the term freebirth, unassisted birth, or any name associated with this phenomenon, and several participants wanted to dissociate from any radical birth ideology, or that they had made an extreme choice.

[2] 'I find it really hard really because I think about the idea of unassisted birth and you immediately mention it and I know the first thing that's going to come out of people's mouths is 'controversial topic' why? Why is it a controversial topic, because to me it's not just freebirth, it's just birth. Like extended breastfeeding – extended breastfeeding? Breastfeeding, just breastfeeding, it's normal. Why it has to be labelled with some kind of extreme choice... it was a choice that I'd come to and I couldn't answer why because

to me it just felt normal to want to make that choice, I didn't feel like it was an unusual decision, I just felt, it just felt right.'

[3] 'I had no name for it, it didn't have a name, at that point I didn't know anyone else that had done it, it wasn't like something I'd read about and it was just something I had in my head, I know my body, I think I can do pain, I don't think it's going to be so bad and if women all over the world can do this there's no reason why I can't be one of those women. There's no reason why… and I didn't feel the need to be excessively prodded or poked or monitored or… I didn't want any of it, I just, you know, I just wanted to have a baby and that was all – but I wanted to have a well baby.'

[5] I don't think having babies should be a debate, I feel there's no middle ground, there's no me, I just want to be in the middle ground, I don't want to be a freebirth loony, and I don't want to be an obstetrician loving mummy. I don't want to be either, I don't want to be an extreme… and I don't want to look like a cowboy, I just want to have my baby where I feel safe…'

Several participants voiced a simple impulse articulated as 'I just wanted to have my baby'; calling what they were doing 'just' birth. Rather than their choice, type, or mode of birth being essentialized to a superimposed category, these participants expressed their birth choice as a unique instance of birth as experienced by them. The manner of birth was thus not a rigid predetermined fixed choice but happened to unfold in this way. Flexibility and openness to assistance from health care professionals was voiced by several participants as an integral part of their birth plan.

[4] But I had this like, whenever I felt, whenever I thought about having him on our own (and I didn't know it was a he) I just felt so peaceful about it, and so did my husband. And also he was saying, well we kind of know how to do this now, we don't really need to have somebody else… so we just decided to go for it and if it felt right to just continue and birth this baby and not call anybody. But if during labour for some reason I had an instinct that something was wrong or that I did need somebody after all then we'd be open to calling somebody, we wouldn't, you know, we wouldn't be stubborn about it.'

[7] so my plan loosely was to enter labour and instinctively do, you know, behave instinctively. So if I needed help, I was going to call for help… freebirthing and not wanting to call someone are two very different things…'

[8] 'we went to all the birth groups for (second baby) as well, so we felt like we were really informed and then I thought there is always the option of calling them if I did want them at the time, but we both felt really comfortable just saying that we would do it.'

[10] 'I'd be perfectly happy doing it [birthing], I think I'm more like the cat who likes to just go off and find a dark place and just do it by themselves.'

These women describe birth as a physiological process that they were capable of enacting unaided. Their capacity to birth was described in a number of ways including 'feeling right', 'instinct', 'feeling safe', 'feeling comfortable', and 'self knowledge'. Birth was described as a first-person activity that can be self-determined by the birthing person as agent, and participants felt strongly that their choice to birth on their own terms was a matter of personal responsibility, agency, self-identity, and the exercise of self-care and did not place them outside the parameters of what birth *is*.

All participants in this study planned homebirths, and the end result of their birthing without a midwife depended in some cases on service provision (or failings), or an inner reluctance to call a midwife in time (referred to in some literature as a 'planned BBA (born before arrival),[1] as well as an intentionally planned homebirth without midwives. It is difficult to name the phenomenon of birth in this study, while freebirth has become a widely used term it is not a term the participants in this study strongly identified with.

This feeds into a very broad discussion regarding how we define birth both physiologically and culturally, and the discussions around what constitutes 'normal' birth (as opposed to usual birth), 'natural' birth and 'technological' birth.[3] The conceptualization of freebirth as a category cannot stand apart from the conceptualization of birth writ large and may indeed contribute something valuable to such a discussion. The problem of what to call birth without a midwife or freebirth points towards something fundamentally important about the variety of what birth is, and how it is experienced. The participants made claim to name their choices as 'birth', as 'just' birth, with the implication that modifying adjectives are better suited to categories of birth such as 'birth with a midwife', or 'attended birth', 'managed birth', 'supervised birth' which at a linguistic level more precisely define the ways in mainstream assumptions of 'birth' (as with a healthcare professional) may be more accurately described.

The sensations of birth

The absence of a healthcare professional acting as documenter and scribe compiling a legal, formal, publicly owned maternity care record of the birth event shifts a freebirth from a public event into a family's private sphere with a first-person birth story and memory as the primary, only, and privileged source of knowledge. This is a significant paradigm shift from the objectification of a third person, formal, technical, systems-owned document to whatever the birthing agent chooses to disclose. The participant's

account and description of their birth experiences did not mirror a set of chronological formal notes of the sequence of physiological events, but rather described vivid memories of sensations, thoughts, and feelings.

[2] 'I was just in a completely different world, but I had a real awareness of what was going on, it's like I had both parts of my brain engaged… I knew I was fully dilated, and I just knew it, and there was nothing I could do about it… I can remember so vividly, it was honestly, I could feel the shape of his body more than something incredibly uncomfortable coming out… I was just on another planet, and it was amazing that I could do that.'

[4] 'the labour was very private… I spent most of it just on the toilet, sitting in the bathroom on my own, my husband wasn't even there, I just really wanted to be alone… and I have to say his birth was painless, it was pleasurable… it was ecstatic and it was so life-affirming, and I don't know, I can't really express it, but just empowering, it was like the best climax ever. And whenever I've mentioned this, people don't really believe me.'

[6] 'I wasn't able to do anything else, I was completely in the zone as you would say. I wasn't interested in anything else, I just wanted to sort of hide within myself and I would come out of my little thing just to have a bit of water, and ask for a bowl to throw up into, and that was it… I would say my births are very intense… my second stage was very quick anyway, it was just one push… the waters broke during the push and she just sort of slipped out [laughs].'

[8] 'I wasn't reflecting on anything like that, I just didn't care and I just totally went with it and didn't care what happened… primal, yeah, as though I was a cave girl and whatever would have happened then, I felt like I was doing that in a modern environment, but doing whatever my body wanted to.'

[9] 'you're blown open, you're blown open. I've got this sense of dilated pupils, dilated eardrums, aware of everything, so words that are chosen that are not helpful go right in, you're exposed… then diving through that [vulnerability] into golden kind of uplifting birth, just that feeling, when [x] came out of me… just one long expletive of like – WOW.'

[10] 'ok, I mean there was pain, and especially towards the end really, no maybe towards the end when it was pushing stage, not so much pain, but just really really intense, like not break between the rushes or contractions, and yeah, then after, just amazing to feel that you'd done that, and done it all by yourself…'

These accounts describe intense sensations of birth which are unanimously positive and convey a high level of personal fulfilment and well-being. Physical sensation is experienced as an intense activity, and the event of birth as an embodied mental and emotional act, something both 'primal', 'in the zone', 'on another planet' and at the same time a sense of achievement, 'wow', 'life-affirming', 'amazing'. What they disclose is not the chronology of the event, but sapiential insight into the activity of birth and the self-awareness of the birthing agent.

Choice, inclusion, and exclusion

Freebirth is often presented in the literature as an intentional choice.[1] This study finds that the concept of freebirth as a free choice is flawed as the unfolding events of participants' complex interactions with the healthcare system were more haphazard and less planned than the concept of 'choice' assumes. Some participants chose to freebirth after a long process of frustrated engagement with antenatal services:

[1] I've had enough of being told what I can't do. If you can't provide me with a service that makes me feel safe then I'll do it without you, because what you did last time was categorically not safe. Um, I knew in my head really that I was planning a born before arrival, but I didn't know that people completely stepped outside the system at this point and birthed their babies by themselves, or I would have made it as a positive choice. So we went all round jumping through their pointless hoops, going through their assessment procedures – all those things, pretending that we're booking a homebirth, knowing absolutely that what I really intended on doing was calling them afterwards… it's not just about the choice to give birth without a midwife, it's about the choice to have my baby with me in the driving seat.'

Some participants did not birth 'outside' the system, they were intricately woven into the healthcare system in ways that they were unable to disentangle themselves, for some this involved the pretence of planning a homebirth (with the intention of not calling the midwife). For one participant a deep inner paradox took place between the desire to be alone, and the need to inform caregivers that she was in labour. The uncertainty of her 'choice' and intentions were a thread running into her experience of labouring and birthing, the description of birth as an unfolding event, the role of intuition and knowing, the openness to asking for help should the need arise – this participant describes only being able to let go and birth (alone) once she had called the midwife, despite knowing the midwife would not arrive in time:

[8] I guess it's just going with the flow whilst in labour, because I probably have the intention of ringing the midwife every time, but in labour it just becomes less important,

and certainly with the fourth one… I just didn't feel to call, I don't think I really believed I was in labour at all… it's funny, after all I've said, it sounds that I'm this bold woman, but actually I think there was this fear of again not wanting to waste their time, not knowing, not 100% sure if I'm in labour… it's just such a funny funny funny thing… the minute she'd [doula] called [the midwife] my waters broke in a massive contraction, and then three minutes later when the midwife called back [doula] left the room again, and she was born. So it was perhaps psychologically the knowledge that now everyone who needed to know knew, but also funnily enough, for the first time, when even my good friend left the room, there was something about me that needed to be alone this time. And it was actually when she left the room that all the action happened.

For some participants the decision to birth without midwives was the direct result of homebirth service provision staffing failures, the family decided (in labour) when told no staff were available that they would continue to birth at home rather than transfer into a hospital setting:

[5] 'you know that whole thing where they say that their staffing levels mean that you can't have your homebirth, well you've got into your space, you've worked out how it's all going to be – to have the rug pulled out from you at the last minute – it's their fault, because you haven't considered your birth plan and how it would go in hospital. Because it wasn't an emergency, it was just a baby.'

Some participants had negative experiences with healthcare services that fed into their decision-making processes; several participants expressed a sadness, a process of disillusionment, or caution towards healthcare professionals that suggests a passive 'happening' rather than an active choice, events unfolded in such a way as to leave participants with a feeling of no choice, limited choice as a reactive self-protective measure, or a feeling of being excluded.

[7] In a way I was having to withdraw regretfully really, I'm not anti-midwife, I'm not even particularly pro-freebirth.'

[9] whilst I've not thought to birth without a midwife I have progressively throughout my four births realised that it's a sacred dance really, and it's my dance and that whoever I'm going to invite into that dance needs to be someone who knows me, and so each time, this time was obvious, the fourth one was obvious, that I just was putting off ringing, but if I look back the feeling was there the whole time… why would I ring someone I don't know, and why would I ring someone I don't know who is the face of a whole story of things that I don't agree with. Why would I want to put myself into the

situation where I may be unsafe right now, when actually it's a life/death, it's not only sacred, there's just too much at stake during labour to dance with that.'

The concept of 'safety' was a key pivot around which decisions were often made; what factors made participants feel safe or unsafe, and how they could self-determine their birth environment to maximise their personal safety. The kind of discourse that took place between participants and healthcare professionals was a major factor in decision making, the dominant theme of healthcare discourse was described by participants as being focused on the concept of risk, and an associated mood of fear. This theme is explored in depth in a previous article, (Plested and Kirkham, 2016).

The birthing self

An important consequence of the experience of risk discourse for participants was an existential awareness which led some participants to a genuine engagement with concepts of their own mortality, personal agency and responsibility (Plested and Kirkham, 2016). Participants described the impact of the experience of birth on the self, personal identity, and the transition to being a parent.

[2] 'giving birth completely shapes who you are as a parent, completely shapes you as a person, it's not just a set of choices that you make, it's part of the floor of the life that you lead.'

[8] it was completely life-changing, I was a bit, I hadn't really thought, before birth, I was the kind of person who would question everything already and not really just go along with the crowd and that was just massively intensified after giving birth.'
One participant described birth as a liminal sacred and spiritual experience which deeply impacts identity.

[9] Sacred, it's very much part of safe, um, because safety is not just physically, it's mental, emotional, and spiritual as well… because where labour and birth touches, in my experience, touches me as a woman, it just takes you to the edge, takes you to the edge of all reality, and so it's just not to be messed with I guess, that's the sanctity of it.'
Some participants described a process of personal growth and self-knowledge gained over multiple births, this self-knowledge, and 'know-how' was part of their identity as an experienced mother.

[4] I've had six babies and so, I feel like I've had, caesarean aside which I haven't had, I've had a pretty full spectrum of birth from my own experience.'

[5] I've worked it out, I've had six kids so I've learned the hard way that's all, I've had six different kinds of birth.

[9] I did an enormous amount of work with all four of them. I think every single birth brought up massive amounts of self-exploration and development…'

Birth choices were part of a personal journey through a variety of experiences of birth, and being an experienced mother uniquely formed a subjectivity and first-hand expertise of self where the 'I' carries a special knowledge of knowing what is right for 'me'. This is different to third-person lay versus professional categories of a birth companion/doula versus midwife/doctor; or categorization of birthing people as amateur or non-professionals, it concerns the unique first-person perspective of this being 'my' birth, 'my life', what I know about 'myself', the kind of knowledge that only I can have about myself and my body as I experience it. Participants described an intuitive self-knowledge during the experience of birth that was utterly unique to being the agent of birth.

[2] I didn't make those choices because I wanted to challenge anybody, because I wanted to reject the system, because I wanted to be different or because I'm irresponsible or uninformed or didn't want to engage with maternity services or any other label that anyone would like to try and put on me. I made this choice because it's my life and those are the choices I see fit to make for me and you know I'm sure that every experience I've ever had prior to this led me to make the decision I did.'

Discussion

The phenomenon of freebirth offers more than a list of maternity service failings in need of address; it produces an alternative perspective and birth discourse to obstetric and midwifery understandings of birth and offers new meanings and conceptualizations of birth as a first-person lived experience. While there is a rich and extensive body of qualitative literature exploring women's experiences of multiple aspects of pregnancy, birth, and parenting they are all founded on women's experiences as service-users. The voices and experience of freebirthing women has a resistant, transgressive, grass-roots disruptive quality which challenges professional definitions and dominant discourses around birth. The phenomenon of freebirth raises wide-ranging philosophical issues and questions and demands an examination of the broad biomedical, institutional, and cultural frameworks in which birth takes place.

The French philosopher Foucault's concepts of biopower and subjectivity offer a framework to understand ways in which healthcare systems operate and ways in which

freebirth seeks to reclaim biopower and make space for further subjectivities by enacting birth practices (the act of freebirth).[4], [5], [6] The concept of biopower, which is the control of human populations through technologies of power and disciplinary institutions (such as healthcare systems) cannot, due to the absence of a universal authorised truth, completely regulate bodies and behaviour – it is never totalizing as it always produces resistance.[7] It is this resistance that marks the human capacity for freedom, this freedom is different to a neoliberal conception of normative agency, it is rather a freedom to transgress socially imposed limits.[8] This freedom opens dialogue where totalizing dominant discourse seeks to close it. Foucault's ideas of stigmatisation and freedom to transgress are a better articulation of the experience of the participants of this study than the conceptualization of freebirth as a positive choice.

DeSouza (2013)[9] uses the Foucauldian conception of subjectivity to critique neoliberal individualism which casts women as 'autonomous social actors who are fully in control and knowledgeable about their bodies and 'free' to make and justify choices.' She frames this individualisation as a form of biopolitics of the state, and argues that the self-disciplining, self-regulating maternal subject has been championed by the nursing institution in its concept of 'individualised care' which promotes choice and autonomy as valid concepts. DeSouza observes that a mechanistic understanding of birthing and mothering practices necessitates supervision (the health care professional, obstetrician or midwife with their accompanying discourses) which in turn produces a new maternal subject which has lost confidence in her innate ability to birth and mother.
This observation shows a nuanced understanding of Foucault's descriptions of how subjectivity, and new forms of subjectivity are produced by discourses, and how objects (or subjects) are disclosed by our practices. Risk discourse functions as a behaviour control technology with specific disciplinary procedures deployed to effect compliance, and what claims to be evidence based practice is selectively utilised as a form of social control. The practice of freebirth sidesteps hierarchical observation at the moment of birth by avoiding documentation, surveillance, and supervision. The absence of public maternity birth records transfers the event of freebirth into the private domain of those who birth in this way.

In addition to Foucault's writing there are many other philosophers whose ideas richly contribute to the analysis and understanding of this phenomenon. Using Merleau-Ponty's emphasis on the body as the locus of knowledge of the world, and Gadamer's ideas on bodily experience and the limits of objectification the embodied act of birth can be understood as an act of subjectivity – of the birthing 'self'.[10], [11], [12], [13], [14] Freebirth integrates physical and mental health concerns in a way which upholds the primacy of the lived experience and the birthing body as a site of

knowledge. Giving birth as a physical 'act' by a birthing subject is a primordially embodied activity, which transcends the physiological process of birth as bodily mechanisms and involves a psycho-somatic subjective depth. The simple formula of 'having a baby' or 'just birth' (rather than freebirth or unassisted birth) centres the birthing self in the definition of birth, to birth is to be a birthing person, as opposed to birth being a bodily process abstracted from a specific person. First-person knowledge of birth will be of an entirely different quality to knowledge about the process of birth.

Participants' descriptions of the sensation of birth speak of this quality of knowledge which forms self-identity and subjectivity. Wellness around birth commonly falls into a binary dichotomy of physical and mental health; the kind of bodily knowledge alluded to by Merleau-Ponty's work suggests a psycho-somatic whole not well accounted for and poorly understood by the scientific community, such as what it means to experience childbirth, what it means to experience from a first-person perspective, what it means to have a body which 'I' experience as 'mine'.

Limitations and strengths

The use of phenomenology, as the methodology of this study, comes with its own backdrop of philosophical assumptions amid a wider theatre of the epistemological truth claims of modern Western science, both qualitative and quantitative. It can be argued that qualitative healthcare research seeks to present something genuine that can be said of participants' life experience, and achieves this via a complex negotiation between participant voices and researcher representation. This negotiation will always fall short of definitive final facticity due to both the complexities of the social and cultural constructions which are latent in participants' own constructions and the researcher's linguistic representation. The contribution of this phenomenological interpretive negotiation is to an 'ongoing conversation' not the formulation of a totalizing account.[15] The findings of this research project merit in depth extended philosophical analysis beyond the scope of this paper.

Conclusion

There is a growing body of midwifery research which focuses on motivation to 'freebirth' in order to highlight maternity service problems and failures,[16], [17], [18] or even as evidence of a 'broken maternity system'.[19], [20] While the phenomenon of freebirth may well show up systemic failings and health service issues, taking those issues as the limit and framework for investigation is problematic and does not provide a sufficient account of freebirthing experiences. Weaponizing freebirth for midwifery political

leverage may overlook fresh and richer understandings of birth that arise out of the experiences and narratives of women who birth in this way.

This is reflected in the very names associated with this phenomenon 'outside', 'free', 'alone', 'without', 'unassisted', all terms which 'other' the subject and set them apart from a dominant discourse which is centred as normative. This study found that participants did not identify with radical tags, but rather saw their birth choices as the pursuit of something essentially simple, legitimate, and uncontroversial, as 'just' birth. The birth practices of the participants of this study are better described as resistance to the biopolitics of public birth systems than intentional birth choices. The experience and sensation of birth was described by all participants in wholly positive ways. Their disclosure provides a unique insight into their unobserved, undocumented, private experience. The language used to describe this experience is in a completely different register to healthcare terminology, it can be described as sacramental rather than anatomical, as testimony rather than documentary. Participants revealed a knowledge of birth grounded in personal first-hand experience as the responsible agent and actor of birth which opens up new possibilities for the way we talk about and understand what birth is.

Implications for practice and further research

The disciplines of nursing, midwifery, and medical science would greatly benefit from interdisciplinary collaboration with the fields of philosophy and theology to deepen epistemological frameworks and understandings of the meaning of birth beyond the dominant healthcare discourses.

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I was nearly one of those induction statistics

by Jo Dagustun

Editor's note: While Jo remembers her 'nearly induction' experience with fortitude and pragmatism - I love the way that she went shopping while she was waiting - her story is increasingly common and does not always end happily. It is a story that describes a sequence of events that not uncommonly leaves women feeling depressed, anxious and even traumatised by the mismatch between the sense of urgency that led to them agreeing to the (often unwanted) induction and the quality and timeliness of the care received (or not received) once that agreement was secured.

Author Bio: Jo Dagustun, mum of four, has been an AIMS Volunteer since 2017. Jo is a geographer and civil servant by background, and wrote a PhD on women's birth experiences (Learning to birth, mastering the social practice of birth: conceptualising women as skilful and knowledgeable agents). As well as working with others to understand and improve maternity services in the UK, Jo enjoys tutoring on The Brilliant Club's free to access Scholars Programme and spending time by the sea.

Induction rate soaring. Maternity units short-staffed and unable to cope. Much talk of some inductions being unnecessary. How can we judge?

18, nearly 19 years ago, I was nearly one of those induction statistics. Would that have been an unnecessary induction? Here are my recollections and reflections. They may not be entirely accurate, but you will get the gist.

Wind back to 2005. I was pregnant, in the zone of term. Baby #2. First labour and birth straightforward, albeit 15 years previously, with a different partner.

Pool set up in the living room, ready for a go at a homebirth, to be attended by NHS midwives; maybe even a home waterbirth.

Monday: leaking amniotic fluid. Midwife came out to visit. This event took me into the PROM category. Induction advised within x hours. Was asked by the midwife to check in at my local hospital that evening, if contractions hadn't started, to be admitted for induction.

An aside: I called a - midwife - friend. She suggested I go in. She'd had a bad outcome with a baby the previous week, I think she'd said. She was clearly nervous. (Never call a midwife?!)

No more buses, I announced, when I spoke to the midwife we spoke (on the phone?) that evening. Thinking I held a trump card.

And even if I come in, I haven't agreed to an induction. (I'm not sure whether I spoke this sentence out loud.)

I wasn't prepared to pay for a taxi. I didn't see the rush. Argued the case for the following day. Midwife suggested I call 999 for transport (!) The transport argument blown away – my main defence - that's what I did. Awkwardly. Yes, I said to the paramedic, that's what I've been told to do, realising the ridiculousness of the situation as they sought to ascertain why they had been called out.

Now an inpatient. Monday night. Tuesday. Wednesday. Nothing. Nothing that resembled care, more like an adequate hotel stay. I had my own room. Probably not en suite, but I wasn't fussed. Explored the local area a bit. Stacked up on magazines and snacks from the local Tesco Local. Chilled out. Seemed a bit silly, but what did I know?

No further offer of induction. I recall being told that they were too busy. How did the expiry of an x hour danger zone (was it 24 or 48 hours, I can't recall) come to count for so little, I wondered?

But no problem. I was settled. I didn't yearn for home. However, I felt that I was being treated well on the explicit staff assumption that I was yearning. I sensed that I had become 'the disappointed home birth in room x'. Who's going to argue with that?

I realised that I might/should be able to do something – some sort of active movement - to trigger the onset of labour, to avoid the impending induction procedure, which felt to me unnecessary. (Labour had been triggered with #1 whilst watching a comedy movie. I think this was relevant!) But the easy opportunity to keep mobile in my home environment was not available to me. No stairs. No cup of tea to make. No village walk to pass the time. (Nor the video player to put on a funny film.)

Wednesday night: a deep squat at the bedside seemed to do the trick. Contractions started. Yikes. Spontaneous onset of labour achieved. Okay, we're ready to go ...
(There's also something to be told then about labouring on the antenatal unit; visiting restrictions; how and when partners get called back when we go into labour on the antenatal ward, but that's another story.)

Thursday morning: a straightforward birth

Postnatal ward: why do so many babies here have broken arms, I wondered? Later to find out that what I saw was antibiotic treatment, not casts and slings ... And that's another issue, not for now.

So, some reflections, with the benefit of hindsight.

It certainly feels that I should have just stayed put at home, with guidance to check my temperature regularly and report in if I noticed an issue. The risk, as I understood it to have been, was infection with the potential of severe consequences for me or the baby, so why did my place in the induction queue involve me being put at increased risk of a hospital acquired infection?[1] I could have gone in when called.

I don't know whether I'd have made it through labour at home, so a transfer might have been necessary in any case.

I don't feel I will ever know whether the staff and I were taking an unacceptable risk in (as I understood it) not following the induction protocol, due to lack of capacity (rooms/ staff, I'm not sure) to deliver it.

Given the delay in induction 'treatment', I feel that I took up space on the antenatal ward for no benefit to anyone, but at a cost to me. The cost was in the potential for this environment to reduce my ability to sleep well, to eat well, and to mobilise well. This might have affected my chances of going into spontaneous labour, I'm not sure.
I've also heard talk of a difference between fore water and hind water leaks. That the amniotic sac might reseal.[2] I hope we know more now, and with that knowledge shared, more accurately understand our options.

I hope that things have changed. That I'd be encouraged to stay at home, to be trusted to take my temperature to check for infection. To call for help if needed. I now wonder: was the inpatient-located induction queue really all about the lack of trust in the service user to look out for ourselves? How hard can it be to take your temperature regularly?

I don't know the cost of my 48 hour inpatient stay for the system.[3]

The opportunity cost[4] must be very high now, with the rates of induction having risen. I hear of new areas in some maternity hospitals now: the induction suites. All needing to be staffed and maintained, inpatients fed and 'cared for'. We've got a new specialist midwife role too: the induction manager or somesuch. That all costs, and takes away from resources that could be spent elsewhere.

I wonder how many women, like me, go into spontaneous labour whilst they're in the queue for the reason of PROM. (Why are so many labours induced nowadays? Perhaps the PROM route is a small minority?) And how many of us are induced just before a healthy straightforward spontaneous onset would have anyway occurred.

Lots of questions, but one thing I'm sure of: I could so easily have been just another induction statistic.

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[2] Editor's note: A single episode of leaking fluid is sometimes attributed to a small tear higher up in the sac of membranes that has resealed. www.ncbi.nlm.nih.gov/pmc/articles/PMC7311775
It is now advised that women do NOT allow any vaginal examinations (either with a speculum or with fingers) if they know their waters have gone, because this increases the risk of infection. If it is not certain if the waters have gone, a short wait will make things clear because if they have gone, the leaking will continue - so it is still a good idea to decline even where there is uncertainty. https://wisdom.nhs.wales/health-board-guidelines/swansea-bay-maternity-file/pre-labour-spontaneous-rupture-of-membranes-at-term-management-2-swansea-bay-maternity-guideline-2021-pdf

[3] Editor's note - at today's prices a hospital bed is about £350 per night, www.theaccessgroup.com/en-gb/blog/hsc-virtual-wards-funding-and-costs

[4] Editor's note: Opportunity cost refers to what you have to give up to buy what you want in terms of other goods or services. In Jo's example, money spent on increasing rates of induction and on induction suites, cannot now be spent on providing more midwife-led units or more one-to-one care.

An interview with Dr Rebecca Moore from Make Birth Better (MBB)

interview by Alex Smith

Author Bio: Rebecca is a consultant perinatal psychiatrist based in London and the co-founder of Make Birth Better an organisation which seeks to reduce trauma for women and birthing people and those working in maternity settings by campaigning and training.

Rebecca is a medical cannabis prescriber and is interested in the use of novel psychedelic medicines for those living with and healing from trauma.

Rebecca believes kindness is a much-underused skill in medicine alongside fierce activism and challenging of the status quo. She is a mum and outside of work enjoys travel, watching trashy TV shows, seeing live music, long dog walks, eating a lot and sleep.

Hello Rebecca, thank you for agreeing to answer some questions about your work with Make Birth Better. I wonder if you would start by introducing yourself and by saying why it is that you were drawn to this role.

Yes of course! My name is Dr Rebecca Moore. I am a perinatal psychiatrist and the Co-Founder of Make Birth Better.

I have been working in perinatal psychiatry since 1999, and I love the field. It's a mix of psychiatry, obstetrics and paediatrics and it's an immense privilege to work with women through a pregnancy and the early part of being a parent.

It is a time of such unique vulnerability and one where women can get very mentally unwell very quickly but can also get better very quickly. It's so important women have

specialist support around this time as maternal suicide remains sadly far too common in the UK, even in 2023, so this is a time where women and birthing people need intensive care and support.

I love psychiatry because in essence, for me, it's about hearing people's stories which are endlessly fascinating and an honour to hear. I have always worked in London and this has meant that I have worked with colleagues from all over the world and worked with families from all over the world too. No one day is ever the same and it's an immensely rewarding career.

Can you tell us a little bit more about how MBB came into being? What was the trigger, who were the founders, and where do you come in?

Over the years as I sat with women and families after birth I heard increasing stories of birth trauma. What people really wanted to do was to debrief their personal experiences and to understand their birth and they often found there was no space for them to be heard.

At that time in 2007 there wasn't much known about birth trauma, and it certainly wasn't something I was taught about during my training. I felt I needed to learn more in order to offer more meaningful support.

So, in 2009, I planned the first annual birth trauma summit and we just had our 8th this year. It was a complete labour of love organised by me with no budget, but the positive power of social media meant that when I asked 'who knows about this?', I got lots of answers. The first conference had researchers, experts by experience, therapists, fathers and partners; over 200 people turned up on the day. It was the most amazing day of stories, tears, sharing about the ripples of trauma, and learning about how we can work together to make birth better.

Then I met Dr Emma Svanberg, a clinical psychologist and she was also looking at birth trauma and had done a thematic analysis of women's birth stories. We joined forces and Make Birth Better/MBB was born.

Since then MBB has grown into an amazing collective and we work via training, campaigning and activism.

We trained over 3000 NHS staff in 2022 around birth trauma and trauma informed care and I am really proud of the work we are doing.

We are part of the first All-Party Parliamentary Group (APPG) in Parliament with a focus on Birth Trauma, and we have just collaborated with PANDAS on a document for new parents to download for free to help facilitate those often difficult first conversations around our mental health with healthcare professionals.

I do a lot of the teaching and training with MBB and I love this aspect of the work. I really value hearing from colleagues about innovative practise and how services all around the UK are evolving.

Why do you suppose there is a need for MBB? What is going on?

Unfortunately we know that many women in the UK, around 30-40% in most studies are traumatised by some aspect of their perinatal experience and that means that large numbers of women, birthing people and partners are subjectively traumatised each year.[1]

We know that a smaller proportion, around 3-8 percent of all women who give birth per year, will go on to develop a clinical episode of post-traumatic stress disorder or other diagnoses such as Depression or obsessive-compulsive disorder (OCD) due to the experiences they had during pregnancy or afterwards.[2]

This might be due to one thing that happens, or it is often a combination of things that might happen antenatally, during the birth, or postnatally.

So here is the story of Kate, a first time mum who had no continuity of care through her pregnancy and saw a different midwife each time. One midwife told Kate the baby was large and this made her feel a bit worried about the birth but no one explored this. Kate was overdue and ended up being induced. it's not what she'd hoped for but she was not really given any options and she said it felt like she was suddenly on a conveyor belt that she couldn't get off. Kate said the induction was very long and she did not sleep for three days. At the very end she said there was suddenly a panic about the baby's heart rate. No one was talking to Kate directly but she could see the midwife's face change and look worried and she hit the emergency buzzer.
Kate said she started to feel really panicked and the room suddenly filled with people and her partner was pushed further and further away from her into the corner of the room. Kate said the doctor said that the baby was in trouble, she did not know exactly what that meant and assumed it meant the baby might die.
Kate said she felt completely terrified and helpless. She said her son was born and did not cry and then he was rushed off to NICU. She said she had not even seen the baby

and so she assumed he had died. It was only after 45 minutes that Kate learned her baby was alive and she did not meet him for several hours.

This is a powerful story and you can see the layers of trauma that Kate experienced. She describes many of the key things that people find traumatic, she felt increasingly panicked and out of control, she did not feel people were talking to her or explaining what was happening. She felt lonely and separated from her partner and she feared her baby was going to die or had died[3]. People often start off by feeling very shocked and detached after such an experience and then over time go onto develop other symptoms of trauma, replaying the events, nightmares, visual images of perhaps the midwife's shocked face, feeling anxious and on edge, feeling something else bad might happen to them or their baby, for example. These are all classical trauma symptoms.

Have you thoughts about what would need to happen within (or without) the maternity services to make birth better?

This is a huge question!
What I know is that huge numbers of people each year are coming away from their perinatal experience significantly traumatised and this has to change.

We need to think really systemically about this in my opinion and tackle this issue on many levels.

Of course, at the very heart of things we need women and birthing people to be able to come into NHS services that are safe. Services need to be fully staffed and teams need to be trauma-informed and healthy so that they consistently provide kind, compassionate and women centred care.[4] We know that maternity services are in trouble in many places, not all of course, and that record numbers of staff are leaving the NHS. We also know that teams are working with members of staff being burnt out and thus providing poor care to women so we get a cycle of trauma going on.[5] We need the government to invest the money it promised into maternity services.

We need better antenatal care and this needs to provide a space where women can ask questions about birth and discuss all the ways birth might be. Women need to be better informed and to understand their real choices around pain control, instrumental birth and/or induction for example. Many women go into labour not knowing this and never having any real discussion and this becomes a trauma that could have been avoided with better antenatal care and discussion.

It's crucial that all people who support women and their families, in whatever setting, understand the importance of birth trauma and that many cases of birth trauma can be prevented.

The words and language we use are important, we talk about this in depth in our Every Words Count Campaign which you can see on our website, with trauma phrases said to people are often a key part of their trauma that can stick and loop in their minds for months and years.

We need to provide culturally sensitive and dignified care to all. The ongoing MBRRACE results identify that we need to act now to improve outcomes for black and brown women, and we need to know about rates of trauma for the LGBTQIA+ community and how we provide bespoke care for them as a group. I think we need to come back to person-led, bespoke care that really listens rather than tick boxes and checklists!
We know that at least one third of the cases of birth trauma stem from a lack of interpersonal factors (including safety, kindness and respect), so we need to constantly teach, train, and model respectful interpersonal skills, and reflect on the care that we give.
Personally I think we don't do this well enough at all in the NHS. We need to ensure that, as teams, we can reflect on our care, safely challenge poor care, and hear the voices of women and their families to learn from these in order to constantly improve and adapt. I think we need to involve peer support more often and to listen to the voices of Networking Maternity Voices Partnerships (MNVPs) and third sector groups.

We need to screen better for trauma during pregnancy and screen for trauma post birth and think about how we do this and when.[6] I would like women to be screened for trauma more at their 6-8 week postnatal check for example or at the eight month developmental check with the Health Visitor. So we need to ensure GPs and Health Visitors feel confident around trauma and work in a trauma-informed way as well.

It can sound daunting but change is happening, and I would say never forget what you as an individual can do in your own practice, to train others or to fight for change. If we hold in mind trauma and work with a set of internal trauma-informed practices - listening, kindness, reliability and advocacy - then each of us can model what we want to achieve and cause wider change.

How can MBB help on an individual level, and how can it help bring about change for everyone.

I hope, for individuals, MBB offers lots of support and stories of healing. At our website, there are a lot of free resources; a supportive online community; and help for women to begin to find access to support. I also think for many, it offers a space to finally feel heard and be validated; we work very hard to be a space where all the stories of birth can be heard.

On a larger scale we work to spread knowledge with our amazing champions who work in their own geographical areas. We campaign and collaborate with lots of other groups to create broader change, and we of course train lots of different groups about birth trauma, trauma-informed care, trauma after loss, and how to look after ourselves when working with trauma. We hold an annual two-day online summit each May, which all can attend to share the amazing research and initiatives going on around the world to reduce trauma and support families after birth trauma.

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3 Editor's note: As Rebecca explains, the experience of trauma is subjective and can follow an experience that on paper is recorded as being normal and straightforward. What trauma stories often share though are accounts of poor communication; lack of empathy, kindness and support; fear; helplessness and neglect.

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Putting a spotlight on women's health

by Charlotte Edun

Author Bio: Charlotte Edun is a doula, MNVP (Maternity and Neonatal Voices Partnerships) lead in Maidstone and Tunbridge Wells NHS Trust, researcher at the School of Nursing, Midwifery and Health at Coventry University and AIMS volunteer. Her areas of interest are decision making, health literacy and physiology informed care.

In September 2023, AIMS was invited to speak on a panel titled, 'Health inequalities and different groups of women', at The King's Fund's 'Putting a spotlight on women's health' event. The Kings Fund was established as a charity in 1897, and has a mission to ensure the best possible health and care is available to everyone in the UK. The conference was an opportunity to discuss the causes and experiences of women's health inequalities, bringing together speakers and delegates from Government and policy, from NHS Trusts, third sector organisations and service users.

Setting the scene – an equal picture

Inequalities – or perhaps variations – in women's health were clearly described by Professor Dame Lesley Regan (Professor of Obstetrics and Gynaecology at Imperial College London and appointed the Government's Women's Health Ambassador in 2022) in the plenary session. Women's health needs are predictable, so it may be anticipated that women could prepare appropriately, yet 45% of pregnancies are unplanned or ambivalent, one in three women over 60 years of age suffer urinary incontinence, and fewer than 10% of women say they have enough information about gynaecological conditions, the menopause and specialist women's health conditions.

However, the point was made that while women's reproductive health forms a generally predictable rhythm through our lives, these specific issues are not the only ones that mark health inequalities between men and women. Symptoms of cardiovascular

disease (CVD) present differently in men and women, and women wait longer for diagnosis. Osteoporosis is a major cause of women's morbidity and mortality in later life. Twice as many women as men live with Alzheimer's disease. While women's life expectancy is higher than men's, the years they live healthily is lower (ONS 2022). (Of course, there are issues which disproportionately affect men, including suicide and alcohol related death, cancer and COVID-19[1]. A question mooted in the plenary session was: should The King's Fund put a spotlight on men's health too?)

Health inequalities and different groups of women

AIMS was invited to join the panel reflecting on how health inequalities affect different groups of women in relation to maternity care. This was an opportunity for AIMS to draw attention to continued failure to implement a universal offer of midwifery continuity of carer (CoC). CoC was recommended in Better Births (2016) and is consistently identified by mothers as an important factor in their care. This model - which provides a named midwife for every mother - has been shown to improve outcomes for mothers and babies, especially those from disadvantaged groups. CoC facilitates a dynamic in which women can confidently and safely disclose information about their pregnancy and circumstances, and midwives can tailor their practice to provide truly personalised care. The absence of CoC, in favour of the continuing bureaucratic, fragmented, institutionalised model, marks a significant structural health inequality for all women, and particularly those who already face intersecting health inequalities.

Intersecting health inequalities include: poor health literacy (4 in 10 UK adults struggle to understand health information[2]); geographical variations in services (for example, whether your local NHS Trust provides antenatal education or not, and whether it is practically accessible to you); and institutional bias[3]. Matrescence, the period of time during which we transform into mothers, has a significant and long-lasting effect in women's lives, so the quality, accessibility and appropriateness of maternity services matter. Despite strategic ambitions for 'woman-centred care', it remains true that maternity and post-natal services grow from the existing form and function of the institutions that are delivering those services and are not truly designed with the needs and preferences of mothers and new families at their centre. This is evident at every stage of women's motherhood journeys, from fertility services, through booking-in and scheduled antenatal appointments, to postnatal care and support.

In preparation for this event I asked for feedback from my AIMS colleagues, from third sector organisations including Baby Umbrella, my independent birth worker colleagues, and those working in the NHS . They were generous in their feedback and keen that their observations on the issues women face in accessing high quality, appropriate maternity care were represented. The AIMS Helpline[4] regularly hear from women who are not

given the adequate and unbiased information they need to make informed decisions, who are not supported in those decisions and who are not listened to when they raise concerns or make complaints. These are all issues that impact safety and well-being, and that we at AIMS believe CoC could address. We already know that having a relationship with your midwife, and being able to continue a conversation about your options and preferences through your pregnancy, leads to better outcomes[5] than the current fragmented system, where it's 'pot-luck' whether you see the same midwife or not, and appointments are focused on managing risk and the completion of scheduled observations and tests.

In addition to the absence of this important condition of continuity in NHS maternity care, colleagues noted that new mothers often face practical and physical challenges that inhibit their access to services. Invitations to postnatal appointments held in clinics, rather than at home, often within days of giving birth, and sometimes with older siblings in tow, makes those appointments stressful and challenging, rather than easy to access, welcoming and positive in these important and often overwhelming early days. For those reliant on public transport this can make travel costly, difficult and time-consuming - sometimes impossibly so.

Colleagues also identified that the referral system is unwieldy and opaque, so new mothers often are not clear on what role the health professional they have been invited to see has, what the intended outcome of their appointment is, or how to follow up. New mothers regularly face long waiting lists for early-days interventions and support for issues including breastfeeding, post-natal recovery and birth trauma. This often means that women rely heavily on either peer-to-peer support, or on charitably funded or private services (if they know that they are available and are able to afford them).

These community and charity groups are, in effect, mopping up what the NHS cannot cope with. It is notable that these groups are facilitated and staffed largely by volunteers, and are subject to the twin threats of increasing costs-to-serve and decreasing funding. Much of the weight of women's health services is carried by 'mothers supporting mothers', investing their own time, drawing little income and managing this work amidst the demands of their own families. As one charity Trustee noted "Imagine we lost funding tomorrow. I wonder how the system would cope?"

Women's health needs don't change, but support for them is subject to the tides of politics and economics

There is, of course, the potential for this to be resolved by the putative Women's Health Hubs that Professor Dame Regan championed in the plenary. Intended as 'one-stop-shops' for a variety of health and social care needs, and linked to 'spoke' networks

connecting more complex services both in-person and virtually, the ambition is to connect health and social care, education and services in formats and locations that replicate the lives and behaviours of the women and families using them.

The investment in Women's Health Hubs sounds wonderful of course. But it perhaps raises more questions than answers. How different are these Hubs from the now defunct Women's Well-being centres of the early 2000s? Where do these sit in relation to the Family Hubs and Start for Life programme[6] intended to 'join up and enhance' services, and existing primary care networks? Where would we be if 1,416 SureStart centres had not been shut-down since 2010[7], [8]? How much more budget would we have to invest in women's health?

There's a pattern here. In 1993 *Changing Childbirth*[9] recommended a significant attitudinal change in maternity care, towards 'woman-centred care'. In 2016, Better Births set a target for relational, woman-centred maternity care, in an environment appropriate for the family in question.[10] In 2019 the Royal College of Obstetricians and Gynaecologists *Better for Women* report stated: "When we get healthcare right for girls and women, everyone benefits" [11]. Yet access to appropriate and consistent maternity care remains an aspiration rather than a reality for the vast majority of women in England, and in many ways seems further away than ever. Why is this? As one of the speakers at this event noted, women in health care are still seen to be "oddly shaped men", and this idea was echoed by one reviewer of the first draft of this article, who commented; "are we simply avoiding reform of core institutions that need to be less male centred and more accommodating of female bodies?"

This merry-go-round of shining spotlights on women's health, generating new initiatives and strategies, appointing new reports and new departments and still, repeatedly missing the mark and failing to give mothers the care and support they need, leaves me feeling frustrated and not a little hopeless. So I am very sorry to say that events like this feel a little hollow. Until the normalcy of female bodies, our physiology and needs, are embedded into the bed-rock of the institutions that provide health and social care, I worry that these events, while an important forum for exchanging ideas and forging new relationships with similarly passionate activists for improvement and change, are essentially toothless.

[1] Men's Health Forum (2022) Levelling Up Men's Health www.menshealthforum.org.uk/strategy-case
[2] NIHR Evidence: Health information: are you getting your message across?; June 2022; doi: 10.3310/nihrevidence_51109 https://evidence.nihr.ac.uk/collection/health-information-are-you-getting-your-message-across
[3] MBRRACE-UK (2023) Saving Lives Improving Mothers' Care 2023: Lay Summary www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2023/MBRRACE-UK_Maternal_Report_2023_-_Lay_Summary.pdf
[4] helpline@aims.org.uk. AIMS supports all maternity service users to navigate the system as it exists, and campaigns for a system which truly meets the needs of all. The AIMS Helpline volunteers are all experienced in providing information and support on pregnancy and birth issues. We do not give medical advice, but instead we focus on helping those who contact the Helpline to find the information that they need to make informed decisions which are right for them, and support them to have their decision respected by their health care providers. They are also able to provide a listening ear and practical support for women who are unhappy with their experiences.
[5]NHS England (No date) Continuity of carer www.england.nhs.uk/mat-transformation/implementing-better-births/continuity-of-carer/#:~:text=The%20continuity%20of%20carer%20model,midwifery%20team%20throughout%20their%20pregnancy.
[6] Gov.uk (2023) Family Hubs and Start for Life programme www.gov.uk/government/collections/family-hubs-and-start-for-life-programme
[7] The New Statesman (2023) Replacing lost Sure Start centres is a tacit admission of austerity's failure www.newstatesman.com/quickfire/2023/02/replacing-lost-sure-start-centres-is-a-tacit-admission-of-austeritys-failure#:~:text=Since%202010%2C%20the%20policy%20of,sites%20linked%20to%20Sure%20Start.
[8] Children & Young People Now (2022) More than 1,000 children's centres closed over last decade www.cypnow.co.uk/news/article/more-than-1-000-children-s-centres-closed-over-last-decade
[9] Department of Health . HMSO; London: 1993. Report of the Expert Maternity Group: Changing Childbirth (Cumberlege Report)
[10] NHS England (2016) *National Maternity Review: Better Births Improving outcomes of maternity services in England A Five Year Forward View for maternity care* London: NHS England
[11] RCOG (2019) Better for women: Improving the health and wellbeing of girls and women www.rcog.org.uk/about-us/campaigning-and-opinions/better-for-women

Maternity services not wanting to listen and gatekeeping the telling of service user experience: a tale from September 2023

by Jo Dagustun

In 2016 in England, Better Births was published. That report launched a huge programme of work, with good intentions to improve our maternity services. But how far have we come since Better Births? What difference, so far, has Better Births made? I've been particularly interested in how we have struggled to operationalise the Better Births vision as something against which we can measure progress. That said, I am heartened by work now underway to establish a set of 'patient reported experience measures' (PREM), to help us get a handle - at a national level - on the direction of travel. But I also worry about this initiative. Insight in this area is perhaps not so easily boiled down to a few key indicators, beloved of those ready to draw up the latest dashboard. So one thing I'm sure of is that the PREM initiative will be just one contribution to our job of listening to, understanding and learning from the service user experience.

And in this context, something really interesting happened yesterday, which seems highly relevant to the national debate about improving maternity services, and that key question about our willingness and ability to solicit, listen and learn from service user feedback.

En route to settling into the tasks I had planned for my morning, I spotted on Facebook an unusual post on a public Maternity Voices Partnership (MVP) page. It was a striking, colourful, large text post. It asked, in big bold lettering, something like this: "what was the worst part of your maternity experience?"

I have been a member, for AIMS, of NHS England's Maternity Transformation Programme Stakeholder Council for the last couple of years. In that role, I'm keenly interested in how we're doing, as a national maternity service, against the vision set out in Better Births (2016). There are many ways to 'test the temperature' on this. Alongside all sorts of national datasets, this sort of direct service user feedback is one.

This question, from that MVP account, was bold. And it 'worked'. It quickly attracted the attention of perhaps ten local service users who each had a story to tell. In a few lines or a chunky paragraph, they each clearly set out their answer to that question.

I truly believe that engaged service users, who are generous enough of their time to offer such feedback on their experiences, are key participants in the job of maternity service improvement. How can we improve if we do not truly hear, if we do not create the spaces in which service users are motivated to speak up? Without doubt, this sort of feedback to the maternity service is gold dust. For me, it is a very helpful prompt in thinking about how far we might have come, or not, in terms of service improvement since Better Births and to reflect on whether all of the myriad improvement initiatives - that each take up precious staff time - are 'hitting the spot'.

When collecting experience data for this purpose, when that experience took place matters, of course. (One of the frustrations for some with the Ockenden Report was that the vignettes, carefully collected, were not dated in this way.) Diligently, then, the person/people behind this local MVP account had come back to the post, asking respondents to indicate the date of their experience. Many did. Some of the responses were shockingly recent.

I have never seen a question on an MVP page generate such positive engagement. Despite the controversial nature of the question, this was a stunningly effective prompt for feedback. And this is such valuable feedback, which we can use, in the maternity service improvement community, to help us identify those 'sticky areas', those parts that service improvement initiatives are failing to reach. And my sense, in taking a very quick look at the responses yesterday, was that they collectively provided some hugely helpful material for reflection and learning, and also that these were unlikely to be purely local issues.

MVPs, via their social media pages, often seek answers to the question of whether service users have any feedback to offer and what service improvements they would like to see. Recently, on another MVP page, I noticed that service users had been invited to share positive experiences of the local maternity services. I will admit that I popped through a query to that MVP: is this really the best way to signal to service users that all feedback counts, especially to those who may not categorise their feedback as positive? In my experience, having dabbled in qualitative research and listened to women tell me about their birth experiences in that context, I am certain that these experiences are complex. Listen for long enough, and they are fascinatingly messy stories, with both 'positive' and 'negative' recollections of the maternity services all

bundled up into the mix. But that complexity can take time to be told and will only be told if the conditions are right.

Often, the learning for the maternity services from patient experience lies buried. Certainly, simple surveys asking women to rate their experience fall far short, in my view, of capturing the data we need for service improvement. Indeed, I'd argue that it is nigh impossible to make any meaningful sense from them. In that context, the question posed by this MVP - from a service improvement perspective - has worked really well to collect feedback that we need to hear. Put to work, it has proved itself as a question of worth.

But as well as responses from service users to the question posed, there were inevitably other responses which challenged the MVP's action. I'm not sure who these responses were from. Maybe some were from staff members, or from those with family members who worked in the local service. I get it: it's hard to see that 'worst experience' question being asked, and to then see the responses to that question coming in.

And then, perhaps the inevitable happened. When I went back to look in more detail at the thread, that evening, I couldn't find it. I assume it had been deleted or at least set to temporarily semi-unpublished. I have no idea who was behind that decision. I very much 'hope and pray' that it was not senior hospital managers, exerting their power in the name of reputation management.

Let's be clear then, this is only a partial telling of the story. Those involved will have more to say. Whether they do talk about this publicly, and offer their reflections as I have done here, is as yet unclear. But one thing is clear to me. We all know that we have a huge problem across our maternity services in terms of quality and safety. We all agree that it is vital to listen to service users. But at the same time – and here's the conundrum - we are deeply uncomfortable when service users do speak up about their experiences, especially in a public forum. And that's why I believe that this story, in September 2023, is an important indicator of that collective discomfort. It tells us, quite powerfully, of what happens when we do speak up, when we do encourage others to speak up. We are reprimanded. At the click of a button, the service user's voice (which always entails some degree of emotional labour) can be simply deleted by those with power from the public record. If I was one of those service users, whose feedback had been deleted, I would be angry. Very angry indeed. It is wholly inappropriate for an MVP to 'share power with us' on their platforms and then unilaterally, at the press of a button, take away our

power to speak. (I am assuming here that the MVP page didn't seek permission from contributors to the thread to delete their text from the public record.)

> **And maybe it's time for service users to get angry, actually. Not just those who have suffered the very worst outcomes, who are doing a stunning job at present in trying to hold senior leaders to account for maternity service failings**.

My sense is that service improvement lessons can be learnt from deep listening to any and all service user experiences, whether that service user has been persuaded to define their experience overall as positive or negative. And maybe we all need to be just a bit more angry that those lessons aren't being learnt. Maybe too we need to work harder to create our own spaces, where we have the power to put what we want on the public record. The AIMS Journal, of course, has played that role over the years.

Initiatives such as They said to me are also crucial as we repeatedly contest who has the right to be heard and what stories are 'allowed' to be told and shared.

Feeding back to a system that has hurt us in some way is hard. When we speak, it is the system's responsibility to listen and listen hard. Bravo that local MVP for finding a way that helped some of us find our voice and speak up. Despite my alarm at what happened yesterday - and maybe the post will reappear/ perhaps it already has - you renewed my hope that the MVP structure we have set up is not always co-opted by the system to mute and sideline any dissent from the corporately approved script.

Editor's note: For anyone wishing to give feedback about their care in a way that won't be immediately deleted, consider following the formal complaint route. A formal complaint can reflect the complexity of the experience that Jo describes, by stating the aspects of care that had felt good, those that were lacking (the focus of the complaint), and a brief description of the care that would have felt appropriate - concluding with a clear statement about what you would like to happen as a result of the complaint. These links take you to guidance about how to do this : AIMS, and Birthrights. This procedure can be frustrating and disappointing, but it does get your feelings and experience on record and it has the potential for bringing about change.
If the formal complaint route doesn't appeal, AIMS recently featured an article about an online organisation called Care Opinion, which appears to be a very effective way of ensuring your feedback is heard.

Influencing the future of midwifery and maternity research

by Jude Field and Jenny Cunningham

Author Bio: Jenny Cunningham - I am one of the part time Research Advisors at the RCM. Prior to this I was a clinical midwife, a research midwife, and a midwife researcher in the southwest of England. I was also the RCM Learning Rep at my local hospital Trust. Since working for the RCM, I have led on the development of the RCM's Research and Development strategy and am now with my Research Team colleagues delivering projects to help and support midwives with their involvement in research. I am also undertaking a part time PhD on the topic of weight stigma in pregnancy.

Author Bio: Dr Jude Field - I job-share with Jenny as one of the two part-time RCM Research Advisors. Prior to this I was a clinical midwife, midwife researcher and midwifery lecturer in North Wales. I completed my PhD in 2018 and my focus was about levelling the playing field within clinical practice in terms of how home birth is offered to women and birthing people. Alongside my RCM role I am a qualitative research assistant on an England wide project exploring the clinical and cost effectiveness of a group-based intervention for women being cared for by NHS perinatal mental health services. My current research interests also include maternity care provision for victims and survivors of abuse.

The background to the project

Maternity services are complex, and multiple elements come together to support the service provision to improve the care that it provides. Research plays an important part in this system, but the RAND report in 2020 found that for every £1 spent on pregnancy

care in the UK only around 1p is spent on research. This compares unfavourably with other areas of health, such as stroke (3p for every £1), dementia (6p for every £1), heart disease (7p for every £1) and cancer 12p for every £1). Over the past three years, we have been implementing the Royal College of Midwives (RCM) Research and Development Strategy to build research capacity amongst midwives and maternity support workers, to increase the levels of research collaboration between midwives and the wider members of the maternity team, and to influence the maternity agenda.

We want to influence policy makers, so they understand where there are gaps in evidence and if their policies have a strong evidence base. Another area of influence is on those organisations who fund research, such as the National Institute of Health and Social Care Research (NIHR), to get more funding for important areas in midwifery and maternity research.

This article is to let you know about an exciting new major project which we are undertaking. The Research Prioritisation Project, supported by stakeholders that includes AIMS and a range of other professional and service user led organisations, was launched in July 2023. We want to find the top 10 priorities for midwifery and maternity research, based upon the perspectives voiced by midwives, student midwives, maternity support workers and women and pregnant people. To this end, we are working with the James Lind Alliance (JLA), which identifies and prioritises unanswered questions or evidence uncertainties with healthcare professionals and those they care for. This is the first time the JLA has undertaken a midwifery and maternity prioritisation project.

Although a major focus will be on establishing the priorities for clinical midwifery and maternity care, we also want to identify priorities for research in the important areas of midwifery education and workforce wellbeing. Any topic that is part of the midwifery and maternity support worker (MSW) sphere of practice will form part of our project. Identifying the priorities for midwifery research means that we can highlight the important areas for research. We hope this will result in better care for women, their babies and their families, although we do acknowledge the challenge of research findings being adopted.

How we will engage and involve individuals and organisations

We recognise that inclusion and diversity is a key principle for this project to ensure that we can be confident that the resulting priorities are relevant for service users across the UK. We know that we will have to ensure that the project reaches a wide spread of people and as possible. We are working with our EDI lead and using our networks across the UK to reach as many people as possible from different backgrounds. We are

therefore very pleased to be working with AIMS on this project. Nadia Higson, a volunteer for AIMS, is on our project Steering Group and AIMS is a Project Partner. The Steering Group is a key part of the project and will support and guide us and is ultimately accountable for the project. The membership of the Steering Group comes from all four UK countries and brings with them different experiences of midwifery, maternity support, research, leadership, education and user experience of maternity care. We are thrilled to have such a strong group of individuals who will work together throughout the length of the project.

It is vital that we involve organisations that can reach and advocate for women and birthing people as well as for midwives and MSWs. This is achieved through our Project Partner network which is a mix of service-user organisations, such as AIMS and the Miscarriage Association, as well as NHS Trusts and Boards and Universities. These organisations will be able to support the project by involving their membership and staff to ensure we have extensive engagement across the board.

How can you get involved?
We will be releasing two surveys next year and would like as many people as possible to complete them and put forward their priorities for midwifery and maternity research. The first survey, early in 2024, will be a short one inviting you to let us know what is important to you or where you think the evidence gaps are. You do not need to have had experience of research to complete our survey – your experience of maternity services is what we are interested in.

The second survey, in the autumn 2024, will be inviting you to prioritise a list of research questions which we will have created from the results of the first survey. The final opportunity to get involved will be as part of our workshop in early 2025, which is where the final top 10 priorities will be confirmed.

You are able to sign up to receive the surveys direct to your inbox or you can look out for communication from AIMS and the RCM around the time of the survey release. To sign up as an individual, click here to complete the form as an 'Interested party'. We would also welcome expressions of interest from any organisations you know, or which you are involved in, who would like to be a Project Partner. The same form is used for this purpose.

Please spread the word far and wide. We want you and your family and friends to influence the future of midwifery and maternity research.

What happens at the end of the project?

Following the workshop, we will produce a report and use this to champion the top 10 priorities. We hope that you will also raise awareness of our priority list and be able to encourage others to do the same. We will use our top 10 list to influence the funders of midwifery and maternity research which in turn will ensure that the right studies are funded. We hope this will contribute to the efforts that are being made in the UK to improve the care of mothers, babies and their families. Above all, we want to influence those who invest money in research and ensure that midwifery and maternity has a fair share of the cake.

We hope this article will inspire you to take part in this exciting project. If you have any questions or comments, please use our project specific email address to contact us: researchpriorities@rcm.org.uk

Birth Activist Briefing –
The new NICE guideline on Intrapartum Care: what has changed?

by The AIMS Campaigns Team

The guideline covers care recommendations for "Women in labour who are pregnant with a single baby, who go into labour at term (37 to 42 weeks of pregnancy) and who do not have any preexisting medical conditions or antenatal conditions that predispose to a higher risk birth" and "whose baby has not been identified before labour to be at high risk of adverse outcomes." This was only a partial update, with many sections remaining unchanged from the 2014 version.

AIMS submitted 32 stakeholder comments and we are pleased to see that the majority of our suggestions were accepted in whole or in part by the Guideline Development Group. You can read our comments and those of other stakeholders, and the responses to them here.

Here we review some of the key changes made to this guideline, as well as some remaining points of concern to AIMS. There are also many minor additions or changes of wording - too many to cover in this short article - so you may like to check the new wording of any sections that are of interest to you.

1.1 Antenatal education about labour

A new section has been added recommending discussion and recording of preferences and choices for care as early as possible in their pregnancy. AIMS was concerned that this might lead to women and birthing people being pressured into making decisions before they felt ready to do so. We are pleased that the draft wording was amended to make clear that "they are free to make their decisions and change their mind at any time, including during labour or while giving birth."

1.3 Planning place of birth

Although most of the recommendations in this section were not reviewed some of the wording has been altered. For example, the recommendation that women be advised of settings that are 'particularly suitable for them' has been replaced by the less directive wording that they should be told that a midwife-led unit (or home, for multiparous women)

"is associated with a lower rate of interventions and the outcome for the baby is no different compared with an obstetric unit."

There have been some useful additions to the list of information that should be given about all local birth settings, such as the availability of birth pools and different medical forms of pain relief.

1.3.6 Impact of BMI on choice of place of birth

The previous guideline simply listed a BMI at booking of 30 to 35 kg/m2 as a factor "indicating individual assessment when planning place of birth." This has now been replaced by a separate section that puts the emphasis on the woman's decision-making:

"Advise women that, in general, the higher their body mass index (BMI) at booking (and particularly with a BMI above 35 kg/m2), the greater the likelihood of complications, so this may be something they wish to think about when planning their place of birth."

In response to AIMS suggestion they have added the clarification that "in general the risks of complications are higher for nulliparous women with an increased BMI compared with multiparous women with an increased BMI." They also amended the summary tables in Appendix B to include evidence that for those planning birth in an alongside midwifery unit it is only nulliparous woman that a BMI above 35 kg/m2 who have an increased chances of an unplanned caesarean or a post-partum haemorrhage compared with those with a BMI of 35 kg/m2. or less. For multiparous women their BMI made no difference.

However, we are disappointed that they failed to include the main point of our comment - that evidence suggests that the chances of a poor outcome for otherwise healthy multiparous women with a BMI over 35 kg/m2 appear to be lower than for nulliparous women with a BMI in what is considered the 'healthy' rage of 18.5 to 24.9 35 kg/m2 .{Ref Hollowell J. et al BJOG 2014 Feb;121(3):343-55} and that birth in a midwife-led unit is therefore an equally reasonable option for them.

The evidence tables in Appendix B are worth reading in detail.

1.4 Care throughout labour in all birth settings

We are pleased that in response to our comment "the committee added an additional overarching recommendation to emphasise that women should be given all the information they need to make a supported decision and consent should always be obtained." This is recommendation 1.4.2 which says:

"When providing information on the benefits and risks of care options or suggested interventions:

- encourage the woman to ask questions
- if possible, give her time to think about the options and
- help her make a supported decision.

Obtain consent before carrying out the chosen care option or intervention."
We regret that NICE continues to use the misleading term "supported decision" rather than "informed decision" but otherwise welcome this addition.[1]

They have also made a couple of helpful changes to the wording of recommendation 1.4.3:

"All staff and organisations should ensure that all birth settings have a culture of respect for each woman as an individual undergoing a significant and emotionally intense life experience, so that the woman is in control, is listened to, **her choices are supported**, and she is cared for with compassion."

Communication

1.4.8 This new section covers how a woman (and her birth companions) should be given information about care during labour. Points include providing information in clear, plain language; tailoring the content and delivery of information to the needs and preferences of the woman; providing reliable interpreting services that are independent of the woman; using culturally sensitive language and adapting communications as necessary for people with learning disabilities or autism.

We are particularly pleased to see the strengthening of the language around autonomy and consent in recommendation 1.4.10:

"Ensure that the woman is **empowered, informed and central to making decisions about her care**, and recognise that the way in which care is given is key to this.
Support the woman so she:

- **can continue to make decisions about her care**
- **feels confident that her care team is there to assist her**
- **understands that she can accept or decline care that is offered, can change her mind, and that decisions she makes will not affect how care is provided to her."**

1.6 Pain Relief

One important addition to this section is a reminder "that every woman's experience of pain is unique and may be expressed in different ways."

New sections have been added on the use of sterile water injections (1.6.13 - 1.6.15) and intravenous remifentanil patient-controlled analgesia (1.6.20 - 1.6.23).

"Consider intracutaneous or subcutaneous sterile water injections as a pain relief option for women in labour with back pain."

The quality of the evidence was insufficient for the committee to make a strong recommendation about the use of this method for back pain, or to recommend it for general labour pain. (Note that NICE guidelines use the word 'consider' rather than 'recommend' to indicate a lower quality of evidence.)

"Consider intravenous remifentanil patient-controlled analgesia (PCA), at 40 micrograms per bolus with a 2-minute lockout period, as an option for women who want ongoing pain relief during labour and birth."

The guideline points out that this is an off-label use of the drug, and cautions that it should only be used in obstetric units because of the risk of it causing respiratory depression.

1.7 Prelabour rupture of membranes at term

AIMS was concerned to see in the draft guideline a recommendation (1.7.2) that all women with suspected rupture of membranes after 37+0 weeks but no risk factors should be seen in person within 6 hours, despite the fact that the evidence review stated that there is no evidence to support the need for review at this stage.

We recognise that some people may find it reassuring to be seen in person and were happy with the recommendation to "see the woman in person as soon as possible if she has any concerns or wishes to be induced immediately." However, we felt that pressure to attend within a certain time limit when someone did not want this could be disruptive to the progress of labour and their emotional wellbeing. Also, we did not agree with the committee's belief that a 6-hour limit would be "sufficient to allow a woman to spend the night at home."

We suggested that this non-evidence-based recommendation be replaced with "offer the woman a review within 6 hours if she wishes." Unfortunately, the recommendation

remains in the final version, but has at least been amended to say "within 12 hours" and with a recommendation to offer the woman a choice of where this review takes place.

1.8 First stage of labour

A small but important addition (1.8.41) under the heading of delay in the first stage is:

"Do not advise transfer to obstetric-led care for amniotomy alone" because "Based on their knowledge and experience, the committee were aware that amniotomy could be safely carried out in midwife-led settings."

There are also some important additions concerning the use of oxytocin (1.8.45 - 1.8.53). We are pleased that they have accepted our suggestion to replace the words "she can be involved in decisions to start, stop or restart the oxytocin" with "her choice to start, stop or restart the oxytocin will be supported", to better reflect that this should be the woman's decision.

Also at our suggestion to explain why oxytocin might be stopped they have added the clarification that "oxytocin can cause hyperstimulation, which may increase the chance of transient fetal hypoxia, and if hyperstimulation occurs the dose will be reduced or stopped."

Another new recommendation is "that the time between increments of the dose is no more frequent than every 30 minutes" which should hopefully reduce the chances of the dose being ramped up excessively.

We are pleased to see the words: "Use oxytocin in labour with caution", and the recommendations to reduce or stop it if a woman is having more than four contractions in ten minutes, and to discontinue it immediately and seek an urgent review "if the cardiotocography is pathological."

Given the role that appears to have been played by excessive oxytocin use in some of the cases in the Ockenden and East Kent maternity service reviews, AIMS hope that these recommendations will be taken to heart.

1.9 Second stage of labour

There are some new recommendations on positions and pushing for women with or without an epidural in place (1.9.5 - 1.9.10.)

A section on **Intrapartum interventions to reduce perineal trauma** includes the reminder to "Discuss the woman's preferences for techniques to reduce perineal

trauma during birth and support her choices." Other recommendations are to offer a warm compress once the presenting part distends the perineum and to consider perineal massage if preferred to a compress. Because the evidence for 'hands on' and 'hands poised' was mixed and there was "no evidence for a technique called 'the Finnish grip'"[2] they decided not to include a recommendation about these approaches. However they did include a 'Research recommendation' to explore the effectiveness of these different approaches.

Research recommendations

There is quite an extensive list of recommendations for research to fill in gaps in the evidence:

Effectiveness of hands on, hands poised or Finnish grip in the second stage of labour for reducing perineal trauma

Effective dose for restarting oxytocin if it's been stopped because of abnormal CTG

Position of the baby during cord clamping

Impact of pharmacological interventions for the management of postpartum haemorrhage on breastfeeding and women's and their birth companions' experience and satisfaction in the postnatal period

How does the provision of accurate, evidence-based information affect women's decision-making processes and choice of place of birth?

What are the long-term consequences for women and babies of planning birth in different settings?

What is the effectiveness of altering the dose of intravenous oxytocin to reduce excessive frequency of uterine contractions?

What is the most effective treatment for primary postpartum haemorrhage?

AIMS is pleased that so many of our suggestions were accepted, although some areas of concern remain. It is particularly encouraging to see the clearer emphasis throughout on autonomy, the importance of providing full information in an appropriate and accessible way, and of supporting the woman's decisions. We hope that all maternity services staff will reflect on what they can do to:

"ensure that all birth settings have a culture of respect for each woman as an individual undergoing a significant and emotionally intense life experience, so that the woman is in control, is listened to, her choices are supported, and she is cared for with compassion."

Actions for Birth Activists

Read the full guideline and familiarise yourself with what has changed.

If you are an MNVP or MSLC user representative, ask how your Trust/Board is updating their guidelines in the light of the changes to the NICE Guideline, if not then ask a local representative to check for you.
Ask your local Trust/Board what actions they are taking to "ensure that all birth settings have a culture of respect for each woman as an individual undergoing a significant and emotionally intense life experience, so that the woman is in control, is listened to, her choices are supported, and she is cared for with compassion."

[1] **Editor's note:** Legally, as with all health care, any care decision in labour is the mother's and hers alone. If she so wishes, it can be a fully informed decision, and all options must be on offer. The term 'supported decision' suggests that the mother needs a medical person's support before her decision can be accepted, when according to the Montgomery ruling, she absolutely does not. However, when she does make her decision, it must be supported by the midwives and doctors involved in her care, even if they do not agree.

[2] **Editor's note:** The Finnish grip (not to be confused with the Javelin throwing hold of the same name) is a proposed method of 'guarding' the perineum by using the index finger and thumb to apply pressure as the head is being born.

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

by The AIMS Campaign Team

Written outputs:

- **24th August: Open letter to NHS Confederation about new guidance on supporting trans and non-binary healthcare staff.**
- **4th September: Freedom of information request to NHS England about the whereabouts of three long awaited maternity related evaluation reports.**
- **6th September: Freedom of information request to the NI Ambulance Service for the script used when women are in labour and birth is imminent.**
- **Review of NICE intrapartum care guideline**
- **3rd October: AIMS Campaign's team commentary on Maternity Transformation - where are we?**

Conferences and meetings attended:

- **5th August: AIMS stand at Breastival NI**
- **10th August: NHS England Maternity and Neonatal (was Transformation) Programme Stakeholder Council meeting**
- **13th September: Wales and South West Maternity and Midwifery Festival**
- **19th September: Women Health Conference at The Kings Fund. AIMS on discussion panel.**
- **September: Make Birth Better Birth Trauma Workshops**
- **18-19th September: HSJ Patient Safety Congress 2023**
- **20th September: Pool Study Stakeholder Event**
- **21st September: Meeting with European Network of Childbirth Associations (ENCA) colleagues, and associated preparatory meetings**
- **22nd September: Stakeholder Advisory Network meeting of the CHERISH project**
- **27th September: Maternity Continuity Network meeting (Jo and Catharine), and associated meetings throughout the period**
- **28th September: NHS England Maternity and Neonatal (was Transformation) Programme Stakeholder Council meeting**
- **12th October: MBRRACE-UK 'Saving Lives, Improving Mothers' Care' virtual conference 2023**

Who we have been collaborating with:

- **9th August: Meeting with NCT Head of Communications and Campaigns to introduce AIMS Campaigns**

- **October: Emailing local MPs about attending Make Birth Better Parliamentary Debate on Birth Trauma on 19th October**

What else we have been reading:

- **Martyn Pitman case with reference to whistleblowing in obstetrics within the NHS.**
- **NHS England - Update from the Maternity and Neonatal Programme**
- **Gates Foundation 2023 report: Imagine a World**
- **CQC State of Care report - focus on maternity services**
- **Henci Goer: Routine 39-Week Induction: Busting the ARRIVE Trial**

What we've been watching/listening to:

- **Maternity and Midwifery Hour**
- **MBRRACE UK (maternal) course online**
- **Parliamentary debate on Birth Trauma**
- **The Maternity Safety Alliance's call for a statutory inquiry into the maternity services**

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