AIMS JOURNAL

Induction: love's labours lost?

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Editorial March 2022

by Salli Ward

Salli with granddaughter, Amara

Well, that's the pandemic done with then… Obviously not, and its shadow is evident in many of the articles in this Journal. Nevertheless, a more familiar maternity topic – induced labour – takes centre stage in this issue and presents us with a mystery: why are women and birthing people distressed, damaged and distanced when they beg for an induction *and* when they determine to avoid one. What does this accumulative distress and damage do to our cultural perception of birth and to our hopes and expectations?

It's been a long time since I gave birth and I'm concerned to see that many of the same issues are around, some having got worse, despite research, campaigning and legislation. On anecdotal evidence – the stories told by my daughter and her friends who have young children – I am saddened, but it is a sadness compounded by the objective and meticulously examined data collected here. It makes me angry that I haven't created a better world than the one in which I gave birth.

Perhaps, you may think, I am not solely responsible for the mess? I did my best – I birthed 3 children at home, left my bloodied pants in the sink though the doctor had specifically said that's what she didn't like about home births; I acquired 5 step-children born without intervention (my husband has a habit of marrying stroppy women); those kids were brought up knowing that the birth they choose is their right – and yet my strong and sorted daughter still fell into a trap – and her friends even worse. No, not all of them, of course, and some supporters, tutors, birth partners, midwives, doulas and doctors still worked wonders – by not pushing the wrong birth on the wrong person, and by smiling, supporting, soothing that baby into the world.

So no, it's not all my fault. It's no one person's. And does it even matter? What matters is surely that we work to turn the tide. This is only my second Journal as an editor, but I have an image in my mind of every word of every article piled into a huge, mighty wall of stacked Journals, metres thick. So tough and strong that the waves roaring and hitting it turn and disperse, weakly trickling away. To break the metaphor, we have to build a world where anyone giving birth feels not controlled but confident, not bamboozled but buoyed, not patronised but powerful.

To this end, Nadia Higson opens this edition with clear and straightforward facts about induction. Lydia and Sarah then each tell very different stories from their own experience of giving birth. Joy Horner, retired midwife, reflects on the changing practice she has seen in her lifetime, covering everything from induction to shamanism in birth. Our poetry writers gift us with sweet, sorrowful and striking tales. Sticking with creatively expressed information, my editorial mentor and vastly experienced colleague Alex Smith talks about three mythical sisters embodying very different qualities that determine how they approach birth. Alex then accompanies Katherine Revel to appeal for volunteer support on the vital AIMS Helpline.

Faiza Rehman introduces us to her dynamic Raham Project, which addresses the need for specific birth support for birthing parents of Black and Asian heritage. Two articles from the AIMS Campaign Team sandwich a reflection on research events by Georgia Clancy. The first of the Campaign articles, by Jo Dagustun, reports

on her interview with Sarah Fishburn, and the second comments on the new NICE guideline. This is followed by Anne Glover's review of the much acclaimed Australian documentary 'Birth Time'. After this, Sarah Hawkins shares her experience of searching for the elusive information about the implementation of Continuity of Carer, before student midwife Megan Disley reflects on action taken by March With Midwives.

The AIMS Campaign Team gives us two further updates; one looks at research on the causes of race inequalities in birth, and the other takes us back to 'Better Births', six years after it came out. Gail Werkmeister reviews three books on the induction theme before we finish with the Campaign Team's round-up of their news and activity.

We are very grateful to all the volunteers who help in the production of our Journal: our authors, peer reviewers, proofreaders, uploaders and, of course, our readers and supporters. This edition especially benefited from the help of: Megan Disley, Julie Milan, Anne Glover, Caroline Mayers, Julie Ann Crowley, Josey Smith, Maddie McMahon, Jo Dagustun, Gulliver Hubbard, and Danielle Gilmour.

We really hope you will enjoy this issue. In our next Journal coming in June we will be exploring the concerning issue of obstetric violence.

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The AIMS Guide to

Induction of Labour

What happens when you have an induction of labour?

What are the reasons why you might be offered an induction?

What does the evidence show about the risks and benefits of having an induction?

What methods are commonly used?

Are there other options?

The AIMS Guide to Induction guides you through your rights and gives you suggestions of things to consider and questions you may want to ask your doctor or midwife, as well as ideas for how to prepare and encourage an induction to work.

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Article

Birth Information page: Induction of Labour

By Nadia Higson

Editor's note:
This article is an example of the AIMS information pages that can be found on our website: www.aims.org.uk/information/page/1. This page is intended to explain in outline the situations where induction of labour might be offered, what it might involve and what options you have. There is a lot more detail on all these topics in our book AIMS Guide to Induction of Labour[1].

What is induction of labour?

There is increasing evidence that babies send chemical signals when they are ready to be born, and in particular when their lungs are ready to start breathing[2]. This causes the mother's body to produce chemicals called prostaglandins that start the physiological process of labour.

Inducing labour means taking action to bring forward the start of labour rather than waiting for this physiological process to begin. It is often understood to mean medical methods, but self-help methods or complementary therapies when used to start labour are also a form of induction. All these methods are trying to stimulate or mimic the physiological process of labour and this can have consequences.

Why might I be offered an induction?

According to NHS Maternity Statistics[3] the proportion of labours in England that are induced has increased from 21% in the year to March 2010 to 34% in the year to March 2021.

There are many different situations in which induction is offered. The point in pregnancy at which it is suggested will depend on the reason for suggesting it. It might be because there is a cause for concern about the wellbeing of you and/or your baby. Depending how far advanced your pregnancy is, your decision on the timing of an induction may need to be a trade-off between the risk to your baby of being born too soon, and the risk of continuing your pregnancy.

More often induction is offered because of a concern that problems might develop or some risks to you or your baby (including stillbirth) might increase if the pregnancy were to continue beyond a certain number of weeks. The quality of the evidence about whether there really is an increased risk in these situations, and if so whether induction would reduce it, varies a lot. In some cases there is good evidence that induction can reduce the chance of harm to you and/or your baby, but often the evidence is limited, of poor quality and even contradictory, and sometimes it is virtually non-existent. It's also usually the case that the actual risks remain low, whether or not labour is induced.

Due to the limitations of the evidence, it's often a case of considering which view you feel more comfortable with: "Induction might help, so why not do it just in case?" or "There's no evidence that induction does any good, so why do it?"

Below is a brief discussion of some of the common reasons for induction to be offered, but there are many others, and a full discussion of the evidence about induction in various situations is beyond the scope of this article. For more details of situations in which you might be offered induction, a review of the evidence for each and a list of things that you may want to consider, see the AIMS Guide to Induction of Labour[1], or contact the AIMS Helpline for information and support.

Your waters broke before your labour started: The NICE guideline[4] recommends offering a choice of induction either after 24 hours or straightaway if your waters break after 37 weeks of pregnancy (though it's up to you if you want to wait longer than this). This is to avoid an increased risk of infection for you or your baby. Most labours will start naturally within 24 hours of the waters

breaking. The evidence review 'Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more)'[5] suggests that induction may reduce your chance of developing an infection yourself, but there may be no difference in the chances that your baby will. None of the evidence is of high quality, and any additional risk appears to be small.

If your waters break earlier in pregnancy there is evidence[6] that it may be better to wait for your labour to start at least until 37 weeks if there is no other cause for concern, to avoid the risks to your baby of being born prematurely.

Your pregnancy has lasted 41 weeks: The NICE guideline[4] recommends that you should be told that "some risks associated with a pregnancy continuing beyond 41+0 weeks may increase over time" and induction from 41 weeks "may reduce these risks", but that you "will also need to consider the impact of induction on [your] birth experience when making [your] decision". The risks they list are: a higher chance of a caesarean birth; your baby being admitted to a neonatal unit; and stillbirth or neonatal death. However, they say that the evidence that induction reduces these risks is not "definitive" and "the absolute risk remains low" whether or not labour is induced after 41 weeks. In fact, the evidence from different types of study is contradictory.[7] One recent review[8] suggests that about 500 inductions of pregnancies that have lasted 41 weeks would be needed in order to avoid one baby dying.

There are guidelines that recommend offering induction or a planned caesarean earlier than 41 weeks if you have any of the following risk factors. Please see the relevant guideline or the AIMS Guide to Induction of Labour[1] for details.

- You have Type 1, Type 2 or Gestational Diabetes Mellitus[9] especially if your baby is also predicted to have a high birth weight
- You have high blood pressure that can't be controlled with drugs, or develop pre-eclampsia[10]
- You develop severe Intrahepatic Cholestasis of Pregnancy[11]
- You are expecting twins or triplets[12]

You might also be offered induction before 41 weeks for various other reasons (such as your age or the fact that you conceived through IVF), but you should be aware that there is no good evidence to support this.

Your baby is expected to have a high birth weight but you don't have diabetes: The NICE guideline[4] says that in this situation "there is uncertainty about the benefits and risks of induction of labour compared to expectant management"[13]. For this reason they have not made a recommendation about offering induction earlier than 41 weeks.

Your baby seems to be growing slowly but is otherwise well: A package of measures designed to address the national stillbirth rate (the Saving Babies' Lives Care Bundle[14]) recommends induction between 37 and 38 weeks for the smallest 3% of babies (below the 3rd centile), and at 39 weeks for babies between the 3rd and 10th centiles. However, the majority of these small babies are born in good health and being born early also carries some risks. At present, we do not have enough evidence to show whether it is always better to induce labour when a baby seems small, or to wait and monitor the baby's growth and well being.

Can I decline an induction?

It is your right to decide whether to accept the offer of induction and no-one should try to pressure or bully you into it. The new NICE guideline on inducing labour[4] makes it very clear that your midwife or doctor should "recognise that women can decide to proceed with, delay, decline or stop an induction. Respect the woman's decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given". For more about your rights to make decisions, and your care team's duty to give you information to help you decide, see our webpage Making decisions about your care[15] and our book AIMS Guide to Your Rights in Pregnancy & Birth[16].

Can I request an induction?

Although you have the right to decline an induction, you do not have the right to insist on one, but your doctor should at least be prepared to consider your request. The NICE guideline[4] says, "Consider requests for induction of labour only after discussing the benefits and risks with the woman, taking into account the woman's circumstances and preferences". If you feel strongly that this is

the right thing for you, or are worried about you or your baby's well being if they are not born soon, and feel that you are not being heard, you have the right to ask for a second opinion from another doctor.

When should I not be offered induction?

The NICE guideline[4] says that induction "is not generally recommended" for babies in the **breech position** (bottom down) but could be considered if your baby needs to be born soon and you don't want a caesarean. It also says that labour should not be induced if a baby has **very poor growth and is also showing signs of distress**, but a planned caesarean should be offered. You should not be offered induction just because of a previous very fast labour.

What is involved in an induction?

Non-medical methods of induction

Unfortunately, very little research has been done on the effectiveness or safety of these methods and most of the studies that have been done were small.

There is some limited evidence that nipple stimulation, acupuncture or acupressure, and eating dates in the last few weeks of pregnancy can help to bring on labour. There is a lack of clinical evidence about whether other self-help methods (such as eating curry or pineapple, or having sex) or using complementary therapies (such as hypnotherapy, homeopathy, reflexology or aromatherapy) work. However, people do report finding them helpful, and trying them may make you feel more in control and able to relax. This could in itself make it more likely that your labour will begin without the need for medical induction.

Raspberry leaf (as tea or tablets) is often suggested but there is no evidence that this helps to start labour, and it may have potential adverse side-effects[17] or interact with other medications such as insulin[18], so check with your midwife before taking it.

Methods of medical induction

This section gives a basic outline of the methods that you may be offered, but for details of the evidence on the effectiveness, benefits and risks of these please see the AIMS Guide to Induction of Labour[1].

The methods that you are offered will depend on how far your body has progressed in its preparation for labour (your Bishop's score). To assess your Bishop's score a midwife or doctor would need to perform a vaginal examination to feel how much your cervix has softened, thinned and started to dilate. A high Bishop's score makes it more likely that an induction will be successful, so before making decisions about induction you might want to ask what your Bishop's score is.

A membrane sweep involves a midwife or doctor carrying out an internal vaginal examination, and at the same time passing a finger inside your cervix and moving it around to loosen the membrane. The NICE guideline[4] recommends you should be offered a sweep at an antenatal appointment after 39 weeks if you want it.

Evidence[19] suggests that a sweep makes it about 20% more likely that you will go into labour without further interventions, but you are no more likely to avoid a caesarean or assisted birth. A sweep may be more painful than a regular vaginal examination and can cause bleeding.

If you have decided to proceed with an induction and your Bishop's score is still six or less, the NICE guideline[4] recommends that you should be offered the choice of either artificial **prostaglandins** or a **mechanical method** to encourage your cervix to ripen further.

There is evidence that prostaglandins are effective at bringing on labour, but they can cause severe pain and nausea, and sometimes very strong, frequent contractions (hyperstimulation), which can be stressful for the baby.

The evidence about mechanical methods is more limited but they do not seem to carry the same risk of hyperstimulation and one type (called a balloon catheter) has been shown to be effective. With both methods it could take 24 hours (sometimes much more) before you are in active labour.

Once your Bishop's score is above six, the NICE guideline[4] recommends having your waters broken artificially (called amniotomy or ARM[20]) and then being given a synthetic version of the hormone oxytocin through a drip to encourage strong

labour contractions, either at the same time or a bit later.

There is no direct evidence for the effectiveness of either of these methods if labour has begun but is progressing slowly following induction with prostaglandins or a mechanical method. There is some evidence that synthetic oxytocin helps to shorten a labour that started naturally so it may have a similar effect in an induced labour. Both methods have potential risks which include more pain and increased stress on you and your baby.

How might having an induction affect my choices for the birth?

Agreeing to an induction could affect your other choices and your experience of birth.

- You would be asked to agree to repeated vaginal examinations to assess your Bishop's score and check progress.
- Your choice of birthplace is likely to be limited to a hospital labour ward as procedures like breaking your waters or giving a hormone drip would not be done at home or in a birth centre.
- It may mean spending several days in hospital before getting into active labour.
- You may not be able to have a partner or supporter present throughout the early stages of induction
- You may have limited options for pain relief especially in the early stages, and may find it harder to get agreement to use a birth pool.
- An induced labour may be more painful, especially if you have your waters broken or use a hormone drip.
- Continuous monitoring is likely to be recommended for an initial period after the insertion of prostaglandins or a mechanical induction device. It may also be offered if you have your waters broken and is usually recommended if you use a hormone drip.
- If the induction fails to work you may need to consider having an unplanned caesarean.

What can help me make decisions about induction?

The NICE guideline[4] recommends that you should have a chance to discuss your options for the birth early in your pregnancy and again later on. You may find it helpful to have this conversation early so that you can start thinking about your preferences, especially if you know you are likely to need to consider an induction. Alternatively, you may prefer to focus on positive preparation for labour and not think about induction unless a reason arises. This could happen late in your pregnancy, and mean that you do not have very long to think about it.

Depending on your circumstances and how things develop, there are various decisions you might want to make including:

- Whether you want to bring forward the time of your baby's birth or wait for labour to start naturally.
- If you decide to bring your baby's birth forward, whether to have an induction or a planned caesarean and at which week of pregnancy to do this.
- If you decide to have an induction, which methods you want to use to try to start your labour, including whether to have one or more membrane sweeps in late pregnancy, and whether you prefer prostaglandins or a mechanical method.
- If you would like to go home in the early stages of induction if all is well.
- If the ripening[21] methods fail, whether to try again (e.g. have another dose of prostaglandin), try ARM and an oxytocin drip, wait a while, or request a caesarean instead.
- What methods of pain relief you'd like to use (See our webpage Ways of managing your labour[22])

You may find it helpful to look at our webpage Making decisions about your care[15] and the section in the AIMS Guide to Induction of Labour[1] called 'Discussing induction with doctors and midwives'. This includes a list of questions that you might want to ask your carers. There are also sections on what may help an induction to work and things to consider if you are planning an induction.

Article contd.

Author Bio: Nadia Higson is an AIMS Trustee. She also volunteers as AIMS Coordinator, and as a member of the AIMS Helpline team and the Campaigns Steering Group. She was the principal author of the AIMS Guide to Induction of Labour and has written several of the Birth Information pages on the AIMS website, including "Coronavirus and your maternity care".

ENDNOTES

1 Higson N. (2020) AIMS Guide to Induction of Labour. https://shop.aims.org.uk/products/aims-guide-to-induction-of-labour

2 Gao L. et al Steroid receptor coactivators 1 and 2 mediate fetal-to-maternal signaling that initiates parturition J Clin Invest 2015 Jul 1;125(7):2808-24. www.jci.org/articles/view/78544

3 NHS Maternity Statistics, England - 2020-21 - NHS Digital, November 2021 digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2020-21

4 NICE Guideline 'Inducing Labour', November 2021 www.nice.org.uk/guidance/ng207

5 Middleton P et al Cochrane review 'Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more)' January 2017 www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD005302.pub3/full

6 RCOG 2019 "Care of Women Presenting with Suspected Preterm Prelabour Rupture of Membranes from 24+0 Weeks of Gestation (Green-top Guideline No. 73) obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.15803

7 Chippington Derrick D. & Higson N 'Labour Induction at Term – How great is the risk of refusing it?' AIMS Journal, 2019, 31:1 www.aims.org.uk/journal/item/induction-at-term

8 Middleton P et al Cochrane review 'Induction of labour at or beyond 37 weeks' gestation' July 2020 www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004945.pub5/full

9 NICE guideline 'Diabetes in pregnancy', December 2020 www.nice.org.uk/guidance/ng3

10 NICE guideline 'Hypertension in pregnancy', June 2019 www.nice.org.uk/guidance/ng133

11 ICP support 'Guideline for managing ICP', August 2019 www.icpsupport.org/protocol.shtml

12 NICE guideline 'Twin and triplet pregnancy, September 2019 www.nice.org.uk/guidance/ng137

13 Editor's note: The term 'expectant management' means waiting to see or waiting for labour to start.

14 Saving Babies' Lives Care Bundle: www.england.nhs.uk/mat-transformation/saving-babies/

15 Making decisions about your care. AIMS 2020. www.aims.org.uk/information/item/making-decisions

16 Ashworth E. (2020) AIMS Guide to Your Rights in Pregnancy & Birth. https://shop.aims.org.uk/products/aims-guide-to-your-rights-in-pregnancy-birth

17 Raspberry leaf tea during pregnancy https://www.babycenter.com/pregnancy/diet-and-fitness/red-raspberry-leaf-tea_40007946

18 Raspberry Leaf and Hypoglycemia in Gestational Diabetes Mellitus
https://pubmed.ncbi.nlm.nih.gov/27824754/

19 Finucane E.M. et al Cochrane review 'Membrane sweeping for induction of labour', February 2020 https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000451.pub3/ful

20 Editor's note: ARM stands for Artificial Rupture of the Membranes. AIMS has a useful glossary of terms here: www.aims.org.uk/general/glossary

21 Editor's note: Ripening refers to the measures taken to soften the cervix in preparation for the further stages of the induction process. Ripening happens naturally in the days before the spontaneous onset of labour.

22 Ways of Managing Your Labour. AIMS 2018 www.aims.org.uk/information/item/managing-labour


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Story

Lydia's Story: Something's Wrong

by Lydia Shiells

This story is about my third pregnancy. I already had two girls who I had carried and delivered happily, the second one being a homebirth. I was well-informed about pregnancy, birth and breastfeeding (I had been a breastfeeding 'champion', no less, in children's centres).

From seven weeks in I felt something was wrong – with the baby, with me or with the pregnancy. I felt sick, tired and anxious. Worst of all, I felt very little connection with the developing baby. At my first scan I was told there was a high risk of Down's Syndrome, which heightened my anxiety and made me uncharacteristically nervous. I declined an amniocentesis because I didn't want unnecessary medical interference; instead I paid for the 'Harmony Test'[1] to tell me everything was fine. And I was having a boy.

I didn't like the idea of carrying a boy – I wanted to bond but wanting him out of my body was a stronger feeling. I started to have frightening, intrusive thoughts and severe anxiety; I lost weight and didn't feel safe near my children. Eventually I was diagnosed with serious mental ill-health and received CBT counselling through an NHS referral. The therapy helped and my psychotic episodes – as I now know them to be – subsided. Yet, I remained uninterested in my baby, detached from the experience. The therapy taught me that I needed to get out of my relationship (with the father of my second child and the one I was expecting). At the time I was heavily involved in a fundamentalist church and I had turned to them for support. Instead, they treated me like I was a sinner who needed to change. It was some time later that I found my way out of that church but my disillusionment with them started then.

I grew quite large in the pregnancy but was not yet diagnosed with polyhydramnios (an excessive amount of amniotic fluid). By 32 weeks I felt I couldn't cope – I couldn't walk because of pressure on my hips, I was huge, exhausted, having nightmares and carrying a baby that moved excessively. Somehow, I carried on to 36 weeks (although I didn't connect with the baby – I didn't wish him any harm) when I saw a consultant and asked to be induced. I was lucky to have the support of the Acacia team at Barnet hospital – midwives who specialise in mental health issues in pregnancy, working with me to lobby for an early birth.

The female consultant said something like: "I understand it's been difficult for you – once you are 40 weeks we will consider inducing you". I knew some people have to fight *against* being induced and couldn't understand why I was being ignored. I now believe my mental health problems were prejudicing people against taking me seriously or treating me considerately.

Outside of the room, imprisoned in a wheelchair and a pregnancy, I sobbed – desperate, close to giving up. A senior male consultant found me there and took it upon himself to do the good version of 'interfere'! The team were instructed to 'get this baby out' and, four days later, they did.

I was ready at 8.30a.m. but left to wait for a good while – I understood the need to wait and was patient, though in a lot of discomfort. Eventually they took me in and declared the baby was breech. He then turned. And turned again. What wasn't understood at the time is that the polyhydramnios meant the baby was practically swimming in a huge bag of water and every movement was painful for me – they just thought I wasn't coping. I knew from my previous experience of giving birth, that if the waters were broken, contractions would start, and the birth would progress quickly. They didn't believe me and insisted on administering a pessary. Suddenly strong contractions were every two minutes, the baby's heart rate was dropping, he was breech again, his hand was round the cord… and mum wasn't coping – again.

Eventually, I was rushed in for an emergency C-section which revealed the excess water. I felt relaxed after the epidural but my blood pressure dropped dramatically and I was blind for a few seconds.

My birth plan included *not* holding him – I just wanted him out. But as soon as I saw him, as soon as he looked just like my daughter, as soon as he was out and he was Humphrey, I wanted him. I held him, fed him and loved him.

After the birth we were in hospital for five days; the baby had a slight infection and I was severely anaemic. Humphrey also lost a little more weight than ideal, though he was feeding regularly. I saw quickly that he was not latching on properly because of tongue-tie. I was threatened in a kindly manner with Social Services if I didn't agree to switch to formula, but I stood firm on that. An NHS Breastfeeding Advisor visited and strongly defended me, agreeing with my tongue-tie diagnosis. As it happened, when he was next weighed (by a lovely midwife) he had maintained his weight and they were no longer worried.

By the time we went home I was a different person; my experience of pregnancy, of birth, and of the attitude of the medics, was so different from what I had previously known. I took home not only a beloved new baby but gratitude for those who had treated me wonderfully – and hurt from those who had misunderstood, dismissed or disrespected me. The care you receive in pregnancy and birth shouldn't depend on luck.

Six weeks after giving birth I saw a perinatal specialist psychiatrist who explained my psychiatric symptoms and their origins in the brain. I felt so much better on acquiring this information. Looking back, I should have stood up to people and relied more on my family, my mum and sister especially – but I was very ill.

Humphrey is 6 now and has a possible autism spectrum disorder; he gets anxious, we avoid sensory overload, and he struggles with going between homes (I'm separated from his father and have since had another baby with my new partner). He is, however, a lovely boy, a karate kicking, popular, comic genius and I couldn't love him more.

Author bio: Lydia is a mother of 4, currently involved in care-work and running a houseplant business. She has ambitions to be a midwife one day when she has the time to do the training.

1 Prenatal test available privately in the UK: www.harmonytest.com

Story

Sarah and Jackson's Story

by Sarah

Jackson, my son, had his second birthday late in 2021. We decided to start a family before getting married as I suffer from polycystic ovaries and wasn't sure I would be able to have children. We were fortunate that I managed to fall pregnant after just a few months. I cannot say I enjoyed pregnancy: though the first kicks and pregnancy milestones were amazing, I had to endure morning sickness from 7 to 22 weeks. Eventually I was diagnosed with Hyperemesis Gravidarum (severe nausea and vomiting) and prescribed medication, although it did little to help.

In total we had 10 scans, for various reasons such as growth concerns, placenta positioning, measurements of my uterus, and being monitored. The scans were a blessing as we got to see Jackson basically every month of pregnancy, but it was very stressful being told I needed yet another scan after every midwife appointment. Finally, after a growth monitoring scan, we were told his growth had slowed and he was better out than in – 10 days before his due date I was induced.

I've always been very anxious and nervous of anything medical. I faint at the sight of blood and have passed out with every injection I've had since about 5 years old. So as soon as I found out I was pregnant I felt nervous about the whole thing. I expected pregnancy would be an extension of all of these feelings, but in fact I surprised myself and everyone around me and was pretty calm and matter of fact throughout.

I decided that for me knowledge would be power; instead of spending time worrying about the 'what ifs', I would sign up to NCT class to be better informed about the whole process. I decided to enrol in Hypnobirthing and James and I attended both sets of classes during my pregnancy.

I found the whole process to be very much a 'tick box' exercise. My midwife appointments were almost pointless as I had all my information coming from NCT and hypnobirthing. I found them to be 'if you don't ask you don't get' - but unfortunately you don't know what you don't know. Everyone I encountered was lovely, but I never saw the same midwife at my appointments and found there wasn't any consistency throughout. This was frustrating as I was having to cover old ground at each meeting; it also meant whilst having all the various scans I didn't have one key contact to speak to.

James was great, as I knew he would be. He wanted to be involved in as much as he could, and I think he knew I would be feeling anxious and nervous and that him being with me at all appointments would help ease that.

I was induced on 31st Oct (Halloween!) – Jackson's due date was 10th November.

I was nervous of being induced as it pretty much went against anything I had been discussing during my hypnobirthing classes, which took pregnancy and birthing back to basics and said it's the most natural thing we do and that there wasn't any need for routine medical intervention and that our body knows what to do and exactly when to do it. I have heard many horror stories from friends about being induced and that essentially it's a catalyst for disaster with drugs being pumped to bring on labour and then more drugs to help with the pain of labour.

For me, I knew it was the right thing to do and so I arrived at hospital packed for 3 days at 9am and received a pessary shortly after. James stayed with me until 7pm when visiting hours stopped; until that point I hadn't felt any different. I had dinner and went off to have a shower at about 9pm. I discovered what I thought was my plug after going for a wee. I told the midwife on duty who said it probably was and to carry on as things can take a long time when you are induced. After around 10 minutes I started getting some period-like pains and again spoke to the midwife who gave me some paracetamol. After taking them and getting back into bed my waters broke. Wow! Nobody tells you how much water comes out and that it Does. Not. Stop. I again spoke to the midwife and asked if I should be calling James back; she again said no and to wait and see as being induced often takes days.

It was about 9.45 at this point and I started to get bad period pains. Something told me I had better check to see how often these were happening and so I downloaded an app on my phone and began to record them. After about five minutes the app and my brain told me I was having contractions and was in full labour. I called James and told him to come back to the hospital and I notified the midwife. She told me that as soon as a bed was available on the labour ward I would be sent up there. I remembered I needed to be on antibiotics once my waters had broken as I was Strep B positive. This got me a fast track into the labour ward, just as James arrived. By this point standing was difficult and the pain was intense. Upon arrival on the labour ward my midwife measured me and we discovered I was 7cm dilated. I requested a water birth and the pool was being run. I then had an overwhelming urge to either poo or push and was measured again and showed 9cm. The pool was stopped as I was told I wouldn't have enough time to get in before baby arrived. Gas and air helped me through the next part and Jackson was born.

Before induction I was anxious about how it was going to play out. I had been bombarded with horror stories of the slippery slope of intervention and was just determined to have as little as I could.

During the induction I felt pretty calm through the day with the pessary but the actual labour happened so quickly I didn't really get a chance to get too worked up about it.

After induction I was pretty chuffed that I had a straightforward birth without much pain relief - no stitches or anything and little blood loss. I was glad that the hypnobirthing and NCT classes had paid off. Not that I did anything in particular but I think they had helped me stay calm and trust my body, which had helped with the birth.

Midwives can be literal superheroes. I feel you have to be a certain type of person to be a midwife; during the birth my midwife was amazingly supportive and comforting; I guess I trusted her with my life. The postnatal ward was very hard - if it's not your own baby screaming it's someone else's! Lack of sleep, not knowing what to do with your newborn and just feeling battered, played a role but the midwives helped

me a few times when I was figuring out breastfeeding, etc. I had to stay in for at least 24 hrs due to Strep B but decided to stay an additional night until I had grasped breastfeeding a bit better. All of the team were super supportive on that front.

My only birthing partner was James. He was great - we were both on the same page in terms of what I did and didn't want but also in terms of us both wanting to be relaxed and as calm as possible. To be honest I think he was just in awe of what I was actually doing.

Looking back, I think the midwife appointments could have been way more informative. I was a first-time mum and was just being directed to videos from the 80s on the internet for advice. I was given the odd information sheet but wasn't offered any prenatal classes that I know are offered elsewhere. I relied on NCT[1] and hypnobirthing for the majority of my information and I think it's a shame as not everyone can afford to pay for this kind of additional support.

I consented to the induction but I'm not sure I had full information. Jackson was born a healthy 7.4lb and had a straightforward birth without intervention. A few days after birth I felt like I had a pulled groin muscle which eventually moved on to my lower back. After 5 months or so of physio I decided to go private for a scan and to my surprise had slipped a disc. We think this was done during birth but can't be sure. Other than that I had no lasting issues post birth.

We are both doing well. I've suffered with anxiety and depression for a long time and I had come off all medication when I found out I was pregnant. Myself and my doctors closely monitored for postnatal depression and I resumed antidepressants as soon as I stopped breastfeeding when Jackson was 5 months. I've been on medication ever since.

Jackson is happy and healthy and you couldn't ask for anything else. He started nursery last week and is showing signs of being a bright and charming little guy.

Lockdown hit when Jackson was 4 months. It made it hard to help combat post-natal depression as I couldn't leave the house, which meant I couldn't socialise or get help from elsewhere and it was me and James on our own in the deep end! I missed the chance for most baby classes due to Covid but we have made up for it since.

Looking back, I wish I had made more of a fuss about my pregnancy sickness to the midwives. I didn't go to hospital until a few weeks before it stopped naturally, and I feel like I could have felt a lot better a lot sooner had I made sure I got some help.

1 The NCT offers a range of income-related discounts: https://www.nct.org.uk/courses-workshops/course-details-and-prices/course-prices-and-discounts

Author bio: **Sarah** is a 31 year old mother of Jackson. She lives in Hampshire with her husband and is currently living a chaotic life as a stay-at-home mum, thinking about expanding the family again soon.

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Article

Reflections on current trends in maternity care: a stream of consciousness

by Joy Horner

Editor: *Joy Horner first trained as a midwife in 1988 and practised for 18 months before deciding that subjecting all first-time mothers to episiotomies and using syntocinon infusions on everyone in labour, and calling it active management of labour, was not what she wanted to do. She thought she was a bad midwife, so she returned to being a registered nurse and didn't go back to midwifery again until 2002 after she had completed a diploma in antenatal education with the National Childbirth Trust. She left the midwifery register in March 2021 due to a multitude of factors; being an independent midwife meant she could no longer attend births because of the lack of intrapartum indemnity insurance, and as she was getting older she no longer wished to be subject to the punitive behaviour of the NMC (The Nursing and Midwifery Council) and increasing restrictions on her practice. When asked to write about induction of labour she realised she had a lot to say on the subject from a less mainstream perspective.*

In my years as a midwife I learned a lot from families I served, especially the families whose choices were outside of guidelines. They showed me what it means to have faith in women and birthing people's abilities. As an independent midwife my education in normal birth, human rights and autonomy skyrocketed. I saw things that doctors said shouldn't happen, couldn't happen, and yet they did happen; things that you don't find in textbooks or from randomised control trials, because birth works best when it is unobserved and undisturbed. I became less hands-on as my clients often declined blood tests, or vaginal examinations; they did not want electronic fetal heart monitoring or for their baby's cord to be cut soon after birth, and they often did not want any talking during their labour. Intuition plays a big part and I embraced spiritual and shamanic dimensions of this sacred rite of passage.

As a recently retired midwife I am used to looking at research-based evidence, but my training in 1988 was definitely more practical. Active management of labour for all clients, and performing an episiotomy on every first-time mother, was considered good practice; now research shows it causes more harm than good. Science didn't know everything then, and it doesn't know everything now. With medical management on the increase, we shouldn't close our minds to the possibility of something we are doing now being proven harmful in the future – or that important factors that have not been studied or that we do not yet understand will come to light and radically change the way we care for people in labour. For example, when I started training I never imagined there would ever be a thing called epigenetics let alone mapping the human genome.[1] These things were a mystery then.

I have respect for our NHS, our doctors, our midwives, our surgeons, anaesthetists, and those who provide science-informed care when we really need it. As a born sceptic, I never take things at face value, and I have to understand exactly why I'm being asked to offer a procedure or treatment. My grandmother used to say, "Believe nothing of what you hear and only half of what you see", but nevertheless, growing up with the stories of my own and my siblings' births in the 1960s has left me with an innate belief in birth. None of us was born in hospital, including a sibling who weighed in at 11½lbs born at 44 weeks of pregnancy, at

home, to my 5'3" pre-diabetic mother. In the 1960s the *art* of midwifery was more widely trusted and respected.

When the Peel report in 1970[2] encouraged all women and pregnant people to give birth in hospital, we started to forget that we can give birth without hospitals and doctors. Hospital became seen as a place of safety where experts could save all women and all babies. As we know, the move to institutionalised birth has not made birth safer across the board, and now we are seeing more cases of iatrogenic harm[3] and more women and birthing people who describe their experience as traumatic. As midwives and birth keepers, we need to maintain the balance between the art and science of midwifery – and to acknowledge the mysteries that remain.

In 2015 I did a year-long shamanic womancraft training with Jane Hardwicke Collings. It helped me see the interconnectedness of our lives, within the wider context of the seasons, moon phases, our family lineage and childhood experiences. It helped me connect with my own spirituality and to see even more of the spiritual side of pregnancy, birth and becoming a parent.

I am currently training with Matthew Appleton in the field of integrative baby therapy,[4] the roots of which are pre and perinatal psychology. Integrative baby therapy acknowledges that babies are conscious beings in the womb and throughout birth, and have experiences that they remember and tell us about even in the preverbal stage. We also look at how birth can affect babies and how trauma can be carried from generation to generation.

I read a book by Mark Wolynn called, 'It didn't start with you: how inherited family trauma shapes who we are and how to end the cycle',[5] which describes how prolonged stress in a parent can affect epigenetic changes in their offspring demonstrable for at least three generations. I consider it essential that anyone supporting families expecting a baby talks with them about ways to manage their stress levels and where they can get help.

Being a born sceptic has given me a very inquiring mind eager to find out the wider truth. I also inherited my father's sense of justice and equality for all. I have been a defender of human rights for as long as I can remember; as a midwife, the rights of a person in front of me have always been paramount. However, from personal and professional experience, I understand the unpredictable nature of birth and the benefits of medical intervention when needed.

Women and birthing people also have a right to understand this and to know when they might welcome medical support. So when the theme of induction comes up, I discuss the medical recommendations, the NICE guidelines, and any information on which clients can balance their decisions. When my clients decline the offer of induction they do so from a point of being extremely well informed; they have considered all the options, looked at all the risks and benefits, and made the decision that they feel is right for their baby. No-one in my care has ever made a decision that is neglectful of their baby's well-being. As a midwife and now birth keeper, it is my duty to support their decisions no matter what my personal beliefs may be.

It is not easy supporting clients who choose not to follow guidelines and policies; it takes courage. I have supported many 'high-risk' births at home including VBAC[6] clients with breech-presenting babies. Sometimes these families have rewarding empowering experiences that prove the doctors wrong, but occasionally a baby has died. In these tragic circumstances we truly learn the nature of spirituality as we call out to everything that is holy to help us understand. Of course, in many of these cases the outcome would not have been better in a hospital situation.

Asked why I think the induction rate is increasing, I say it's not just because of NICE guidelines or because of rising insurance premiums; it is to do with economics, our social and our cultural expectations around birth, and our belief in the paternalistic and technocratic maternity system. We live in a culture where nobody likes to wait and where we have been brought up to rely on 'experts' to know what is best for us; in doing so we have lost touch with a more instinctive way of being. When I was born in the 1960s my parents had to trust that they were just carrying one baby, that the baby would be healthy, and that labour would start when the baby was ready to be born. They knew that most labours went well, and most babies were born healthy. Neonatal mortality has improved since the 1960s,[7] but at what cost? The number of inductions needed to save one baby is in the hundreds,[8] and those treated unnecessarily may be left with physical or mental birth trauma. However, for the family of that one baby, all that matters is that their baby arrives safely.

We no longer have such large families so there is a lot of expectation that children will survive childbirth and infancy. In my grandmother's day people had larger families

and although it was hard it was widely accepted that some babies would die during pregnancy, birth and childhood. Because we invest so much in our children we ask the help of the experts, hoping to improve their chances of health and survival. Yet scientists, researchers, doctors and midwives may also not know how best to achieve this. The industrial revolution and the advent of the NHS made way for a growing reliance on the skills of 'professionals' and on state-provided services. Over time this resulted in a loss of individual skill and autonomy, and a loss of trust in our own instinctive decision-making ability. Of course, when the NHS first started, the belief was that it would provide free care for everyone – but with medical advances and the increasing cost of equipment and drugs, it has been a victim of its own success. Hospitals are millions of pounds in debt and have to look to save money wherever they can. This includes cutting down on staff and other resources, which ironically compromises safety and contributes to far more costly litigation claims.[9] With fewer staff to provide continuity of care we have to rely on technology for the information that we used to be able to get from spending time with families, taking good histories, forging trusting relationships, and good palpation and auscultation skills.[10] It can sometimes be easier to look after someone who has an epidural and may even be asleep, than the woman or person giving birth in the next room without analgesia who may need a hand to hold, and soothing words after each contraction. Furthermore, staffing levels are easier to manage when we can control and predict the flow of people onto the labour ward. This can be achieved by saying that *all* women with a particular due date will give birth by that date plus a given number of days – either spontaneously or by induction.

We can inform clients of the chances of an undesired outcome according to research, but that research has not included the unique individual before us. So when counselling families about induction I give accurate information so they can make informed decisions, but also explain the uncertainty involved. We look at the multifactorial reasons why pregnancies can last beyond 42 or even 43 weeks. A personal or family history of longer pregnancies and being older might increase the chances of having a baby that is post-term. We also have open and honest discussions about why babies die. As an independent midwife, any baby death leads to an investigation and when this has happened with me I have been cleared of any wrongdoing; yet each time I support one of these families I search my soul for what I could have done differently. I became a trustee of a baby-loss charity 10 years ago and I learned that quite often no reason is found, even after a post-mortem. Science knows a lot but not everything. Not all babies will survive pregnancy or birth yet this is not discussed with parents. We may fear undermining parents' confidence in medics, but I have learned that if I admit to not having all the answers (which none of us does), my clients feel more empowered to trust their intuition. It seems that honesty about the limitations of science allows people to reclaim their ability to tune in to what they truly need in their pregnancy and birth time.

We know that labour is initiated by the baby when the pregnant person is ready to give birth and that occasionally there are physical and emotional reasons why the onset of labour is delayed. Physically, the baby may not be in an optimal position – if the baby has not engaged or is in a deflexed position that could prevent labour starting. Emotional reasons may include fear of giving birth, fear of becoming a parent, fear of having a child of a particular sex, or fear because one is not in a safe place or with safe people. If we treat the baby as a conscious and emotional being, we can entertain the thought that the baby has some agency over entering the world and might be reluctant to do so.

I have cared for people whose babies have been stillborn who have told me retrospectively that they had a sense that their baby would not survive birth. It seems as if the extended pregnancy did not cause the baby's demise but may have prolonged his or her life in the womb. I have been told by people after a birth that they have a strong sense that not going into labour or not giving birth vaginally, though disappointing at the time, somehow protected them from a birth complication that might have happened otherwise. Women talk about these things but they remain a mystery to science.

Why would clients choose not to be induced? The choice might be because of: cultural reasons; deep fear of hospital or intervention as a result of previous trauma; belief in birth and nature, and faith that their baby will be born healthy without intervention; the knowledge that intervention is

not benign; and religious or spiritual beliefs that take into account the fact that some babies die even with the best care, and that whatever happens is divine or cosmic will.

With regard to intergenerational trauma,[11] I have helped clients make their own connections between what happened in their labour and birth and something that happened in their childhood or to one of their ancestors. A few clients have felt that a postpartum haemorrhage, or unplanned emergency caesarean, enabled their body to be rid of something that they no longer needed in a shamanic or spiritual way. For example, a client who had a difficult relationship with a relative was able to ponder what may have been healed in experiencing a birth that was far from the one she had planned. Previous abuse can make clients unwilling to give birth in a way that involves interventions and invasive procedures, and they can sometimes claim back their power by birthing unassisted with the minimum of medical care. If they were to follow the recommendations to be induced, previous trauma could resurface. In fact, feeling out of control, being in powerless positions, being told to lie down, to be quiet or do as they're told, or invasive procedures such as vaginal examinations can result in a person's first experience of trauma; trauma that is then handed down through the family.

Our ancestors paid attention to other factors that could affect the onset of labour. We know, for example, that the moon affects the tides and women's menstrual and reproductive cycles,[12] and some women decline induction in favour of these natural cycles.

However, many women and pregnant people decline induction because they are very well read, have looked at all the pros and cons, have considered how the current research applies to them in this pregnancy and are making well-informed decisions about what is right for them and their baby.

Regardless of the reasons, anxiety at the end of pregnancy in itself can delay the start of labour. Adrenaline decreases the production of oxytocin. Instead of threatening, coercing and frightening people whose pregnancies continue past 40 weeks, we should help them to rest and relax and increase oxytocin levels. Oxytocin receptors in the uterus increase over time [13, 14] and labour will always start given time.

In conclusion, it is the right of every pregnant woman or person to accept or decline any treatment even if it's thought to be to the detriment of her baby. The NMC clearly states that our duty is to support the choice of the person in front of us. Our clients do not have to give us a reason that they are declining treatment but spending time with them may help us understand their choices. In this way we can increase the likelihood of any birth, induced or spontaneous, being a positive and happy experience.[15]

I want to end with a wonderful quote by Ani Di Franco in Ina May Gaskin's book '*Birth Matters: a midwife's manifesta*'. Di Franco describes how, after a long and difficult labour at home, she felt the exaltation of having given birth to her first baby:

> *What if the medical establishment that purports to be saving women from the specter of pain and danger is instead ejecting them from the seat of their power? … I have many friends now who have given birth, most of them in hospitals with a myriad of interventions, and a truly shocking number of them by caesarean section. Young, healthy, and strong women. It confuses me that I, an educated, privileged woman in twenty-first century America, am surrounded by women who think they need saving and, because they are denied the opportunity to know otherwise, may believe it forevermore. They look at me with wide eyes and say, "I couldn't have done what you did," and my heart breaks as I think quietly, "yes you could have! In fact, I bet you could have done better!" How could all these otherwise empowered young women go so unquestioningly into the role of damsel in distress when it comes time to have their children? How are they convinced that they "couldn't do it"?*

ENDNOTES

1 Editor's note: Epigenetics is the study of how behaviour and environment can cause changes that affect the way genes work. One group of scientists concluded their study (*The EPIIC hypothesis: Intrapartum effects on the neonatal epigenome and consequent health outcomes*) by saying:
A fundamental tenet of clinical practice is to "do no harm". The EPIIC [Epigenetic Impact of Childbirth] group hypothesizes the routine application of interventions during a healthy childbirth event can alter physiological epigenetic remodeling, with the potential for negative health effects. This suggests that physiological labor and birth is finely tuned to generate optimal epigenetic effects for later wellbeing. It is paramount to the wellbeing and protection of mothers and babies to adequately explore this area of research.(www.ncbi.nlm.nih.gov/pmc/articles/PMC3612361/)

2 Ministry of Health (1970) Domiciliary Midwifery and Maternity Bed Needs: the Report of the Standing Maternity and Midwifery Advisory Committee (Sub-committee Chairman J. Peel), HMSO, London - https://archive.org/stream/op1269001-1001/op1269001-1001_djvu.txt

3 Editor's note: Iatrogenic harm is harm caused by medical care or treatment. This study addresses iatrogenic harm in maternity care:

Liese KL, Davis-Floyd R, Stewart K, Cheyney M (2021) Obstetric iatrogenesis in the United States: the spectrum of unintentional harm, disrespect, violence, and abuse. *Anthropology & Medicine*. 28(2):188-204. doi: 10.1080/13648470.2021.1938510. Epub 2021 Jul 1. PMID: 34196238.

4 Appleton M (2020) Transitions to Wholeness: Integrating Prenatal, Transpersonal and Somatic Psychology. Independently published.

5 Wolynn, M (2017). It didn't start with you: how inherited family trauma shapes who we are and how to end the cycle. New York: Penguin Books.

6 Editor's note: A VBAC client is a person having a vaginal birth after a previous caesarean.

7 Editor's note: Statistician Marjorie Tew established that the decline in perinatal mortality during the post-war decades was largely due to improved diet and living conditions: https://academic.oup.com/fampra/article/16/3/321/485609

8 Middleton P, Shepherd E, Crowther CA (2018). Induction of labour for improving birth outcomes for women at or beyond term. Cochrane Database Syst Rev. 5(5):CD004945. doi: 10.1002/14651858.CD004945.pub4. Update in: Cochrane Database Syst Rev. 2020 Jul 15;7:CD004945. PMID: 29741208; PMCID: PMC6494436.

https://pubmed.ncbi.nlm.nih.gov/29741208/

9 Lintern S (2021). Revealed: Unsafe maternity care has cost the NHS £8.2bn in 15 years. The Independent.

https://www.independent.co.uk/news/health/maternity-negligence-compensation-nhs-safety-b1902095.html

10 Editor's note: Palpation (in this context) is when someone examines the pregnant belly and the baby within by using their hands. Auscultation (in this context) is when the unborn baby's heart rate is listened to through the pregnant person's abdominal wall.

11Editor's reading suggestion: Hendrix CL, Dilks DD, McKenna BG, Dunlop AL, Corwin EJ, Brennan PA (2021). Maternal childhood adversity associates with frontoamygdala connectivity in neonates. Biological Psychiatry: Cognitive Neuroscience and Neuroimaging,4 6(4):470-478. doi: 10.1016/j.bpsc.2020.11.003. Epub 2020 Nov 21.

12 Kelleher, S (2021). Moon cycles exert an influence on menstruation and sleep patterns, www.aaas.org/news/moon-cycles-exert-influence-menstruation-and-sleep-patterns

13 Prevost M, Zelkowitz P, Tulandi T, Hayton B, Feeley N, Carter CS, Joseph L, Pournajafi-Nazarloo H, Yong PE, Abenhaim H, Gold I (2014). Oxytocin in pregnancy and the postpartum: relations to labor and its management. Frontiers in Public Health, 2, DOI 10.3389/fpubh.2014.00001, www.frontiersin.org/articles/10.3389/fpubh.2014.00001/full

14 Buckley S (2011). Undisturbed birth. AIMS Journal, 23(4), www.aims.org.uk/journal/item/undisturbed-birth

15 Editor's note: For more information about making consensual decisions about pregnancy and birth read: AIMS, 'Making decisions about your care', www.aims.org.uk/information/item/making-decisions,

and Birthrights, 'Consent: the key facts', www.birthrights.org.uk/factsheets/consenting-to-treatment

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Birth poetry from the pandemic

introduced by Danielle Gilmour

Danielle Gilmour

In our last Journal - 'Birth of a pandemic: How we coped'— we heard from mothers, healthcare professionals, birth supporters, volunteers and birth activists about how the pandemic has had profound and lasting effects on the birthing world. From the (ever-changing) rules and regulations, to staff shortages, to changes in our very bodies — the conditions under which people have been giving birth are truly unchartered waters. How are we coping? One of the most powerful ways some women have found of processing their experiences is to express them through poetry. And in so doing, they hold up a mirror to the world in a way that makes us all reflect on how we've fared.

The following three poems are deeply personal and yet they speak to experiences that will surely be shared by thousands of people the world-over. We approached the writers for the Mum Poem Press for the voices of women who have given birth during this pandemic. One thing remains true – bringing new life into the world is still beautiful and joyous, if fraught with uncertainties. But that joy has sadly been tempered by isolation from loved-ones, fears around contracting Covid, and the road ahead so unknown.
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Road unknown By Helena Lyon-Shaw

This time
I knew you before I knew about you
I sensed your presence
In the hallway
Under the half moon
My response was a knowing smile
I knew

How different it all would become
When the rest of the world got involved
We were wing clipped and starved
Far removed from our loved ones' gaze
We stood on empty street corners
In the dark
Grieving our loss

Later
You were called a lockdown baby
I was appalled
You were always my spirit baby
I knew you before I knew about you
That knowing smile
Under the moon
The world has now joined in
Joined us in our universe
Time is a healer
But things are not the same
We are forever marked by circumstances
By this road of ours
The road unknown

Author Bio: Helena is a mother of two, a forensic nurse and a dreamer. She lives in Berkshire with her children, her husband and their dog. She enjoys poetry, reading, sewing and drinking tea on woodland walks.

Giving Birth at the Height of a Pandemic By Lizzie Wilkins

I watched every episode of one born every minute
But not one episode
showed
what it is like
To give birth at the height
Of a global pandemic: April 2020

Not one episode told
About lockdown and face masks
The fear of each stranger past
In long corridors
Markers signifying 2 metres stuck to the floor

Not one episode explained
What it's like to feel a contraction's pain
But to be too scared to lean on a window's ledge
Because covid was deadly and easily spread

Not one episode suggested
My husband would not be my side
As I attempted to hide
The pain and fear of being alone
Whilst he was sent hesitantly back home

Not one episode predicted
That the sense of being in hospital had shifted
No longer a safe space to rest and recover
Childbirth over and you're now a new mother

Tiny baby in need of protection
Which leads your logic to the rejection
Of time in a hospital to heal and to rest
Desperate to leave after all of their tests

I want to go home
I want to go home

Even though home meant we were alone
So very removed from what we thought we'd known

Everything changed because the fear of this disease
Instilled with me a sense of unease
Which I connected to my tiny baby
And thoughts flashed through my head like... Maybe

Maybe I've made a mistake
Because they say it takes
A village to raise a child
And I have no idea when we will be reconciled

And fear won't be the baseline
Connected to this child of mine

Author Bio: Lizzy became a first time parent during the peak of the Covid-19 pandemic (April 2020). After the birth of her son, Lizzy experienced severe postnatal depression and anxiety. As a result, she struggled with bonding and attachment towards her baby. After being admitted onto a Mother and Baby Unit, Lizzy began writing poetry and drawing as a way to process and express the emotions and experiences she was living through. Writing became an outlet and a release; a way for her to articulate her experiences in a way she was unable to in any other form. She now uses her work as a platform to raise awareness of maternal mental health and wellbeing.

Lockdown Love by Laura Gooch

The wait before
Was long and arduous.
Every step an uncertain one,
Every decision a tentative one,
With back-ups and plan Bs in place.
When it happened
I was on the ward for 24 hours.
Alone.
Waiting for the time to call my husband and say,
Come up. Come up. It's time.
You can be here with me.
You can hold my hand,
And rub my back
And whisper 'you're doing well' through the veil of your mask.
She came into the world unaware of the social distancing and lockdowns that awaited her.
She came in fresh and new,
Bold and brave.
He held her in his arms and we had hot toast and warm cuddles.
All was well for a short while.
Then he had to go,
And I held her and wept.
She met her sister on video call -
First embraces had to wait.
Everything had to wait.
Some things are still waiting.
I am full of joy that she came into the world,
And full of sadness for the world she came into.

Author Bio: Laura is a marketing and content officer and mother of two. She loves soul music, strong tea and savage banter, and lives in sunny Eastbourne with her lovely husband and two gorgeous girls.

Article

Sophia, Phronesis and Stultitia

by Alex Smith

I often wonder why *so many* healthy women, women who express strong concerns about induction, reach 41+ weeks and just go along with it. We know that fear and coercion play a big part, but is wisdom also involved? The ancient Greeks had different words for wisdom. In this article, I reflect on two of these - and throw in a third word of Latin origin - to help me better understand the disparity between women's general preference for a straightforward labour, uncomplicated by excessive medicalisation, and their apparent willingness to accept the ever increasing offer of induction. I invite you to imagine three sisters.

The first sister **Sophia** is named after the Greek word for wisdom - wisdom that relates to the possession of knowledge. She has lots of information, has read the research and her facts are up to date. Sophia knows all there is to know, and in this way she is considered wise and *sophisticated* (I will come back to that word later). The second sister **Phronesis** is named after the Greek word for a more advanced form of wisdom - wisdom that assumes the possession of knowledge but also the ability to appraise it, understand its implications, and to take action. Phronesis envisions the good end to which she will apply her understanding in a practical way, and has a plan for how to go about this. While Sophia knows how a car works, Phronesis knows how to drive, where she wants to go, and how to get there.

The third sister, the younger **Stultitia***,* has a name that comes from the Latin word for stupidity or folly (her parents should have checked). Stultitia is far from stupid or foolish but she has somehow come to believe that ordinary people don't drive a car, that they cannot be that wise. Her self-determination (her inner drive) has become dulled and she has lost any enthusiasm or initiative; she has become stultified. Stultification is the effect of having every enthusiasm, initiative, or freedom of action stifled by others to the point where it would feel foolish to even think of exercising autonomy; and nobody wants to appear foolish. Stultitia has developed an external locus of control[1], a general belief that success or failure results from external factors beyond her control. She believes that any attempt to think for herself would be folly. Stultitia is driven where others think best and without question.

When these three sisters (now expecting babies) are offered induction of labour at 41 weeks, they talk together and all agree that, based on what they have heard from friends, this is not what they had wanted. Stultitia feels dazed and helpless; "What can you do except go with the flow? It is out of my hands", she says. Her fear is that if she holds out for a normal birth she will look silly when that doesn't happen. It would be foolish to question the experts; her friends agree. Sophia, reads the NICE guidelines and the hospital protocols and accepts the recommendations without question because, if the experts and scientists have decided on these, they need no further analysis. She steps onto the induction conveyor belt in the full knowledge of why this has been offered, and to some extent, of what to expect, but quickly realises that she doesn't like the direction in which the belt is moving. Sophia senses that she should have known better, but can't admit that as her wider circle of friends and family all agree that she made a wise decision.

Phronesis has read more widely; she is aware that much of the evidence on which the recommendations are based is either of poor quality or is not relevant to her and, moreover, that induction itself is not without risk. She realises the risk balance is marginal and very difficult to weigh for any one person, so she consults her gut instinct and adopts her personal rule-of-thumb philosophy for these situations. Phronesis schedules a Doppler scan of her placenta, checks in on the baby, and declines induction for the time being at least. Stultitia thinks Phronesis is crazy and Sophia feels judged by her. The three sisters are at odds.

Meanwhile, Phronesis contacts AIMS just to hear a supportive voice. She says that she is feeling coerced by the midwife and by society at large; everyone is making her feel that she is risking her baby's life, but even her doctor was unable to provide actual numbers to back this up. Being Phronesis is not easy. She is aware of the disparity between the immense fear that is evoked by her declining induction and the very low level of actual risk as outlined in the research, and she oscillates between anxiety and confidence. Phronesis manages this by putting her plan into practice; she uses her calm breathing, positive affirmations, like-minded friends and her deepest instincts to allow the wisdom of her body to prevail. But how long can she hold out?

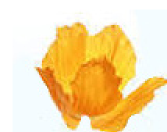
In real life, Sophia, Phronesis and Stultitia rarely live alone, they reside together within each of us - complexly entwined and still very much at odds. Their separate voices argue back and forth as we grapple with their different persuasions. Sometimes they reach a consensus, but that often feels like compromise and is cloaked in anxiety and disappointment. When one sister wins the internal debate it will be the sister most nurtured by the socio-cultural and family influences surrounding that person; it is rarely Phronesis.

While the Greeks considered phronesis to be the highest form of wisdom, Phronesis the sister was considered to be the difficult child. She would never just do as she was told and her mother would say that she 'could argue the hind leg off a donkey!' Sophia did well at school, Stultitia was meek and compliant, but Phronesis, though top of the debating society and just as studious as Sophia, was often in trouble and not always liked. Her feistiness and intentionality were unsettling and tightly reined in by her parents and teachers; her behaviour was punished while her sisters' was rewarded. Grown up, Phronesis is still perceived as the wild child and her actions as destabilising.

Just as the individual maternity service user experiences this internal conflict, so does each individual midwife and doctor. Generally it is a combination of Sophia's received and conventional wisdom and Stultitia's compliance that shapes the decisions and behaviours of everyone involved, while Phronesis experiences institutional bullying when she tries to campaign or to question the status quo. And this is why, even when a woman says that she hopes not to be induced, and even when her midwife and doctor empathise, and even when our collective societal Phronesis suspects that there is something fishy about the sheer extent of medicalisation of birth, our collective Sophia and Stultitia (having been so often rewarded and much more strongly nurtured) hold sway.

By way of an epilogue, let's go back to the word 'sophisticated'[2]. It has a double meaning. It shares roots with the word sophia (wisdom), but its other meaning is 'adulterated', 'tampered with' or 'deprived of simplicity', with its antonym being 'uncorrupted'. Etymologically, sophistication carries a sense that it has been attained through the use of fallacious argument, and sophistry is defined as the use of clever but false arguments, especially with the intention of deceiving. Many parents would feel that they have witnessed this in the 'shroud-waving' they experience on declining induction. The medical model of maternity care has become very sophisticated, and phronetic efforts to counter this are easily stultified… for maternity service users and practitioners alike.

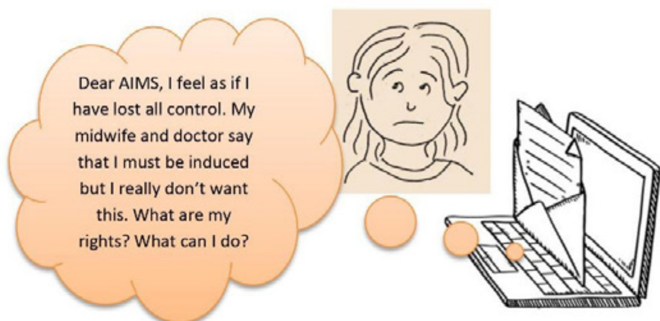
An epilogue ought to serve as a conclusion, but one escapes me… suggestions on a postcard please.



1 External Locus of Control: www.simplypsychology.org/locus-of-control.html

2 Sophisticated: www.etymonline.com/word/sophistication

Volunteering on the AIMS helpline



"Do I need to be induced?"

With the rising tide of induction, this is a frequent question the Helpline Volunteers are asked. Along with the majority of other enquiries, people want to know their rights, they want information so that they can make fully informed decisions, and they want to feel heard, believed and respected.

The Helpline team at AIMS is a small group of volunteers who are in touch with members of the public on a daily basis, answering queries about many different issues relating to pregnancy, birth and early parenthood. We are looking to recruit more volunteers, so if this is something that interests you, read on.

What qualities are we looking for?

- You need to be a lay person, not qualified as any kind of medical practitioner
- You need a background knowledge of pregnancy, birth and advocating for parents, for example, a doula, birth educator, or someone with relevant experience on a support helpline
- You need to be able to write to a reasonable standard - we operate mainly by email and all phone calls are followed up by email
- You need to be able to commit 3-4 hours per week
- You need an active interest in current issues affecting human rights in childbirth

Who are we?

As Helpline Volunteers we are active listeners and we take a person-centred approach. We make sure we answer the question that has been asked, and are careful to give options and not advice. We frame our response in terms of evidence based information and, where appropriate, in terms of approaches that others have found useful, providing references and links to resources for people to follow.

What support is there?

AIMS has a wealth of resources from which to draw information, including template responses, AIMS books, Birth Information pages and Journal articles, NICE guidelines, Cochrane evidence reviews, and resources from similar organisations such as Birthrights. We meet monthly on an online video chat to keep up to date with each other and talk through any issues or concerns that have come up.

What are the benefits?

As an AIMS Helpline Volunteer you increase your knowledge and skills - it's a steep learning curve to begin with but it soon gets easier. You learn about all aspects of childbirth and keep up to date with current guidelines and legislation and what is going on both inside and outside the system. You help people, which is deeply rewarding. When someone feels calmer and more in control of their situation and can go forward in their decision-making as a result of their interaction with you, it is very satisfying and worthwhile. As one volunteer said, "it restores the soul in a soul-destroying world!".

You also get to be part of the AIMS community, which is a wonderful place to be. We are drawn together through our passion for women in childbirth - our opinions may differ but we have a mutual understanding of respect and trust.

It does make a difference to people's lives, being on the helpline. Even if you only help one person then that may be the most useful thing you have done with your day. This is what makes being on the Helpline sustainable - it's a healing thing.

Interested? What to do next?

If you are interested in volunteering for AIMS and meet the criteria for this role, we would love to hear from you. Our email contact is *volunteer@aims.org.uk.*

Introducing Raham Project

by Faiza Rehman

Faiza Rehman was born and raised in the U.K. in a tight knit south Asian family. She is the mother of two young children and a qualified midwife, who has been practising since 2011. She comments, "I am hugely passionate about all things midwifery and ensuring we care for families so they emerge from their birth both physically and emotionally safe. This passion has driven me to start a grassroots organisation: Raham Project, a platform to support families from diverse ethnic backgrounds".

Raham Project is a registered Community Interest Company, based in Peterborough. It is currently funded by the Peterborough and Cambridgeshire Integrated Care system. This company is created out of my own experiences as a British Pakistani, a mother of two young children and a qualified midwife. As I was growing up, I would hear stories from various women from within my community discussing collective experiences of birth, life, and death. These stories took place in safe circles of trusted women and these women had voices and experiences worth listening to.

Stories of motherhood and birth fascinated me. I would feel joy hearing about the community support provided to women during their birth and postnatal period; this support mechanism was emphasised as being essential when women had their children. My mother was 16 when she gave birth to my brother; he was born at home in a small rural village in Pakistan. My mother was surrounded by her tribe of women at that time. Culturally, men were not expected to be part of the birth and this coincided with dad working abroad. My father was informed about the birth of my brother via a cassette recording that was received by him a week later; communication through such measures was common at that time. My mother was encouraged to walk, squat, eat, drink and rest when she needed to. She often spoke about comfort measures, like the group of women massaging her back, and after a day or so of labour, she birthed her baby at home. She described the experience as the hardest thing she had ever done; however, she never doubted her ability to birth. She remembers the joys of the space she shared and the feelings she felt. My brother didn't breathe straight away so they held him upside down over a Tava (a flat chapati griddle) which was heated quickly and they splattered water on it so the steam stimulated him to breathe. I recognise this was their form of stimulation for a baby based on previous knowledge and experiences they had. From birth onwards she was relieved from doing any home duties and rested as she learned to breastfeed and take care of her newborn baby. She did not leave the home for the first 40 days after her birth, and all the women took it in turns to support her to rest with her newborn.

These positive stories were often followed by the reminder of the cruel inequality and inequity that families faced because of the part of the world they were born in. For example, my aunt had numerous miscarriages, nine live children and four who passed away within the early months/years of life. I recollect travelling to visit my family in the summer holidays as a child and meeting one of her newborn babies. I look back and realise she was most definitely small for gestational age, and I am almost certain now she was born preterm. She died a few weeks later. I recall hearing about a woman that gave birth at the same time as my mother - she died because they believed her placenta touched her heart. Initially, I assumed this happened because they lived in a poorer country, but as I developed my passion for all things midwifery, I learned that despite living within the UK there was a disparity in health outcomes for ethnic minority mothers as well as mothers who lived in the most deprived areas[1,2].

At Raham Project, we offer support to mothers with ethnic minority backgrounds and their partners. The support is focussed around pregnancy, childbirth, and the post-partum period – with an emphasis on maintaining and improving maternal mental wellbeing. The support ranges from informational, emotional and advocacy.

We engage directly with our community by creating digital media content to help represent, educate and raise awareness about the perinatal period. The content is simple

to understand and when key themes are suggested by people, we then take them further to create informative videos. We have begun to focus on creating videos in Mirpuri, a language understood by most people within our local Pakistani community.

Finally, we offer monthly listening sessions. This is where we hold online monthly events to listen to people that connect with us; we then use their voices and stories collectively to give feedback to our Cambridgeshire and Peterborough Local Maternity and Neonatal System. These stories are shared within a safe space of trusted women. If people wish to have a one-to-one conversation, we offer this on a case-to-case basis. Over time, we have developed a small voluntary online peer support group led by mothers from diverse ethnic backgrounds for mothers that identify with them.

Raham project continues to develop and support families from ethnic minority backgrounds. We are developing links with other charities such as Cambridgeshire, Peterborough and South Lincolnshire Mind and Barnardos. We're looking forward to creating a partnership project of a central hub space for minority ethnic women local to Peterborough.

These are early but exciting days. We are currently based in a small city, but the power of social media has provided us with access to people from other places and there is scope for us to grow all across the UK.

We have and will continue to be the voice of those who either need to be heard or want to strive for change, a change that will require a whole community.

Author Bio: Faiza Rehman was born and raised in the U.K. in a tight knit south Asian family. She is the mother of two young children and a qualified midwife, who has been practising since 2011. She comments, "I am hugely passionate about all things midwifery and ensuring we care for families so they emerge from their birth both physically and emotionally safe. This passion has driven me to start a grassroots organisation: Raham Project, a platform to support families from diverse ethnic backgrounds".

1 MBRRACE-UK Saving Lives, Improving Mothers' Care 2017-19, November 2021

2 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2019, October 2021

Campaigns

Interview with Sarah Fishburn

Interview by Jo Dagustun

Many different organisations and individuals play a part in the mission to improve UK maternity services for all. In this interview, the AIMS Campaigns Team talks to Sarah Fishburn, a maternity improvement campaigner who was inspired to get involved following her own maternity service user experiences, and who is now - amongst other roles - the chair of the NICE Multiple Obstetric Guidelines Update Committee. This committee oversees the development and updating of many NICE guidelines of relevance to the maternity service. We hope that our readers will be inspired to read about the way in which Sarah - starting as a 'mere' service user! - has demonstrated a long-standing commitment to improving maternity services.

Thank you for agreeing to be interviewed by AIMS, Sarah. To start, can you tell us about what drives your interest in a well-functioning maternity service, and how you got started?

Thanks very much for inviting me Jo, it's a pleasure to take part.

I became interested in improving maternity services after having my first baby. During my pregnancy I was reassured that having difficulty walking and generally moving around, due to pain in my pelvic joints and a feeling that my pelvis

was unstable when I tried to move, was completely normal. I was told it would get better as soon as I had my baby and not to worry because the baby was fine. I went on to have a forceps birth and afterwards was completely unable to walk, but was again reassured that this was normal and this was what having a baby was like. I should just get on with it. Physios told me to exercise more, rest more, lose weight, push the pram – none of these things were possible with a painful pelvis and a small baby. This went on for weeks, which turned into months, during which time I met lots of other mums with similar problems. It felt like nobody else was listening and life was pretty grim. Eventually, after my baby was a year old, a friend told me about a sports physio who was good at treating pelvises. She did a simple assessment putting her hands on my pelvic joints, and actually looked at and felt how my pelvic joints moved. She found that one of them was a bit stuck and got it moving again, all in a half hour session. I could immediately walk a bit better, and continued to improve with the treatment that followed.

I felt very let down realising that this treatment could have started during my pregnancy had I been listened to, and I started to get involved with the local Maternity Service Liaison Committee (MSLC), and remained with them for 13 years until they were stopped during a reorganisation.

I was also meeting an increasing number of women with pelvic girdle pain (PGP), which, it transpired, was why I couldn't walk. This used to be known as Symphysis Pubis Dysfunction, but the name changed in the UK in 2008 when we developed a new national guideline alongside the Pelvic, Obstetric and Gynaecological Physiotherapy (POGP) group. In 2002, a previous national support group closed, and local friends in Oxfordshire were keen to set up a replacement group as we were struggling to access treatment locally. The Pelvic Partnership was formed, and became a registered charity in 2003. The charity is one of the achievements I am most proud of in my life. We provide information and support to women with PGP, and have a proactive approach to encouraging women to seek treatment (the word "suffering" is banned as we think implies that women are passive recipients of care, rather than individuals who should make choices and say when things are not getting better). Our emphasis is on women 'experiencing PGP', a condition that you will recover from, as most women do when they access good quality manual therapy treatment.

I chair the charity, answering the telephone helpline, and leading the amazing team of trustees who support women and health professionals, develop information leaflets and website content, and run the Instagram and Facebook support networks, fired by the enthusiasm and skill of Jen, our coordinator.

The MSLC network gave me an insight into the opportunities that were evolving for service user involvement, first auditing with the Local Supervising Authority, then with the Nursing and Midwifery Council.

I also heard about the opportunity to be part of the committee developing the NICE guideline for socially complex pregnancy where I was one of two lay members. I loved the systematic way that the evidence was reviewed, the way that all the members of the committee were viewed as equal, and also came to understand that there are not simple research answers to all questions, and that there are some really sticky questions that require in depth committee discussion to find an answer, which may not be perfect but is the best you can do. I also liked the focus on women's choice, and I think this element has been strengthened throughout my involvement with NICE.

Can you tell me a bit about your day job?

My interest in maternity care and NICE guidance led me to take a role within the former Clinical Networks, part of NHS England, where I led a project to measure implementation of the NICE Quality Standard for Antenatal and Postnatal Mental Health across the south of England. This was a fascinating project linking midwives, health visitors and various mental health services for pregnant and postnatal women, and measuring how well they were implementing the standards, and supporting quality improvement activities as a result. This role changed during COVID-19 when I spent some time supporting the homeless health team and an investigation team, and I'm currently on an exciting secondment with the quality improvement team.

I enjoy variety in my work, and I have a particular interest in keeping service-user experience at the heart of everything I do. This is one of the key elements of quality that we discuss every day. The combination of safety

(was the episode safe?), outcome (was the outcome of the episode/intervention successful?) and experience (did the person and their family have a positive experience of care?) are inextricably linked to make up good quality care.

You currently hold the role of chair of the NICE Multiple Obstetric Guidelines Update Guideline Committee. AIMS is clear that NICE is a key element of an effective maternity service infrastructure, so we thank you for this work. But for many people, the role of NICE and its internal workings are rather murky. Can you say a bit more about this role, what you bring to it, and what are the essential qualities of an effective NICE committee lay member?

I am very proud to be chairing this NICE committee. It has been enormously rewarding and has also had its challenges during COVID-19. Chairing all-day committees online, and making sure everyone stays connected, is very different from chairing a room full of people, but the fantastic team at the National Guideline Alliance, which hosts this particular guideline, are very experienced and support the whole process.

People sometimes think that NICE processes are rather opaque, but I think that the complexity of what they achieve is astounding, and there is a huge amount of information available on the website www.nice.org.uk that explains the processes.

One of the key strengths of the development process is the involvement of both stakeholders and lay members in all guideline development activity. Most of the updates we are currently working on have been identified by stakeholders who have contacted NICE (anyone can do this by contacting surveillance@nice.org.uk).

Stakeholder comment shapes the final wording enormously and we are really grateful to everyone who takes the time to suggest improvements to our draft guidance. There are often times when the research evidence is not as robust as we would like, and we have to use committee expertise to add detail to the recommendations. We then welcome stakeholders who tell us whether they do or do not like what we have developed (and why) as part of the consultation phase of the guideline's development.

AIMS devotes much of its precious Volunteer time to reviewing and commenting on draft NICE guidelines. Do you agree that this should be a priority for AIMS, and what are your tips on how we - and our colleagues across the maternity services improvement community - could be more effective in this work?

I think AIMS does a great job reviewing and commenting on NICE guidelines. I know how time-consuming it can be reading the guidance and conferring with others on the response, and the turnaround times can seem quite short. Every comment that is submitted is read and receives a response from the committee, and we really appreciate the work that has gone into the comments.

Without stakeholder review and comment, the guidelines would be less robust, and would be less useful as a result, both for clinicians and for women and families making decisions about care. The guidelines are for both groups.
I think one of the great strengths of the NICE guidance development process is the involvement of lay members right from the scoping stage, through development and into the consultation and post-consultation phases. It influences the focus, the language and the final use of guidance as a working document in practice. The fact that it is publicly freely available means it should be accessible to anyone who wishes to read or use the information in the UK.

The NICE guideline development work on inducing labour has been a hot topic across the maternity services improvement community, perhaps most infamously for the - now dropped - draft recommendation to offer induction on the basis of race/ethnicity. How can we ensure that all NICE recommendations are evidence-based?

Evidence comes in a variety of forms. Gold standard evidence in the form of randomised control trials is ideally what we want to base our guideline recommendations on. The MBRRACE-UK Maternal Report 2021 and other research shows that women from Black and Asian backgrounds have a higher risk of dying for both the women and their babies. NICE publishes draft guidelines in order to ensure they are robust, and the consultation period allows feedback from anyone interested in the topic. This really does make sure we produce the best guidelines possible both for service users and professionals. The stakeholder response to the draft guideline was very helpful in raising the profile of this difference in outcomes, along with the need for increased focus on discussing decisions and choices with women and supporting these choices. I think the finished guideline reflected the strong and constructive stakeholder response and helped us to produce a better guideline.

Would you like to tell us a little about the #ReadyForPregnancy project that you've been working on?

This South East of England project started as a social media campaign, focussing on reducing inequalities by sharing information about ways that women and their families could take action to begin their pregnancy healthier, in order to improve outcomes for women and their babies. This project became much bigger than we had anticipated and, as part of our regional equalities impact assessment, we identified a need for materials translated into languages other than English, as well as materials for families who were visually impaired or deaf. We included video clips from women talking about their experiences. We developed a downloadable and printable leaflet, which we translated into the 10 most common languages in the South East of England, along with a subtitled video with British Sign Language translation.

Following the success of this campaign, we're now running a #ReadyforParenthood campaign using the same principles, and we're starting work on additional materials as the campaign progresses – please look out for it and join in.

What do you think is the biggest challenge faced in maternity service improvement work in the UK today?

I think in the current COVID situation, the key challenge is workforce. I have a concern that the tremendously positive emphasis on providing person-centred care is at risk of being lost in the complexity of providing COVID-secure care with fewer people providing the care. I hope that one of the things that will emerge from the pandemic is an increase in the workforce, who will all have been educated to use recent, evidence-based and person-focused practice.

AIMS celebrated its 60th birthday in 2020. Looking forward, how do you think AIMS might best focus our limited resources, to help ensure improved maternity services for all?

I think AIMS does a great job of focusing on understanding and sharing the views of parents, and standing up for these. By continuing to share the combined knowledge and experience of so many thoughtful and well-informed people, and horizon-scanning for areas where evidence and practice diverge, AIMS can continue to keep parents at the centre of the focus of care, which I think is where they should be.

The AIMS Guide to

Giving Birth to Your Baby

Your body's physiology is in the spotlight in this book.

The AIMS Guide to Giving Birth to Your Baby focuses on the second and third phase of the birth process: from your cervix reaching full dilation and your baby descending through your pelvis, to the final stage when your baby is born.

You will learn about the supportive role of hormones, about how to use your body's powers and your instinct and emotions to help your baby negotiate his or her way into the world.

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the AIMS shop

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Article

Sharing is Caring - and that goes for maternity research too! Reflections on a public engagement event and why we need more of this

by Georgia Clancy

For me, researching maternity and childbirth experiences is fascinating because it represents an event in the lives of women when different perspectives and approaches converge and tensions can arise as important negotiations take place. Ideas about pregnancy, birth and motherhood affect most women's lives, whether they have children or not, and motherhood is often wrapped up with morality; the need to do the 'right' and 'proper' thing, in order to confirm not only your status as a 'good' mother, but by extension a 'good' woman. This can be identified in the sort of questions that we hear often, such as:

> *When are you going to have a(nother) baby? – Isn't that too old, or too young?*
>
> *Will it be at home or a labour ward?*
>
> *Breastfeed or bottle-feed?*
>
> *Will you return to work or be a stay-at-home mum?*

These are complex decisions, and what might be right for one person might be wrong for someone else. That can make being on the receiving end of someone's judgement inevitable.

I spent four years researching women's childbirth choices, namely how and where they gave birth, in light of the latest NHS England maternity care policy, Better Births (2016). I'd read how choice was promised to women in the predecessors of Better Births - Changing Childbirth (1993) and Maternity Matters (2007). I'd also read studies and articles that followed those policies, reporting that women's childbirth choices were going unfulfilled. I wanted to understand why there was a continuing disparity between the births women wanted and the births they actually had, necessitating the repetition of the same aim - to improve women's available choice in birth - across three national maternity care policies spanning 23 years. Unsurprisingly, the answers I found were complicated and included challenges such as limited resources, the 'increasing complexity' of birth, workplace/professional culture, and risk management by both women and practitioners.

I am now working to share the findings of my research with those who are most affected by, and invested in, the improvement of maternity care: maternity service users, families, practitioners, maternity charities and organisations, and policymakers. One of the ways that I did this recently was with an online event that took place as part of the ESRC's (Economic and Social Research Council's) 2021 Festival of Social Science. This is a festival specifically designed to engage the public in social science research. The event was called, 'Sharing childbirth experiences: choices, challenges and conversation'. Lasting just 1-hour, my event started with a performance of a woman's childbirth story, based on what I heard during my research. Not knowing who would be in the audience, I wanted to bring to life some of the issues that affect choice during pregnancy and childbirth. The performance then acted as a springboard for a discussion with a panel of experts made up of Nadia Higson (AIMS), Alicia Burnett (midwife) and Anna Madeley (midwife, PhD student and AIMS volunteer). We had lots of great comments and questions from the audience, which steered our conversation. We talked about the complexity of choice in childbirth, how choice is represented in the NICE guidelines, obstetric violence, home birth, fear and risk in birth, and the importance of antenatal education, postnatal care and continuity of carer. The event was recorded and is available online.

So why hold public engagement events like this? Aside from the fact that public engagement is increasingly required of higher education institutions, it can also help make research more accessible, transparent and relevant.

By engaging the public, researchers learn to become more accountable to the public about how research funding is being used. Explaining what researchers are doing and why is a key part of conducting ethical research and can help to build public trust, demonstrate how the research is benefiting society, and create a conversation that allows research to be more responsive to what the public needs. Public engagement doesn't need to be reserved for sharing findings, of course, but can help to shape all stages of the research process. With this particular event, I aimed to raise awareness amongst maternity service users about the complex issues involved in maternity care provision in England today and contribute to the public and professional debates surrounding them.

One thing that strikes me whenever I talk to people about my research is their willingness to share their own experiences. From the women who participated in my PhD study, to those who attended the *Sharing childbirth experiences* event, to strangers who ask what I do for a living and immediately recount their birth story to me, the goodwill extended to me as I research this topic is clear. It is an honour and a privilege to be trusted with these stories, and the responsibility to try and do something positive with them is one that I take seriously. I think women's willingness to tell their birth stories is often altruistic, they hope that by sharing *their* experience *someone else's* experience might be better. But more than that, I often get the sense that many women are looking for an opportunity to talk about their maternity experiences, still trying to unpack what happened to them, perhaps welcoming the opportunity because they had never really had the encouragement, or time to reflect on it previously.

With this in mind, and to support AIMS' mission, I hope to organise more events like this in the future. In collaboration with AIMS, these events would be an opportunity to create and strengthen the dialogue between researchers, those with lived experience of pregnancy and birth, practitioners, and the AIMS team, to share and learn from one another, as well as to discuss some of the key issues facing maternity care today. Watch this space!

Georgia Clancy is a research fellow at the University of Warwick. Her research explores women's childbirth preferences, decisions and outcomes in light of NHS England's Better Births policy. Georgia is also a member of the AIMS Campaigns Team.

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Article

The new NICE guideline Inducing labour: what has changed?

by the AIMS Campaigns Team

A revised version of the NICE guideline 'Inducing Labour'[1] was published on 4 November 2021. As a stakeholder, AIMS submitted sixty-five detailed comments on the draft version. We were pleased to see that the majority of these resulted in positive changes to the final version, although there remain a number of areas of concern to AIMS.

There are many reasons why induction of labour may be offered, and many factors to consider when making a decision about it. For more on this see the AIMS Birth Information page 'Induction of Labour'.[2]

Recognition of the right to decide and enabling informed decision-making

The previous version of this guideline made it clear that induction of labour is a choice to be offered in certain circumstances and that a decision to decline that offer should be respected. We are pleased to see that the new version, following our comments, now includes a greater emphasis throughout on respect for this principle of autonomy, and guidance on how to enable informed decision-making about induction. However, we regret that the authors have not removed the term 'shared decision making' completely. (See the AIMS Position Paper Decision Making in Maternity[3].)

The section on 'Information and decision making' now includes a specific recommendation to *"recognise that women can decide to proceed with, delay, decline or stop an induction. Respect the woman's decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given."*

We hope that all doctors and midwives will take this recommendation to heart, so that the AIMS Helpline no longer has to support large numbers of people who are being pressured into having an induction against their will.

The same section also makes it clear that women should be given information about how agreeing to induction "*will affect their birth options and their experience of the birth process*" as well as details of why the induction is being offered, the alternatives, risks and benefits of induction, and the options if the induction is unsuccessful. It further recommends that women be given time and opportunity to discuss this information with others, to look at other information sources, to ask questions and to think about their options before deciding whether or not to accept the offer of induction. Of course, this should be happening already, but we know it doesn't always, so having the correct procedure spelt out in this way is helpful.

Pregnancy lasting longer than 41 weeks

AIMS is pleased to see this more accurate title replacing the previous "Prevention of prolonged pregnancy" with its implication that a longer pregnancy is automatically pathological. We also welcome that in place of the previous version's specific recommendation that *"Women with uncomplicated pregnancies should usually be offered induction of labour between 41+0 and 42+0 weeks to avoid the risks of prolonged pregnancy"* the new version recommends a less directive and more balanced approach. It says that women should be told that *"some risks associated with a pregnancy continuing beyond 41+0 weeks may increase over time" and that "induction of labour from 41+0 weeks may reduce these risks [our emphasis], but that they will also need to consider the impact of induction on their birth experience when making their decision."* This is a helpful clarification that it is for the individual to decide how they feel about the balance of risks and benefits of induction in late pregnancy.

AIMS was concerned that the new wording will increase the pressure put on women by doctors and midwives to accept induction at the earlier point of 41 weeks, which could lead to a further significant increase in the number of labours that are being induced, with most of them

being unnecessary. To address this, AIMS suggested that the guideline should include information to be given to women both on the actual risks of waiting beyond 41 or 42 weeks for labour to start and on how likely it is that labour will have started by 40, 41, 42 and 43 weeks of pregnancy. Both these suggestions were accepted. Evidence has now been included on how likely outcomes such as caesarean birth, perinatal death and admission to a neonatal intensive care unit are when induction is carried out at different weeks of pregnancy. However, we feel that the recommendations should be clearer about the limitations of the evidence, and the fact that even in the later weeks of pregnancy the risks remain low. As Appendix A of the guideline[4] states, the information on risks "should not be taken as definitive evidence based on the limitations of the included studies" and that while "the risk of perinatal mortality, NICU admission, and caesarean birth increases over time with a prolonged pregnancy, the absolute risk remains low". (For more on the evidence around this topic see the AIMS Journal article Labour Induction at Term – How great is the risk of refusing it?[5]) We are particularly concerned that in calculating the risks, the guideline authors decided to include the 'SWEPIS' study[6] despite recognising that because the study was stopped early it may have overestimated the apparent benefit of induction at 41 weeks.

The guideline also now includes, as AIMS suggested, information to be given to women about the high proportion of labours (16%) that start between 41 and 42 weeks without the need for induction. We hope that this important information, about the chance of going into spontaneous labour between 41 and 42 weeks, will be shared by midwives and doctors, as well as the information on the risks and benefits of induction during this period.

Timing of induction for 'higher risk' groups

The draft guideline that was put out for consultation contained a highly controversial recommendation to, *"Consider induction of labour from 39+0 weeks in women with otherwise uncomplicated singleton pregnancies who are at a higher risk of complications associated with continued pregnancy (for example, BMI 30 kg/m2 23 or above, age 35 years or above, with a black, Asian or minority ethnic family background, or after assisted conception)."* Many stakeholders pointed out the racist nature of a recommendation based purely on ethnicity. AIMS also drew attention to the fact that for all the groups mentioned there was no evidence to support the recommendation and it could have led to high numbers of women having unwanted inductions purely because they fell into one of these 'higher risk' categories. We are relieved to see that this recommendation was withdrawn. However, it has been replaced by a rather vague comment that "*women from some minority ethnic backgrounds or who live in deprived areas have an increased risk of stillbirth and may benefit from closer monitoring and additional support*" – without suggesting what form that monitoring and support should take. AIMS feels that this could best be achieved by the rapid roll out of a culturally sensitive Continuity of Carer model of care to women in these groups, as called for in the NHS Long Term Plan[7].

Timing of induction

On the topic of the timing of induction, the authors made two research recommendations. One is to try to identify more precisely, "the optimal timing of induction of labour in the low-risk population of pregnant women" through analysis of when stillbirths actually occurred. The other is to look for evidence about whether earlier induction reduces the risks for women who may be at higher risk of stillbirth or other problems. While we welcome further research we feel it is crucial that research includes the role different factors play in driving the observed higher stillbirth risk for certain groups, including individual health and socioeconomic characteristics, and the role of racial discrimination, bias, stereotyping and culturally insensitive care. As the NHS Long Term Plan observes: "We cannot treat our way out of inequalities."[7]

We note the lack of research around the physiology of spontaneous onset of labour, and on the potential benefits of the physiological process compared with induced labour, for both short and long-term wellbeing of mothers and babies.

If the waters break before labour

After 37 weeks - The Guideline Development Group explained that the management of this situation was "not within the scope of this guideline update" so they did not review the evidence. They did add some wording that makes it clearer that it is up to the woman whether to wait for labour to start, and for how long, after her waters have

broken. AIMS is glad to see that the list of factors to discuss now includes, “the woman's individual circumstances and her preferences” as well as possible medical issues.

Before 34 weeks - In the case of ‘preterm prelabour rupture of the membranes’ there is now a recommendation to offer expectant management until 37+0 weeks if the waters break before 34 weeks as long as there are no other concerns.

Between 34 and 37 weeks - If it happens after 34 but before 37 weeks the recommendation remains to “discuss the options of expectant management until 37+0 weeks or induction of labour.” It is confusing that in the former case expectant management till 37 weeks seems to be presented as the preferred option, but not in the latter, especially since the RCOG guidance[8] is to offer expectant management to anyone whose waters break before 37 weeks.

There are also updates to this section in line with recent guidelines on preventing neonatal infection to say that women who have tested positive for Group B Streptococcus at any time in pregnancy should be offered immediate induction of labour or a caesarean if their waters break beyond 34 weeks but before labour.

Suspected high birthweight in the absence of diabetes

Another useful addition to the guideline is evidence about the risks and benefits of induction or expectant management when a woman without diabetes is thought to be having a big baby. The committee rightly recognised that, *“there was not enough evidence to recommend one method over another” and therefore said that “women should be provided with information about different modes of birth so they can make an informed decision.”* This information should include the fact that *“there is uncertainty about the benefits and risks of induction of labour compared to expectant management”*, that induction may reduce the risk of shoulder dystocia but increase the risk of a severe tear, and that, *“there is evidence that the risk of perinatal death, brachial plexus injuries in the baby, or the need for emergency caesarean birth is the same between the 2 options”.*

We hope that this will put a stop to cases where people are told that they ‘must’ be induced because their baby will be big or are scared into agreeing to induction by the threat that “your baby could die” if they refuse.

Conclusion

Overall, AIMS finds much to welcome in the updated guidelines and we are pleased to have been able to influence the text for the better.

It is good to see the clearer emphasis throughout on autonomy and informed decision-making. In practice the effectiveness of this will depend on healthcare professionals really taking to heart the recommendations on providing full information, including the limitations of the evidence and information on the potential impact of induction, and then being prepared to respect and support a mother’s decisions even if they disagree with them. The NICE strategy vision[9] commits them to, “drive the implementation of our guidance, forming key strategic partnerships to make sure it’s used” and to “make sure it delivers improvements and contributes to reducing inequalities, with measures to routinely track adoption.” AIMS therefore calls on NICE to ensure that these measures include research with maternity service users to find out how far their experience matches the NICE recommendations.

A limitation of the guideline remains the broad-brush nature of the recommendations to ‘offer’ induction in various situations, which is likely to mean that many mothers and babies continue to experience inductions that do not benefit them.

Finally, we note that the NICE vision also includes a commitment to, “provide dynamic, living guideline recommendations that are useful, useable and rapidly updated.” AIMS will be sharing our comments with them now, with confidence that these will be carefully reviewed and hopefully addressed to our satisfaction in the next update.

References

1 NICE Guideline ‘Inducing Labour’, November 2021 www.nice.org.uk/guidance/ng207

2 AIMS Birth Information page ‘Induction of Labour’ 2022 www.aims.org.uk/information/item/induction

3 AIMS Position Paper Decision Making in Maternity, November 2021 www.aims.org.uk/assets/media/727/aims-position-paper-decision-making-in-maternity.pdf

4 NICE Guideline 'Inducing Labour' Appendix A: Risks associated with different induction of labour timing strategies, November 2021 www.nice.org.uk/guidance/ng207/resources/appendices-a-b-and-c-10883967373/chapter/Appendix-A-Risks-associated-with-different-induction-of-labour-timing-strategies

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7 NHS Long Term Plan Chapter 2, section 2.28 www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/stronger-nhs-action-on-health-inequalities

8 RCOG 2019 'Care of Women Presenting with Suspected Preterm Prelabour Rupture of Membranes from 24+0 Weeks of Gestation' (Green-top Guideline No. 73) obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.15803

9 The NICE strategy 2021 to 2026 www.nice.org.uk/about/who-we-are/corporate-publications/the-nice-strategy-2021-to-2026

Review

Birth Time: the documentary – a review

by Anne Glover

Birth Time: the documentary [1] is an Australian production, released in November 2021. It questions why an increasing number of people are being left traumatised after giving birth, and what can be done about that.

The documentary can be viewed at private screenings in UK cinemas and is now available to stream online for 48 hours at a cost of £7.99. It was co-written, directed and produced by three Australian women, one midwife and two doulas. A further doula joined their team to introduce the documentary to the digital world and to create an online educational platform.

The three co-producers spent four years travelling and filming, to bring about this powerful and informative documentary on birthing today, based in Australia. The main thread of the documentary is to address the question of what it would take for all women to emerge from their births both physically well and emotionally safe. It is a beautifully presented documentary with a good balance of evidence-based information and real-life drama. I was enraptured from the beginning as I listened to both midwives and parents, from various communities, tell their own personal stories, including about their birthing experiences and the physical and emotional trauma they experience. It is raw, powerful and very moving. The consistent message is that globally we are losing trust in our ability to give birth, in our maternity systems, and how the focus should be on individualised and nurturing care by having one midwife for one woman[2] (#OneWomanOneMidwife).

The documentary directly addresses the stark realities of the failings of the maternity system in Australia, in a way that will resonate with the UK audience. It questions the increasing intervention rates and why there is a lack of continuity of carer. It queries why the system is broken and why there is so much trauma experienced throughout communities around the world. Unfortunately, these are not new questions and discussions. The documentary goes on to suggest how we can all be involved in the change, in the hope that many viewers will sign up to the Birth Time movement mission to "change current politics, practice and funding of maternity care across the world." In this way, there is so much more to this documentary: it is also seeking to be the beginnings of a new movement that will bring about real change. There are further resources that anyone can access via the documentary's website, featuring a global online education resource supporting those involved with and interested in birth.

The message is clear. Everyone who works in the birth world needs to do better to support women and birthing people, to ensure the focus of care is on the birthing person and baby. It will be fascinating to see how this movement evolves, as it seeks to make a difference across the world. As a doula, I wholeheartedly recommend the documentary.

1 Birth Time: the documentary – https://www.birthtime.world/stream-now
2 Birth Time: our mission – https://www.birthtime.world/our-mission

Author Bio: Anne is a doula and HypnoBirthing® educator in Northern Ireland, and currently volunteers with the AIMS Campaigns Team.

Further reading:

www.aims.org.uk/campaigning/item/implementingbetterbirthscontinuityofcarer

www.aims.org.uk/campaigning/item/continuity-birth-activists

www.aims.org.uk/journal/item/campaign-update-continuity-carer

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Article

My experience of trying to find out how Continuity of Carer implementation is going locally: Like getting blood from a stone

By Sarah Hawkins

As a birth worker supporting many women and families under the care of three NHS Trusts, it hadn't escaped my notice that not one of them was getting any continuity of carer in line with the vision set out in Better Births[1] published in 2016, nor in line with the Implementing Better Births:Continuity of Carer[2] guidance (NHS-E, 2017).

The 2017 guidance "set out an expectation that each area will, by October 2017, establish a shared vision and plan to implement Better Births by the end of 2020/21. These plans are expected to show how most women will receive continuity of the person caring for them during pregnancy, birth and postnatally. Local Maternity Systems have been asked to put in place plans to meet local ambitions in this area."

To put this into context, I had clients through 2020 and 2021 - in the midst of the pandemic - who didn't even know who their named midwife was and who never met the same midwife more than once. This left my clients feeling bewildered, and had a particularly negative impact on the wellbeing of women categorised as 'high risk'. It is also my observation that this lack of continuity seemed to create more work for an already overstretched maternity service. I had increasingly more people coming to me later in pregnancy, desperate and in distress.

I live in Somerset, sandwiched between what used to be five NHS Trusts that are now three. These three Trusts cover a large area, inside and outside the county of Somerset, and include hospital labour wards, many birthing units, as well as community midwife and homebirth teams. I therefore contacted the following three Trusts to gather some information: Royal United Hospitals Bath, Somerset Partnership and University Hospital Bristol.

I decided to reach out to all three for information they held on how well they had delivered a Continuity of Carer model of care during the most recent month (a month when the pandemic was not considered to be at its height). First I looked online for the relevant contact details for the maternity safety champions for each of the Trusts (as mentioned in the NHS Resolution Scheme guidance) and met a dead end on all counts through their respective websites. I then contacted each Trust by phone and asked for that information directly. I was met with confusion and inquisition about who I was and where I was calling from, even though I was asking for information that should be readily apparent and available to members of the public. It took many calls, many incidents of being put through to "someone who can help" and then many emails, leading to many more emails, because eventually I did get the email address of someone in each Trust who I was told "can provide that information". I then put a simple email together that read: "I am a local resident and I am interested in knowing how well the Trust is doing in terms of Continuity of Carer in maternity services across the Trust. I would like a copy of the latest monthly implementation report as per the NHS Resolution Scheme."

Article contd.

After 4 months of jumping through hoops, being sent information I had not asked for, and applying for Freedom of Information requests, I still have not got the information I requested. I am at the point where I am convinced that they don't want to share their reports with me - if, in fact, they have them.

What do I know now? I know from my own work supporting families that local women and birthing people are still not receiving continuity of carer. I know that maternity services appear to be getting worse and not better, despite efforts to implement a way of working that was to benefit all and lead to better outcomes. And I know that it is harder to get information than it ever was before.

I feel frustrated and deeply concerned that there seemed to be a reluctance to give me information, and an avoidance and deflection from the one question asked, not just by one Trust but three. I feel despondent and deeply sad that the NHS is failing to provide what it said it would within maternity services, and that it doesn't appear to be trying - or even allowing itself to be held accountable. It feels as though I've been trying to get blood from a stone.

Author bio: Sarah Hawkins is a Doula, mother and AIMS volunteer who lives in Somerset with her partner, constantly tripping over 2 very small dogs while caring for 4 children including identical twins. Having had two hospital births and a planned freebirth, Sarah is a strong advocate for informed choices in the perinatal period, and for raising awareness of the potential complexities of multiple pregnancy and birth.

1 National Maternity review (2016) BETTER BIRTHS - Improving outcomes of maternity services in England: A Five Year Forward View for maternity care
www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

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www.england.nhs.uk/publication/implementing-better-births-continuity-of-carer

Article

March With Midwives: reflections from a student midwife

by Megan Disley

On Sunday 21st November 2021, midwives, doulas, other birth workers, mothers, fathers, children, and maternity supporters took to the streets in towns and cities across the UK to take part in peaceful vigils to raise awareness of the maternity crisis.

'March With Midwives' was founded by doulas (Becki Scott, Maddie McMahon, Verina Henchy, and Paula Cleary) after a conversation regarding concerns about the state of maternity services being expressed by many birth workers. They wanted to build a campaign to raise awareness of the conditions that midwives are facing, the strain midwives are under, and the impact that this is having on women and pregnant people. After creating a Facebook group, momentum built and vigils were soon organised up and down the United Kingdom.

I attended my local vigil in Colchester, Essex, along with my son and a few of my fellow first-year student midwives. As a student midwife I am very aware of the crisis in maternity. The overstretched staff, the fear of disciplinary or legal action, the bullying and toxic hierarchical management systems, and the silencing of whistleblowing when staff know conditions are unsafe[1]. I am aware of the impact on the mental health of midwives, and how for some of them this was leading to breaking point and them giving up the career they had worked so hard to enter. In a recent Royal College of Midwives (RCM) survey, for example, 57% of midwives said they would leave the profession within the next year[2]. There is also a real impact on parents. Midwives are doing their best in the current conditions, but stories of the service failing parents and the likely trauma of birth resulting from poor maternity care are numerous[3]; this will trickle down to future generations.

Starting the year, I was one of 90 excited students wanting to make a difference. But an RCM study suggests that such cohorts only make a small difference to the overall midwifery staffing situation: for every 30 newly qualified midwives graduating from universities each year, 29 existing midwives leave the profession[4]. So if that trend continues, out of my 90 strong group, only 3 of us will represent growth in the workforce. We need to grow the workforce faster than this.

As I write this, I am excited about beginning my placements in January. I have worked hard for this. But I am worried about the situation that I am going to walk into. This isn't just one day in a woman's life. As a mother myself, I know that it is much more than that; it is time to expose the painful truths of these lived experiences and the midwifery crisis. This is why I joined the March With Midwives movement.

A few dozen people attended the Colchester vigil. A speech was given by one of the midwives from the local trust, placards were on display, stories and thanks were shared in an open book (which will make its way to Downing Street with the many others across the UK thanks to the national steering group). Cars tooted in solidarity, signatures were added to the online petition (created by Cheryl Samuels , now a lecturer in midwifery) and, hopefully, passers-by paid attention and walked away understanding our concerns and hearing our pleas. I felt hopeful that our voices will be heard. I felt privileged to be part of that, and to know that I am working my way into a profession that truly cares about advocating for women, and that there are people outside of the profession that want to advocate for midwives.

Maternity service standards affect every single one of us: we are all born, after all. Everybody knows somebody that has given birth. If these stories come with trauma, that negativity and fear around birth is spread. We are already living with a generation where fear of birth is growing along with increased unnecessary medical intervention. I don't want to see midwifery lose its core value of being 'with woman'[5] because of staff shortages, burnout, and there simply not being enough time for midwives to listen well to women and advocate for them due to workload pressures. I don't want to see women for generations to come fearing birth. Women and birthing people are powerful, their bodies are physiologically designed to give birth. We need to address that fear. Adequate funding and support for the maternity services is at the heart of that. Without more staff and reduced workloads, midwives are stuck not truly being able to deliver the time and women-centred care that they went into the profession to offer. After all, nobody answers their university midwifery interview question, 'why do you want to be a midwife?' without letting that passion for being 'with woman' shine through.

Over 80 vigils took place around the UK, not to mention

the social media posts from those unable to attend in person. This demonstrated an incredible level of support, galvanised in just 5 weeks. And it doesn't end here. The steering group are debriefing and planning the next steps and will be taking the petition to Downing Street with its 100,000 plus signatures. We must continue to raise awareness.

As a future midwife, it means so much to me that this action is being taken, offering an opportunity for our voices to be heard. I would like to thank the steering group for getting the movement off the ground, every single person who organised a vigil across the UK, and everyone who supported the vigils and those who shared and signed the petition.

Author bio: Megan lives in Essex with her son, and is a first year student midwife at Anglia Ruskin University. She is passionate about breastfeeding support, and advocating for all women and birthing people. She is an AIMS volunteer working within the AIMS Campaigns Team with her main focus on health inequalities.

You can read the AIMS statement on March with Midwives here: www.aims.org.uk/campaigning/item/march-with-midwives

[1] March With Midwives, 2021. Manifesto drive.google.com/file/d/1lxqBBgNKFEC_3UrtjY6I8wiPgpnuqA48/view

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[5] Editor's note: The word midwife derives from Old English mid, "with," and wif, "woman," and thus originally meant "with-woman,"

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Article

Racial inequalities in maternity outcomes: what are the causes?

by The AIMS Campaign Team

Data from the annual MBRRACE reports[1, 2] have for some years been highlighting the fact that mothers and babies of Black, Asian and mixed ethnicity backgrounds are significantly more likely to die than their white counterparts. Campaigning groups such as Five X More have been working to draw attention to this issue, and this has led to the setting up of various initiatives to try to tackle the problem. These include the RCOG Race Equality Taskforce and Birthrights Inquiry into racial injustice in UK maternity services. Recently NHS England published five pledges[3] and guidance to Local Maternity Systems[4] on how they should plan for and implement actions to improve equity for mothers and babies from Black, Asian and mixed ethnic groups and those living in the most deprived areas, and race equality for staff. For AIMS comments on the NHS England plans, and our calls for action, see this AIMS Journal article and look out for our position paper on Racial Inequalities in Maternity Services, to be published soon.

What has been lacking to date is a clear research-grounded explanation of the underlying causes of the observed inequalities between racial groups. It is sometimes suggested that this is simply due to people in these groups being more likely to be socially and economically deprived, to give birth at older or younger ages than average, or to suffer from underlying health conditions such as high blood pressure or diabetes. There has also been debate about the possible contribution of underlying biological differences that might make people from some ethnic backgrounds more prone to develop problems during pregnancy or labour. However, it has become increasingly apparent that it is likely to be due, at least in part, to differences in the care that is offered as a result of racial discrimination, bias, stereotyping, and cultural insensitivity. This article reviews several recent reports that have started to shed light on the question of what causes the observed inequalities.

MBRRACE data on perinatal deaths

The most recent MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2019[1] published in October 2021, included analysis of stillbirth and neonatal death rates both by the mother's ethnicity and by the level of social deprivation in the area in which the mother lived. Small areas across the country were grouped into quintiles, with group 1 consisting of the areas of lowest social deprivation and 5 the highest. This shows that, for areas within a given quintile, the death rates are higher for babies born to mothers of Black and Asian ethnicity compared with babies born to white mothers from similar areas. This means that social deprivation cannot be the whole story. What is even more shocking is that the stillbirth rate for babies of Black mothers living in the least deprived areas was markedly higher than for babies of white mothers living in the most deprived areas – 6.05 per 1,000 births, compared with 4.65.

Data taken from Table 19 of the MBRRACE report for births in 2019: stillbirth per one thousand births

	Level of social deprivation				
Ethnicity	1=lowest	2	3	4	5=highest
White	2.84	3.11	3.35	3.84	4.65
Mixed	2.92	3.47	3.97	4.44	5.31
Asian	4.13	4.44	5.84	6.22	6.0
Black	6.05	7.06	7.22	7.61	8.43

Some more detailed analysis of the last six years of ethnicity data was presented at the perinatal report launch meeting, but has not been published yet[5]. This suggested that stillbirth rates across all ethnicities are highest in mothers under 25 or over 35, but in each age group the stillbirth rates were higher for babies of Black, Bangladeshi and Pakistani ethnicity than for white babies born to mothers in that group. They were also higher for babies of these ethnicities born to mothers in the 'lower risk' age groups (between 25 and 35) than for white mothers in the 'higher risk' age groups (under 25 or over 35). This data analysis shows that the inequalities of outcome are not fully explained by differences in deprivation or in the age at which women of different ethnicities give birth.

NMPA sprint audit on ethnic and social inequalities

This report from the National Maternity and Perinatal Audit (NMPA)[6] looked at data on 1.37 million births in England, Scotland and Wales over the three years to March 2018. The audit reviewed variations in outcomes for mothers and babies across ethnic and socioeconomic groups. This is really important as previous reports have focused on inequalities in the most serious outcomes of maternal and perinatal deaths, but we know that those must only be the tip of the iceberg of health inequalities.

The authors note that, "The results presented in this report are crude and therefore descriptive." Such a study can describe the differences that are observed but cannot explain the factors which may be causing them, although it does comment on some variations between ethnic and socio-economic groups. For example, there were higher rates of high blood pressure and pre-existing diabetes, but less smoking, amongst women from South Asian and Black ethnic groups compared with white women.

There is a lot of detail in the report, but one interesting finding was that women from Black ethnic groups were slightly more likely to experience a birth without intervention (defined as spontaneous onset of labour, and spontaneous vaginal birth, without epidural/spinal/general anaesthesia or episiotomy) than those from either white or South Asian ethnic groups. This could be positive if these women were having straightforward labours and not being offered unwanted interventions, but the concern is that it could in part be because they were not offered interventions that were "desired or indicated". We know from other research that women of Black, Asian and mixed ethnicity are less likely to receive pain relief in labour.[7] This is an area where more research into Black and Asian people's experiences of care would be valuable.

In contrast, though rates of planned caesareans were similar across ethnic groups, the rates of unplanned caesareans were "*highest for women from Black ethnic groups and higher for women from South Asian groups when compared with those from white ethnic groups.*" Taken together, these two findings could indicate that some Black and Asian women were not receiving interventions that could have helped them avoid an unplanned caesarean, although without more detailed research, we can't be sure whether or not this is the case. The fact that Black women in the sample were more likely than other ethnic groups to have a BMI of 30 kg/m2 or above, to be aged over 35, have high blood pressure or have had a previous caesarean, could all have contributed to their higher caesarean rate and higher chance of experiencing serious blood loss.

Babies born to mothers from Black ethnic groups were more likely both to have a low Apgar score[8] and to be admitted to a neonatal unit when born at term than were white babies. However, whilst those born to women from South Asian ethnic groups were less likely to have a low Apgar score, they were more likely than those born to white mothers to be admitted to a neonatal unit. Again, the audit cannot give the reasons for this, though the authors comment that babies of South Asian ethnicity are more likely to be admitted for jaundice, and also more likely to be classed as 'small for gestational age' (SGA). The latter might reflect the use of growth charts standardised for white babies.

This audit raises some interesting questions and AIMS supports the authors' call to, "*prioritise further research in NHS maternity and perinatal care that could improve outcomes for women, and their babies, from ethnic minority groups and those in the most deprived areas*", which should include both quantitative analysis to investigate the causes and qualitative research to explore the experiences of people accessing maternity care.

Cohort study: Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England

Further information on the underlying causes of some of the main inequalities comes from a recently published NMPA cohort study[9] looking at data on stillbirth, preterm birth (before 37 weeks of pregnancy), and fetal growth restriction (FGR: defined as babies with a birthweight below the third centile - in the lowest 3% of the population). The data covered about 1.2 million births in 132 hospitals in England in the two years to March 2017. The authors looked at how these three 'adverse outcomes' varied by level of social deprivation and ethnicity and calculated the 'population attributable fraction' (PAF). This is defined as the proportion of a group that would *not* have experienced an adverse outcome had their group had the same rates of these outcomes as the 'reference group.' For social deprivation, the reference group was mothers in the least deprived areas, and for ethnicity it was white mothers.

The analysis showed a significant excess of stillbirths, pre-term births and FGR for those from more deprived areas, which increased with the increasing level of deprivation. Similarly, there was an excess of stillbirths and FGR for those of Black, South Asian, mixed or other ethnicity compared with white mothers, though little difference in preterm births.

The authors then looked at the impact of adjusting the PAF to correct for other risk factors. Here is the data from Table 2 of the report for PAF before and after adjustment.

PAF due to:	Socioeconomic deprivation			
	Unadjusted	Adjusted for ethnicity	Adjusted for ethnicity, smoking and BMI	Adjusted for ethnicity, smoking, BMI & all maternal factors
Stillbirth	23.6%	19.0%	11.6%	12.4%
Pre-term birth	18.5%	18.4%	11.9%	10.1%
FGR	31.1%	25.3%	16.4%	16.5%

In the case of socioeconomic deprivation, adjusting for ethnicity, smoking status and BMI resulted in substantial lower PAFs, with most of the impact coming from the adjustment for smoking and BMI. In other words, much of the difference that is apparently due to social deprivation can be explained by these other factors, although there remains a substantial contribution from social deprivation in itself. A further adjustment for other maternal risk factors made little difference to the figures.

PAF due to:	Ethnicity			
	Unadjusted	Adjusted for socioeconomic group	Adjusted for socioeconomic group, smoking and BMI	Adjusted for socioeconomic group, smoking, BMI & all maternal factors
Stillbirth	11.7%	10.8%	13.0%	12.6%
Pre-term birth	1.2%	0.1%	2.6%	1.2%
FGR	16.9%	15.2%	19.2%	19.5%

In contrast, in the case of ethnicity, adjusting for socioeconomic deprivation, smoking, BMI and additional maternal risk factors made little difference to the PAF. This shows that higher rates of stillbirth and FGR seen in Black, South Asian and mixed/other ethnic groups compared with the white population is unlikely to be due to socioeconomic deprivation alone, or to factors such as rates of smoking or BMI, and we need to look elsewhere for the cause.

The authors comment that, "Other factors related to discrimination based on race, religion, and culture can contribute to a societal disadvantage and increase the risk of poor pregnancy outcomes" but also speculate on possible biological differences between ethnic groups. They call for research to understand the role of these possible causes to be a priority, but also for recognition that public health approaches and action to address wider inequalities are likely to be needed.

Conclusion

What these three pieces of research show is that racial inequalities in maternity outcomes are not a simple matter of socioeconomic or health/biological factors alone. AIMS welcomes the recognition that they are likely to be due at least in part to differences in the care that is offered, and to institutional racism, unconscious bias and lack of individualised, culturally competent care. These issues need to be acknowledged and addressed throughout the maternity services.

There is also a growing understanding of the impact of long-term everyday racism (for example, everyday microaggressions[10]) on health, which means that there will be disparities in the underlying health of women preceding the point at which they access maternity services. AIMS welcomes the recognition in the NHS Long Term Plan[11] that "we cannot treat our way out of inequalities", but that the NHS can (and AIMS would say *must*) "ensure that action to drive down health inequalities is central to everything [it does].

1 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2019 Reports | NPEU > MBRRACE-UK (ox.ac.uk)

2 MBRRACE-UK Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19 Reports | NPEU > MBRRACE-UK (ox.ac.uk)3

3 NHS England pledges to improve equity for mothers and babies and race equality for staff September 2021 NHS England » Equity and equality: Guidance for local maternity systems

4 NHS England Equity and equality Guidance for local maternity systems September 2021 NHS England » Equity and equality: Guidance for local maternity systems

5 Matthews R, 'Understanding ethnic inequalities in stillbirth rates', presentation at Virtual Conference – Presenting the MBRRACE-UK Perinatal Report 2021, October 2021

6 Webster K, NMPA Project Team. 'Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies: Assessing care using data from births between 1 April 2015 and 31 March 2018 across England, Scotland and Wales.' London: RCOG; 2021 maternityaudit.org.uk/FilesUploaded/Ref%20308%20Inequalities%20Sprint%20Audit%20Report%202021_FINAL.pdf

7 Henderson, J., Gao, H., & Redshaw, M. (2013) Experiencing maternity care: the care received and perceptions of women from different ethnic groups. BMC Pregnancy Childbirth 13 (196) bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-196

8 Editor's note: Named after Virginia Apgar, the Apgar score is a test given to newborns soon after birth. This test checks a baby's heart rate, muscle tone, and other signs to see if extra medical care or emergency care is needed.

9 Jardine J. et al 'Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study' The Lancet, 398:10314, pp1905-1912 November 2021 www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01595-6/fulltext

10 Editor's reading suggestion: Racial Microaggressions in Everyday Life: Implications for Clinical Practice www.cpedv.org/sites/main/files/file-attachments/how_to_be_an_effective_ally-lessons_learned_microaggressions.pdf

11 NHS Long Term Plan Chapter 2, section 2.28 www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/stronger-nhs-action-on-health-inequalities/

Article

Better Births six years on: the implementation programme continues

The AIMS Campaign Team

In this commentary, the AIMS Campaigns Team reflects on why the successful implementation of Better Births across England - to deliver personal, safe and equitable maternity services - is more important than ever. In doing so, we recommit AIMS to playing our part as a 'guardian of Better Births implementation' and we encourage others to do the same.

Over the last two years, two issues have perhaps dominated the landscape of maternity service campaigning in England. First, the increased exposure of the stark statistics concerning the inequalities in maternity outcomes for mothers and babies - epitomised in the well-founded and shocking 'FIVEXMORE'[1] phrase - has galvanised a raft of campaigning activity, as the maternity service improvement community seeks to better understand what's going on and carry out the vital work necessary to eradicate inequalities. Second, changes to maternity services, introduced in response to the global COVID-19 pandemic, have driven calls on NHS Trusts to (a) reverse what seem to be damaging and at times ill-judged restrictions and (b) ensure that a broad view of what constitutes safety in the maternity services informs necessary service changes. These two agendas overlap. For example, we know that the presence of a support person for many people dealing with the medical system, whatever speciality, is not just 'nice to have' but a key component of mental wellbeing and physical safety. It is no surprise, therefore, that discussions around the importance of the inclusion of support people feature highly both in campaigns for eradicating inequalities and in campaigns calling for COVID-19 service restrictions to be reviewed.

Besides those two campaigns, there has been the hugely troubling ongoing rumble of news about the unsatisfactory quality of some maternity service provision, most notably brought to the fore when the stories of families hit by near-unspeakable tragedy, or the names of the relevant NHS Trusts, are thrust into the headlines by way of legal cases, Care Quality Commission report[2] or other investigations. It is impossible to minimise the impact of this news stream on confidence in the maternity services as a whole. Why is it that similar failings seem to be revealed time and time again? More recently, the Covid-19 pandemic has exacerbated the pressures on maternity staff to the extent that a public conversation was necessary, with action to draw attention to the maternity staffing crisis[3] taking place around the UK in November 2021, mainly through the impressive efforts of the March With Midwives campaign. This conversation revealed unsustainable working conditions that must be addressed. Again, these two agendas surely overlap.

It may sound glib, but in the face of each of these separate but interconnected challenges it is the view of the AIMS Campaigns Team that it has never been more important to refocus our attention on the implementation of Better Births, as represented by the ongoing and evolving Maternity Services Transformation Programme. Better Births (2016)[4] laid out a blueprint not for 'just another initiative' but for a radical shift in the way that maternity services are organised. Only such a radical shift will effect the change we need, to ensure that maternity services become truly personal, safe and equitable.

As part of the Better Births implementation work to date, there has been a welcome emphasis on strengthening leadership and management capacity within the maternity services, including the development of key national and regional leadership teams. AIMS is optimistic that this new structure will play a critical role as we move ahead with further implementation. The many challenges of transforming the traditional maternity model of care into one based on the important principle of 'continuity of carer' have also been identified. There is now updated guidance[5] based on listening to experiences of, and learning from, the implementation efforts to date: there is now much greater clarity in the guidance about the

implementation challenges, recognising that this transformation requires a radically different way of organising staff and impacts on both the working lives of many midwives as well as how they understand their role. In that context, the updated guidance reiterates why this transformation is so important and how it can best be achieved. That said, there still remains much work to be done in winning over the 'hearts and minds' of a workforce who have organised their lives and professional identities around the old ways of working. That's where the new leadership teams will need to come into their own, to unravel ways of working that for decades now have served neither service users nor staff well.

So AIMS looks ahead with cautious optimism. We are grateful for the work done since Better Births to lay the foundations for an overhauled maternity service. Notwithstanding the recent severe shock that is COVID-19, and the ongoing revelations of severe weaknesses in parts of the current maternity service, AIMS notes the determination at a national level to press ahead with this much-needed transformation of our maternity services[6].

In 2022, amidst the many individual maternity service improvement issues on the agenda, AIMS is clear that the Better Births vision remains a powerful one[7]. It is - importantly - a whole system approach. At its heart, it calls for a maternity service that treats its staff well and enables them to do their work effectively, so that all service users may benefit from a service that is personal, safe and equitable. And that, surely, is a call that we can all get behind. As a member of the Maternity Transformation Programme's Stakeholder Council[8] we pledge to play our part.

1 www.fivexmore.com

2 www.cqc.org.uk/publications/themes-care/safety-equity-engagement-maternity-services

3 www.aims.org.uk/campaigning/item/march-with-midwives

4 www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

5 www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22

6 www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance

7 www.aims.org.uk/journal/item/better-births-policy-implementation

8 www.england.nhs.uk/mat-transformation/council

Book Reviews

What we need to know about the physiological onset of labour and the option of induction: three books to inform and inspire

Reviewed for AIMS by Gail Werkmeister

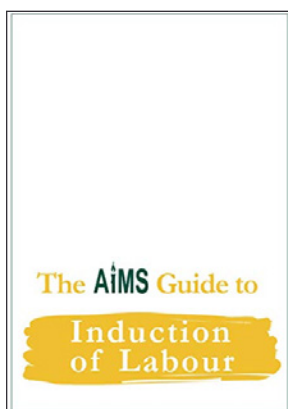
Originally I worked as a research scientist, ironically in obstetrics, then I became an NCT antenatal educator and I have worked with parents and students for over 30 years. I have been a representative of the 'users' of the maternity services on labour ward forums, Maternity Service Liaison Committees (MSLCs) and national guideline groups. I agreed to write these reviews because I am genuinely shocked to meet an ever increasing number of healthy 'low risk' pregnant women who are suddenly, in the last few weeks of their pregnancy, facing induction and who feel overwhelmed and disempowered by decisions that they often feel are being made for them.

In my experience as an antenatal practitioner, I see these pregnant women planning for straightforward births and then being induced, often at 38 weeks. This early term induction may well result in long labour with a 'cascade' of interventions including assisted birth and caesarean birth. I have witnessed the longer term effects of this on the mental health of these women and their birth partners, such as postnatal depression and birth trauma. From reading the three books below and talking with my peers, I know I am not alone in this observation.

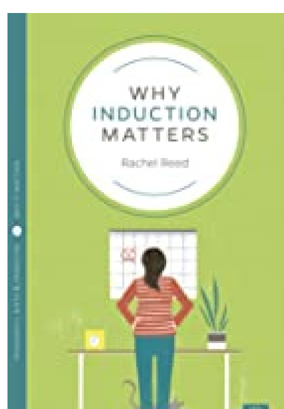
Here I must emphasise that I, along with the authors below, recognise that induction of labour can be vital for the safety, health and wellbeing of a pregnant woman and her baby. I know that the experience of induction, as with any birth intervention, can also be positive and empowering if the pregnant woman feels she has been well supported and has played an active part in the decision-making process.

All three books provide a massive amount of both evidence-based and practical information. They also contain wisdom and advice on making decisions that are relevant to each woman in her own specific situation. They show that the use of generalised guidelines and protocols, applied to all women, does not result in good care because all women and babies are different and should be treated on an individual basis. The authors suggest women need 'personalised care', 'woman-centred care', 'continuity of care' and I agree. Each book is written in a unique style which will appeal to different readers and they are aimed not only at pregnant women and their supporters but to all healthcare professionals involved in their births.

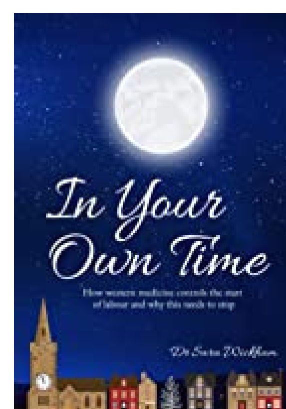
The three books are reviewed overleaf separately:



The AIMS Guide to Induction of Labour



Why Induction Matters



In Your Own Time

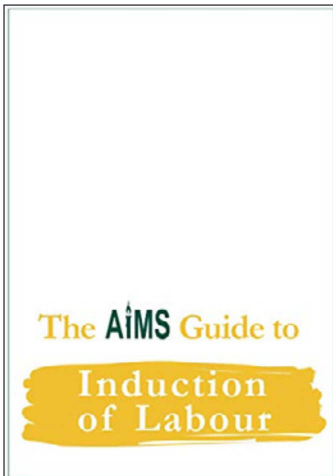
Book Reviews

The AIMS Guide to Induction of Labour

by Dr Nadia Higson

ISBN: 978-1874413493

Published by AIMS
218 pages
£8 from the AIMS website



Principal author Nadia Higson is a scientist and educator. I feel that she brings her knowledge and skills particularly as an antenatal educator (with the insight this gives her), to plan the layout of the book with a clear and practical structure. The research base is impressive and the layout is visually pleasing too with simple and clear diagrams and graphs when they are helpful. This is not necessarily meant to be a book you would read from start to finish, but a handbook that a pregnant person, supporter or educator might dip into to find the information most relevant to them at that moment in time.

Higson begins with a very clear and informative chapter on generic guidelines and what is meant by evidence-based information (including its limitations), and on how to have discussions with doctors and midwives to make informed decisions. Here she aims to enable pregnant women to gain confidence in their right to decide how they birth their babies and suggests the questions they may need to ask to achieve this aim.

This is followed by a chapter on the reasons induction might be offered. Each topic subsection explores in depth the evidence for the given reason for induction, for example 'Length of pregnancy' it is then followed by a short 'Summary' of that evidence and then a section titled 'Things to consider' which suggests questions a woman might ask herself about her own feelings and instincts. Also, what she might want to explore with doctors and midwives, and how she feels about the risks and benefits for herself and her situation.

The third chapter covers in detail the stages in the induction process, encouraging women to consider all possibilities. A subsection 'What may help an induction to work?' describes ways to make the process more successful and empowering. There is a visually helpful flow chart of the process showing decision points where a woman and her birth supporters could assess how she is feeling before moving on to the next step or not!

In addition this handbook has the thoughtful inclusion of a glossary, which I am sure will be a useful jargon buster for many.

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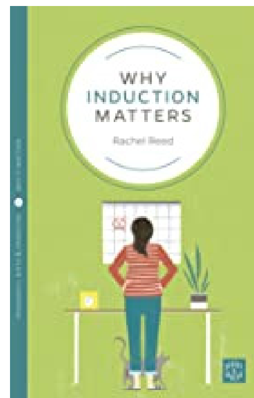
Why Induction Matters

by Dr Rachel Reed

ISBN: 978-1780666006

Published by Pinter & Martin 2018
176 pages
RRP: £8.99



Rachel Reed is a midwife, academic, writer, blogger and presenter who has worked in the UK and is now based in Australia. In her PhD she explored women's experiences of birth and midwifery practice during birth. She states that it's not necessarily the type of birth a woman has but the sense of empowerment from it that matters. A woman in labour needs to feel that her decisions and wishes have been respected, she needs 'woman-centred' care.

I was impressed by Reed's first chapter which gave an insightful analysis about how decisions are made. This included the roles and responsibilities of healthcare professionals to give unbiased information, and the writing and uptake of NICE and other clinical guidelines. She notes
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that these guidelines can include 'expert consensus' (of the guideline group) where evidence is not conclusive or is of poor quality.

Reed explains that decision-making isn't simply about looking at the statistics but how our own personal beliefs, cultural norms and intuition all play their part. This chapter culminates in a guided 'Decision-making framework'. This consists of pertinent questions applied to the individual, which, when answered, align with the BRAIN, **B** (benefits) **R** (risks) **A** (alternatives) **I**(intuition) **N** (now/nothing) acronym decision-making tool.

In my opinion, a definite strength of this book is that Reed shares, as another form of 'lived' evidence, several women's very different experiences of induction, weaving their accounts effectively throughout her narrative. I know from my own experiences as an antenatal educator that birth stories are very powerful and can influence women's decisions and help them to feel more confident in their own bodies when approaching the birth of their babies.

The following chapters of her book are fascinating and focus in great detail on the complications of pregnancy such as pre-existing and gestational diabetes. Another focuses on the variations of pregnancy such as pregnancy length and advanced maternal age. The pros and cons of induction of labour in these scenarios is forensically examined. Although mostly to dip into, the information in these chapters will be incredibly useful for women who want to have detailed knowledge of their condition.

As in the AIMS book, this is followed by chapters on the mechanisms of spontaneous labour compared to medical induction. There is also a comparatively well-researched overview of the effectiveness of alternative and complementary methods of induction which I know many pregnant women would be interested in reading.

The book ends on a positive note with a framework for creating a birth plan to maximise a positive experience both for the woman and her baby. Reed states her wish that 'every woman regardless of how she gives birth, steps into motherhood feeling strong and empowered, knowing that she is the expert when it comes to her body and her baby'.

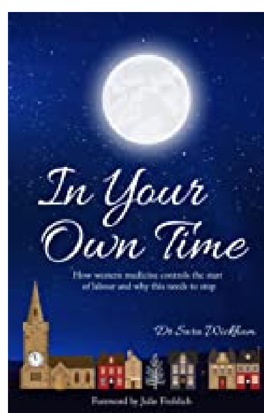
In Your Own Time

by Dr Sara Wickcham

ISBN: 978-1914465024

Published by Birthmoon Creations 2021
203 pages

RRP: £10



Sara Wickham is a well-known and respected authority on birth matters. She is a midwife, author, blogger, speaker and researcher who thinks 'out of the box'. Her book is 'for anyone questioning the value of routine induction or concerned about rising induction rates'. It is a passionate criticism of the current status quo in UK maternity services with an induction rate around 34% of all births. This represents a peak in the medicalisation of childbirth that in real terms means one in three pregnant women are being induced.

Unlike the other two books, Wickham does not describe the induction process in detail or the pros and cons of this intervention, but she looks at the bigger picture. She draws a narrative arc stretching from the history of the 'due date', tracing the first documented length of pregnancy to Aristotle in Roman times, when women counted the length of pregnancy and birth in ten lunar months, up to our current practice of estimating due dates using ultrasound.

She suggests that the evidence shows that 'normality' is a range of a month and that the due date as calculated by Naegele's rule is approximately in the middle of it. However, referring to induction after their due date 'Women do not turn into pumpkins overnight'. She discusses the advantages to both mother and baby of 'the waiting days'. Briefly, she argues that babies are born when they are physiologically ready and, if forced to be born before this point, there are disadvantages and possible long term repercussions. She states that there is a span of several weeks during which, at some point, each individual baby will attain optimal physiological readiness and, as midwives have long thought, it's not useful to have a fixed point due date.

This being the latest of the three books, there is an excellent chapter on the new NICE Guideline Inducing Labour 2021. Wickham has several concerns about this guidance, for example the recommendation to discuss induction and caesarean birth with women in early pregnancy. This could undermine women's confidence in their body's ability to give birth spontaneously. She is also concerned about moving a suggested cervical sweep from 40 to 39 weeks and suggesting induction at 41 weeks as opposed to 41-42 weeks in the 2008 guideline.

Why does this all matter? Wickham makes the point throughout her book that there are medium and long term effects of induction on the health of mothers and babies. We know that induction can often lead to a 'cascade of intervention' and the concomitant risks attached to these further interventions might outweigh the often relatively small but very serious risk of stillbirth that the induction is meant to prevent. Pregnant women must have all the pros and cons to weigh up their decisions.

This is a powerful book. Wickam states that there are no simple answers to high induction rates because 'it's complicated'. However she does have some suggestions, such as working together to change the culture and conversation around pregnancy and birth. This book is aimed at everyone involved in maternity services: doctors, midwives, educators, pregnant people and their birth supporters. We all need to keep learning, questioning, and most of all listening to women, while, as Wickham writes, "...not forgetting to look up at the moon now and again, just as our ancestors might have done, and wonder at the miracle that is birth and the fact that, in most cases, if we leave well alone, it happens at the right time."

Author Bio: Gail Werkmeister is an NCT Senior Antenatal Practitioner and Assessor, and a past President of the NCT (2005-2010)

The AIMS Guide to

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Campaigns

What has the AIMS Campaigns Team been up to?

The AIMS Campaign Team

Covid-19:

- AIMS continues to work with the But Not Maternity Alliance to monitor where restrictions on partners/supporters attending the maternity services remain or have been reimposed, to promote awareness of the guidelines for lifting these restrictions, and to call on Trusts to review whether maintaining restrictions is a proportionate response to the current Covid risks. We also attended a meeting to support closer collaboration with the Royal College of Midwives and NHS England on concerns about maternity service restrictions.
- We continue to update the webpage Coronavirus and your maternity care with updates to the guidance and new research information as this is published.

Written outputs:

- Continuity of Carer Implementation Programme campaign update
- Review of the MBRRACE and NMPA reports on racial inequalities in maternity outcomes {link to Journal article}
- Review of the new NICE guideline on Inducing Labour {link to journal article}
- Position Paper on Racial Inequalities in Maternity Services will be published soon!

Conferences and meetings

- AIMS volunteers participated in local March With Midwives vigils, including in Manchester and Colchester {link to journal article)
- We attended the European Network of Childbirth Associations (ENCA) Conference, 20th November 2021, where we presented the UK country report and a separate presentation on the work of AIMS and the But Not Maternity Alliance during the pandemic
- We attended the one-day International Normal Labour and Birth Research Conference 2021 (online)
- We attended regular meetings of:
- NHS England's Maternity Transformation Programme's Stakeholder Council
- The Royal College of Midwives re:Birth Project Oversight Group
- We attended online sessions organised by the Midwifery and Maternity Festival team, including the weekly Midwifery Hour and an informative briefing on Vaccines in Pregnancy
- We had a meeting with NICE staff to discuss the principles that underpin their work and how these are embedded in practice
- We attended Shared decision making: a reality for everyone?: a webinar hosted by the Patients Association
- We attended a Care Opinion research chat: Using online patient feedback in research: a case study
- We attended Contextual Readiness for Transforming Maternity Care: a webinar organised by University of East Anglia (UEA) Health and Social Care Partners

* We participated in a Festival of Social Science event Sharing childbirth experiences: choices, challenges and conversation.

This event, exploring some of the current issues facing women and the maternity services, was run by AIMS Volunteer Georgia Clancy, with participation from two other AIMS Volunteers, Anna Madeley and Nadia Higson. {link to Journal article}

- We attended a JCVI (Joint Committee on Vaccination and Immunisation) briefing on COVID-19 vaccination and pregnancy
- We attended an NMPA (National Maternity and Perinatal Audit) webinar Inequalities in maternity care
- We are participating with other stakeholders in a new series of informal meetings to consider issues surrounding the implementation of Continuity of Carer in England from a public/patient perspective.
- We attended and presented at the Doula UK Annual conference, January 21-23

What we have been reading about:

- The NMC's (Nursing and Midwifery Council) congratulations of Scotland's new Chief Midwifery Officer, Justine Craig
- The new NICE guideline on Pelvic Floor Dysfunction and comments from stakeholders.
- The recent findings from You & Your Baby 2020, the latest National Maternity Survey (NMS) carried out by the National Perinatal Epidemiology Unit (NPEU). The study looks at maternity care satisfaction during the Covid-19 pandemic. The full report can be found here: www.npeu.ox.ac.uk/maternity-surveys.
- Experiences of maternity services in Nottingham and Nottinghamshire during the Covid-19 pandemic, in a report by Healthwatch Nottingham and Nottinghamshire and Nottingham and Nottinghamshire Maternity Voices Partnership, December 2021
- ASPIRE Covid-19 Collaborative Group 'Companionship for women/birthing people using antenatal and intrapartum care in England during COVID-19' December 2021 BMJ Open 12:1 http://dx.doi.org/10.1136/bmjopen-2021-051965

What we have been watching:

- A short film on your rights to safe and appropriate maternity care: Speak Up, Speak Out
- A short video to raise awareness of obstetric violence: https://twitter.com/RodantevdWaal/status/1456593650402697224?s=20
- Adjournment debate on midwifery staffing in parliament: Debate: Midwives in the NHS - 17th Jan 2022

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

There for your mother

Here for you

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