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A Matter of Trust

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A Matter of Trust

Trust and responsibility: Going with the flow

by Alex Smith

Image Source

Welcome to the September 2024 issue of the AIMS journal. The theme for this quarter explores different aspects of trust encountered in the course of a person's maternity care.

Bringing a baby into the world is fraught with uncertainty, and always has been. Do I really want this? Will I find the support I need? Will the pregnancy go to term? Will the baby be all right? Will I survive this? WIll my partner-relationship (if there is one) survive this? Will I still have a job? Will I be a good parent? Will I be able to provide for another person? And, an uncertainty down the generations, will the world be a safe place for my baby? The honest answer to all of those questions is, 'probably, hopefully, I trust it will, but who knows?'.

Uncertainty is part of life. It is natural and inevitable, and we weigh probabilities every time we climb the stairs, cross the road or use a toaster. While our mothers may secretly worry about us, we generally get used to living with these everyday uncertainties; we generally learn to trust ourselves. In pregnancy however, self-trust is systematically undermined. From the moment of conception we are taught to defer decision-making to the midwife and doctor, and to the birth technology - it is *as if* the

mother is merely an incubator and cannot be trusted with responsibility for the baby, but that is not the case in law. With very rare exception, even when we might actively want to abdicate responsibility and appoint 'experts' to make the best decisions, the appointment of those other people, and whether or not we comply with their advice, require 'master' decisions that are ours and ours alone to make. However much we may want to trust the doctor or midwife, if we experience any sense of doubt or reluctance or uneasiness in response to their advice or behaviour, we have a moral and ethical duty to ourselves and our baby to respect and trust this intuition.
As Rachel Wolfe and Sarah Fisher describe in their accounts in this issue of the journal, parents too often look back at their birth experience wishing they had trusted themselves more. Medical authority is not always right, and even when it may be right for some, it may not be right for others. Therefore, unquestioning obedience, in the presence of personal doubt, could be regarded as irresponsible - we have only to think of the Milgram experiments in the 1960s to be reminded of this.

Unquestioning obedience ("I will do anything they tell me to") is also unfair to the practitioner who is then burdened with a *sense* of total responsibility. It is a powerful sense, but only a sense because, legally, nothing can happen without the mother's consent. In truth, the practitioner is only responsible for the *quality* of care that they offer; they are not responsible for whether or not that care is accepted. Unfortunately, this sense of total responsibility is so real and so burdensome (as is the accompanying fear of litigation) that the practitioner, as Mary Nolan touches on in her article, may feel that they cannot trust themselves, or indeed, trust the mother. Instead, just as many parents unquestioningly trust the midwife and doctor, many midwives and doctors unquestioningly trust the current protocols and feel unsafe when parents do not comply. This is when the shroud-waving begins - further undermining the ability of parents to trust their own instincts.

Parents who do experience doubt, reluctance or uneasiness about medical advice are obliged to make an active decision. In the face of uncertainty, a common decision-making strategy is to 'do what most other people do', or 'to go with the flow'. But there are two flows, *the flow of the physiological process*, a flow that does not require decisions, only responses, and the *mainstream maternity care flow*, which, in modern times, is the deeper channel carved by what most people currently do. Naturally, without one's hand on the rudder, this is the flow that we tend to be swept into, and to resist this flow risks incurring social disapprobation. Reflecting on freebirth recently, Malika Bonapace, who writes in this issue, said to me:

Isn't it ironic that those who place 100% of the responsibility for their birth into the hands of strangers are considered the most responsible, while those who assume 100% of the responsibility for their birth are considered the most irresponsible.

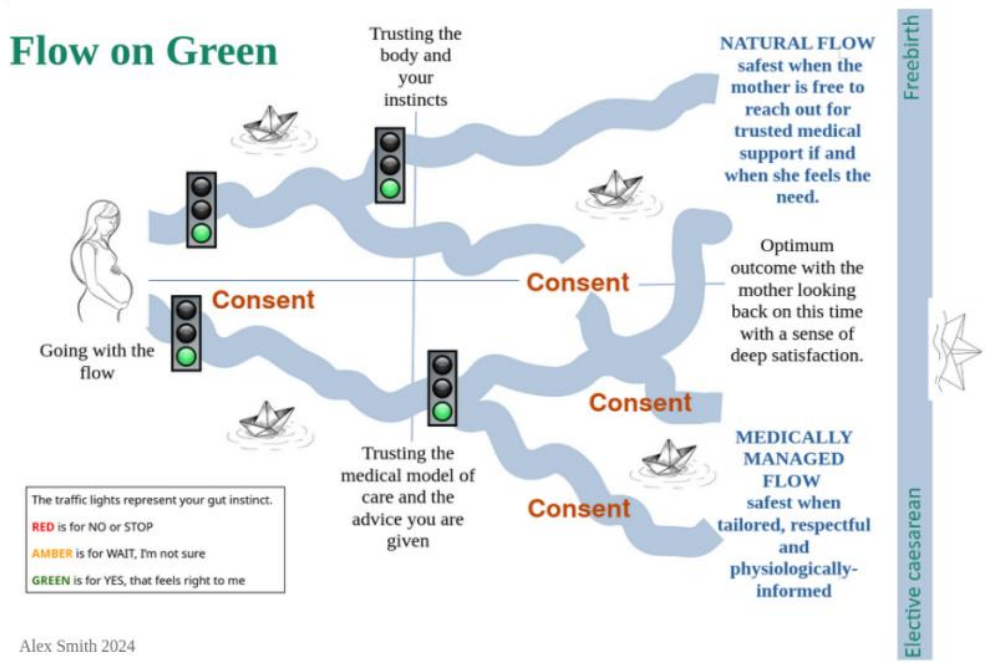
Even if we know the maternity care flow has risks or repercussions we would rather avoid, the fear of the disapproval makes it hard to really trust ourselves and our instincts. What to do?

When parents tell me that they wouldn't trust themselves to know what to do at any given point, I invite them to 'trust their traffic lights'.

Imagine that you have an internal set of traffic lights, red, amber and green:

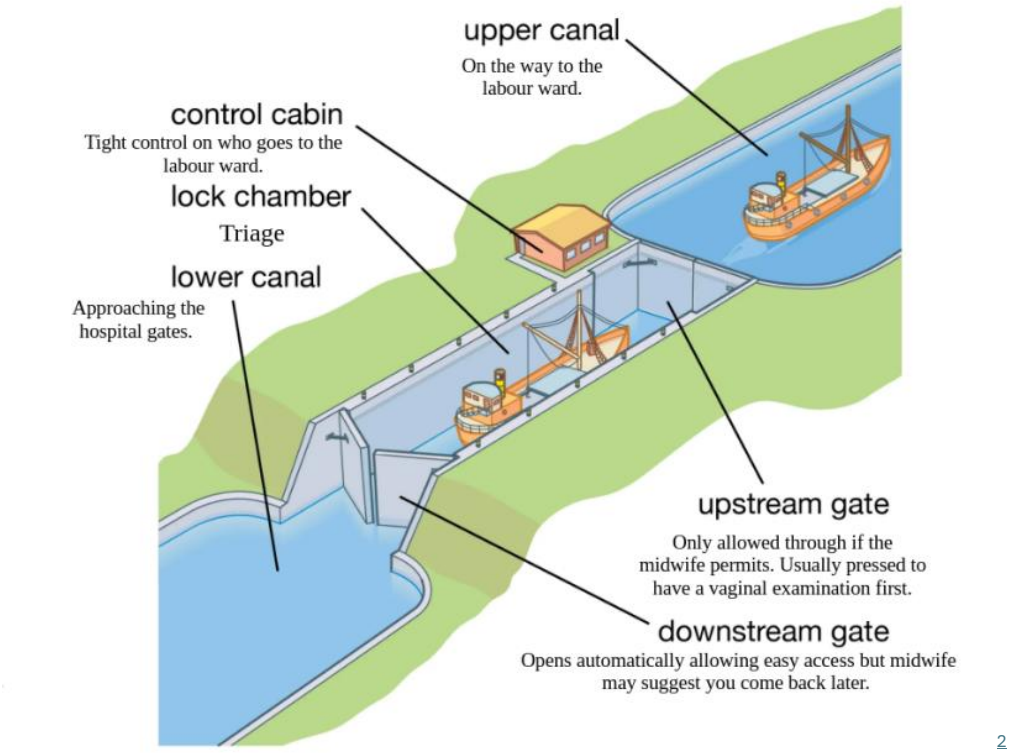
- **The red light** would flash if someone wants you to agree to something that immediately makes you feel distressed, on high alert, afraid or coerced. Red is for when your instinct is to shout NO or STOP.
- **The green light** would flash if the suggestion immediately triggers a wave of relief and a sense of being heard, cared for and respected, if it resonates comfortably with every fibre of your body and you want to shout YES, LET'S GO.
- **The amber light** would flash if you are just not sure. You may need time alone to tune in to your body, you may need more information, you may need to discuss things in private…or you may just be feeling 'possibly yes, but not just now'. Amber is always WAIT.

The body is intelligent and the green light will always respond to an offer of help if the situation is urgent. Reaching out for help is one of our deepest instincts. It is safe (as safe as life gets - stairs, road and toaster safe) to trust our internal traffic lights. Whichever flow you decide to go with, only *flow on green*.



Flowing on green means that you trust and do what *feels* best at any given point. The physiological process of labour is like a river. With rare exception, it is likely to flow unimpeded, to its destination. No decisions are required but instincts might draw you to move or vocalise in certain ways, seek a deep warm bath, hide away in the loo, or call out for help. The body knows what it is doing.
As Kath Revell writes in this issue, "Trust is at the heart of physiological birth", and this was certainly the case with Salli Ward when she had her three babies at home. When the idea of letting nature take her course stirs a green light feeling, trusting this is entirely reasonable and responsible, and safer today than ever before with easy access to medical support should the lights change.

The maternity care flow in labour is more like a canal with a series of 'locks' representing the sequence of predetermined maternity care customs and procedures that both disrupt and then govern the course of labour.[1] **Lock one**: labour must start by a certain time or be medically induced. The mother must trust whether this is really necessary or not. **Lock two**: when labour starts spontaneously the mother must trust herself to know when to 'go in', or call the hospital and trust that someone who she has never met will be better placed to make that judgement. **Lock three**: when she does go in the mother is 'triaged' to determine whether she can go to the labour ward, her own feelings about this are not to be trusted; and so the flow proceeds.



[2]

If a mother has decided to go with the maternity care flow, each 'lock' (or offer of a test, examination or procedure) is a chance to check in with the traffic lights, and to only flow on green. For example:

- When a mother is told she is not in labour and should go home, but she is not so sure (amber light) she can simply stay put and WAIT for a while.
- If she really doesn't want a vaginal examination but is told she has to have one in order to progress to the labour ward (red light), she can cheerfully and firmly say NO.
- If she is having really strong contractions and the midwife offers to get the pool ready and the thought of that feels glorious (green light) she will say YES, LET'S GO!

Even when there is a good reason for the advice being given, there are always alternative ways of going about things. Nothing can be done without the mother's willing consent, and legally, gaining consent must involve all the options being on the table.[3] However, the maternity care flow runs along a deeply entrenched 'canal'. The midwife or doctor's assumption that you will 'go with the flow' (accepting every procedure offered) is a powerful force for compliance. It almost feels dangerous, badly behaved and ungrateful to say no, stop or wait.

If the mother's red or amber light is flashing it may be useful for everyone to know what the possibility of actual danger really is. The parents should be able to trust the person

offering the procedure to provide an accurate answer and then to support the mother's decision.
For example, a midwife offering induction because pregnancy is continuing beyond 40 weeks could refer to research showing that for mothers continuing pregnancy to 42 weeks or beyond the possibility of a perinatal death is about 2 in 1000 compared with 1.3 in 1000 for babies born at 40 weeks, and that when babies struggling to grow in the womb are taken out of the equation, there may be no difference in risk at all. She should then have the information to hand that will enable the mother to balance this risk with the risks of induction. If the parents cannot trust the midwife or doctor to offer impartial and balanced information - and if the midwife or doctor cannot trust that they will still have their job if they do support women in this way - then the system is untrustworthy. As Claire Dunn and Ryan Jones found from their separate experiences, when trust in maternity care has been breached it feels quite shocking.

The maternity care flow works best when, as midwives Marie Lewis and Bernadett Kasza note in their personal reflections, there is continuity of carer and a developed relationship of trust between the mother and her midwife. The AIMS Campaigns team actively campaigns for this, because as described in this issue, continuity matters.

When there is no continuity, the next best thing is that every 'stranger' practitioner trusts and respects the consent process by offering every option at every 'lock'. For example: *At this point in the pregnancy we are able to offer you induction of labour, but there are other options you may prefer to consider. What are your immediate feelings? Here is some information so that you can consider the pros and cons. Have a think and let me know. Whatever you decide, you have our total support.*

Truly consensual care allows the person, the person whose body is doing the work, to trust their instincts and to flow through those 'lock gates' on green. At the same time it safeguards the practitioner who is acting in accordance with their code of practice[4] by offering truly consensual care at every step of the way - a prerequisite of every NICE guideline and an absolute legal requirement. The midwife or doctor practising in this way need have no fear that 'trusting the mother' may result in disciplinary procedures, as they will be recording this "*properly informed consent"* process in the notes - "*before carrying out any action"*. No one can argue with that, it is stipulated in The Code.[5] Trusting the law (the 'rules') in this way is a brilliant form of 'working to rule' or of non-violent direct action, or ironically, of civil disobedience (ironic because the act of resistance is taking the form of obedience to the law) - and perhaps even, a brilliant way of changing the system and restoring our trust in birth.

Continuing the exploration of trust in this issue, AIMS volunteer Danielle Gilmour has sourced two thought-provoking poems on the theme.

Jo Dagustun reflects on whether the word 'trust' in relation to 'NHS trusts' is simply a way to seduce us into believing exactly what they want us to believe about their organisation, and Gemma McKenzie challenges yet another attempt by health care practitioners to silence women and their use of the term 'obstetric violence'.
Birth activist Mars Lord gives an impassioned account of the disparities for Black bodied women in trusting maternity care, while the AIMS Campaigns Team calls on all birth activists to help their local community - and improve national practice - by investigating the accessibility (and trustworthiness) of the Care Quality Commission (CQC)'s rating for their local maternity services.

In her second piece, Jo Dagustun calls on us all to 'actively' attend more conferences, and Nadia Higson on behalf of the AIMS Management Team asks you to consider supporting us to continue our work by becoming an AIMS member, if you are not already one. We also have an update from our PIMS (Physiology-Informed Maternity Services) team, and last but never least, the AIMS Campaigns Team updates us about their recent activities.

1 I once heard an obstetrician proudly describe the channelling of labouring women through the hospital care system as being like the channelling of flight passengers through the airport security system.
2 Adapted from an image in the Encyclopedia Britannica
3 AIMS Making decisions about your care. www.aims.org.uk/information/item/making-decisions
4 NMC The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.
www.nmc.org.uk/standards/code/read-the-code-online
5 NMC The Code: "**4.2** make sure that you get properly informed consent and document it before carrying out any action."

Trust in maternity care – Going, going, gone?

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.

While in this article, 'woman', 'women', 'she' and 'her' are used to refer to the person giving birth, this is in no way meant to exclude birthing people who do not identify as women.

What is trust?

Trust has been of interest to academics working in a variety of fields, including psychology, sociology, philosophy, theology and economics. There seems to be general agreement that:
Trust is the belief that another person will do what is expected. It brings with it a willingness for one party (the trustor) to become vulnerable to another party (the trustee) on the presumption that the trustee will act in ways that benefit the trustor.[1]

For someone to trust another, she or he must be confident that the other person has good intentions. The trustor is willing to follow the advice of the other person (or group of people such as a profession) because she believes that this person knows 'the truth'; will tell the truth as they know it; and have the trustor's best interest at heart.

The key components of this definition are that the trustor is vulnerable, and that the trustee has integrity and will act in such a way as to meet the expectations and needs of the trustor. Perhaps the most vulnerable of all people in our society are babies and young children, and this is why 1001 Days practitioners put so much effort into educating and supporting trustors not to let their tiny trustees down. Babies acquire an understanding of trust when their carers respond to their fears and distress consistently and lovingly. People whose earliest experiences lead them not to trust will struggle to form healthy, satisfying relationships over their life-course.

In the case of maternity services, we find another group of exceptionally vulnerable people, namely birthing mothers. First-time mothers in particular need to be able to trust their midwives to be confident in their ability to birth their babies and to convey that confidence strongly in the way they communicate with them, touch them and support them.

Their midwives' confidence signals to the birthing mothers that they are strong women, able to make the transition to motherhood and to cope with the challenges motherhood brings.

During pregnancy, women's self-concept undergoes radical reformulation including their understanding of who they are, of the key relationships in their lives and of how they want to conduct their lives. During labour, that self-concept undergoes further transformation so that by the time they have birthed – twelve hours, a day or two days later – they are literally different people from whom they were only a short while before. The confidence midwives demonstrate in their ability to make good decisions that are right for them is a powerful yeast in this transformation.

Until the mid-twentieth century, birthing mothers placed their trust in women whom they already knew. The trustees were their own mothers or female relatives, or community midwives who knew local families well and may have been at the birth of two or even three generations of the same families' babies. Today, birthing mothers are expected to place their trust in midwives whom they generally do not know. They do so because they trust the profession to which midwives belong; they trust that, as professionals, midwives adhere to codes of conduct and ethics that make placing trust in them a reasonable thing to do; they share in that confident expectation that

midwives *'can be relied upon to act with good will and to secure what is best for the person seeking help'* (Carter, 2009:393).[2]

It is in many ways a leap of faith to place our trust in complete strangers. However, as citizens of an 'advanced' economy with a highly regulated, evidence-based health service, we have been programmed to trust that we will get excellent care when we encounter healthcare professionals.

The problem is, as we are all beginning to understand from the relentless exposure of failures in maternity services across the country (Morecambe Baby,[3] Shrewsbury and Telford,[4] East Kent,[5] Nottingham[6]), that the trustees are sadly conflicted. They may be relied upon to act with good will – instances of healthcare professionals acting with deliberate malice are fortunately rare - but they cannot be relied upon to 'secure what is best' for the birthing mother because the mother's concept of what is best may be at variance either with the trustee's, or with 'the system's' concept. The trustee's concept of what is best may be the same as the mother's or the same as the system's but either way, she may run into conflict in honouring the woman's trust.

'The system' is *not* a listening system. Even when forced to listen, for example when the subject of official inquiries, its only means of demonstrating that it has done so is to amend its protocols. This does not necessarily increase confidence on the part of either the trustor or trustee because protocols are rigid whereas each birthing mother is unique.

A situation thereby is perpetuated where, in order to act in the best interests of the birthing mother, the trustee who decides to listen to her rather than to the system may have to be prepared to face criticism, ostracism and possible disciplinary procedures. Understandably, most are fearful of the repercussions and aren't willing to run such a risk.

When even independent trustees can't be trusted

A young friend of mine – we'll call her Amy - has been recently pregnant with her second baby. Her local hospital is, as is so often the case, short of midwives and it was clear that they could not support the home birth she wanted. Although her friends had had good experiences at the hospital, Amy was concerned about high induction rates and

the consequent cascade of interventions. The hospital was also associated in her mind with a tragedy that had occurred there involving a member of her family.

In order to give herself the best chance of having an uninterrupted, peaceful birth, she decided to employ an independent midwife. This was not an easy decision because the midwife's fees put a heavy strain on Amy's already tight domestic finances. Nevertheless, she went ahead and started to form a strong relationship with her midwife who gave her the time she needed to think through both her birth plan and how she could help her toddler daughter adjust to having a sibling.

Monthly, and then fortnightly, visits continued until Amy was 30 weeks. At this visit, the midwife measured the bump and was alarmed to find the measurement a lot less than she would have expected at this stage of pregnancy. The baby was lying transverse which probably explained the unexpected measurement but the midwife was clearly disturbed and strongly advised Amy to go to the hospital for an emergency scan.
An ironic reversal of roles then took place. Amy tried to reassure the midwife that the baby was kicking vigorously – keeping her awake most of the night! – and that she knew from having been pregnant before that this was *not* a small baby; in fact, the baby felt much larger than her daughter who had been born a very healthy 8lbs. Amy was confident that all was well. The midwife, however, wanted the reassurance of a scan and very reluctantly, Amy went to the hospital where she was told that her baby was thriving.

Of course, this incident led Amy to lose trust in her midwife. She felt that the midwife did not trust what she, the mother, knew about her own body and her unborn baby. She questioned the extent to which the midwife put her trust in a technological approach to pregnancy and birth. The relationship between the two was fractured.

Of course, the independent midwife was in a difficult position; she had to cover her back by exerting pressure on Amy to have a scan once the fundus/pubic measurement seemed to suggest the baby wasn't growing well. But Amy felt, as so many women who contributed to the recent Report on Birth Trauma felt,[7] that she was not listened to and was not respected. She felt forced to make a choice that was what her carer wanted, not what she wanted.

Amy hopes to have another baby but says that she will freebirth as she now doesn't trust either NHS-provided or private maternity care.

Where do we go from here?

The sad reality to emerge from this story is that once trust is lost it is very very hard to regain. This includes trust in a particular healthcare professional, or profession, or system of care. There is an asymmetry in relation to trust, namely: **It is much harder to build it than to destroy it.**

My feeling is that trust in the maternity service is at an all-time low. In her wonderful book, 'Birthing Autonomy',[8] Nadine Pilley Edwards discusses trust at some length. She asserts – surely correctly - that trust is based on relationships. She argues that women desperately want to trust their midwives, but repeatedly find that the hospital or 'the system' disrupts a trusting relationship:
There is an inherent paradox in obstetric ideology focusing on safety and at the same time decreasing safety by placing obstacles in the way of trust developing between women and midwives. (p186).

So where do we go from here? If many midwives are finding it increasingly difficult to respond to women's choices in labour and birth, and to trust women's understanding of their bodies and their babies, this will ultimately reduce women's trust in themselves.

The likely consequence of this will be a gradual or steep decline in the incidence of straightforward, unassisted, uninterfered with labour and birth. There would be those who argue that a 100% caesarean rate would be no great problem. It would. Every time a medical intervention is administered – and surgical birth is *not* a minor procedure - there is a risk that something will go wrong. And with a 100% surgical birth rate, the frequency of things going wrong will inevitably increase. This is simply statistics. If every medical procedure carries a 1% risk of iatrogenic harm, and 100 caesareans are performed, all of which are necessary, 1 woman will be harmed as a result of the procedure itself. If caesareans are performed on all 650,000 women who give birth every year in the UK, 6500 women will be harmed – a large proportion of whom didn't need a caesarean in the first place. And, of course, this isn't taking into account harm that may be caused to the babies exposed to surgical birth.

Donna Ockenden, who has spearheaded the inquiries into failings in maternity care, has made numerous recommendations that she believes would improve trust in the maternity service, but remains pessimistic about the future. Her doubts as to whether

the ‘whole system’ can be rescued are very evident in the ‘if’ of the final sentence of this extract from an open letter to the Secretary of State for Health:

NHS maternity services and their trust boards are still failing to adequately address and learn lessons from serious maternity events occurring now. We recognise that maternity services have very significant workforce challenges and this must change. Clearly, workforce challenges that have existed for more than a decade cannot be put right overnight. However, it is our belief that ***if*** *the ‘whole system’ underpinning maternity services commits to implementation of all the [recommendations] within this report, with the necessary funding provided, then this review could be said to have led to far-reaching improvements for all families and NHS staff working within maternity services.*[9]

So what is the answer? I believe that **if** trust is to be restored in the maternity service, firstly midwives’ training has to be looked at. A midwifery lecturer told me recently that it is now common for students to graduate from her department without ever having witnessed a normal physiological birth. This is in direct contravention of the Nursing and Midwifery Council’s (NMC) 2023 directive:

> ***The aim of the birth standard is for all student midwives to facilitate 40 spontaneous vaginal births. Facilitated spontaneous vaginal births enhance the confidence in student midwives for registration and prepare them to practise autonomously, and in some instances, on their own in the birth environment.***[10]

It is not entirely clear what the NMC defines as a ‘spontaneous vaginal birth’ although it uses the term ‘unassisted’ alongside ‘spontaneous’. If ‘spontaneous vaginal births’ include the whole panoply of medical interventions, including induction, acceleration, labour in bed, and epidural, and the 40 births students attend are all characterised by such interventions, then midwifery training is going rapidly in the direction of obstetric nurse training. In order to prevent this from happening, it is going to be vital, as Ockenden says, that government increases the number of midwives to enable continuity of carer. This is an unfulfilled aspiration of at least 30 years’ standing, ever since it was the keystone of the famous ‘Changing Childbirth’ report, chaired by Julia Cumberlege.[11] Enabling continuity of carer in this way would facilitate better relationships between women and midwives, better births, and greater job satisfaction for all those midwives who want to be listening, responsive carers, and, by extension, create an optimal training experience for student midwives.

However, more midwives can't be the whole answer. The system remains strong, although I believe that the first inklings of a rebellion against 'the evidence' can be perceived, signalled by a growing appreciation that the evidence is often limited, insecure and based on analysis of populations which are racially, ethnically and culturally homogenous. 'The evidence', whatever it is and however derived, cannot be applied in all circumstances to all people. Human beings are far too varied in their epigenetics, their genetics and physiology, as well as their experiences, lifestyles and temperaments for it to be reasonable to believe that 'the evidence' could apply equally and without qualification to every single person. Instead, the 'evidence-based' approach needs refining to become far more nuanced; we need to ask 'what works for whom, and in what circumstances?'

[Evidence Based Specialists] have highlighted the ..... importance of evidence-in-context [and advocate] more context-sensitive approaches to evidence evaluation, requiring multiple methods and information sources to be considered as the relevant evidence accumulates over both time and place.....Nutley et al. (2019)[12] argue that the evidence required for effective decision-making includes evidence of the gravity and (a)typicality of any particular situation. They encourage academics and practitioners alike to deepen their examination of 'what works' by asking supplementary questions, such as precisely how and why interventions work, for whom, at what price and with what consequences.[13]

In the meantime, it may be that women will need to look elsewhere for people to do the listening and provide the advocacy that the system quashes. They may need to look for people whose unique selling point is that they are *not* in the system. Would doulas fit this role?

In putting together a recent issue (Vol 11, Issue 4, July 2024) of the International Journal of Birth and Parent Education of which I am Editor, with the theme of 'Doulas and Re-Imagining Birth', I was struck by how extensive the doula offer now is. Organisations such as the European Doula Network (EDN), and Doula UK provide support and resources for doulas; the EDN has recently organised doulas to work with displaced pregnant Ukrainian women. The NCT in the UK trains Birth Companions. Red Tent Doulas not only train doulas in the UK but support doulas working in some of the most dangerous parts of the world, such as Gaza. In the United States, the prestigious International Childbirth Education Association (ICEA) has a well-established and

respected doula training programme and the American College of Obstetricians and Gynaecologists (ACOG)[14] has recognised doulas as an important strategy for improving maternal outcomes.

Midwives will rightly say that doulas are taking over their role, or, at least, the best bits of their role. This may be the case but until midwives can be liberated to truly be 'with women' in their vulnerable hour of need, what are women to do?

The tone of this article will seem to you pessimistic. And I do have very deep concerns about the relationship between mothers and midwives. This should be one of the most precious relationships a woman may experience in her lifetime, a relationship that can be transformative and leave a woman healed and triumphant, who was previously broken by lived experiences of not being able to trust or be trusted. I'll finish with the following quotation from a book written by a politician (a member of another much vilified and mistrusted profession); it captures the existential challenge that midwives and the maternity service are facing in the mid 21st century:

We come back to the question of trust.....Trust is a two-way process. You cannot secure trust simply by asserting that you are trustworthy. You can only win trust by showing that you are willing to work in a spirit of mutual respect with those whose trust you seek. (Cook, 2003:87)[15]

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Trusting myself in birth

by Salli Ward

Salli and her mum on a bench commemorating the midwife who attended when she was born.

Author Bio: Salli is mother/stepmother to 8 grown-up children with 2 – almost 3 – grandchildren. Born and bred in the north west of England, she now lives with her husband on a narrowboat around London – to where most of the children have moved – but she dreams of the countryside and looks forward to inter-generational communal living planned by two of the kids. Salli has been a dramatherapist, a charity CEO, a celebrant, and a fundraiser but is now a writer of policies, funding applications, articles, letters to the Guardian and unpublished (but extraordinarily good) books.

I was born at home in 1962 in rural Cheshire. My mum recalls watching from her bedroom window as the midwife arrived on her bike across the field. The midwife/district nurse who delivered me into the world was well known and highly respected. My mum recalls the doctors (there were only two) saying, 'yes Maud' when she instructed them. She was *the* expert.

When I was first pregnant in 1986, I assumed I would also have my baby at home. In my innocence, I didn't think this was so controversial - though obviously I was aware it was slightly unusual - because I didn't associate giving birth with anything medical – certainly not with illness. I didn't entirely mistrust the medical profession; I wouldn't hesitate to involve them if I was poorly, and they have saved much loved lives and limbs over the period of my life.

In birth, however, I believed in my body, in the bodies of women, and in nature. This isn't to say I don't think we should interfere with nature – surgery, antibiotics, defibrillators – they all interfere with nature that would have us die – but what has this to do with birth?

Yes, people can have problems giving birth (I now believe, the more interventions, the more problems) but we can have problems climbing mountains, crossing the road, slicing bread, yet we don't have doctors on stand-by when we do those things.
Back then I didn't think all this through until my GP refused to – well, what do you call it? - be my GP! I found another GP, read a book called Birth Matters, and found out about my rights and about research into homebirth. All long before the recent very worrying signs of impending doom in maternity services.[1]

Back then I somehow knew my body would be able to give birth. I wasn't super-assertive, so I found it hard to insist, but I trusted myself. I didn't even ask my then husband; to me, it was no-one's business but my own. I expected (and got) his full support.

I now have two grown up daughters; one has experienced giving birth and it was awful. She did plan to have her baby in an excellent birthing centre but it was closed on the day. My second daughter is pregnant now and planning something similar, but in a different area. My step daughter-in-law is also pregnant but I can't claim to have the right or the reality of much influence over grown people.

I cannot understand why women, particularly feminist women like my own stroppy, strong and mighty daughters, put so much trust in medics, in hospitals, in intervention, when they are planning delivery of their babies. I don't understand why they fight misogyny, stand up for equality, dismiss damaging stereotypes and push themselves forward – yet willingly hand their beautiful, powerful pregnant bodies over to male dominated services (I know there are plenty of women in medicine now, but I believe it is forged in the fires of masculine domination). Furthermore, why do they fall for the notion that their bodies aren't good enough, that they can't stand the pain of childbirth, that they need interference to do what their bodies are built to do?

I am aware this sounds critical of other people's choices. I want to stress that I believe in choice and if women want to choose hospital birth or caesarean or pain relief or whatever, that's fine by me. What I question is how much it is a free choice. What puzzles me is why people make that choice when they are otherwise quick to stand up for women's rights.

When I announced I was having my baby at home, the most common response was 'how brave'. I took this to mean they thought I was doing something dangerous – this is worse than criticism to me. It means they thought I was deliberately putting myself and my baby in danger. For years I wanted to say, 'how brave' when friends announced their impending hospital birth, but I'm older now and have two birthing daughters – what can I say?

I *did* have my baby at home – and two others. My pregnancies were marred by concerns that I would be two weeks overdue and feel forced into being induced (my daughter was automatically booked for a cervical sweep when she was only a week 'overdue'). With each of my births, I had to find my own doctor – all three were good – and work with the community midwives, who were amazing. I trusted them. I trusted myself and I trusted the power of nature. In labour with my first baby, I paced the floor until ready to push. I know that natural birth[2] can happen in a hospital but I would be scared ('how brave!') of interventions and attitudes getting in my way (possibly literally).

I am aware that these days some conditions of birth – such as breech – can be dangerous because there are so few midwives left with the skills to assist a natural birth under those circumstances. Women's bodies are essentially the same (actually better and stronger) and birth is unchanged, but so few people really know how to assist. My dad, born in 1927, famously (in the confines of our village!) came out feet first and had to be 'pushed back in' (full disclosure – he was a twin). My daughter's baby is breech now – 5 weeks before she is due – I can't advise her to resist intervention if the baby doesn't move because I don't know if we can trust anyone to deliver that baby safely. The skills may not be there.

This is a tragedy. As we move towards more caesareans and other interventions, will the human race eventually lose complete trust in women's bodies? If my granddaughter is pregnant in 30 years' time, will there be no-one who knows how to attend a natural birth?

This isn't progress for women. I learnt recently that in America natural birthing (and breast-feeding) women are considered anti-feminist. It seems to be connected to the idea that women should be able to do exactly what men do – go back to work ten minutes after birth? What women do – especially if men can't do it – has become so devalued that even ardent feminists are convinced it has little worth.

Why aren't we demanding respect for what we do – what *only* we can do?

I try to trust the next generation will see sense. My three-year-old granddaughter knows that boys can wear dresses, that some children have two mummies (or daddies), that no-one can touch her without her consent, that bodies vary – and that's all so very good. I hope that one day she trusts herself, her body and nature enough – I hope we can still leave her that legacy.

Bench in the village where I was born, remembering Nurse Hatton who delivered me

[1] Editor's note: The author may be referring to the increasing reports from parents of poor support and of traumatic experiences, alongside documented concerns about staffing numbers, increased rates of induction and caesarean, and lack of support for women's choices about where they have their baby.
[2] Editor's note: Please refer to the AIMS position paper on Physiology-Informed Maternity Services: www.aims.org.uk/assets/media/730/aims-position-paper-physiology-informed-maternity-care.pdf

An invitation to contemplate the meaning of trust

by Bernadett Kasza

Author Bio Bernadett Kasza is a birth professional who works independently with women, birthing people, and families. She specialises in getting her Doula clients the birth they wish to have and has been doing it with a 100% success rate.
She can be found at: Womanly Art of Birth

When I began my midwifery training, I was beaming with hope, eager to be 'with woman' and fulfil my lifelong call. Coming from a world where I believed in the ethos of the Hippocratic Oath: "I will do no harm or injustice to them." I still get goosebumps when I read the translation of this ancient Greek text.

Although taking this oath today is rarely required, I feel it should be basic moral guidance for all medical professionals - the foundation on which trust can flourish between families and maternity staff, and among colleagues working together to support women, birthing people, and families, during one of the most pivotal life events: birth.

Trust feels like a hollow word only mentioned briefly during university lectures and, in reality, has faded into the realm of some long-forgotten ancient kingdom.

It's almost as if the tapestry of maternity care provision had been ripped, and the threads were disintegrating between midwives and policymakers, healthcare practitioners and families but most importantly between policymakers and women's bodies.

This rupture was so great that it pushed me to leave midwifery to carve a path to support women and families in the way that is best for them. I aim to stay true to the deepest

meaning of the word: trust. According to the Oxford Dictionary of English, 'trust' is, " A firm belief in the reliability, truth, or ability of someone or something".[1]

When it comes to pregnancy, birth, and early parenthood, it seems that trust is an extremely complex and fragile phenomenon. In this modern, busy, overwhelming, and loud world, it has become difficult for women to trust themselves, trust in their own body and trust in their deep instincts. The widespread feeling of mistrust in one's ability to conceive, to grow a baby, and to meet the baby's needs in the womb is experienced at a visceral level, and when the ability to trust in one's capabilities is damaged, birth suffers. This loss of trust has become an avalanche that affects everything we hold as precious, rolling onto early parenthood and its questions, concerns, and worries. Of course, I cannot speak for everyone, as I am limited to my own professional experience, and there are always notable examples of women whose body confidence is greatly intact, however, I cannot dislodge the sadness from my heart when I think of how women's trust in their body's natural abilities is bleeding from a thousand wounds.

Could the loss of trust be a symptom of our modern ways of living? Can patriarchy be blamed for spreading its power and robbing women of their unwavering and proud trust in themselves across millennia? This issue, like many others, is not simple but multifaceted; however, it could be of great benefit if women were fully aware of their worth, and could say no without concerns, feelings of guilt, and second thoughts.

Which trust was lost first? Women's confidence in their capabilities of growing and birthing a child - or the 'medical men's' loss of trust in women's bodies and their need to date, sedate, medicalise, proceduralise, and un-naturalise the process because there is a perceived danger in the female body that cannot be trusted? I trust you know the answer.

Medical trial and error, the obstetric dilemma, one-size-fits-all care, and the constantly reaffirming messages implying that women's bodies are failing. Expressions like failure to progress, prolonged pregnancy, trial of labour, incompetent cervix, poor maternal effort, and so on, send the message that women's bodies, and thus women per se, cannot be trusted.

If women are not supposed to trust their bodies, who can they trust then? Doctors, midwives, doulas, antenatal teachers, sisters, their mother or mother-in-law, social media groups, friends, or their neighbours? Research? Guidelines? Old wives' tales? Superstition? Google? Logic? Physiology? All of them? None of them? Some of them?

Why do I feel like there is a lack of an expecting family's 'firm belief in the reliability, truth, or ability' of maternity care providers? Is it a Herculean task to anchor our trust in medical professionals? I have seen it in my practice. I have worked mostly with second-time mums as a doula, and their choice of working with a doula was fuelled by the general wish of not wanting to have the same birth experience they had before. They were looking for someone they could trust, a person from outside the system who would represent their wishes and keep them safe. That's when I could see that those women and families lost their trust in midwives and doctors.

Let me share another very personal experience. Back in the days when I had my uniform on, I felt an omnipresent barrier between me and the women, whether it was on a ward or at the antenatal clinic. Generally speaking, women were a lot more withdrawn. This could have been for a plethora of reasons of course, but it made me wonder whether not feeling so at ease in the presence of a uniformed healthcare practitioner could have a negative impact on women's birth experiences, or if that distance was a sign of an already inherent mistrust that I picked up on. When I meet an expecting couple for the first time as a doula, they are relaxed. Understandably, we aren't meeting in a hospital or a birth centre, so that might be partly adding to the general mood of the meeting.

I am aware, there is a long list of reasons for both of the above, however, I can't help but think that some of those reasons are rooted in the loss of trust in healthcare practitioners. How can trust be restored; in whom can a pregnant person trust?

Maybe women are looking for answers from outside as opposed to searching from within. Restoring an individual's self-trust, both in their intuition or instinct, and in their ability to interpret appropriate, quality information, may lead to them making better choices about who they would choose to support them during birth and what they want and don't want to happen during pregnancy and birth and postpartum.

Wouldn't it be amazing if women could tell poor-quality information apart from good-quality information? But that isn't necessarily their job. Of course, like every hero or heroine in global folklore, women and families could go through the arduous task of sorting out the seeds of information and meticulously separating them. It is a laborious task, one that is rooted in mistrust and feeling the need to arm themselves with information and research in anticipation of their consultant appointment.

How can professionals enhance their trustworthiness? Good intentions are not enough. Do you know the saying about good intentions and how the road to hell is paved with

them? I think that professional dedication and loyalty to the birthing families can be a good starting point, but this does not mean just working a shift. It is my belief that to be with women during childbirth is a calling, not a 'workload'.

A driven and eager midwife may always find the best way to acquire new knowledge to integrate into their practice to enhance women's and birthing people's experiences. Listening is gold but most professionals do that. The real concern is that listening does not equate with respecting, believing and trusting what is heard. During my years of working in the field of birth support, the problem I heard the most started with, "They didn't believe me when I said…". This issue could be easily solved by simply trusting what women say is happening in their bodies. The simple notion of giving credit to women may enhance their trust in their healthcare providers.

I will leave you with a few questions:

What can be done about outdated protocols, low-quality research, and decades of 'cultural conditioning'?

What can be done about the low morale and backstabbing culture among staff of some maternity units?

What can be done about long-embedded notions of medicalised, 'high-risk label', trigger-happy maternity care?

What can be done about the litigation culture so that midwives and doctors are not fully preoccupied with continuously watching their backs?

How can education increase the level of mutual trust between women and healthcare practitioners?

What can be done to build trustworthy maternity services?

Perhaps we already have the answers and we simply need to trust them.

1 Stevenson, Angus. Oxford Dictionary of English. 3rd ed., Oxford, Oxford University Press, 2010

Exploring trust within the midwife-mother relationship

By Dr Marie Lewis (RM BSC MA Phd)

Author Bio: Dr Marie Lewis, a senior midwife with wide-ranging experience and a passion for woman-centred care, is now working as an independent healthcare improvement consultant.

This paper is a personal reflection on the journey of trust within the midwife-mother relationship, highlighting its significance in modern maternity services and advocating for its continued cultivation and prioritisation. While in this article, 'woman', 'women', 'she' and 'her' are used to refer to the person giving birth, this is in no way meant to exclude birthing people who do not identify as women.

My perspective on relationship-based trust:

Relationship-based trust is a mutual confidence and reliance that develops between individuals over time within the context of their interactions and shared experiences. It is built on a foundation of honesty, integrity, and consistency, where each party believes in the other's competence, intentions, and commitment to the relationship.

Background:

In 2008, I embarked on a journey that would lead me to research one of the most fundamental yet intricate aspects of healthcare: trust within the midwife-mother relationship. Now, as I reflect on my research, published in 2017[1] I am struck by the profound impact it has had on my understanding of the dynamics between midwives and mothers during the birthing process. This reflective paper revisits the foundations, methodologies, findings, and implications of my study, shedding light on how the

concept of trust has evolved and remained relevant in the years since its publication. Join me as we delve into the complexities of trust in the midwifery realm, re-examining its significance and exploring the pathways it creates for nurturing a supportive and empowering environment for mothers and midwives alike.

Research summary:

My PhD research explored the concept of trust within the midwife-mother relationship, aiming to deepen our understanding of individual women's experiences of trust and its significance within the caring relationship. Employing a **hybrid model approach**,[2] underpinned by a **Heideggerian phenomenological perspective**,[3] the study seamlessly integrated theoretical concepts with **empirical data**.[4] Longitudinal semi-structured interviews were conducted with women navigating through the journey of becoming a mother at three key time points: early pregnancy, 37 weeks of pregnancy, and 8 weeks postnatal, with a **purposive sample**[5] of nine women experiencing uncomplicated pregnancies and receiving continuity of carer. **Thematic analysis**[6] revealed that trust evolved over time as a series of building blocks, influenced by the developing relationship between midwife and mother.

Initially, trust is associated with an expectation of midwife competence, but it becomes more nuanced as the relationship progresses. The study highlighted the importance of women's agency in developing a two-way trust, where the midwife also trusted the woman. Key themes identified included the need for trust, expectations, the nature of the midwife-mother relationship, the impact of continuity of care, and the significance of women's agency. This research provided valuable insights for clinical midwifery practice, emphasising the dynamic nature of trust and its pivotal role in fostering positive birthing experiences.

Trust within the context of today's maternity services:

In today's maternity services in the UK, trust within the midwife-mother relationship holds a central and dynamic position. Midwives play a crucial role not only in providing clinical care but also in facilitating emotional support and empowerment for mothers throughout their pregnancy, childbirth, and postnatal period. Trust is essential as it forms the bedrock of this relationship, fostering an environment where mothers feel safe, respected, and empowered to make informed decisions about their care. With the increasing emphasis on woman-centred care and continuity of midwifery support, the role of trust has become even more significant.

In 2013 Coxen et al published a study[7] about how discourses of risk, blame and responsibility influenced women's birth choices. They argued that planning the place of birth is mediated by cultural and historical associations between birth and safety, and further influenced by prominent contemporary narratives of risk, blame and responsibility. I believe that the growing number of reports of bad care, shared via social media, has damaged the reputation of maternity services in the UK and significantly impacted trust within the midwife-mother relationship.
Negative publicity, whether through news reports or social media, can erode trust by creating doubt about the quality and safety of care provided. Mothers may feel anxious or hesitant to engage with midwives or maternity services, fearing that their own care may be compromised. In 2018 there was a global call to action for respectful maternity care and Betron et al (2018)[8] examined the links between inequalities and unequal power dynamics and the quality of care and women's capacity to exercise their rights. The limited evidence available showed that pregnant and labouring women lacked information, voice, and agency to exercise their rights. Mistreatment of women inside and outside of the health facilities was normalised and accepted, including by women themselves.

I hear from midwifery colleagues' anecdotal evidence that a growing number of women today are choosing to freebirth or seek the services of doulas to ensure that they can remain in control of decisions surrounding their care. Ford, Crowther and Waller (2023)[9] wrote about midwives' experiences of personal and professional risk when providing care to women who declined recommendations, and their willingness to support such care. Their argument revolves around the violation of women's rights to bodily autonomy and choice in childbirth, and the restricted access to safe midwifery care for physiological birth, within maternity systems that are adversarial toward midwives providing the care women want.
Midwives who offer such care often face risks including damage to their reputation, conflicts with colleagues, intimidating disciplinary processes, inner conflicts, and significant psychological strain. Despite these challenges, these midwives persist because they believe it is ethical and morally right, recognising that women depend on them. However, maternity systems and colleagues can pose significant risks for these midwives, particularly those who support women in declining recommendations. These risks can render it unsustainable for midwives to continue providing woman-centred care, contributing to workforce attrition, and limiting options for women, paradoxically increasing risks for both women and babies.

Literature is growing exploring the psychological and physical impact of birth trauma from the perspective of both those who experience poor care resulting in sad loss and those who have felt betrayed, bullied, and abused by a care pathway that was not of

their choosing and a system that would not support their needs. Rebuilding trust in such circumstances requires transparency, accountability, and a commitment to addressing underlying issues, reassuring mothers that their concerns are being taken seriously and that steps are being taken to improve care standards.

Developing understanding as a cornerstone to building trust:

Recognising the significance of understanding and trusting women has been a valuable lesson for me since completing my PhD. National initiatives promoting greater cooperation and co-production with service users in the development of new care models have become a significant political priority. However, in practice, there seems to be a disconnect between the political push for user involvement and the prevailing culture, where reciprocal trust based on relationships and shared decision-making are often challenged. Crowther and Smythe (2016)[10] describe the importance of relationships in rural midwifery care; they suggest that relationships are built on mutual understanding attuned to trust and that trust culture builds healthy communities of practice[11] where collaborative learning, open respectful communication and acknowledgment of personal and professional differences enables focus on what matters most - safe positive childbirth.

I believe that 'understanding' is the cornerstone of the midwife-mother relationship. It appeared that the women in my study grasped this concept well, which is why it was crucial for the women that the midwife truly 'knows' them. It is possible that they need to establish this understanding so that trust can be an informed decision, rather than blind trust. The women in my study possessed an understanding of the system, the midwives, and how to collaborate with them and they often talked about trust as though it were a given, yet never described it as absolute. The thing that appeared to hold them back was believing that the midwife understood them and was able to trust them in return. As I reflect on the changes in maternity services since my PhD I wonder if this notion of reciprocal trust would be even more important today, where a reliance on intervention and technology over relationship building has changed women's experiences of maternity care.

While on holiday, I had a moment of reflection about trust as I went for a swim in the Mediterranean Sea. The day was beautiful, and the water was refreshing, but the waves were quite high. Despite being a good swimmer, I found the waves splashing over my head and in my face unpleasant. As I tried to stand firm on the bottom, the waves crashed harder around me, pushing me over. I realised that by floating instead of fighting, I could ride with the waves. As I relaxed, I noticed the waves gently bobbing me up and down near the shore, and I felt safe, comfortable, and trusted the water. It struck

me as bizarre to trust the sea, but then I had a light bulb moment: it's not just about trust but understanding. Trust without understanding could be mere stupidity. Trust with understanding, on the other hand, could be comfortable. Trust isn't about blind faith in medical advances or an expectation of perfection within a service. It's about comprehending the options, possible outcomes, weighing risks and benefits, and truly 'knowing'. I knew what was happening in the sea, accepted it, and understood the potential outcomes. So, I was able to relax, be comfortable, and trust. If we are to maintain a culture of trust within maternity services and the midwife-mother relationship, we must prioritise systems that enable relationship building and understanding.

Benefits and challenges of building trust through the model of continuity of carer:

One of the advantages of continuity of carer models lies in the relationships that midwives can form with women and their families. Sandall (2017, updated 2024)[12] suggested that the advantage of relational continuity was the development of a therapeutic relationship between the user and midwife, which over time positively impacts experiences and outcomes. Bradfield (2019)[13] described the trusting relationship as central to being 'with woman'.

In my postdoctoral research study, which delved into midwives' experiences of providing continuity of care (Lewis 2020),[14] midwives described continuity as a facilitator in getting to know women and developing understanding. The data highlighted the benefits of this acquaintance, including an increased understanding and empathy that fostered a buildup of trust, mirroring findings in Rayment-Jones et al.'s (2020) study[15] on continuity of care with vulnerable women.

In my study, the primary challenge in working with the new model was the on-call system, particularly the number of on-calls expected of midwives. The data illustrated times when this was particularly challenging, especially during periods of high activity or when the team experienced staff shortages. However, there was an acknowledgment that the new model had some advantages too. There was a perception among midwives that despite being on call for more days, they were called less frequently than in the standard model. This perception stemmed from the belief that women who were familiar with the midwives would only call out of hours when they truly needed to, rather than for less urgent inquiries. This phenomenon was linked to the establishment of relationships and mutual understanding. There is limited evidence in the literature on studies exploring this phenomenon, and I believe it warrants further investigation, particularly in relation to building trust.

Continuity of carer models, where women are supported by the same midwife or small team of midwives throughout their maternity journey, have been shown to enhance trust by promoting familiarity, consistency, and personalised care. However, in the context of today's maternity services, challenges such as staffing shortages, resource constraints, and institutional pressures have impacted the development and maintenance of trust. Therefore, it is crucial for maternity services to prioritise practices that nurture trust, including effective communication, shared decision-making, and supportive relationships between midwives, mothers, and other healthcare professionals, ensuring that trust remains at the heart of maternity care in the UK.

Closing remarks:

Relationship-based trust is a cornerstone of effective healthcare, fostering mutual confidence and reliance between individuals. Rooted in honesty, integrity, and consistency, it forms the basis for fruitful interactions and shared experiences. My PhD research aimed to deepen our understanding of trust within the midwife-mother relationship. The study revealed that trust evolves over time, influenced by the developing relationship between midwife and mother. It became apparent that trust is not a static concept but rather a dynamic process, shaped by understanding, empathy, and shared experiences.

I believe that building trust requires understanding and reciprocity. The women in my study emphasised the importance of being truly known and understood by their midwives. They sought mutual trust, not blind faith, in their caregivers. This notion of reciprocal trust is even more crucial today, amidst a changing landscape of maternity care. Thus, it is imperative to prioritise practices that nurture trust, including effective communication, shared decision-making, and supportive relationships between midwives and mothers.

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[2] **Hybrid model approach:** Hybrid research is a combination of research techniques such as qualitative and quantitative. **Quantitative research** is numeric and objective, seeking to answer questions like how many, how often or how much. **Qualitative research** is concerned with subjective phenomena that can't be numerically measured, like how people experience an event, how they feel, or why they behave in a certain way.

[3] **Heideggerian phenomenological perspective:** Based on the ideas of Martin Heidegger, this approach provides the qualitative researcher with a structure for analysing the lived experience of study participants.

[4] **Empirical data:** Data collected from empirical research, which is simply any form of research based upon direct observation.

[5] **Purposive sample:** An intentionally selected group of study participants based on their characteristics, knowledge, experiences, or some other criteria.

[6] **Thematic analysis:** A method of analysing qualitative data. A set of texts, such as an interview or transcripts are closely examined to identify common themes – topics, ideas and patterns of meaning that come up repeatedly.

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[11] Editor's footnote: "Communities of practice are formed by people who engage in a process of collective learning in a shared domain of human endeavor" www.wenger-trayner.com/introduction-to-communities-of-practice

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An interview with Dr Malika M. Bonapace, D.Psy

by Alex Smith

Author Bio: Malika M. Bonapace is a doctor of clinical psychology specialised in perinatal psychiatry, a trainer of the Bonapace Method for over 15 years, and an internationally recognised speaker.

Thank you for agreeing to be interviewed by AIMS, Malika. How would you introduce yourself?

My name is Malika Morisset Bonapace. I am a doctor of clinical psychology and I specialise in perinatal psychiatry. It was in the course of this work that I discovered how Mother Nature has provided the innate vulnerability of the perinatal phase and how protective this is supposed to be. Yet I saw with my own two eyes what the system's lack of respect for this does to women's health. I saw that when women give birth in a context that is not safe, it creates a lot of damage. I was a clinician for some years but have now closed my clinic and am training health care professionals about physiologic birth and about an approach to non-pharmacological pain management called the Bonapace method.

The Bonapace method was put together by my mother Julie Bonapace. My mother has been training parents and health professionals for 35 years, enabling those accompanying the birthing woman to help her, her partner and the baby in a humane way.

What drew you towards your interest in birth and early parenting?

I feel as if I was born into it, literally. My mother developed the method while she was pregnant with me and it has been part of my life since I was very young. I remember her addressing conferences and bringing and showing pictures of my tooth that had been drilled by the dentist. She would explain to the delegates how non-pharmacological

methods of pain management work and that even children can use them, that even I could get a filling without a local anaesthetic. So I discovered through the teachings of my mom that the body is resourceful and by tapping into those resources we can accomplish amazing things and feel really empowered. This discovery fostered my deep trust of human potential, my deep belief that we are part of a beautiful world of love and energy and that through love we can truly make humans shine and that's always been something that I wanted to do.

Taking the work that my mom has done and making sure that it keeps on going through the generations made so much sense because I believe that birth is not only a fundamental moment in the experience of women but also in the development of a society. I believe that birth is pivotal and if you can get birth right you can change the world. That is my true belief.

You say that "*the way the world sees pregnancy is broken…*", can you say a bit more about that?

Yes, I do believe that. Humans exist today because humans are able to reproduce. Based on evolution principles, it is highly likely that some species became extinct because their method of reproduction was unsustainable, and those species are no longer here. But we are still here, and I believe that we are still here specifically because our bodies are perfectly adapted and made to reproduce; it is our innate ability. I believe that seeing women as *unable* to bring their babies to the world causes tremendous harm. I believe that, because we are so fearful, we routinely do things in caring for pregnant women that cause problems,[1] and then we are really good at fixing those problems. This vicious circle (FEAR - MEDICAL RESPONSE - IATROGENIC HARM - FEAR) perpetuates our belief that pregnancy and birth is dangerous. In actuality, the way we take care of pregnant and birthing women is the problem. If we understood that behind this uterus and this fetus there is a human that is intrinsically made to create connections with other humans, we would never send her into the arms of strangers; never, that's dangerous. So when we say what's 'safe' is for you to give up all of your responsibility and give it to someone else who is a stranger who doesn't know who you are and where you come from and who has no emotional links and connections to you, that's when we cause harm and create these problems that we're really good at fixing. And then healthcare professionals say, "It's a good thing we were there to fix the problem" while, so often, they caused the problem in the first place.

As long as we're good at fixing these harms, why does it matter?

Birth is a pivotal moment for the mother and the baby, the father, the couple, and the family. Birth is a transformative experience for mothers, an opportunity for them to discover their power, to discover their innate abilities, to discover their connection with the universe, and to heal from deep trauma. Birth is meant to be protective for women.

Birth also has a deep impact on babies because during birth, in order for birth to happen, oxytocin needs to be released and oxytocin is the hormone of love. Humans are deeply emotional creatures and so we are meant to experience this huge tsunami of love from oxytocin when we come to the world. We now know through the study of epigenetics that the way humans are born will impact the way their brains develop.[2] So birth is protective for babies. We are meant to come to the world with this huge wave of oxytocin. When we give birth in unfamiliar clinical settings where the oxytocin levels are so much lower, coupled with synthetic oxytocin quasi-systematically used in labour, we probably impact those babies' ability to create oxytocin for the rest of their lives.[4] Lower daily levels of oxytocin increase depressive symptoms,[5] and, in years to come, girl babies grow into women who may be unable to produce sufficient oxytocin to give birth easily themselves. When Michel Odent talks about the risk of no longer being able to reproduce,[6] he says that, sure, we were able to make that baby come out of the mom alive, but what about the safety of our species?

When mothers experience this huge wave of oxytocin and when they are connecting with their baby, they fall deeply deeply in love, mother and baby. This is what is necessary to make sure that these mothers will take fierce care of these babies, that they will protect them and choose for them exactly what they need. When you take that away from mothers and you tell them, "We will tell you what your child needs", then we lose the most precious resource that we have as humans, which is human connection.

So yes, I do believe that this matters and I believe that it's very important for couples too. Mothers and babies fall deeply deeply in love because of all this oxytocin and this happens *in proximity* to the *father*. The father also gets submerged by the wave of oxytocin and in turn falls deeply in love with his wife and with his baby. We want this because a father who is present, who is dedicated, who is in love with his wife and baby, is a father who will protect them. We need that. We need men to step up[7] and protect this dyad, the mother-baby dyad. When men are there to protect and to support women and to say to their wife: "You know our baby best - you know your body - you know who you are, you are the holder of the sacred knowledge of what this dyad needs and I will fiercely support and protect you", then this shapes the way families operate as a whole and function in society. The way this family will then take care of the child, being bonded and in sync with its needs will shape the next generation and in turn, society and the rest of humanity. Truly, birth is a pivotal moment.

This moment can't just be discarded as, "Oh it's just the baby coming out of the mother". No, it is a moment where everybody gets empowered and imbued with this knowledge that humans are to be loved, and are to love, and are to be surrounded in this deep love.

Have we reached a tipping point? Is it too late to rescue physiological birth?

Wow, that's a tough question! There is a part of me that believes that that's the case. When I've had a really bad day and I've been exposed to the obstetrical violence that we perpetrate on women and babies, I start to wonder if that's the case. Then at other times I have real hope, especially when I see more and more mothers awakening and questioning, “Wait a minute, why is it that we all have these broken bodies that can't work?”. When I see these beautiful books written about free births (births unattended by a midwife or doctor), and these women reclaiming their birthright of being able to give birth under their own resources, then I become more hopeful. Ultimately I believe that God has a plan for humanity and that I can only do what God's plan is for me and that is to talk about physiologic birth to as many health care professionals as I can find who are willing to question current birth practices. I don't know the bigger picture but I trust that yes, all I have to do is my part.

You are teaching all of these health professionals about trusting birth. How do you go about that? What exactly is the Bonapace method?

Its hidden objective is to protect families; that was my mother's goal from the very beginning. What do we know about protecting families? We know that a lot of couples get separated and divorced and we know that a lot of those divorces are initiated by women. When my mother worked for the Ministry of Justice here in Canada, she worked with couples who were in the process of separating. She always asked the same question, “When did it start going wrong - when did this relationship start dismantling?” and they systematically answered, “When we started having kids”. The men would say, “I know we weren't doing so great, she was no longer very interested in intimacy, but I had no idea it was that bad”. But the women would say, “Look it's simple, I've got to take care of the kids, the house, the groceries, the food, the car, my job and him. If I get divorced, not only will I no longer have to take care of him but on top of it I'll have every second weekend off from the kids”. And so basically, many separations stemmed from the unfair distribution of work between the couple reaching a point that was unsustainable. It didn’t feel fair and didn’t add up mathematically. Research on paternal involvement shows that couples are more likely to stick together when the women say, “I don't know how I would do it without him; we're such a good partnership; we do this together”.

My mother considered what was necessary for men to become more involved postpartum and what the predictive factors for this involvement were. She discovered through research that really clear prenatal involvement of fathers predicted their postnatal involvement, but she knew that if she offered dads a class on how to protect the family unit, nobody would come. What parents were really motivated to learn about in pregnancy was connected with their fear of pain in childbirth. So my mom studied in a

lab that was dedicated to pain management and she was able to create a connection between the non-pharmacological methods that the human body has access to and show how these apply specifically in childbirth. She enabled the dads to become highly involved prenatally by preparing the couple together during pregnancy ensuring that the dads could be highly involved in the management of pain during childbirth.

As such, the Bonapace method, at its origin, was really focused on pain management. The more my mom studied the more she discovered that actually, if you respect what the body is supposed to do, you have less pain, and that's when we started learning and teaching about physiologic birth. In our experience, the primary ways of ensuring the family is safe is by understanding the nature of birth; by showing women that they have deeply embedded natural resources and strategies to manage whatever Mother Nature presents them with in childbirth; and by giving men specific tools and techniques for supporting their wives in that moment. And so we create this deep sense of trust within women that they are able to harness these innate resources, that they can work in partnership with their husbands, and that together, they can safely bring this baby to the world.

What opposition or challenges have you faced and how do you counter these?

When health care professionals are only trained to see what goes wrong, and to only use outside resources to fix problems, huge doubt is cast on the natural or physiologic ability of the body to do what it is meant to do. We could apply this to any form of physiologic process. There's a wonderful (spoof) video that was made by an Italian group that compares birth to conception. A couple goes to the hospital and the really well-intending health care professionals try to assist them in having sex to conceive their baby. However, the health professionals don't understand that privacy and non-disturbance is necessary for the couple to be able to just have physiologic sex. They keep intervening and it just doesn't happen, so artificial insemination is required. The point is that, if this is only what health professionals have ever seen, then they will naturally be convinced that the only way women can become pregnant is through insemination.

So the opposition I am faced with most often is from health care professionals who have never seen physiologic birth. They don't even know that it exists and what it looks like. The vast majority of healthy women come to them for care - care that disrupts the physiologic process and creates pathology and danger, from which they then rescue the mother and baby. They do not understand the vicious circle effect and have no knowledge of the virtuous circle of TRUST - PHYSIOLOGIC CARE APPROACHES - SAFER BIRTHS - TRUST.

So the absence of knowledge creates this opposition. As soon as information starts seeping through to them though, if it's done with sensitivity and love and gentleness,

then they can start seeing the problems that they cause, but it's a long and arduous process. I was once told by an obstetrician that the definition of birth is a catastrophe to be prevented. The belief that you can only know in retrospect if you've done a good job as a doctor or midwife by having avoided all those catastrophes, shows how deeply ingrained is the accompanying belief that women's bodies cannot be trusted to give birth safely to their babies.

If you had a magic wand and could change the birth world in any way, what would you do?

If I had a magic wand the thing that we would need to do first and foremost is to take all of our health care professionals and take care of them really really well. We would need to allow them lots of healing time because they have been very mistreated, both through their education process, and by the way the system treats them. It would require a lot of self-love, self-compassion and willingness to heal on their part, but that would be step one.

Next, I would abolish women giving birth with strangers. I would make sure that women are only accompanied in birth by health care professionals who love them. The creation of a deep bond between the mother and her attendants, one where they can trust each other on a deep fundamental basis, is vital.

I believe that if we were to allow the care-givers to heal, and if we were able to create the space for there to be a bond of deep human connection between the care-giver and the pregnant women, that this would drastically, rapidly and spontaneously change what is going on in the way we give birth presently. As it is right now, the absence of connection allows the continuation of harmful practices. With healing and connection, our broken view of birth would fix itself because health care professionals who are there with really good intentions would realise where they are going wrong and they would figure it out, and women’s innate abilities would be honoured and supported.

The last use of my wand would be to sprinkle training about physiologic processes to everybody so that they would understand what's going on and have a model to grasp what undisturbed birth actually looks like. Then, I feel like things would just fall into place from there on. I think those are the necessary ingredients for a different world of birth.

1 Editor's note: Harm caused as a result of medical care is referred to as *iatrogenic* harm. Read: Liese, Kylea & Davis-Floyd, Robbie & Stewart, Karie & Cheyney, Melissa. (2021). Obstetric iatrogenesis in the United States: the spectrum of unintentional harm, disrespect, violence, and abuse. Anthropology & medicine. 28. 1-17. 10.1080/13648470.2021.1938510.

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6 Michel Odent (2015) Do we need midwives? Pinter & Martin

7 Editor's note: The Bonapace Method has an inclusive approach and during the official training they systematically refer to 'the partner' rather than 'the father'. The use of the words 'father' and 'wife' in the context of this informal interview is in no way meant to exclude female partners and co-parents.

I trust we can change

By Claire Dunn

Author Bio: Claire Dunn lives in a magical area of West Wales. She has been a naturopathic nutritionist, laser therapist, energy worker and lover of the natural sciences for over 20 years. Her passion and vision is that of sharing her knowledge for all those who seek the transition of their everyday lives into a healthy harmony with themselves and with Mother Earth.

I found myself sitting in the waiting room of a prestigious hospital in West London pondering what lay ahead, for I was on my first placement studying as an Adult Nurse. The details given to me by the University had been somewhat scant; however, I trusted that my mentor would soon arrive, explain what was expected and provide me with an outline of the day.

Time was ticking by and I was starting to feel anxious. I left the room and started to enquire if anyone had seen or knew the whereabouts of my mentor, Maia. No success; she seemed elusive, so I settled myself in the staff room and waited patiently. My excitement started to dwindle and I had a feeling that new students on the ward were something of a bind.

This unfortunate beginning was the start of a spiralling downward progression that confirmed my suspicions about the medical world, but it also fueled my passion to help bring about change. Ultimately, we can and must strive for a better future. I was already a Naturopathic Nutritionist[1] and had healed my own issues where doctors had failed. I saw the integration of holistic and modern as the way forward.

The door was suddenly flung open and a flurry of midwives entered the room ready for the ‘hand-over’. I had been waiting for nearly two hours and was relieved to finally meet Maia.

“But I have no information about you. I was not told I was to mentor you”, she said. It was clear that Maia was not interested in sharing her time with a student. She was very serious and I sensed she was on her own journey, climbing her own ladder, so to speak, and that I was definitely not on her agenda! I followed diligently behind Maia and was told to “observe”. I took that to mean, “Don’t get in the way!”.

So, finally, we entered a private room on the ward where a lady had been in labour for some time. It was quite bizarre. No words were spoken. Maia took to checking monitors, reading notes and writing down stats. That was it. I felt such compassion for this lady and her husband as, to me, they did not seem to be in a good place. Intuition told me that she was exhausted and in a great deal of pain. I wanted to get a cool flannel for her sweat-beaded brow. I wanted to talk to her anxious husband. I wanted to help her move into a position that felt more comfortable for her. As it was, she was lying on her back on the hospital bed with half a dozen wires and beeping machines hooked up to her, and her ability to move was completely restricted. Is this really what a maternity ward is all about? Surely not, for haven't we progressed as a society to the very best in health care? I pushed this doubt aside and held on to the adage, ‘Trust in the plan’ - this presumably is the best for modern women in childbirth.

I waited and waited, standing in the corner of the room as Maia scurried in and out. Hardly any words were spoken let alone directed to me. It was such a bizarre situation. I had to keep trusting that the very best things were happening in this situation and that this was what was expected of a student nurse. My entire first day consisted of simply standing and watching this poor couple go through their first experience of childbirth with such anxiety, confusion, and exhaustion. The underlying dogma was ‘this is how we always do it and no one is going to stray from the guidelines’ - and God forbid anyone to actually help this woman with a change of position or with other humane and natural efforts. I am afraid to say that her labour continued with the administration of an epidural, after which I could see that not only the mother but the baby as well was getting tired. Finally, the mother was taken for a caesarean later that evening.

I had moved to West London from my home in Wales with the hope that I could bring my knowledge and passion for health and total body healing to the larger audience of our capital. I wanted the opportunity to show how, by merging innate knowledge and wisdom and natural integrative approaches with modern medicine, we could bridge the gap between success or failure in how we approach medicine today. Unfortunately, that was not to be.

The events that unfolded over the following week became even more concerning and ultimately led to me walking out of the ward and never returning to nursing. My high hopes were dashed.

To summarise what I observed over the following days - I observed mothers-to-be and their families placing their whole-hearted trust in a system that was creaking and groaning under the weight of a dogmatic management that favoured procedure and checklists over nurturing care - with never a hint of the uplifting and exciting energy that one would expect to accompany the bringing of new life into the world.

“Can anyone help please!” A gentleman stood in front of the reception desk on the ward, wide-eyed and clearly distraught. I waited for a midwife to answer him. Silence!

Again - “Please, anyone. Can you help my wife, she is covered in a rash and it’s driving her mad. What can I do?” Silence again! I had learned that being behind the reception desk was where midwives could hide away and no one ever wanted to be the first to help out. My mouth opened and I felt desperate to reach out to this man. “What about trying calamine lotion or calendula? That may help with the irritation”, I offered. Then an older midwife finally joined in saying, “We have done what we can. Your wife can take some paracetamol. We can’t administer any lotion; you will have to go and buy some”. My heart sank. So many ideas rushed through my mind on how I could help soothe this poor woman’s skin condition - surely these things were common knowledge?

Later, I followed ‘Sue’ into a private room where a very young new mother of around 17 years was waiting to see us. Sue had told me that she was going to help the young mother in getting her baby to latch on to the breast. We must have been in there for a whole eight minutes; it definitely was under ten! Sue had a brief conversation with the mother, saying, “Ahh, is the baby not feeding properly?” The young woman looked very upset and in discomfort. Apparently her nipples were sore, but the baby was strong and healthy and eager to feed. Sue immediately said, “Well, sometimes it’s just not to be. Better on the whole if we start with the bottle. Don’t worry, it happens all the time”! Sue then reported to the sister on the ward saying, “Yes, I’ve spent some time with the mother showing her how to latch the baby on correctly; there doesn’t seem to be any more we can do”. Case closed - the mother was to bottle feed.

I couldn’t believe what had just happened. It was utter nonsense. We had spent no time at all with the young mother let alone made any efforts to help her and her baby try different positions - no offer of extra pillows - nothing. I felt saddened.

I knew only too well the importance of breastfeeding for the baby and for the mother, and she received no skilled support at all. This was definitely not my idea of care. The mother was alone and had complete trust in the midwives; a trust that was very much betrayed. It was nearly the end of the shift and I had the feeling that I just couldn't accept the methods and practices that were being used. I would either get into trouble or get thrown off the ward if I spoke about everything I had observed.

Two midwives came to the desk. "Well, I'm not having another late one so we've managed to stretch her", said one. Apparently, I learned, this practice was all part of a system where the mother needed to be at a certain dilation (of the cervix) before she could be moved to the active labour ward. I couldn't believe my ears when I was told that in the process of trying to speed things up they had accidentally ruptured the mother's membranes as well,[2] and then "overdosed" her.[3] "Well, we will keep that quiet", said one of the midwives, and this incident wasn't recorded. I was in utter disbelief. Three midwives were huddled in a corner with a clipboard; the incident was kept quiet, and I suspect that the mother was unaware of what had happened. This was the final straw. I had seen enough and couldn't cope with this experience any longer. It was a far cry from what you would expect on a maternity ward. I gathered my belongings and left.

I left not with a heavy heart or broken morale - the experience fuelled my belief that, even if it was to be in a small way, I could still forge ahead in sharing knowledge, information and better practice in helping others embark on a more nurturing and empowering journey of self-healing.

When it comes to caring for ourselves and others, how have we become so far removed from our deep, innate, intuitive and inherited wisdom - wisdom that has stood the test of time. It was not so long ago that midwives made daily visits, patiently offering all of their knowledge and support on a one-to-one basis in the calm, familiar and caring space of the mother's own home. Why did we let that go so easily?

This account is not intended to be a criticism of the NHS and all of its employees. In many cases we are indebted to their help, support and intervention. But, I believe we must stand in our sovereignty and authenticity when speaking the truth. Just because a system has evolved in a way where standard practices have become entrenched, it doesn't mean that those practices are good practice; it doesn't mean that things cannot be changed. The willingness to change is a practice we should all embrace. We should

not be afraid to return to older ways now that, with hindsight, we can appreciate their value - or to merge these older ways with modern skills in a new integrative approach.

I know there is a movement, a shift within society where people are becoming more conscious of a desire to explore and delve deeper into their intuitive knowledge of self-help, and a desire to return to a more natural way of living and all that that encompasses.[4] I truly believe that, one by one, little by little, if we all speak out for what we know is the truth, the collective consciousness would support this shift. There are better practices, there is greater knowledge and this older wisdom could work seamlessly alongside the true advances in modern medicine. But there has to be a desire from all of us as individuals to push the powers that be to hear the voice of those who speak out and speak in truth. I trust that we can do this. I have faith.

1 College of Naturopathic Medicine - What is Naturopathic Nutrition? www.naturopathy-uk.com/home/home-what-is-naturopathic-nutrition

2 Editor's note: This is at best, 'meddlesome midwifery', and without the fully informed consent of the mother, it qualifies as obstetric violence.

3 Editor's note: I imagine that the mother was given a large dose of pethidine to sedate her.

4 Editor's note: Perhaps an undercurrent shift away from the pathogenic and toward the salutogenic? See - 'Salutogenesis: Putting the health back into healthcare.' www.aims.org.uk/journal/index/33/1

A review of the Joint position statement: 'Substandard and disrespectful care in labour – because words matter'.

by Gemma McKenzie

Author Bio: Gemma is an ESRC post-doctoral fellow at King's College London who is exploring freebirth, obstetric violence and social concepts of 'good' motherhood. She is also the organiser of Threads of Protest, a crochet exhibition on human rights in childbirth. You can find her on Instagram as @dr_gemma_mckenzie

I read the article in the title with a cup of tea and a raised eyebrow. It comprises yet another attempt by health care practitioners to silence women and their use of the term 'obstetric violence' when describing their own knowledge and experience. As someone who researches obstetric violence and who has been subjected to it, I find the article both startling and confusing. There are a lot of linguistic gymnastics used as a way of (unsuccessfully) arguing that 'violence' should not be used in the terminology. I do note with some relief however that no British obstetrician or midwife has signed their name to the piece; my hope is that anyone who was approached, recognised the authors' argument for what it is: out of touch, one dimensional and misinformed.

Before we dive into the article under review, let's ask a basic question: who has the right to decide what should be labelled 'violence'? When we discuss other forms of violence, we do not ask the perpetrators or their institutions what language they prefer. If they offered a suggestion, we would certainly not be under any obligation to use it. And that is doubly true if we are the victim/survivor. While there may be many more articles written by health care practitioners on their distaste of the term and the labels they would prefer to use, no one is required to follow their attempts at instruction.

Importantly, there is power in language. Suppose we refrained from using the term 'domestic violence' and instead replaced it with 'marital disharmony.' Or if we dropped the term 'rape' in favour of 'non-consensual sexual relations'. Perhaps a more appropriate example reflecting the insidious nature of obstetric violence would be to swap the word 'racism' to 'unfavourable treatment'. If these changes were pursued, the seriousness of the acts would be undermined, resulting in a minimisation of the victim/survivor experience. Ultimately, we need to ask whose needs are served when violence is minimised. Whilst the authors may consider this a good way to forge collaborative working "between individuals and institutions" in aid of improving women's experiences, I consider it a way for the medical establishment to dictate the narrative and silence women.

Obstetric violence versus 'substandard and disrespectful care'

Obstetric violence is a nebulous term. Academics who study the phenomenon are still grappling with the creation of a specific definition and the ways in which it can manifest. One thing that muddies the waters is when authors substitute the term for other phrases, such as 'disrespect and abuse', 'D&A', 'mistreatment' and even sometimes 'birth trauma'. 'The authors in the article under review have introduced an additional term: substandard and disrespectful care in labour.

There are several problems with the authors' use of this term and their description of what it constitutes. Let's begin with substandard care. This is described as:

- The use of healthcare interventions that are not considered best practice.
- Inadequate use of interventions.
- Situations where best-practice interventions are not offered or are withheld from patients.

What the authors are describing here is medical negligence. In the UK, laws already exist regarding this. An additional example the authors provide for substandard care is:

- The performance of healthcare interventions without adequate informed consent.

In England and Wales, this is not simply 'substandard care' – this is a criminal assault. A non-consensual vaginal examination, episiotomy, stretch and sweep, forceps birth, and all other non-consensual interventions are forms of battery. Laws already exist against this, and assault and battery are legally recognised forms of violence.

The authors' use of the term 'disrespectful care' creates an even more incoherent picture. Although in their title, the authors contend that "words matter", the term 'disrespectful care' is an oxymoron. Care is the very opposite of disrespect and it is difficult to think of an example when both can co-exist.

According to the authors, 'disrespectful care' includes "disrespect for ethnic, cultural, religious, gender or other beliefs". It is interesting that this language is used. Are the authors actually referring to behaviour that would be better described as racist, homophobic, sexist, misogynistic, transphobic or incorporating forms of religious discrimination such as antisemitism or islamophobia? The dangers attached to these types of discrimination go far beyond the concept of 'disrespect'.

The authors also state that 'disrespectful care' includes verbal, emotional, physical and financial abuse. Again, such behaviour can amount to a criminal act. Notably, verbal, emotional, physical and financial abuse are forms of domestic violence. Within that sphere, we do not describe those acts as simply 'disrespectful'; we correctly describe them as forms of violence. Yet the authors perceive the label of 'disrespect' as appropriate when such violence is carried out on pregnant women by health care practitioners.

The authors do provide a definition of 'violence'. There are (feminist) scholars who have spent their whole careers exploring this term, its meaning and the way it manifests. Sadly, the authors did not engage with this literature, preferring instead to simply refer to the dictionary. Bizarrely, the authors' definition of violence includes "the use of physical force so as to injure, abuse…" yet this is exactly what they describe as simply 'disrespectful care' and argue should **not** be termed violence.

So why is obstetric violence a more appropriate term?

It is unfortunate that the authors believe obstetric violence is simply healthcare practitioners' substandard or disrespectful 'care'. This limits their understanding of the concept to the idea that it occurs simply during one-to-one interactions. This is not the case with obstetric violence. Of course, there are 'bad apples' in medicine – as there are in all professions – but obstetric violence is not just about individuals not following guidelines. To make an analogy, that would be as simplistic as saying sexism only occurs when men hit women.

Obstetric violence does not require a 'bad' midwife or doctor who deliberately harms people in their care. It can exist even when health care staff have the best of intentions. For example, obstetric violence can be institutional. A hospital may insist a woman be 6

cm dilated before she can move to the delivery ward. This requires the labouring woman to submit to a vaginal examination and undermines any notion of real informed consent. It is likely that the midwife who undertakes the vaginal examination has no intention of violating the woman concerned, but her act is a violation of both the woman's rights and her body.

Obstetric violence can also be structural and emanate from wider social inequality and discrimination. For example, the maternity system operates within a capitalist and patriarchal society that reveres scientific and medical knowledge and the people who claim to possess it. In capitalist countries without free maternity care, women may be subjected to over-medicalised births because they are financially more lucrative to the health care practitioner and the institute in which they work. In patriarchal societies like our own, there is a power imbalance weighted against women and this does not suddenly disappear once they enter the maternity system.

With regards to scientific knowledge, this assumption is evident in the article under review. The authors write that some doctors may have "judgemental or paternalistic" approaches and allow this to reflect in their behaviour "particularly in situations where they hold the power of knowledge and decision". It is important to consider here, when do doctors hold the "power of knowledge and decision"?
In other words, when do pregnant women and people have no knowledge and no right to decide? Beyond situations in which women do not have mental capacity, for example, if they are unconscious, it is difficult to conceive of such a situation. Even in an emergency situation, if a woman has mental capacity, she can decline a medical intervention.

In addition, women always possess some form of knowledge, for example, of their own bodies, preferences, needs, previous life history and family lives. These are all important forms of knowledge that impact decision making. When health care practitioners do not recognise this, they have fallen foul of social assumptions that there is a knowledge hierarchy, and their medical knowledge is at the top. It is this very attitude that permeates maternity care and fuels obstetric violence. It also flies in the face of what the authors are claiming they want to achieve: individuals and organisations coming together to improve maternity care.

A final note

I wanted to make one final point with regards to this review. The authors simply do not understand the impact obstetric violence can have on a woman's life. They claim that it can leave her with "negative feelings" and she may "feel mistreated, humiliated ...

abused". Negative feelings minimise the reality of women experiencing post-traumatic stress disorder (PTSD) and post-natal depression (PND), not to mention stress and anxiety linked to obstetric violence. These are recognised mental health conditions and are not simply "negative feelings".

Further, when people use this turn of phrase about *feeling* mistreated or abused, it avoids any contrition from the abusers, their institutions and systems. It is similar to the type of apology that begins "we are sorry you feel that we…" In other words, the fact that you *feel* abused does not mean that you actually were. This type of approach smacks of the dehumanisation that is central to obstetric violence. If the maternity system and its practitioners cannot empathise with the people they are supporting, then obstetric violence will continue unabated.

And finally

Everyone is entitled to call their own knowledge and experiences what they want – especially victims/survivors. Some victims/survivors may hate the term obstetric violence, and that's fine. Others may feel it appropriately reflects their experience. As to health care practitioners' attempts to stop people using the phrase, the horse has already bolted, and the genie is well and truly out of the bottle. We do not need health care practitioners' blessing to use the language we feel most appropriate.

Whilst it would be great to have as many medical professionals aligned with the views of organisations such as AIMS, it is not entirely necessary. Vast improvements to the culture of maternity care, and in particular that which enables obstetric violence to thrive, will only come from pressure outside of the system. The problems fuelling obstetric violence are too ingrained socially, institutionally, structurally and culturally. It is up to us as women, pregnant and birthing people, activists, researchers and all others who want to challenge obstetric violence, to use our voice, to use the language that feels right for us, and to share our knowledge and experiences in the ways *we* feel best.

[1] EJOG (2024) European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG), European Midwives Association (EMA). Joint position statement: Substandard and disrespectful care in labour – because words matter

www.ejog.org/article/S0301-2115(24)00107-6/fulltext

Getting on my soapbox on the theme of trust: what's in a name, and do you trust your local NHS Trust?

by Jo Dagustun

Author Bio: Jo Dagustun has been an AIMS Volunteer since 2017 and lives in Greater Manchester.

I'm worried about the way we are compelled to recognise and refer to much of our local NHS service as an 'NHS trust'.[1] I'm uncomfortable about the connotations of the word trust in this context. I don't think I want to refer to NHS trusts in this way.

What's in an organisational name? How do the - generally self-selected - names of organisations impact on the way we are able to relate to and 'know' an organisation? Do they give sufficient space for us to make our own minds up about what the organisation is, does and represents? Or are they simply a way to seduce us into believing (consciously or not) exactly what they want us to believe about their organisation?

But here we are in England, with a situation that forces us to engage, at least at some level, with a conceptualisation of NHS trusts as organisations that are inherently trustworthy - ones we *should* trust. Of course, I'm working with the everyday language of trust here. I have not tracked down any discussions at the time of NHS trust development about the use of the word trust in this context. A quick wiki search tells me that "NHS trusts are not trusts in the legal sense but are in effect public sector corporations".[2]

Working alongside maternity service users and advocates for improved maternity services, I know that many service users don't feel that they can trust NHS maternity

services. Rather, for them, memories of time spent engaging with their local trust are ones of mistrust. It annoys, upsets or possibly infuriates to have to recognise an organisation, which for them is untrustworthy, as a trust. None of this is unique to maternity services.

Personally, I have come to dislike having to refer to local NHS services in their organisational form as trusts. It feels like a particular kind of gaslighting. We all know that trust is not something that any organisation can demand from others. Trust must be earned.

Where next?

I have learnt in preparing this piece that NHS trusts have been in place since 1991,[3] and that it would take legislation to remove the word 'trust'. I accept that legislation and rebranding costs time and money that would be better used for other purposes. So it's unlikely that we'd be able to change the names of our local healthcare services to remove the word trust, even if there was a strong call to do so. We are where we are.

So for me, going forward, I'd like instead to see a focus on the extent to which trusts - and parts of trusts - are trusted by their local communities. Do individual trusts measure this? As near-monopoly providers, do they care? We hear much talk of organisational focus on (generally defensive) reputation management, but I'm not sure at all that this is the same thing.

If anything in this article resonates with you, please get in touch. I would love to hear your views.

This article was written in response to AIMS putting out a call for a Journal contribution on the subject of trust. Jo had a soapbox moment ready and waiting! Perhaps you do too? If so, please get in touch with our editor.

1 From Wikipedia, last accessed 10/2024, NHS Trust article: "An NHS trust is an organisational unit within the National Health Services of England and Wales, generally serving either a geographical area or a specialised function (such as an ambulance service). In any particular location there may be several trusts involved in the different aspects of providing healthcare to the local population.

2 Wikipedia page on NHS Trusts: https://en.wikipedia.org/wiki/NHS_trust

3 I found this 2021 article really helpful when I was looking for information on why Trusts are called Trusts: https://nhsproviders.org/news-blogs/blogs/the-anniversary-of-the-first-nhs-trusts-reflections-on-the-trust-model-and-its-future

Revisiting pregnancy and birth through an autistic lens

by Sarah Fisher

Author Bio: Sarah is a mum of three, including twins. She is a women's health advocate and Patient and Public Involvement Leader for health research.

Like many autistic mothers, it is only since having my children that I have learnt I'm autistic. My eldest is now nine and my twins, five. What I describe as 'my autistic epiphany' triggered me to re-examine all sorts of events and experiences through a new autistic lens, not least, my births and perinatal journeys.[1] Looking back there were clues that I'm autistic, many relating to my natural instincts and trust-related issues. My body clearly always knew, even before my mind caught on.

Trusting my pregnant body and intuition

The start of both of my antenatal journeys was marred by overwhelming and debilitating nausea that didn't ease until later in the second trimester. I've since learnt that hyperemesis gravidarum (HG) can be 'dry', but due to the lack of regular vomiting my condition went largely undiagnosed. There's evidence to suggest that autistic women are particularly prone to HG.[2,] Despite being unaware I was autistic or conscious of the extent of my sensory sensitivities, I knew I had a good sense of smell, which was heightened in pregnancy and which I felt was a factor aggravating my nausea.

During the nauseous months my diet was extremely limited in sharp contrast to my usual healthy and diverse pescatarian diet. It was hard to find much at all that I could stomach. After a few attempts of forcing down something nutritious backfired, I learnt to trust when and what my body was allowing me to eat - even when the only liquid I could manage was diet coke and the only fruit to pass my lips was banana - albeit only

with custard, a childhood comfort food. Thankfully, once the nausea eased, I went through a ravenous stage that I interpreted as being compensatory and was more than happy to indulge.

Another early indication that my instincts were trustworthy included that feeling of 'being pregnant'. This feeling kicked in very early, before women can usually feel it. I was on holiday when I realised I was pregnant the second time. Knowing that I had only a matter of days before the all-encompassing nausea, I wanted to run home and frantically battle my to-do list. Despite words of encouragement that 'every pregnancy is different', I knew that the nausea would be the same, and I was right.

Likewise, when I started sensing movements weeks before most pregnant women do, I was met with disbelief. Yet as the tiny sensations grew in frequency and intensity, my suspicions were confirmed. I can understand this now because with my autism comes hypersensitivity, including to my own bodily sensations.

Less easily explained, my predictions about the sex of my babies turned out to be accurate. These days I have more trust in my intuition. I am more attuned to inner thoughts and feelings and this attunement has bestowed on me a sense of power. Armed with my new autistic self-understanding I have more self-trust and confidence.

That trust and confidence would have been useful, especially the first time around. New parents often feel bombarded and overwhelmed by multiple sources of contradictory information, advice and opinions. I'd worked as a researcher for NCT, which helped, but had I known I was autistic I would have been more comfortable with differences in opinion and less bothered by unwanted advice and interference.

My instincts during pregnancy now make even more sense. As my due date approached, or the induction date for my twins, I felt an even stronger need to make my world smaller by withdrawing from contact and retreating further into myself. Hoping for physiological births, I wanted to remain calm and confident by avoiding any interactions that might be overstimulating and intrusive.

I even found well-meaning friendly messages extremely irksome. I had no desire to be with or hear from anyone other than a few trusted people who I would seek out if I wanted to. I just wanted to be left to it. I imagine my family felt frustrated and hurt at times, given they naturally wanted to be kept informed. Now I've insight into my

interaction and communication preferences, I feel more able to explain and justify them, and find they're better respected in return. But how sensible I was wanting to block out the outside world, both before and during labour.

When I went into labour in my first pregnancy, my partner and I didn't tell anyone because I didn't want the distraction and stress of update requests. When our son was born I regretted the news being shared so soon. Even just a couple of hours of peace and quiet after the birth with just the three of us would have been precious. Knowing it's time you can never get back, we enjoyed some beautiful 'golden hours' after the birth of our twins. This skin-to-skin time helped to get breastfeeding established.

Establishing trust with health professionals

I wasn't fortunate enough to have continuity of carer throughout my pregnancies. I hardly saw any midwives or obstetricians more than once, which led to deepened feelings of anxiety, stress and uncertainty. This was particularly challenging in my twin pregnancy as I was planning and hoping for a physiological twin birth.[3] During that pregnancy my mental health was poor.

Like many autistic women, I was prone to anxiety. When our planned second and final child turned out to be twins, I knew that being a mum to three would be overwhelming. This unexpected news triggered great anxiety, spiralling into depression.

Had I known I was autistic, providing a continuity of care team would have been a 'reasonable adjustment' that I would have requested.[4, 5] Continuity of carer is known to be an important factor for building trusting relationships between autistic women and health professionals and improving women's overall maternity care experiences.[5] I would have greatly benefited from developing a trusting relationship with my care providers, assuming they were kind, flexible and accommodating of my needs and communication preferences. Reducing the number of health professionals I communicated with, and ideally, having someone to advocate on my behalf, would have saved stress and time all round.

As a service-user I'm interested in the evidence-base and rationale underlying any decisions or courses of action. I have many questions, a need for detail, and like to do things in my own way and my own time. If that is respected it usually works out well. I've

always been conscious that I can seem inflexible, demanding or difficult. But now I understand why. These are not simply desires but autistic needs. Continuous, trusting relationships with healthcare professionals are more likely to deliver care that meets my specific, autistic needs, including my need for a sense of autonomy and to come to my own informed decisions.

I'm not someone who responds well to false assurances or having my feelings dismissed. I experienced this regularly when I expressed upset or reservations about twins, only to be told it was a 'blessing.' Continuity would have helped my mental health and reduced the number of times I had to share difficult feelings, and help those caring for me avoid saying things that, although well-intended, made me feel worse.

Concerns about that and involving yet another person in my care meant I didn't access mental health support. I was fortunate however, to find and have the continuous support of Jane Denton, then Director of the Multiple Births Foundation,[6] based at my chosen hospital. She provided the sensitive and emotional support and consistency that I was lacking from my care providers, accompanying me along my antenatal twin journey, mentally, and sometimes physically, at hospital appointments.

Trust and the birth environment

I need to feel informed and prepared with reliable information and at no time was this more evident than in pregnancy. Already more informed than most, I did a lot more reading and research to inform my decision-making about where and how I wanted to give birth. I had a strong desire for a calm and less intrusive birth environment, which I now realise was rooted in my sensory needs. I formulated birth plans that set out preferences. Looking at these now, it's interesting that the requests I made are common adjustments favoured by autistic pregnant women, such as avoiding unnecessary interruptions, and low light and noise levels. Being given full information and explanations about my care and opportunities to discuss any changes was also important.

These preferences are also common hypnobirthing suggestions, known to help the production of the hormone oxytocin that brings on contractions and helps you stay calm.[7] It pleases me to know that my autistic instincts and needs also made sense from a biological perspective. I'd practised hypnobirthing religiously during both pregnancies, which I found helped increase my confidence and trust in my ability to give birth, and to stay relatively calm.

In my first pregnancy I opted for the standalone Edgware Birth Centre where I believed I would feel more relaxed. When my 12 week scan put my due date forward by five days it was very stressful. I was sure of my ovulation and conception date and I had more faith in my own calculated date than the one from the scan. This was significant because if overdue by a certain number of days (according to the scan date), the birth centre referred you to the obstetric unit, and I don't cope well with uncertainty or changes to plans.

As it happened, I was sent straight there anyway, because labour started with the release of meconium stained waters. Suddenly being deemed higher risk was stressful, as was the more medicalised care and environment that I'd sought to avoid. This wasn't helped by the increased monitoring due to the meconium, nor by the largely unflexible care I received from the array of staff who came and went who I'd not previously met. My pleas to turn down the bright lights mostly fell on deaf ears. My request to turn down the CTG[8] volume which I found distracting and stress-inducing wasn't permitted, even with a midwife sitting observing it. Despite requesting minimum disturbances and for questions to be put to my partner (also covered in the birth plan we kept handing out), this was largely ignored. If I'd have known I was autistic I could have been all the more guided by my intuition and assertive about my needs, and I hope they would have been more accommodating in return.

As well as the noise of the CTG being problematic, the seemingly constant need for readjustment of the sensor pads and straps drove me crazy. Not liking fuss and being fiddled with, I just wanted to be left alone and feel my labour would have 'progressed' better if I had been. Doing what I could to block it all out, I resorted to labouring in an eye mask and fleeing to the toilet to hide, only to be retrieved.

Fast forward to my twin pregnancy, I chose a different NHS Trust, but my preference for the along-side birth centre wasn't permitted and so I was bound for the obstetric-unit once more. However, my previous poor experience of a hospital birth - not only the environment but also the feeling of being frightened and coerced into things rather than having genuine discussions and involvement in decision-making - only made me more determined to birth in a way I trusted was right for myself and my babies. The more complex twin pregnancy made this somewhat trickier, but given my anxiety, all the more important.

Labour commenced when I was at 38+3, the time I trusted was right for induction rather than the 37 weeks suggested. Thankfully, despite the gruelling journey I'd had to formulate my birth preferences, and not having met any of the health professionals there that day, the care I received was far better. They seemed gentler and took my requests more seriously, perhaps due to my clear anxiety and vulnerability. Knowing that I'd not had a good experience at a different hospital, there seemed to be a genuine desire by my carers at Queen Charlotte's hospital to give me a positive experience, and this resulted in my wonderful twin births.

Trust in labour

The trusting relationships I formed with two midwives were key to my positive twin birth experiences.[9] Firstly, consultant midwife Arezou Rezvani, who I approached at 34 weeks when I was struggling to get clarity and support in relation to my birth options. She enabled me to exercise choice, and was seemingly unrattled by my desire for great detail and autonomy. As some of my preferences were contrary to the multiple pregnancy guidelines, she spoke with senior consultants and, following a healthy 35 week scan, she briefed the necessary staff, and added my preferences to my file to prevent obstacles on the day. Secondly, Laura Forster, a wonderful midwife with whom I soon felt confident and at ease, and therefore more grounded. Looking back, I feel this trust was reciprocated in terms of the way she enabled me to labour and behave in my way. Despite limited experience with twins, she was warm, encouraging, respectful of my choices and worked confidently to achieve them. She remained consistently nearby sitting quietly and unobtrusively rather than popping in and out which I'd have found disruptive.

I wonder if I'm the only woman who prefers and finds it easier to cope with intense, established labour? I found all the uncertainty and fiddling with me that I associate with early labour very stressful, so welcomed stronger contractions which made it easier to focus, go into myself and block out my surroundings. Reflecting on the primal, stripped-back person I became in labour, did being autistic exacerbate my sense of this, or mean I was more able to go there?

Yet some sensory sensitivities couldn't be blocked out… When birthing my first twin, I swiftly banished my partner from my side when I smelt coffee on his breath and thought I'd vomit. This autistic clue had eluded me until I heard strong aversions to coffee on the labour ward mentioned in a Maternity Autism Research Group (MARG) webinar.[10] I've also joined the dots between my autism and the lip balm I insisted my partner apply for me in between every contraction during the pushing stage with my oldest son. I can't

bear having dry lips or hands but at least my rapid consumption of lip balm and hand cream is now explainable as a sensory thing.

On the subject of support from my partner, it amuses me to recall the suggestion in antenatal classes that your partner massages your back to ease labour discomfort. I couldn't bear to be touched, unsurprisingly given that uninvited touch bothers me at normal times when I'm focusing on or distracted with something. Yet I can't imagine having coped in labour without my partner's trusted presence which I wanted and needed. Albeit mostly at a distance and following orders!

My autistic births

As my awareness of what being autistic means for me has deepened, so has my understanding of strange and disconcerting labour experiences. At times during the most intense moments, I felt like a completely different person. In this intense state of being I was far less aware of others, their presence was confusing, and I was more likely to take things literally. Despite being blunt myself, I was extremely sensitive to the words of others, especially during my first child's birth when I had contact with more health professionals and felt less at ease.

This unnerving alien-like feeling was something that kept puzzling me. My autistic awakening has completed the puzzle, for I believe that the physical intensity and altered state of my mind I experienced during labour revealed my true autistic self, stripping me of over 40 years of learning, conditioning and masking. I was reminded of myself as a child, before I'd learnt that all words are not literal, and when I understood others less. I don't doubt that in active labour women become more raw and inward-facing, regardless of neurodiversity. Without being able to experience and compare birth as a neurotypical person I've questioned my autistic interpretation, and wondered if Entonox played a role. But there have been other times during moments of physical and mental intensity that I've had similar, although less extreme, feelings. Many in the postnatal period, and other situations involving great stress, sleep deprivation or over-stimulation. These states, for want of a better way of explaining it, make me feel 'more autistic', by which I mean my sensory sensitivities and communication differences are heightened and daily life is more challenging.

Minutes after my first son was born I asked the midwife what he weighed, and she replied by asking how she was supposed to have weighed him when she'd been with me all the time. Despite having only had gas and air, I was disoriented and felt strongly criticised by that small remark. I also felt shamed by the tone of another response she made. The tone of what is said can be more important than the words. My older, wiser

self might have been more patient or at least have felt less chastised by the sensed criticism, but my feelings at the time remind me of childhood experiences and feelings. I mentioned these comments to my partner some time afterwards and he was surprised they bothered me. Yet nine years on these fleeting interactions and words replay in my mind when thinking about my first moments of motherhood. I hate to imagine how traumatised I'd feel had I been spoken to more harshly.

While all women are vulnerable in this way in labour, I wonder if being autistic left me more so. You can forget some details about what happened and when, but not how you were made to feel. On paper my first and twin births wouldn't look dissimilar. What was missing from the first was the trust established with a gentle, respectful and considerate midwife who was consistently there for me. Her flexibility, good communication and kind words made so much difference. This type of personalised and accommodating maternity care from health professionals with whom women have had the opportunity to get to know and trust, seems fundamental to understanding and meeting autistic women's needs, but would of course greatly benefit all women, irrespective of neurodiversity.

1 This article focuses predominantly on my birth experiences. For more autistic reflections on my antenatal and postnatal experiences see: Fisher, S. (2024) Navigating pregnancy, birth and early parenthood as an autistic mum. Available at: https://www.ndbirth.com/post/navigating-pregnancy-birth-and-early-parenthood-as-an-autistic-mum-sarah-fisher

2 Hampton, S., Man, J., Allison, C., Aydin, E., Baron-Cohen, S., & Holt, R. (2023). A qualitative exploration of autistic mothers' experiences I: Pregnancy experiences. Autism, 27(5), 1271-1282. https://doi.org/10.1177/13623613221132435

3 I've written about my twin birth journey. See: Fisher, S. (2023) A quest for a physiological twin birth. *The Practising Midwife,* 26 (11), pp.31-34. Available at: https://www.all4maternity.com/a-quest-for-a-physiological-twin-birth/

4 Henry, K. (2023) Providing Accessible Healthcare for Autistic Women. *The Practising Midwife,* 26 (02), pp. 37-41.

5 Fox, D (2022). 'Supporting autistic pregnant people', National Autistic Society. https://www.autism.org.uk/advice-and-guidance/professional-practice/pregnant-autistic

6 The Multiple Births Foundation corroborated with Birmingham City University to establish the Elizabeth Bryan Multiple Births Centre. For more info see: https://www.bcu.ac.uk/health-sciences/research/centre-for-social-care-health-and-related-research/research-clusters/ebmbc

7 Howell, M. (2009) Effective Birth Preparation: Your guide to a better birth. Surrey: Intuition Un Ltd.

8 Editor's note: CTG stands for cardiotocograph. A CTG machine records the baby's heartbeat on a paper printout and this makes a beeping noise.

9 Editor's note: The two midwives who provided Sarah with such excellent support are mentioned by name with their permission.

10 The Maternity Autism Research Group (MARG) is an Autistic-led collective of health professionals and researchers working together to improve care for Autistic women and people. https://www.maternityautismresearchgroup.co.uk/

We always have a choice, no matter how much we are made to feel otherwise

by Rachel Wolfe

Author Bio: Rachel Wolfe is a 37 year old full time mum of two in Lincolnshire, Rachel works on the side in virtual fashion design when time permits.

“What would have happened to me, you know, in nature, before modern medicine?” I asked from where I lay on the hospital bed, unable to move without intense pain. I had my newborn son tucked in beside me.

The midwife, whose face I could not see, paused and looked at me over her mask. “Well, one in twenty women died in childbirth” she shrugged, before stepping out of the room and leaving a heavy imprint on my life I doubt was ever her intent.

I don't remember anything else of that particular midwife. The whole experience of my first birth during April of 2021 is a blur of faceless people doing things to me. I know I am hardly alone in this experience. I also know that, had I seen their faces, it may have been less traumatising, but it would not have changed the underlying issue that caused the trauma; and that is trust. My trust had been abused and I didn’t even understand it, not at that moment, and not even in the coming months of difficult, gradual recovery.

I gave my trust to our NHS maternity care system, or '*uterus on a conveyor belt*' system as it felt like at the time, and I haven't since changed my opinion. I was at my most vulnerable, trusting my life and that of my unborn baby to the hands of people I'd never met before; people who will forever remain faceless to me. It is only their eyes, staring over the edge of masks that I remember and the tone of their voices casting judgements and coercive lies that I oh so trustingly lapped right up.

Trusting was my mistake. I gave my trust to these people, to this system. Why? Because for most of us, it is the only option we have. But there is a choice - we always have a choice, no matter how much we can be made to feel otherwise.

My journey into motherhood started like many from my middle class background. I read some books, I did an online NCT antenatal course, I did hypnobirthing courses and I learned about the physiology of natural birth, which, like many women, was what I wanted for myself and my baby. It made sense and felt empowering to trust in this natural process, and, most importantly to me, it had the best clinical outcomes. I come from a scientific family and I simply wanted the best potential outcome, not just physically, but psychologically, too, at this important point in my life where I was now responsible for another person.

I am writing this as I lie in bed on a sunny, summer's afternoon, feeding my three-month old daughter. I am so content, oxytocin is flowing, just as it is meant to. I can hear her swallowing a nice even flow. There is no pain, no discomfort, no stress or worry, just lovely warm feelings as I watch her lie here with her eyes peacefully closed, swallowing that gentle flow of milk from mother to baby, just as our species is designed to do.

I cannot remember ever feeling this level of peace with my son - my first baby, born three years before. What I remember is fear, anxiety, and worry; worry over everything from, do I have enough milk, to what if he cries and I can't make him happy. You might think these are normal first time mother fears, but it is not normal to find that your body will not let you sleep, that every time you drift off, you wake back up with a terrible sense of falling.

It is not normal to fear leaving the house, because doing so feels like wading through a bottomless sea of worries and stress; and then to feel so riddled by loneliness and guilt that you are forced to take that risk. It is not normal to swim in that endless ocean and to hear every cry as if it is the end of the world with the walls closing in.

I was told it was simply a common reaction to the physical trauma of my birth, but I have since learned it is so much more than just that.

Trust is at the heart of all care. That's what I wish I had understood then, before I obediently handed over my trust to people in a system where avoiding litigation seems more important than patient care. That is my personal opinion, but it is also the opinion of many midwives, sonographers and even doctors that I have spoken to. Sadly, this is simply the reality. It should be different. I know that people do not become doctors or midwives in order to hurt women or to bombard them with negativity simply because they are terrified of being sued, but that seems to be the reality we are now living in.

So, I am writing this personal account hoping that just one other person might be saved from the needless suffering that I endured. If I had seen an account like this, before I'd had my son in 2021, my first experience of motherhood may have been the beautiful, happy experience that my second baby's birth has been. If only it could have been so. If only it could be this way for everyone.

Here is the story of my two birth experiences, both under the NHS. The first in Devon in 2021, the second in Lincolnshire in 2024.

My son's birth

There was never a more wanted baby. I was over the moon, blessed with a wonderful pregnancy and so happy. Classified as low risk, I instinctively decided on a home birth with the community midwives. If things changed and I needed or chose to go to the hospital with my homebirth midwife, that was fine too. I trusted in myself and my body.

This plan all came to a sudden and distressing halt when I was diagnosed with gestational diabetes in my 3rd trimester. This is the first point where my trust was abused. I was informed that I 'could no longer have a home birth' and 'would need to be induced'. This is the language that was used. I trusted this without question. I thought I had no choice. This is not the case in the UK. Any woman legally has a right to birth wherever she chooses and to receive midwife-led care. I was lied to. Why?

Well, the doctors would say for my own good and my baby's, I'm sure.
My blood sugars were beautifully controlled through diet, exercise and medication, I was reassured my baby was not measuring large, and none of the potential issues diabetics can face were ever of concern. In short, my pregnancy remained entirely 'normal and healthy'. But diabetes in pregnancy is never regarded as normal and,

despite all being well, I was repeatedly told that my baby would 'need' to come out by 38 to 39 weeks. I never really questioned this as I had always been someone who trusted doctors and medical care implicitly. I asked questions to understand their advice better, but never to *question* their advice, and I had no notion of how their use of authoritarian language secured my obedience.

I did a lot of research. I came to a decision that I would ask to have a planned c-section if my baby had not come naturally by the point they deemed an induction necessary. This was a purely personal decision mainly based on the statistical outcomes of induction of labour for first time mothers. I wished to avoid a drawn out medicalised process as I was afraid of how that might negatively impact me and the early days of motherhood. Sadly, as it turned out, I could not have been more right.

When I requested the planned c-section, I was talked out of it by a seemingly caring and well-meaning obstetrician. I could blame her for what was to come, and there is certainly a part of me that does, but ultimately I am responsible for being my own voice. I did not express myself strongly enough. I approached with meek, obedient language because I trusted her. I trusted she would understand and listen to me. I trusted this hugely important decision to someone I had never met before and who only saw me for a few minutes. I was passive. I was obedient. I was so meek, and now I wish so much that I could go back and tell myself to "Stand up for what you need - don't trust her, just because she's a doctor wearing a kind smile".

The long and short of it is this: I trusted that doctor that day, I let her talk me out of what I knew was the right choice for me. I wanted to be a good patient. I wanted her to think well of me, so her coercive language worked a treat.

I also trusted the doctor that happened to be there on the day they finally decided to induce. I was 39+5. Everything was fine, except I needed a little less insulin than previously and they feared this might be an indication the placenta was failing, despite there being no other sign of this. I requested a scan to check and was told that wasn't possible for some garbled reason I don't even recall. Once again, I was lied to. Once again, I was far too meek, far too trusting.

I was actually ready to refuse the induction. I was in early labour and already 3cm. I felt well and they said nothing was wrong with my baby. It felt best to wait, but the doctor stood beside me and looked me in the eyes and I asked what he would recommend, if it

was his wife or sister in this situation. Naturally he raised the issue of stillbirth, making it sound as if this was likely when I know now that it isn't, and he said that induction was the safest thing for my baby. So I agreed. I had an induction. I went into it excited and positive. I was going to meet my baby. I knew I had to embrace this for it to work. I really tried.

It didn't work at all, not even 16 hours solid on pitocin maxed out, it didn't work. Thankfully there was no concern over my baby, but they 'needed' to get him out after this point because the induction was clearly not working and I was on that conveyor belt you can no longer get off because they had broken my waters.

So my wonderful, beautiful son was born by an emergency c-section. It was a blessed relief to have that nightmare of an induction end and to finally have him in my arms.

My memory of that birth was of being in shock, lying stunned and shaking, unable to think.

I was so tired I couldn't hold my eyes open afterwards.

About 12 hours later, having only just got the feeling back in my legs from the epidural, I was returned to theatre, this time with a spinal block. Blood was coming out of my incision and would not abate. I had to sign away my uterus in order to have this operation. I now know my life wasn't in imminent danger or I would have been given a general anaesthetic. I felt very scared yet strangely detached. I was in shock but none of the communication I recall suggested I had a choice. I saw no one's face.

The midwife and the obstetrician both advised me that I should be happy just to have a healthy baby and to be okay myself. I so wanted to be happy. I tried. It was the comment by another midwife that stuck with me and that angers me to this day. I wanted her reassurance that I had at least experienced active labour, but she replied, "Oh no, you never reached active labour". She made me feel so weak. I had required an epidural and it hadn't even been active labour. What could possibly be more intense than what I'd experienced? I never dilated any further than 3cm, but I was certainly in active labour as far as contractions go. That's what that woman should have told me. Why she felt the need to belittle my experience, I'll never know. Again, I put far too much trust and care in strangers.

I went home 2 nights after this. I was in agony from breastfeeding. Everything was darkness that only got worse as I could not sleep. I got into a very bad state where I felt I had to die. Not because I wanted to. I was blessed with such an instant, overwhelming sense of care for my son. I'm not sure if love is the right word, as I don't recall happiness, only a desperate care for him. It was this very anxious, all encompassing care that made me feel I had to die, because how could I take care of him without sleep? I had this piercingly sharp feeling that he needed better than I could give.

Thankfully the one community midwife who I had some continuity of care with picked up on this and immediately had sleeping pills prescribed for me that day. My immediate crisis was dealt with and I felt so much better from just getting some sleep, that I don't think I realised how bad things still were. I didn't want them to be bad and I very quickly bonded with my son and was utterly enraptured with him. I've always been a happy person and I just wanted to get on with it. So I did.

A miscarriage

In late 2022, I suffered a miscarriage of an unexpected but very much wanted pregnancy. I had known something was still very wrong with me at my booking-in appointment when I experienced a terrible wave of darkness washing over me.
I learned of the miscarriage on a scan and fled the hospital after being left waiting alone in a room for over half an hour. I did not feel cared for. I answered their follow up call outlining my options and chose to wait for nature to take its course, and a few days later it did. In the midst of loss, I found healing.

With my miscarriage, I felt waves of natural contractions. These were very different; something my body did all by itself. I could move about. I wasn't trapped. And it was so, so powerful. It hurt, it was intense, and yet it was beautiful, somehow. Despite how utterly broken and defective my first birth had left me feeling, my body knew how to do this thing after all. It was this experience that gave me the courage to pursue birth on my terms when I fell pregnant again.

My daughter's birth

I started my second pregnancy with no trust in my care and I left my first appointment in tears. The diabetic doctor suggested termination at 7 weeks gestation because of my Hba1c[1] at conception, but she would not give me the information I needed to make an informed decision. I had asked for care when I was first trying to conceive but my diabetes had been left un-tended. Even in this, my trust was abused and I now feel so utterly foolish to have trusted in the system rather than being proactive in my own

health. I believed my diabetes wasn't a problem because no one seemed concerned. It was only once I was pregnant it seemed like a panic button had been flipped.

This time, I did things differently. I was no longer the pliant, passive patient who did as she was told. I educated myself. I researched. I found the moral and emotional help of the most wonderful doula a mum could ask for. I even paid to speak to a private obstetrician to provide me with actual statistics of the risks I was facing with my pregnancy.

I am so very glad I did not place trust in the NHS doctor. I do not doubt their job is a hard and difficult one, and I certainly do not envy their role working on the conveyor belt system, but I would not have my happy and healthy daughter if I had given my trust to this person whose concern, I felt, was not for me or my baby, but simply for avoiding litigation due to NHS neglect in treating my diabetes.

As the birth approached, I found myself trusting the home birth midwives. They made me feel heard. They made me feel sane and sensible. Every appointment left me feeling uplifted, excited and optimistic. They understood my thinking and supported my informed choice for my birth and I know I had their genuine support. If one of these women had turned to me and voiced concern over anything, I would have trusted in their judgement.

The consultants were another thing entirely. Each one I saw left me feeling utterly hopeless and defective. The closest I came to feeling trust in them was one who admitted that they just don't know, so they err on the side of caution. However, without strong clinical evidence to support medical intervention, erring on the side of caution was not good enough. This was an informed decision I made for myself and my baby. I understood the risk of stillbirth for women with well controlled gestational diabetes to be the same as for any non-diabetic pregnancy. They could not tell me this was wrong.

I had a choice to make - to trust myself or the fear mongering of the consultants. It was very difficult to go against medical advice. I refused any induction outright, and was not pushed on this, probably as I had been diagnosed with PTSD. The offer of a sweep or a planned c-section was discussed but I made an informed decision that felt right for me.

My body had safely and effectively miscarried at home, which was like a mini labour. I trusted in this natural process and trusted the midwives. I did not want an obstetrician breathing down my neck, focusing on the tiny chance of stillbirth. I needed people who believed in my ability to give birth, and I trusted in those that believed in me, including my doula Emily.

In Emily I found the continuity of care that was not being provided in my antenatal appointments. She was deeply invested in my experience being a positive, empowered one. She was a sounding block, cheerleader and advocate who wanted the very best outcome, however that looked like for me, and in the end she helped me achieve what truly mattered, a positive birth experience.

I knew from reading on birth trauma that I *must* trust whoever was providing my care. In the case of a c-section, I narrowed it down to one thing I needed above all else. I needed the surgeon on that day to look me in the eyes beforehand and promise to take extra care to avoid the bleeding that happened the first time. This was not just about avoiding blood loss, it was about feeling heard. It was about that obstetrician seeing me as a person and not merely a womb. I needed to know I could trust this person to really listen to me and to understand the impact of my first birth, and to do everything possible to avoid such a negative experience this time, and that is exactly what happened. He was also the first doctor to apologise to me for what had happened to me that first time.

Almost three weeks after the proposed date for induction - three weeks of enjoying the delight and wonder of my pregnancy, and three extra weeks for my baby to become ready to enter the world - I gave the go ahead for her to be born through what Emily refers to as a calm and gentle belly birth. It was nothing like the first c-section. Seeing her emerging was the most amazing moment of my life. I then had five wonderful hours holding her skin-to-skin and all my wishes were honoured. Everything was perfect and there was nothing wrong with my placenta. Do I regret not holding out for longer? I find it hard to regret the best moment of my life, so no.

In my first birth my unquestioning trust was abused and broken, I know that now. With my second, I only bestowed my trust once my needs had been met. The goal of a live mother and baby shouldn't require widespread brutality. That is a low standard in anybody's book. We are told that birth is but a brief moment in our mothering journey, but it is also an important and defining part of our story. This revelation helped me to heal from the trauma and enabled me to trust myself and to approach the birth of my daughter with hopeful excitement rather than with the anxiety and fear that had crippled me for years.

1 Editor's note: HbA1c is a blood test that is used to diagnose type 2 diabetes. It is also used to monitor blood glucose control in people with diabetes. The option of termination would have been on the basis that the best outcomes for a diabetic mother are when medical supervision of a pregnancy starts before conception. www.diabetes.org.uk/guide-to-diabetes/managing-your-diabetes/hba1c

Black Trust Within Maternity

By Mars Lord

Author Bio: Mars is a Certified Life Coach and birth activist. She is the Leading Voice in Black Maternal Health and Cultural Competency. A multi award-winning doula, mentor, and educator, she is on the RCOG Race Equality Taskforce and on the Birthrights Legal inquiry into Black Maternal Health panel. With 20 years experience. Mars is in high demand, both in the UK and across the world, as a speaker and trainer. Mars created Abuela Doulas, a doula preparation course primarily, but not exclusively, for Black and brown bodied people.

The NHS is made up of hundreds of different organisations of differing sizes at central, national, regional and local levels, each with different roles and responsibilities. The NHS Maternity system in the UK provides care throughout pregnancy, birth and early parenthood. It starts with antenatal check-ups and continues through labour, birth and postnatal care. Women and birthing people can choose where to give birth, at home, in a midwife-led unit or in the labour ward. Care is typically provided by midwives for low-risk pregnancies, with doctors involved for high-risk cases. The system aims to offer continuous care from a known midwife or team, integrating community and hospital services, though we know, currently, that this is not always the case. Women and birthing people are encouraged to make informed choices about their care, with support available for various aspects of pregnancy, birth and early parenting. Giving birth in the UK is, for the greater part, safe. Maternal mortality rates are not something that most people want to think about even though our maternal mortality rates are low. To date we have no figures on the maternal morbidity rate: morbidity is defined by the World Health Organisation as *'any health condition attributed to and/or complicating pregnancy, and childbirth that has a negative impact on the woman's well-being and or functioning"*[1]

It is important to understand the makeup of maternity services in order to see the points of intersection for trust and also to look at the available statistics. In 2022 according to the Office for National Statistics there were 605,479 live births in England and Wales. Data from Sands and Tommy's show that there were at least 100,000 miscarriages in England in 2021/22. There were 13.41 maternal deaths per 100,000 pregnancies between 2020 and 2022, according to figures published by the MBRRACE-UK investigation into maternal deaths in the UK.

Trust, therefore, is an important part of parents' interaction with maternity services. They trust that both they and their babies will be kept safe within the system that is 'designed' to care for them. This is one of the most vulnerable times in their lives and one which society, the healthcare system and the media tells them is the riskiest time for them.

Trust is a firm belief in the reliability, truth or ability of someone or something, in this case the healthcare professionals and system which includes midwives and doctors. This begins from the moment engagement starts. What is expected is that there will be effective communication so that medical advice can be accurately weighed when making informed decisions. When the healthcare professionals and the system within which they work are trusted, there is higher satisfaction with the services provided, even when the outcome is not what was expected. What this article looks at are the specific challenges and disparities faced by Black bodied women in the UK maternity system. There is a huge erosion of trust amongst Black bodied women in the maternity system due to systemic issues and individual experiences of discrimination and anti Black racism, and we have a ways to go to change all of that.

There are many racial disparities in healthcare here in the UK.[2] These include but are not exclusive to, maternal mortality, fertility treatment, miscarriage, mental health, COVID-19 outcomes, cancer screening, diabetes, cardiovascular disease, access to GP services, access to pain management, organ donation and transplants, representation in medical professionals and language barriers.

When we look at historical causes for the disparities in Black maternal health, we remember the gynaecologic experiments in the 19th century of Dr J Marion Sims, who until recently was, and in some circles is still, called the "father of modern gynaecology".[3] As a quick sidenote, there are still medical instruments named after him in current use. He conducted experiments on enslaved Black women without

anaesthesia and he performed surgeries to develop techniques for treating vesicovaginal fistulas which often caused great pain and suffering. In the early to mid 20th century, eugenics programmes in countries which included the UK disproportionately targeted Black bodied women for sterilisation, and they were based on racist ideologies about population control and "racial improvement".[4, 5] In the 1950s, early contraceptive pill trials were conducted on Puerto Rican women who were not fully informed about the risks or the fact that they were a part of an experiment. At least 8 women died. In the US there were efforts to eliminate traditional Black midwives in favour of hospital births ignoring the cultural importance and community role of those midwives, which led to poorer care for Black bodied women.[6] Whilst not about midwifery and birth, another example of the disregard for Black bodies, their health and informed consent, is the Tuskegee Syphilis Study (1932-1972).[7]

There is an underrepresentation and exclusion of Black bodied women in research studies which leads to gaps in understanding, and there is also an underrepresentation of Black bodied researchers.

Racialised medicine is where there is a false belief in the biological racial differences which leads to misdiagnosis and inappropriate treatment for Black patients. This belief accounts for the historical belief that Black bodied people have thicker skin and a higher tolerance to pain.[8]

It's not just within the US that Black bodied midwives have been discriminated against and mistreated. Whilst here in the UK there was no strong tradition of Black community midwives, the discrimination was just as rife. Post World War II, Black women were recruited from across the Caribbean to work in the NHS but they often faced discrimination, being relegated to lower paying jobs, less desirable roles and facing barriers to career progression despite their qualifications and experience.[9] Today they are most likely to be complained about by both service users and their colleagues. There are fewer opportunities for access to training and professional development for them and they face higher instances of workplace bullying and harassment and cultural biases and discrimination.[10], [11], [12],[13]

When we recognise the attitudes towards Black bodied midwives, it can come as no surprise that Black bodied women and people don't fare well within our maternity system. Through the 1960s-1980s there were reports of Black bodied women facing discrimination in maternity wards which included being placed in separate wards

and/or receiving less attention from medical staff.[14] In the 1990-2000s studies began to emerge highlighting disparities in maternal care and outcomes for Black bodied women. We see the evidence of this with the reports by CEMACH (Confidential Enquiry into Maternal and Child Health) showing higher maternal mortality rates amongst Black bodied women.[2] In 2017 we saw the story of Serena Williams when she gave birth to her firstborn, Olympia, which is a clear example of Black women not being listened to. Despite telling her healthcare professionals the symptoms that she was experiencing, and her own recognition of the fact that she was prone to pulmonary embolism, she was ignored by different nurses and doctors before finally getting the CT scan and heparin drip she had asked for.

A 2019 study by MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) showed that Black bodied women were five times more likely to die during childbirth than white bodied women. Black bodied women experience a 43% higher rate of miscarriage compared to white bodied women. The COVID-19 pandemic highlighted and exacerbated the existing disparities. Black pregnant women were more likely to be hospitalised with COVID -19. In 2021 Birthrights found that 43% of Black or Black British respondents said they were not treated with respect during pregnancy or childbirth. In 2020 Nicole Thea, a popular YouTuber, who'd documented her pregnancy journey, suffered a cardiac arrest caused by an undiagnosed condition called hypertrophic cardiomyopathy (HCM). Nicole went to the hospital with breathing difficulties. Despite guidance issued by the Royal College of Midwifery saying that Black bodied women presenting with breathing difficulties should be fully examined, she was sent home by a midwife who told her that difficulty breathing was common in pregnancy. No checks etc were ever made. Nicole Thea was 24 years old. Just recently in 2024 Laxmi Thapa's son was born with a blue spot (Dermal melanocytosis) - blue-grey markings common on babies with brown or black skin. After being referred to hospital in Basingstoke she was arrested when medical staff and police followed procedures for suspected child abuse. Despite being a breastfeeding mother, Laxmi was kept apart from her son for over 20 hours.

The Ockenden report (2022) provides an extensive overview of findings, including the failings identified within antenatal care, intrapartum care, postnatal care, maternal deaths, obstetric anaesthesia, and neonatal care, which each helped to inform the subsequent recommendations they outline. On 19 October 2022 Dr Kirkup's report Reading the Signals was published by the Government. The report from the independent investigation found that women, babies and their families had suffered significant harm because of poor care in our maternity and new-born services, between 2009 and 2020. To date, no such highly publicised report on the scale of the Ockenden Report has been commissioned or published into the disparities in the maternal

mortality rate for Black and brown bodied women. The most recent report from the Government, Black Maternal Health: Third Report of Session 2022-2023 shies away from directly naming structural and systemic racism, focusing more on pre-existing conditions without talking about their root causes.

And so we come to the issue of trust.

We have increased reporting about Black maternal health, with the emphasis being on the "trauma porn" aspect. People want to hear the stories, stories which *deserve* to be told and heard, but they do not wish to look beyond the stories and move towards action. What we have instead is a generation of Black bodied women who are increasingly scared of birth and a health system that continues to pathologize Black birth. When there is no trust in a system or trust in the people perpetuating harm and working within said system, broken trust is a given.

The implications of this are that Black bodied women are withdrawing themselves from maternity care. They are not, however, withdrawing without fully investigating all of their options. They are making informed decisions about what they want for their care and who they wish to provide it. There are no figures and statistics at this moment, but anecdotal evidence speaks to increasing numbers of freebirths. After all, why give birth where it is riskiest for you - within a racist system that has much to do to change and repair trust. Perhaps a reason for the lack of numbers is the prevalence of some outside agencies and health care professionals who disregard the fact that freebirth is a legal option, and threaten as well as report women, particularly those who are from marginalised communities, to social services and the police.[15]

When the data points to higher rates of complications and maternal mortality, there will also be an increased risk of poorer mental health. Increased stress and anxiety leads to higher levels of cortisol, cardiac and respiratory problems, all of which play their part in the poorer outcomes and increased disparities. The MBRRACE-UK report shows that Black bodied women are dying of the same issues as their white counterparts, but at much greater levels. Research shows that poor treatment and ineffective communication in healthcare settings often leads to women avoiding seeking necessary care.[16]

It is important to look beyond the medical sphere to recognise how the societal narrative is mirrored within the maternity system. Black bodied women and birthing people do not suddenly develop the health predispositions on presentation to their healthcare providers. The continual micro and macro aggressions, the racial biological weathering begins before birth, continuing the cycle of discrimination and resulting in

the disparities. Consider this. When the body is under stress it produces cortisol. An effect of cortisol is the overproduction of insulin. An overproduction of insulin can lead to diabetes. What this suggests and demands is a wider look at the anti Black racism and discrimination throughout society. Whilst this is an enormous task, that will not be resolved in my lifetime, indeed within the lifetime of my grandchildren, it is imperative that we recognise the mirroring of society within the healthcare system and most especially, in this instance, within the maternity system.

It is said that a good birth heals both seven generations forwards and backwards. We begin to understand more and more about epigenetics and how DNA is affected and how trauma travels through generations.[17] So how as healthcare professionals, birthworkers, doulas, activists and campaigners can we begin to change what is, and begin to influence the health of generations?

First comes the rebuilding of trust. Once trust is broken it is hard to rebuild and it can take many years. There is no quick fix, but it is possible for us to create short term goals that lead to long term goals and outcomes. This requires honesty and less 'clutching of pearls' and knee jerk defensive responses. Taking time to consider what is being presented and slowing down our initial responses is a good place. Two questions that I often ask of my clients (both in birth work and as a Life Coach) are:

1. What has caused you to respond defensively? Take time with this one and be honest with yourself. There is no one judging you. This may take a little more time than you realise, but taking time may well be the thing that brings about change.
2. What if it were true? I ask this question because people can sometimes have fixed beliefs and instantly reject what is put in front of them. To further extend the question.. And if it were true, then what?

Once time has been spent reflecting on those questions (and any others that come to mind), it is time to plan forward and move to the next questions:

1. What can you do now, personally?
2. How do you take ownership of your thoughts and beliefs to make change in your life, allowing you to *then* begin to work to build trust amongst the different communities that you serve?

When we look to the most marginalised in our communities, when we lift up Black bodied women, the rest of society follows. The other marginalised groups are seen and recognised too. This isn't about 'whataboutisms'; the different groups will have similar issues and problems, but the solutions for them will be different. Today we are looking

at the trust of Black bodied people and the maternity system. This is where I invite you to start. For far too long when Black bodied women are the centre of the conversation there is a shouting, shoving and bustling to bring in the 'whatabouts', therefore relegating Black bodied women to the bottom of the pile, again and again. So pause. A way to build back trust is to honestly look at and focus on Black bodied women and people birthing within the maternity system. For when we treat the most disadvantaged in society well, *everyone* benefits.

How does your medical curriculum look? Who is it based on and how can it be adapted and expanded to *include* the marginalised? What can you as an individual do to begin rebuilding trust?
There are many questions that are continually being asked and there are questions that still need to be asked individually as well as collectively. Imagine what would happen if we were to look at Black bodied people and support them to thrive. How can we throw off the societal and historical narrative that speaks of them as less than and blames them for the disparities in maternal mortality and morbidity outcomes? How do we treat them as people rather than pathologizing their Blackness? Let's stop calling for Black bodied women and people to speak up, and take a moment to actually listen.

The disparities in maternal health outcomes for Black bodied women and people in the UK are not just statistics—they represent real lives, families, and communities. These inequities stem from deeply rooted historical injustices and persist due to systemic racism within healthcare and society at large. Rebuilding trust between the maternity system and Black communities is crucial, but it requires honest self-reflection, sustained effort, and meaningful action at both individual and institutional levels.
As healthcare professionals, policymakers, and members of society, we must confront uncomfortable truths about bias and discrimination. We need to critically examine our practices, policies, and educational curricula to ensure they serve all birthing people equitably. This means centering the voices and experiences of Black women and birthing people, and actively working to dismantle the structures that have led to their marginalisation.

The path forward demands more than performative gestures or temporary solutions. It requires a fundamental shift in how we approach maternal care, medical education, and healthcare policy. By focusing on improving outcomes for Black birthing people, we have the opportunity to elevate care for all marginalised groups and, by extension, the entire population.

The questions posed throughout this piece are not rhetorical—they are calls to action. Each of us has a role to play in this transformation. Whether it's through personal

education, advocating for policy changes, or reimagining healthcare practices, the time for change is now. The health and lives of Black mothers, parents and babies depend on our collective commitment to creating a just and equitable maternity care system.

As we move forward, let us remember that trust is earned through consistent, compassionate action. It's time to move beyond acknowledgment and into the realm of tangible, systemic change. The journey may be long, but with dedicated effort and unwavering resolve, we can work towards a future where every birthing person receives the respectful, high-quality care they deserve, regardless of the colour of their skin. We have a long journey ahead of us, and my hope is that, perhaps inspired by the recent Workforce Race Equality Standard report, you identify and take your personal first steps.

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The Physiology of Trust

By Kath Revell

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

Feeling safe is the prerequisite for physiological birth (Michel Odent).[1] If a mother has to be on her guard, scanning the environment for threats, the hormones that promote labour (predominantly oxytocin and endorphins) will be inhibited by the hormones of survival (predominantly cortisol and adrenaline). Survival hormones are incompatible with birth hormones, which will be suppressed until the perceived danger has passed.[2] Only when a mother feels safe, can she let go of her inhibitions and allow the process of birth to happen through her. If the flow of birth hormones is delayed then labour will be delayed, which can lead to exhaustion and unwanted interventions.

In order to feel safe, a mother has to trust. She has to trust the people around her – her birth partner, her midwife, her doula, her mother, friend, sister, or whoever is present at the birth. If there is someone in the birth environment who makes her feel unsafe, someone she doesn't know, or who makes her feel self-conscious, or someone who is fearful and emphasises risks and dangers, or who constantly chatters and asks questions, however well-meaning, then the process can be disrupted and labour delayed.

Trust is at the heart of physiological birth. The same hormones that flow when a person trusts someone, are the ones that flow during physiological birth (Thomas Harvey,[3] Ben Igoyota[4]). Hormones are very complex, but also very simple. They link with our emotions and operate on a subconscious level. So even if a mother logically thinks she should feel safer in a hospital environment, with all the latest technology to monitor her and her baby, underneath the surface she may not feel safe, and her hormones may tell a very different story. Odent has shown the impact of being observed, even by a machine, on the flow of labour hormones. It may be that the very equipment designed with safety in mind, actually makes her feel less safe on a subconscious, hormonal level. This is a problem, because most births take place in hospital, and most hospitals are risk-averse environments that inhibit physiological birth.

Trust takes time to build. It is earned. You can't just tell someone "Trust me" as it is not something that responds to commands. Often in labour wards the maternity staff are not known to the birthing woman in advance and so there is no time to build trust.

Sometimes people just "click", which is lucky. Sometimes labour is so far advanced that trust is no longer a prerequisite – the baby will be born anyway. More often though, there is no time to build trust, especially if there are shift changes and new staff arriving. This can be very disruptive, with consequences of delay and subsequent intervention.
Trust is also very fragile – it is easily lost. In long-term relationships, minor betrayals and loss of confidence can be accommodated. But in a new relationship, such as a mother and her midwife, trust can be lost with the roll of an eye, with a negative comment or an inaccurate note recorded. And it is not easily regained.

It's not just the people around her and the birth environment that the mother has to trust in order to enable the flow of labour. The main person she needs to trust is herself. She needs to trust her judgement so that she can make the right decisions. She needs to trust the physiological process. She needs to trust the wisdom of her body and her instinct. She needs to trust the universe, and to trust her ancestors who gave birth before her.[5] She needs to trust her baby. All these manifestations of trust will strengthen her and she can draw upon them in labour, especially if she has practised beforehand. This is why hypnobirthing works so well. It builds a woman's self-trust.

Trust is a subtle, shy thing. It requires peace and quiet and concentration. Any slight thing can disturb the physiological process and draw her out of her "zone". Being moved

is a big disturbance, so the journey to hospital is often a cause of labour being delayed. Time pressure is another major cause of hormone inhibition. So are the routine labour protocols, such as monitoring the baby, measuring blood pressure, vaginal examinations, taking temperature – all these things disrupt the flow of the labour hormones and it takes a while for them to build up again.

The mother needs to trust that she will know if things don't feel right. And she needs to trust that she will be listened to if this does arise. So, in order to trust herself, she needs to know that the staff attending her also trust her. They need to trust her instinct, they need to trust the physiological process too, they also need to trust the universe and trust her baby. They need to trust themselves to know when things are straightforward and when there are signs that the labour is running into difficulties. Trust is a mutual thing.

Why is trust important? Because it enables physiological birth. Why is physiological birth important? Because the same hormones that promote the flow of labour are the love hormones (Odent[1]) that promote bonding between the mother and her baby.[6] Trust is at the heart of all relationships and relationships are at the heart of a healthy society and a healthy world.

How is trust fostered? By building relationships, specifically by having continuity of carer (the same midwife all the way through pregnancy, labour and birth and postnatally), and by building an environment that encourages the labour hormones to flow – quiet, dark, peaceful, respectful. In other words, the person's own home, or another homely setting where the person feels completely safe and undisturbed.[7,8]

1 Odent M. (1994) Birth Reborn: What Childbirth Should Be. Souvenir Press
2 Editor's note: If the birth is imminent, this hormonal safeguarding effect also works by speeding the birth so that the mother can escape with her baby.
3 Thomas Harvey (2024) "High oxytocin levels result in or are a product of, amongst other things, – Trust. Higher levels of oxytocin result in higher levels of trust, and visa versa." LinkedIn.
4 Igoyota B. (2020) Measuring Trust with Psychophysiological Signals: A Systematic Mapping Study of Approaches Used. www.mdpi.com/2414-4088/4/3/63
5 Editor's note: While mention of the universe and of ancestors may feel like challenging 'unscientific' concepts for some people, human birth is considered by others to be part of, and affected by, the scientific concept of a universal ecology (www.the-scientist.com/the-dawn-of-universal-ecology-66605), with the sustainability of the medical paradigm of birth being widely discussed. https://maternityandmidwifery.co.uk/green-birth-how-modern-birth-is-killing-the-planet-and-killing-us
In addition, much has been written about birth as a spiritual/philosophical experience. As "Physics and Philosophy are historically intertwined and each continues to contribute to developments in the other", this leaves even the scientists amongst us scope for enjoying and respecting a range of rich and diverse ideas when reflecting on birth. (www.ox.ac.uk/admissions/undergraduate/courses/course-listing/physics-and-philosophy)
6 Editor's note: More on this in Dr Malika M. Bonapace's article in this issue.
7 Editor's note: AIMS supports the right of all pregnant women and people to decide where to birth their baby in line with the 'principle of autonomy', which is protected under Article 8 of the European Convention on Human Rights. www.aims.org.uk/assets/media/725/aims-position-paper-choice-of-birthplace.pdf
8 Andrén A, Begley C, Dahlberg H, Berg M. The birthing room and its influence on the promotion of a normal physiological childbirth - a qualitative interview study with midwives in Sweden. Int J Qual Stud Health Well-being. 2021 Dec;16(1):1939937. doi: 10.1080/17482631.2021.1939937. PMID: 34148522; PMCID: PMC8216256.

Two Poems

Transference

By Adeline McCann

Author Bio: Adeline has been using writing as an expressive tool throughout her recovery from postpartum psychosis in 2021 after the birth of her son, Reuben. This poem is about her stoic, unwaveringly supportive partner, Malcolm.

You held me

And something took place
Like magic
You absorbed my turmoil
Crushing it into a million pieces
Allowing it to fall and scatter and mess
Into the earth
You held us
Where the sun eventually shone
And slowly
The pieces grew light

Lifeboat

By Snehal Amembal

Author Bio: Snehal is a freelance writer and poet based in Surrey (UK). Her writing primarily reflects her motherhood journey, memories of her own childhood and the essence of everyday moments which she tries to document on her Facebook blog page,' Notes On The Go'. She has authored three poetry chapbooks, 'Pause', 'I Am' and 'In Between Love'. Snehal is a Young Onset Parkinson's Disease (YOPD) warrior and creates awareness about the condition through her writing. You can find her on Instagram: @mommy.snippets.

"Mummy, mummy, mummy"
You never tire of me
Always holding onto me
Hoping I'll save you

Like a lifeboat in tumultuous waters
Unconditional love surrounds me
Your innocence enamouring me
Hoping you'll remain like this
My most precious treasure
Your pain torments me
Your tears stinging my soul
Making you believe in miracles
However morose the morning
And in the middle of the night
When you prise my sleep away
I gather you in my arms

And feel the weight of the day slowly
Leaving my body

Get out there and conference!

By Jo Dagustun

AIMS Volunteer, Jo Dagustun, reflects on her recent day out at the Northern Maternity and Midwifery Festival, and encourages others working for maternity service improvement to give this series of free conferences a go.

With my free ticket booked for this event, I woke up last week to a lovely sunny day, recalled how unreliable our local train service is, and for a few minutes - I will be honest! - wondered whether it was really worth travelling to the conference. After all, I could watch quite a bit of it from my kitchen table, via the livestream, and other sessions would be on catch-up. But I'm so glad that I attended the event in person, and I've written this article to tell you why. Maybe it will tempt you to attend one of these festivals in your region?

But first, I want to put this activity in context. I am a part-time AIMS volunteer, and I have a lot of flexibility in how I use my time.

Moreover, whilst there is - quite rightly - much attention focussed on continuing professional development (CPD) for healthcare professionals, I'm also on a bit of a mission to see 3rd sector/service user maternity service improvement advocates prioritise their own CPD, to help us become ever more effective advocates for improvement.

So back to the conference and why I found it useful for my AIMS work to attend in person:

- **The keynotes.** I really appreciated the quality of the keynotes last week. I don't underestimate the power of simply being in the room when a relevant and hard-hitting keynote is delivered. I am sure that being there improves my learning and recall; the important messages seem to stick in my mind far better than if I watch such sessions on screen. It's also wonderful to listen to speakers in person, especially if you've been admiring their work from afar (e.g. via papers, books or social media). And of course, there is also the possibility of asking questions or making observations in the plenary session - if you're brave enough. Another option is to hang around and ask your question privately, if the queue to do this isn't too long! Last week, the plenary sessions included **Benash Nazmeen** on 'working with language barriers' (including an excellent briefing on further work needed to ensure high quality **interpretation services** for all who might benefit from them), **Manisha Sheth** on 'culturally safe maternity care' (which included a challenge to the audience: have you read **The Invisible Report** yet?), and **Kathryn Gutteridge** on 'perinatal mental health' (with a moving and thought-provoking focus on **sexual abuse**). All of these were fascinating, challenging and highly thought-provoking sessions, with plenty of time for interesting questions and reflections from the audience.

- **The opportunity for fruitful conversation.** This one's a bit of a lottery, perhaps: what's the likelihood that you'll meet someone with whom you have something in common and with whom you can have a really useful conversation? The one certainty is that this won't happen if you're not there. Last week I identified a shared interest with a speaker - an issue that coincidentally had been on my desk just the day before - and we were able to have a really good chat (that's the technical term for exchange of views and information), with plans for follow up. I would never have had that conversation - or made that new connection - if I'd been sitting at home.

- **Expanding horizons.** There are things I know about the maternity services and things I don't, but also plenty that I don't even know I don't know. This again is where these festivals come up trumps. If I'd been at home, I might have skipped some of the 'less relevant looking' sessions. But physically being in the conference zone, this is far less tempting. So I sat in on some presentations that - frankly - I didn't think would be of any interest to me. But I should have known better: of course, I soon discovered they were. The conference offers the opportunity to learn about whole new areas of the maternity services, which as well as being interesting in themselves, really helps to put whatever you're working on into perspective and encourages a more holistic way of thinking about maternity improvement. My mind was buzzing, and I came away with a

whole new appreciation of the importance and professionalism of our midwifery educators in particular, as well as a renewed commitment to professional curiosity.

I am grateful to have sat in on presentations on such a wide variety of work, including new topics and methods for teaching and learning ('a **memory making workshop** to increase the self-reported confidence of student midwives' - thank you Rebecca), student experience ('Navigating Disparities: **a Student Midwife's experiences and perspectives** on maternity inequalities for Black women in the UK' - thank you Olga), and - to end the day - a tale of the start of new research into a potential birth-room therapy ('**cold therapy methods** in labour and birth - thank you Emily). I also learnt more about **Baby Buddy** (a service-user facing information and support app developed by Best Beginnings - thank you Mari) and work underway to better understand **how to reduce pre-eclampsia** (where recruitment is now underway for the Starship Study - thank you Lucy).

- **Building connection.** Last but not least, the Festival was a great opportunity to prioritise catching up, face-to-face, with some AIMS and Maternity Continuity Network colleagues; in this era of widespread homeworking, this possibility is a real treat in itself!

Cost of the day: my pro-bono time plus expenses (of just £7.40 for my train fare) charged to AIMS. I call this a win! Not all of my outings are as cheap for AIMS. In that context, I want to add in a heartfelt reminder to please support AIMS if you can, as our Campaigns Team costs do mount up. Information on how to become an AIMS member and how to donate can be found on our website: AIMS For a better birth.

I hope that I've whetted your appetite a little. Why not go to your next local festival (other types of conferences are available) with curiosity and an open mind, and see what you can make of it? I'd also love to know what your favourite low-cost maternity conference is: let me know!

Thanks as ever to the Maternity and Midwifery Forum for facilitating these conference spaces. You can find out about their programme of regional festivals here: Events – Maternity & Midwifery Forum (maternityandmidwifery.co.uk).

DOI: I am not in any way financially linked to the Maternity and Midwifery Festival team, nor have I any other known conflicts of interest to report. I did win a Festival award last year, however, as per the accompanying photo!

Issues of trust led to me becoming a volunteer for AIMS

By Ryan Jones

Author Bio: Ryan Jones is a trustee of AIMS and full-time dad, having taken a break from his previous roles as company founder and data team lead in cyber security and insurance.

This is a journal article about trust, and it's also a journal article about my journey to becoming a volunteer at AIMS.

I have a high trust in the medical establishment. My experience is I have generally received high quality care when I have needed it and that it has 'worked' i.e. I have felt better after it. However, as a white, straight, cis gendered, middle class, university educated man in my late 30s I am in the least likely category of people to receive poor care. This is both because I am vanishingly unlikely to be discriminated against and almost all medical research considers a body like mine to be the default.

My wife was keen for me to read books on birth to better support her and after a bit of cajoling, I got started. As my wife was part way through the first on the reading list, I started with another. My first book that I read on birth was "How to give birth like a feminist". The lack of care, unnecessary medicalisation and obstetric violence discussed in the book, angered me and made me worried for my wife. It made me realise how important it was for me to be an advocate for her, especially when she would be at her most vulnerable. Also, crucially, it made me doubt the maternity services, becoming the first step in eroding my trust.

I became very aware of the phrases of permission that midwives used and the policies that they were working to.
This is how my trust in the maternity services changed throughout my wife's pregnancy.

Week 16 – Continuity of Carer
At our second appointment with the very pleasant midwife, my wife asked about whether she would have continuity of carer during pregnancy and the birth. After having to clarify what that meant, the midwife scoffed and laughed at the idea explaining that there were no-way enough midwives for that.
Loss of trust.

Week 16 – Care Quality?
During the same meeting, we were told to our surprise that our local hospital's maternity services were excellent. We were told that the Care Quality Commission report agreed. When we got home, we looked up the report: "Requires improvement".
Loss of trust.

Week 25 – Gatekeeping
My wife told the midwife at the next check-up that she wanted a home birth. The midwife said that we didn't need to decide that yet, we'd talk about it later on, and it triggered a set of gatekeeping language such as "we'll have to see your bloods" and "if you're allowed". This meant that in the leadup to the next checkups we were prepared for a 'fight' over the right to a homebirth – an adversarial relationship is not optimum with your caregivers.
Loss of trust.

Week 31 – Permission and Silos
At this appointment we were given the go-ahead for the home birth. Hurrah! We were confidently told of the process and how the midwives would be supporting us. This was fantastic.
Big improvement in trust.

We did learn something of concern, however. Because we live on the boundary of two maternity units' areas, our home birth midwives would be coming from another NHS Trust from the one she had been cared by to-date. Blood test data could not be shared between the systems, so my wife needed to have repeat blood tests just so results could be loaded onto the other NHS Trust's system. This did make us wonder about whether there were any other important details about my wife's pregnancy that may also slip through the cracks.
Loss of trust.

Week 41 – In the hour of need

After my wife's contractions were coming every 5 minutes, I phoned the midwives as we had been told to. I was informed that there were no midwives available to attend. The recommendation was for my wife to go to the obstetrician led unit as the midwife led unit was closed. I was called back by the senior midwife on duty and told the same thing.

I felt no compassion from them. I felt that my wife was completely let down. I felt useless and helpless.

We decided to stay at home. Around two hours later, I phoned again and was told the same thing.

Loss of trust.

Our doula managed to make some calls and have midwives attend from our original hospital. I thought doulas were great even before she pulled off this amazing feat!

Week 41 – Poor system, excellent carer

Around 6 hours after my first call to the hospital, our midwife arrived. My wife was exhausted by this point, and she was worried as she didn't feel like she was making progress.

Our midwife immediately made my wife feel at ease. Our baby had a heartbeat that raised no concerns. The midwife also offered my wife an internal examination. My wife explained she would prefer not, but was open to it if it was recommended. Our midwife said there was no need as she could see how much she had progressed without the examination. Knowing that avoiding an internal examination was important to my wife, it was great to see the consideration the midwife gave.

Improvement in trust.

Our baby was born a few hours after the midwife arrived.

Supporting my wife through her pregnancy opened my eyes to how difficult it is to navigate the maternity services and receive the care you are entitled to. I am also struck by the fact that anecdotally it appeared, despite the challenges we faced, that my wife felt the most positive about her birth experience out of all the mums in our NCT class. This can't be right. With the challenges we faced with my wife's low risk pregnancy, it must be unimaginably difficult for those from minority backgrounds and those with complications or special circumstances.

We have discussed what we would do, if we have another baby. We would pay for a private midwife, so my wife can receive the care that she is legally entitled to and has

been recommended in review after review of the maternity services and inquiry after inquiry of failing departments. We are very fortunate to be able to afford this.
It was this injustice, along with the belief that it's possible to really make a difference to the maternity services and those that use them, that drove me to volunteer for AIMS.

Why be an AIMS member?

By the AIMS Management Team

If you are reading this Journal you may already be an AIMS member, in which case, thank you so much for your support. You will already know how much we rely on membership subscriptions to fund our work. Read on to see why we hope that you will continue to support us.
If you subscribe to our mailing list you will be getting an email from us asking you to consider supporting us to continue our work by becoming an AIMS member. We hope you will.
If you are neither a member nor on our mailing list we would also like to appeal to you to become a member.

This is why

For over 60 years AIMS volunteers have worked towards better births for all by campaigning and information sharing, protecting human rights in childbirth and helping everyone to know their rights, whatever birth they want, and wherever they want it.
Now we **need your support** to continue.

Every year our Helpline team helps hundreds of people with information and support about a wide range of topics including lack of consent/coercion, induction, lack of support for home births, and referrals or threats of referral to children's services. We want to continue to be there for the people who need us.
Here are some comments that people who have used the AIMS Helpline have given us permission to share.

"I just think that you and the AIMS charity are wonderful and I wanted to say a huge thankyou for helping to put my mind at ease. I came away from our conversation feeling empowered and determined."

"It's been so helpful and reassuring for us to have your responses and we both can't quite believe what an amazing service AIMS offers. We asked friends and family to donate to you, instead of buying us more clothes and teddies, so we really hope that some resources might come your way too."

Birth Information pages on the website are accessed around 6000 times every month and we are working to get some key pages translated in order to make them more accessible to those whose first language is not English.

Here's what people have said about the value of our birth information pages.

"AIMS gave me the essential support and resources that I needed in order to make informed decisions about my pregnancies and births for myself. Informed decision making has the power to completely transform birth experiences for the better, and AIMS showed me the way."

"AIMS was so important to me in getting the births that I wanted. Without AIMS I wouldn't have known my rights to make it happen."

We have two new AIMS Guides in development, Breech Birth and Birth after Caesarean, but will need to fund the production of these.

AIMS Journal articles are available to everyone free of charge and each Journal now reaches thousands of readers, helping to spearhead discussions about change and development in the maternity services and giving a platform for the voices of parents, birth workers and staff in the maternity services. We want to continue to produce this fantastic free resource.

Our Campaigns team remains an influential, effective and well-informed lay voice in the national debate on maternity services improvement. But they can only continue to do this if we are able to fund them to attend conferences and meetings.
All of these services are provided by volunteers.

Why we need more AIMS members

AIMS has had a long history of upholding our independence from receiving any funding or benefit from being linked with any commercial enterprise. We believe that it continues to be of vital importance that AIMS is, and is seen to be, wholly independent of any third parties in order to preserve our reputation for providing information impartiality.

As an almost entirely volunteer run organisation we are able to keep our running cost very low. We estimate the value of the hours our volunteers give each year to be in excess of £70,000 based on the Real Living Wage of £12 per hour, though most of them are highly skilled people who could command much higher rates than this. However, we need to be able to pay our part-time Office Administrator (our only paid member of staff) to enable our volunteers to do this work for AIMS. This essential admin support, plus running the AIMS helpline and online shop, producing the AIMS Journal and paying for volunteers to attend meetings and conferences to further our campaigning work all cost money. These costs have been increasing. At the same time our main sources of income - sales of publications, membership subscriptions and donations - have all fallen substantially in the last couple of years as the cost of living crisis took hold.

The need is real and urgent. On current budget projections, AIMS will, quite simply, run out of money within three years. If we are not able to increase our income within the next 12 months we will need to start making drastic cost savings in order to survive. Then our ability to continue the vital work that we do will be at risk.

What's in it for you?

First and foremost, there's the satisfaction of knowing that you are helping AIMS to survive and continue its mission:

‘We support all maternity service users to navigate the system as it exists, and campaign for a system that truly meets the needs of all.’

If you think, as we do, that this is important and want to help make sure that we can continue to do it, please think of it as an investment in the future. We frequently hear people saying how much they value the work that AIMS does.

If you can be here for us, we can be there for those that need us.

As an AIMS member we will send you a newsletter with updates about our work and opportunities to get involved with AIMS activities. You will also be entitled to a discount off the cost of our online interactive workshops, and to attend our AGM.

What does it cost?

The subscription can be paid either as a one-off payment of £45 or as 12 monthly instalments of £4 - that’s the price of a coffee a month.

While we hope that as many people as possible will pay the full rate, we know that not everyone will be able to afford this. As we truly want AIMS membership to be accessible to as many people as possible we are happy to arrange a reduced rate for you if you need it. Please let us know if you would like to pay a lower rate by emailing membership@aims.org.uk

So how do I join?

You can join online by clicking here or details about setting up a standing order can be found here.

AIMS is concerned about the accessibility of CQC local maternity service ratings: should you be too?

By the AIMS Campaigns Team

Women have a choice about which local maternity service they want to support them through their pregnancy, birth and postnatal period. One quality indicator that many women consider important is a service's CQC rating. AIMS has evidence, however, to suggest that CQC ratings for local maternity services aren't always easily accessible when women are doing their research to help make that choice. We call on all birth activists to help their local community - and improve national practice - by investigating the accessibility of this information in your area, sharing good practice and letting us know if you have any further concerns about the accessibility of local trust data.

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. Following some high-profile local maternity reviews that highlighted worrying shortcomings, and because inspections are generally infrequent, the CQC is currently carrying out a maternity inspection programme. This should ensure that every local maternity service receives more regular external scrutiny and feedback, and that CQC maternity ratings are as up-to-date as possible. After each inspection of a local maternity service, the CQC updates or confirms its rating of various aspects of the service then produces a publicly accessible report. Few local service users are regular readers of the CQC website, or are signed up to its notification service, or follow the CQC's busy social media channels. While local press seem to do a good job in picking up on new inspection reports, this information is not easily accessible in retrospect and may not reach a wide audience.

AIMS is keen to ensure that these ratings and reports are not 'hidden in plain sight'. They need to be easily accessible to local citizens, in places they'd expect to find them. But we've been finding out that this is not always the case:

- We have been given an example of a local trust where members of its Maternity Voice Partnership (MVP) were not notified that a CQC maternity inspection report had been published until they were being briefed, months later, on the trust's action plan in response to the CQC report (an action plan which had clearly been drawn up with no reference to the MVP and without MVP input).
- We have noticed that not all trusts are sharing information about CQC maternity inspection outcomes on their websites. For example, trust maternity pages might have a 'CQC Good' footer on their maternity pages (a rating related to the

entire trust) whereas the maternity services are currently rated 'requires improvement', both overall and for both safety and leadership. Whilst this may be compliant with CQC guidance, it is misleading for service users specifically interested in the maternity services.

- We have found an NHS Local Maternity System endorsed website that purports to offer information to service users about their local maternity units, to enable choice. But this website doesn't include all relevant CQC maternity ratings and instead includes information that seems to conflict with the latest CQC inspection outcomes.
-

So our question is this: are these localised problems or systemic behaviour that is more widespread?

We hope that by investigating this in your local area you can be reassured that this CQC information is reaching local service users, and take action if not. We are also keen to hear about examples of good practice:

- Perhaps your local maternity service does an excellent job in reporting their latest CQC inspection outcomes - including to their MVP - even when the rating is not as positive as they'd hoped?
- Maybe you have examples of how your local trust encourages reflection on the published CQC report from all local stakeholders?
- We're particularly interested in positive examples of how trusts involve local stakeholders in producing the local response to the CQC inspection report, and in seeing some particularly impressive responses to the CQC challenge.
- Very importantly, we are keen to hear how local trusts ensure that information about latest inspection findings is accessible, and how they ensure all existing material (on websites/ leaflets etc) is updated promptly with the latest CQC report.

Please join AIMS in helping to ensure that taxpayer-funded and resource-intensive maternity service regulation is accessible to all service users and is making a positive difference.

P.S. This birth activist briefing is focussed on CQC inspection reports, but we would also be interested to hear if you have been working on other problems around the accessibility of trust maternity information/data, as we'd love to share your work. Thank you.

Continuity Matters - Women's Voices

By the AIMS Campaigns Team

The Continuity of Midwifery Carer model of maternity care is being rolled out in Northern Ireland, and is now in its second year. Every trust has a dedicated Continuity Lead Midwife, with at least one continuity team in each trust. There was a trial team set up in one of the trusts in August 2020 that we wrote about at the time. Now we hear from one mother who benefited from this model of care:

"I opted into the care of the Lotus continuity of carer team at 8 months pregnant, when the trial of this service commenced in Northern Health and Social Care Trust. With the support of my doula, I had looked into various options for where to birth my baby and felt that doing so under the care of the Lotus team would be best for me.
From the day I opted into the Lotus team's care, one primary midwife was with me for all appointments and the birth of my baby. Even though I was quite far along in my pregnancy, this enabled me to quickly develop a strong, trusting relationship with one healthcare provider.

My partner and I were also able to meet with my midwife and doula on several occasions to discuss our birth preferences, concerns, etc. It was fantastic to have the support of both a doula and midwife as they brought different but complementary skills. My midwife and doula were both fantastic throughout my pregnancy, birth and postnatal experience; I felt they worked really well together, communicating throughout to help ensure I got the best support possible.

Throughout my care, I felt I was the primary decision maker as I was able to fully discuss my choices and preferences with people who were very respectful of these, offering me helpful advice and information as appropriate. This really helped develop a relationship based on trust and respect.

During labour my midwife ensured my partner and I were fully informed about potential procedures and their risks/benefits. This helped me feel in control at an extremely vulnerable time. Other staff from the Lotus team also provided support postnatally as I had one overnight stay in hospital.

Overall, I would highly recommend the continuity of carer model. I think it leads to safer, more woman centred care that helps empower parents. I think it is a fantastic service that should be the norm for all maternity care. I would also highly recommend birthing people invest in the support of a doula. I have heard it said that the best birth team is

comprised of a supportive midwife, doula, partner and birthing person. Having experienced this first hand I can vouch that it is true!" Bevin

AIMS extends a big thank you to Bevin for sharing her experience. We hope that it will encourage others, including healthcare professionals and anyone who has experienced continuity of carer, to document their experience, so we can raise their voice too. We need to raise our voices, as we continue to campaign for the implementation of Continuity of Carer for all. Please get in touch with your experiences, stories and reflections via campaigns@aims.org.uk.

AIMS Physiology-Informed Maternity Services (PIMS) - September 2024

by the AIMS Campaigns Team

In June Catharine from the PIMS team featured on the Blossoming Midwife podcast which is run by Holly Ingram, a midwifery lecturer from Anglia Ruskin University. Catharine gave an introduction to AIMS and talked about the first three PIMS case studies that the team put together for the British Intrapartum Care Society (BICS) Conference last year.

The first case study was **optimal cord clamping**, supporting Amanda Burleigh's excellent campaign, "Wait for White" (for more information see www.waitforwhite.com and www.bloodtobaby.com). As part of this she talked about offering bedside resuscitation. Bedside resuscitation is where breathing help can be started before cutting the cord. This has been shown to improve outcomes for many newborns. See our poster for more details.

The second case study the team put together was about Molly O'Brien's great **Biomechanics** course. The course includes techniques for spotting and resolving problems with the baby's position or with delays in labour ('labour dystocia'), techniques that can be used not only by midwives but by birthing women and people themselves. (Please also see our journal article about Molly's work available here).

Our third case study was **Family-Centred Caesarean birth**, which differs from a conventional Caesarean birth mainly by emphasising slow delivery of the newborn's body and includes optimal cord clamping and immediate or early skin-to-skin contact.

We are continuing to develop more PIMS case studies into Optibreech training and the microbiome - watch this space for more!

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

by the AIMS Campaigns Team

Written outputs:

- AIMS response to APPG Birth Trauma Inquiry
- 20th June: Completed survey for Sands & Tommy's Policy Unit call for evidence on 'What do you think needs to deliver safer maternity and neonatal services'.
- Open Letter to Wes Streeting on Continuity of Carer
- Comments on Plan-A decision aid and other documents

Conferences and meetings attended:

- 2nd May: NHS-E MTP Stakeholder Council meeting online, focus on mental health
- 7th May: monthly AIMS Campaigns Team meeting
- 14th & 15th May: Birth Trauma Summit
- 16th May: NHS-E Board
- 16th May: Plan A meeting
- 20th May: RCM Research Prioritisation Project meeting
- 20th May: AIMS Team Lead meeting on student midwives video.
- 21st May: Campaigns Orientation Session for new team members
- 21st May: Brainstorming session on APPG Birth Trauma Inquiry
- 22nd May: Continuity of Carer Huddle
- 23rd May: Maternity Continuity Network facilitation team meeting
- 30th May: Plan A meeting
- CSG meeting every Tuesday morning
- 4th June: monthly AIMS Campaigns Team meeting
- 11th June: Aims Team Leads meeting
- 12th & 13th June: NHS ConfedExpo 2024, NHS Advisory Group
- 13th June: ARM Summer Meeting
- 20th June: Continuity of Carer Huddle
- 18th - 28th June: Microbirth online Summit
- 26th June: RCM Research Prioritisation Project meeting
- 27th June: Plan A meeting
- 2nd July: monthly AIMS Campaigns Team meeting
- 3rd July: CHERISH 'World Cafe' event
- 11th July: Continuity of Carer Huddle
- 24th July: Crochet workshop for AIMS piece on human rights in childbirth for Threads of Protest Exhibition

Who we have been corresponding with:

- NI Ambulance Service on responders directions to labouring woman
- Podcast with The Blossoming Midwife 8th June 2024
- Launch of the " target="_blank">BESt-UK study
- ARM - comments on their pamphlet
- Make Birth Better on response to Birth Trauma APPG report
- Signitatory to Baby Feeding Law Group UK letter to Devex raising concerns about them partnering with Nestle to put on an event.

What else we have been reading:

- Responses to Birth Trauma APPG report
- NHS-E's One Year On report for the NHS-E Public Board
- Cochrane review of models of care
- City continuity evaluation report

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