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SALUTOGENESIS
PUTTING THE HEALTH BACK INTO HEALTHCARE

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Editorial

Salutogenesis – Putting the health back into healthcare

by Alex Smith

The theme for our March edition of the AIMS Journal is Salutogenesis. Salutogenesis is a term introduced by sociologist and academician Aaron Antonovsky in the second half of the 20th century. It comes from the Latin 'salus' meaning health and the Greek 'genesis' meaning origin or source. By defining health from a salutogenic perspective as 'holistic well-being', rather than from a pathogenic perspective as 'the absence of disease', the term offers us another way of thinking about how to make things better.

The salutogenic approach and the pathogenic approach are not mutually exclusive; access to good quality medical care, offered in a timely, tailored and respectful way, is very much part of a salutogenic philosophy. The two perspectives form part of a spectrum. However, we know that outcomes in all areas of health, including maternity, are improved when the conditions and factors known to build and maintain holistic well-being are placed first and foremost.

These days, we often use the terms health care and medical care interchangeably and we refer to people with medical qualifications as healthcare professionals. In this way, and quite unwittingly, we have bestowed the monopoly of authority for all matters concerning health to a body of people whose primary authority is embedded in their knowledge of illness and medicine. It is then only natural that when we ask these people to create a model of maternity care, it will be a medical model, and when we ask them to look for ways of improving birth outcomes, they will turn to medicine for inspiration and answers. This was highlighted in a 2014 study of 102 reviews that looked at labour and birth outcomes, where only 8% of 1648 individual outcomes were agreed as salutogenically focused[1].

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Such medicalisation of birth has considerably narrowed the scope we give ourselves for finding ways of improving birth experiences and outcomes. It is as if we have a full chest of drawers of possibility to explore, but mostly only ever look in one drawer. The appropriation and medicalisation of birth has been enabled by the consistent disparaging of anything in the 'other drawers'. When we talk about 'old wives tales', we are disparaging women's wisdom. When we only hold with 'evidence-based' practice (with the 92% bias towards pathogenic research), we are disparaging the insights and skills of those with non-medical knowledge and expertise, and dismissing the voices and experiences of those who actually bring babies forth from their own bodies. When we look at non-medical strategies such as relaxation and breathing[2], making the birth environment more homely[3], positive visualisation and affirmations4 and

sweepingly dismiss them as 'all that hippy stuff', or more quietly dismiss them by allowing them to go 'out of the window' the moment we enter the medical arena, then we are disparaging the evidence that these things improve outcomes and well-being; betraying our own bias toward the pathogenic 92%.

So deeply ingrained is the pathogenic way of viewing health and maternity care that the vast majority of people feel it is responsible and educated to think this way; to only or mostly turn to that one drawer. The pathogenic way of thinking is reflected in the very language we use to talk about our bodies so that we all agree that the 'proper' words to use are the medical words and that practitioners who speak in medical parlance are 'the experts'. Even more insidious is the use of words that infer ownership of a medical procedure to the person being offered it, so that 'your sweep' or 'your scan' seem as natural and unquestioned a part of pregnancy as 'your bump'. And more insidious still is how this pathogenic perspective has become embedded in the body itself so that it feels almost instinctive for a healthy person to consult a doctor about normal pregnancy, and feels almost naughty to look in the other drawers for ideas for keeping well.

When we talk about 'old wives tales', we are disparaging women's wisdom. ... we are disparaging the insights and skills of those with non-medical knowledge and expertise, and dismissing the voices and experiences of those who actually bring babies forth from their own bodies.

So, in the face of this heavy weighting toward a pathogenic view of pregnancy and birth, the March journal takes a brief salutogenic glimpse at other ways of making things better. We open with an article I have written, which in part explores the politics of health philosophy. Mary Nolan introduces and explains the concept of self-efficacy, which refers to a person's belief in their capacity to act in a way that will produce a desired outcome, perhaps by making decisions and taking actions in pregnancy in order to achieve a satisfying birth. This takes the helplessness and passivity of wishful thinking and turns it into positive action, no matter what the circumstances and preferences of the individual, and in doing so greatly reduces the chance of the events being experienced as trauma. Sophie Martin shows us how we can build on or undermine this sense of being strong and capable by the stories we hear and the stories we tell ourselves, explaining how language can and does have a positive or negative effect on well-being and can shape our experience of pregnancy and birth. Cathy Welch writes about yoga for pregnancy and how not just the yoga itself but the sharing of stories within a supportive social space is considered one of the key contributory factors to improved mental health in pregnant women, leaving many feeling stronger, more confident and filled with self-belief. However, when the going has been challenging, three authors show how coming together as women and parents to share our experiences enables people to discover their innate strength and resilience without pathologising their natural feelings. Katharine Handel describes The Motherkind Café, an Oxfordshire post-natal peer support group where women who are worried about their mental health after having a baby can come and talk about it in a supportive and non-judgemental environment. This model of mothers helping other mothers by drawing on their own experiences is a great example of salutogenesis. As part of the AIMS 'Introducing' series, Samantha Gadsden describes her awareness-raising forum, 'They said to me', which has gathered thousands of followers who draw strength from each other in exercising their rights concerning pregnancy and birth. Nicola Enoch writes an incredibly moving and inspiring account of her experience as a mother of a son with Down syndrome and of the wonderful support groups she has set up for other parents. Neve Spicer has shared her very attractive infographic providing links to the evidence of 23 benefits for babies and their parents of 'baby-wearing' or carrying the baby close to your body in a sling, while Anne Glover talks about the value of continuity of carer, the parents' social support network, and, when needed, the additional support of a postnatal doula, working together in complementary ways to support the new family. And midwife, Professor Soo Downe, is interviewed by Jo Dagustun, an interview that

includes Soo's account of how a salutogenic approach might lead to improvements in the maternity services.

Moving somewhat away from the salutogenic theme, Annie Francis reflects on the five years since the National Maternity Review, led by Baroness Julia Cumberlege, issued its report, Better Births, in February 2016. Anna Madeley and Jo Dagustun both look at the Ockenden Interim Report, published on 10 December 2020. Gemma McKenzie and Virginia Hatton review 'Birthing Outside the System: The Canary in the Coal Mine', which, according to Gemma is a "jaw-dropping, anger-inducing, galvanizing text that makes you want to get out of your armchair and join the battle to protect human rights in pregnancy and childbirth." And last but not least, the AIMS Campaigns Steering Group give their quarterly account of what they have been up to.

Thank you as ever to all our contributors, to our peer reviewers Emma Ashworth, Verónica Blanco, Jo Dagustun, Virginia Hatton, Maddie McMahon and Caroline Mayers, to Bonita Khan, Alicia Mosley, Judith Payne, Josey Smith, Zoe Walsh who proofread this issue, to Danielle Gilmour who uploaded all of the material to the website, and to all our readers and supporters.

We hope you will enjoy reading this issue. For our June 2021 issue we will be exploring the experiences, traditions, languages and cultures of people when they bring different, foreign or marginalized worlds into the world of "giving birth in the UK".

1 Smith V, Daly D, Lundgren I, Eri T, Benstoem C, Devane D. Salutogenically focused outcomes in systematic reviews of intrapartum interventions: a systematic review of systematic reviews. Midwifery. 2014 Apr;30(4):e151-6. doi:10.1016/j.midw.2013.11.002. Epub 2013 Nov 11. PMID: 24290422

2 Levett KM, Smith CA, Bensoussan A, et al Complementary therapies for labour and birth study: a randomised controlled trial of antenatal integrative medicine for pain management in labour. BMJ Open 2016;6:e010691. doi:10.1136/bmjopen-2015-010691

3 Jenkinson, Bec & josey, natalie & Kruske, Sue. (2014). BirthSpace: An evidence-based guide to birth environment design. 10.13140/RG.2.1.3962.8964

4 Cascio CN, O'Donnell MB, Tinney FJ, et al. Self-affirmation activates brain systems associated with self-related processing and reward and is reinforced by future orientation. *Soc Cogn Affect Neurosci*. 2016;11(4):621-629. doi:10.1093/scan/nsv136

Article

Salutogenesis: How philosophy shapes practice

by Alex Smith

Life on Pathogenia: A story from a parallel world

Oliver is nearly six months old. Until now, his mother Eileen has been allowed to feed him at home; he is breastfed and so the risks are minimal. Had he been formula fed, she could still have fed him at home but only under regular supervision. This is because Eileen is not a trained infant feeding practitioner, nor is she qualified to recognise the early signs of gastroenteritis and other potential medical issues associated with this higher risk situation. Very soon, Oliver will be prescribed an introductory diet of solid foods by his paediatrician and will join his family and neighbours to take every meal together at their local community eating centre.

It may be difficult to imagine, but things were not always this way. Before the Family Nutrition Report was published, many decades ago now, the majority of families planned, prepared and ate their own food at home, but this came at a dreadful price. A government enquiry found that morbidity and mortality from accidents and illness directly associated with home cooking and eating was unacceptably high and largely avoidable. These direct causes included chip-pan fires, food poisoning, choking, burns and knife injuries. Even greater in its impact, the enquiry found, was the indirect effect of poor nutrition on the rates of illnesses such as diabetes, heart disease, gastrointestinal problems and many cancers. In all, the report found that the costs to the country in terms of the use of precious NHS resources and lost days at work could not be sustained on either economic or ethical grounds. In conclusion, it recommended that all families should have access to free-at-the-point-of-contact eating centres where balanced meals would be available throughout the day, to be enjoyed in the safety of a specially designed environment attended by medical experts trained in nutrition and the Heimlich manoeuvre.

Surprisingly, there was very little resistance to this new policy. Academics believe that this is explained by the growing concern about food poverty and obesity at that time; the steady demise of the family meal; the fact that working practices found more and more children already eating breakfast at school; and the idea of eating out or ordering takeaway becoming much more normal. The thrice daily use of an eating centre situated on every street corner, with no need to take responsibility for shopping, cooking and washing up, was an attractive and welcome prospect for most families. In fact, the scheme was successfully promoted with the government slogan, 'Don't do a thing: Eat like a King', which tapped into the suggestion that the upper classes had always eaten out or employed a professional cook. The report did not specifically ban home cooking and eating, indeed, these things are one's human right and protected by law, but people are no longer prepared to take unnecessary risks, preferring instead to leave culinary matters to the experts; and safety apart, few people these days would welcome the mess and palaver that home cooking and eating used to entail.

Unfortunately, a lack of funding and under-staffing means that the eating environment is invariably functional, the pace rushed, and the menu limited; you rarely see the same staff twice. These factors were cited in recent research as possible reasons why community eating centres have not seen improved outcomes in the way that was hoped. However, the majority of people are reassured to know that while eating, friendly staff will watch them closely to check that they are chewing and swallowing properly and that gastrointestinal motility meets normal measures. In addition, people value the routine weight, stool and blood tests that check for signs of illness that might otherwise have been missed.

While today, our primal instinct to gather and prepare food is vicariously satisfied by watching programmes such as 'Call the Chef', the actual idea of an intimate candlelit meal prepared and eaten at home involves skills that have been lost over succeeding generations and is both indulgent and archaic. The important thing is that everyone gets safely fed. Eileen and Oliver are so lucky to have help at hand!

Whether or not this offers you a utopian or dystopian sense of life on Pathogenia is a personal call, but even in drafting this rather obvious analogy, I almost had myself convinced!

Eating and digestion are normal physiological processes. Almost all physiological processes are entrusted to our good sense to manage safely at home despite the numerous complications that can arise. We are not without expert advice on these matters, but the decision-making is known

to be ours, and ours alone. This is because the integrity of the body is enshrined in law; we cannot be forced to eat our greens. We are credited with the ability to recognise and self-treat minor issues in family-preferred ways, and to know or sense when to consult a pharmacist or doctor. Until that point we take an entirely positive or salutogenic approach in taking care of our physiological well-being, and this is widely encouraged. The one exception is the normal physiological process of pregnancy and childbirth, which, in the same way as eating on Pathogenia, has been systematically pathologised to the point where it barely feels reasonable or responsible to imagine it otherwise.

Pathogenesis

So what does that mean and why does it matter? A pathogenic approach to care focuses on identifying and treating illness. It assumes a mechanistic view of the body as a 'faulty machine'[1], generally using a limited range of physical morbidity, and mortality, as the sole measures of the success of the treatment. Iatrogenic harm, the range of potential harm caused by a treatment, is often disregarded, not given credence, or dismissed as a small price to pay. In pregnancy and childbirth, due largely to the fear of litigation, the bar for normality is set very low. The battery of tests and measures offered in pregnancy will on occasion pick up a serious health issue, but far more frequently it uncovers small 'findings' that are considered as being outside the range of normal even though the person remains well. The label 'high risk' is then applied to the now anxious mother, usually without any explanation that the *actual* increased risk for her or the baby is very small or even entirely uncertain, especially when weighed against the known risk of the treatment itself. She is then denied options known to increase safety and well-being such as home birth or birth in a midwife-led unit. Even those considered as 'low risk' are routinely hospitalised, and so profound and entrenched is the pathological mindset in regard to birth, few people think this odd. Yet, rather than improving outcomes for all, the hospital as a birth environment places a majority of healthy mothers at increased danger of experiencing a complex birth[2], with 28,000 new mothers each year in the UK being diagnosed with post-traumatic stress disorder[3], and many more going undiagnosed. Even when a birth is recorded as straightforward, if a person felt neglected, ignored, unbelieved, or unable to escape, and consequently in danger, it may have been experienced as trauma. Unfortunately, in a busy maternity unit, those feelings are experienced all too often.

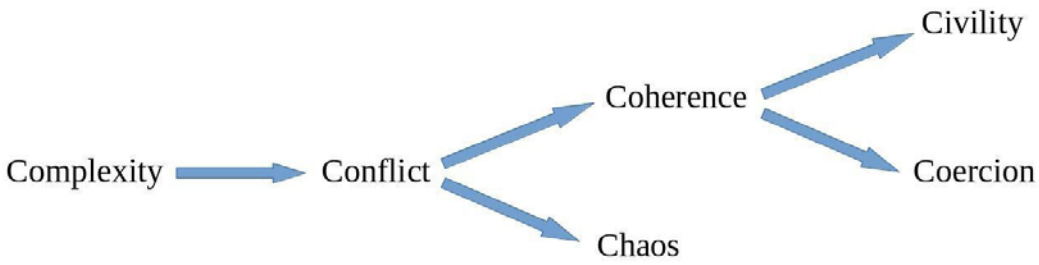
Salutogenesis

In contrast, a salutogenic approach to health has a focus on the things that cause wellness. A term introduced through the work of Aaron Antonovsky[4], salutogenesis comes from the Latin 'salus' meaning health and the Greek 'genesis' meaning origin or source. The primary sources of health include safety and security, good food and clean water, friendship and belonging, sound sleep, fresh clean air and exercise, pleasant surroundings, access to education, and good medical support within reach f and when needed. These are known as the social and physical determinants of health[5]. When they are in place, morbidity and mortality in all areas of health, including maternity, are very much reduced. Walking hand in hand with these external resources are qualities within the individual that also support and increase well-being. These include: self-determination, the belief that you have the right and ability to make your own decisions; self-efficacy[6], the confidence that you have the ability to exert control over yourself and your environment in order to act on your decisions and accomplish your goal; and resilience, the ability to bounce back if the going has been tough and to remain hopeful and positive. In the salutogenic approach, wellness

1 Davis-Floyd R. The technocratic, humanistic, and holistic paradigms of childbirth. International Journal of Gynecology & Obstetrics 75 (2001) S5-S23
2 NPEU (2012) The Birthplace cohort study: key findings. Nuffield department of Population Health. Available at: www.npeu.ox.ac.uk/birthplace/results (accessed: 21st January 2021)
3 Dekel S, Stuebe C, Dishy G. Childbirth Induced Posttraumatic Stress Syndrome: A Systematic Review of Prevalence and Risk Factors. Front Psychol. 2017;8:560. Published 2017 Apr 11. doi:10.3389/fpsyg.2017.00560
4 Antonovsky A, Sagy S. Aaron Antonovsky, the Scholar and the Man Behind Salutogenesis. 2016 Sep 3. In: Mittelmark MB, Sagy S, Eriksson M, et al., editors. The Handbook of Salutogenesis [Internet]. Cham (CH): Springer; 2017. Chapter 3. Available from: ww.ncbi.nlm.nih.gov/books/NBK435855/ doi: 10.1007/978-3-319-04600-6_3
5 Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. Public Health Rep. 2014;129 Suppl 2(Suppl 2):19-31. doi:10.1177/00333549141291S206 (www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/)
6 www.aims.org.uk/journal/item/salutogenesis?cubed-preview=a9a6e49dded522204a613b2c8c29e132

is not simply the absence of illness, but a far richer state that Aristotle referred to as Eudaimonia or human flourishing.[7] Salutogenesis underpins a holistic philosophy of care that does not separate different aspects of wellness, nor does it focus on one at the expense of another. Emotional, social and spiritual well-being are seen as not only inseparable from physical well-being, but as vital to it. The measure applied in the salutogenic approach to maternity care sets the bar high. It asks not simply that the mother and baby pull through, but that they and the new family flourish. However well-intentioned, routinely pathologising a normal physiological process by removing the healthy person from the very conditions that support wellness, and then undermining their autonomy, does not make sense. As expressed beautifully in the title of a newly published book by Lord Nigel Crisp, former Chief Executive of the NHS, '*Health is Made at Home: Hospitals Are for Repairs*'[8].

A central tenet of salutogenic theory is 'sense of coherence'. The greater a person's sense of coherence, the more able they are to navigate the normal stresses and uncertainties of life feeling healthy and resilient. A person with a strong sense of coherence views life as comprehensible, manageable, and meaningful. They understand or comprehend that life (including birth) is complex and uncertain, but they trust that with the resources available to them, they can manage inevitable challenges or conflicts in a way that is meaningful and satisfying. This leads to higher reported levels of well-being. On the other hand, a person with a low sense of coherence can more easily feel overwhelmed, out of control and unwell.



Antonovsky's 6 Cs ([9] p.969)

Even when equipped with a strong sense of coherence, it is important that the individual is able to manage the challenge or conflict in an atmosphere of civility. This means that they should be able to express their needs and decisions in a calm and confident way, secure in the expectation that they will be listened to, believed, and their decisions respected. This maximises well-being for all concerned. When self-determination is met with coercive attempts to gain the person's compliance, relationships of trust break down and the situation can become very stressful. Civility between health professionals also improves outcomes by creating a healthier and more civilised environment for everyone[10], and this is helped when the physical environment is designed to support wellness[11].

7 Kraut, Richard, "Aristotle's Ethics", The Stanford Encyclopedia of Philosophy (Summer 2018 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/sum2018/entries/aristotle-ethics/>.
8 Crisp N, (2020) Health is made at home, hospitals are for repairs : Building a healthy and health-creating society. United Kingdom. SALUS Global Knowledge Exchange
9 Antonovsky, A. (1993a). Complexity, conflict, chaos, coherence, coercion and civility. Social Science & Medicine, 37(8), 969–981
10 Civility Saves Lives. Website. Available at: www.civilitysaveslives.com (accessed 28th January 2021)
11 Jenkinson, Bec & Josey, Natalie & Kruske, Sue. (2014). BirthSpace: An evidence-based guide to birth environment design. 10.13140/RG.2.1.3962.8964.

Another story: Life on Salutogenia

Maria is in her last month of pregnancy and, like almost all healthy women, is expecting to give birth in the warmth and familiarity of her own home. Naturally, she has been monitoring her own well-being supported by family and friends, but she also drops into the local maternity centre as often as she likes. While there she can enjoy a massage, chat with friends over lunch in the cafe, relax in the beautiful garden, join a walking or singing group, take a yoga or birth art class, find out about activities that are aimed for partners and families, or check in with her midwife. Each maternity centre is attended by the same small group of midwives, one of whom will be with Maria when she gives birth.

To ensure continuity of carer, each midwife is supported in their home life by a home-help. This is a vocational role often attracting people whose own children have grown. Home-helps are highly valued for the wisdom, compassion and skill they bring to supporting the well-being of the family. They also help care for people in labour, new families, the sick, the dying, and the newly bereaved as these natural life experiences often require a spare pair of experienced loving hands. They gain this experience through apprenticeship and are regarded as wise friends or aunties. When preferred, family members may assume this role and will be remunerated as fitting the importance of the work. Everyone acquires a solid grounding in these skills and philosophies at school, and from modelling within the home. Birth, death and illness are part of life, and life is everyone's business. Health care on Salutogenia, including maternity care, is distinct from medical care. The government follows the paradigm, policy, practice approach. It has naturally adopted a salutogenic paradigm or philosophy of health, it has put policies in place known to support this, such as secure housing and minimising income inequality, and it has been conscientious in putting policy into practice. The result has been a massive improvement in well-being and a corresponding reduction in the costs of medicine. This has been possible because, as Antonovsky suspected, people on Salutogenia care about each other.

Last week, Maria felt a bit odd and decided to drop in to see her midwife Sally. She was disappointed to find that a potential complication had arisen. However, she has grown up understanding that life is complex and challenges are inevitable. With her strong sense of coherence she rallies her resources. She contacts AIMS for evidence-based information and talks it through with her family. Then she checks in with Sally about the exact test readings and together they map out Maria's different options. Maria knows that these are her decisions and hers alone, and that she will be supported whatever she decides.

As events unfold, Maria decides to have her baby in hospital. Women on Salutogenia tell wonderful stories about their hospital stays, not least about the food! The home birth culture, and the alternative of beautiful birth centres, have freed up the hospital system for those most needing medical care, thus improving outcomes and hugely reducing workplace stress. Combined with the deeply embedded culture of civility, reduced stress means that staff satisfaction, staff well-being and staff retention is optimised. The physical environment of the hospital is just gorgeous. With no extra demand on the budget, everything that is known about environmental psychology and well-being has been applied to the design of the building, furniture and decor, with measurable benefits for all within. Medical and clinical equipment is discreetly hidden but close to hand. The colours are warm and relaxing, the lighting can be adjusted, and nature is brought into each room in creative ways. People unable to access the hospital gardens for any reason can choose a nature-scape to be projected onto the walls and favourite music can be enjoyed. All of the factors that support physiological birth and perinatal transition are skilfully and lovingly applied to these more complex situations to great effect. Importantly, privacy, instinct and autonomy is respected at all times. Staff are encouraged and supported in this way of working because it fosters a matrix of trusting relationships that reduce trauma for parents and staff alike, and is cost effective in every way. Maria, like all new parents on Salutogenia, will come through the challenges of pregnancy and birth feeling safe, nurtured, respected and strong.

Birth room design informed by healing architecture and Snoezelen theory[12]

12 Nielsen, J.H., Overgaard, C. Healing architecture and Snoezelen in delivery room design: a qualitative study of women's birth experiences and patient-centeredness of care. BMC Pregnancy Childbirth 20, 283

Article

Self Efficacy: What is it? Why is it important? And what can we do about it?

by Mary Nolan, Professor of Perinatal Education, University of Worcester, UK

Self-efficacy refers to a person's belief in their capacity to act in a way that will produce a desired outcome. So having low self-efficacy in relation to a particular challenge in your life – such as giving birth – means that you feel you will have no control over what happens to you and that you are likely to 'fail' the challenge – however it is that you define 'failing'. Having high self-efficacy means that you approach a challenge with confidence that you have the inner strength and the external resources (such as a loving birth companion or a doula) to enable you to meet the challenge successfully.

Self-efficacy is a really important concept for all of us who aim to support women to make their own choices in pregnancy and achieve a satisfying birth. The concept helps us understand how people can move from a position of hopelessness where they feel that they simply can't do something that they would dearly like to do – for example, have a vaginal birth rather than a caesarean – to one where they have confidence to say 'I WILL do this' and then do it!

The term 'self-efficacy' was coined by the Canadian psychologist Albert Bandura, now a very old gentleman in his mid-nineties. The main body of his work was published in three ground-breaking books over a 20-year period from 1977 to 1997[13],[14],[15]. In these, he explored ideas around self-confidence, motivation, learning and behaviour. His conclusion was that key factors (all at least partly modifiable) influence a person's self-efficacy, that is their belief that they can take control of situations in which they find themselves.

So let's take the example of a woman expecting her first baby who is thinking about her forthcoming labour and what she would like to happen. What factors will affect her confidence and ability to make her own choices about the care and interventions she receives?

According to Bandura, there are four factors that influence a person's self-efficacy.

1. MASTERY EXPERIENCES

Our life experiences shape our sense of being in control of our circumstances and our confidence to make our own decisions. If all the decisions we have ever taken have turned out badly – for example, we chose to go to university and hated it; we chose a partner and the relationship failed; we chose a particular job and it led nowhere – we are likely to have low self-esteem and lack confidence in our capacity to 'get it right'. I remember once discussing informed choice with a group of pregnant parents and one woman shared that everything she had ever tried to do in life had gone wrong so she was going to leave all the decisions during her labour to the staff at the hospital. On the other hand, if our life decisions have turned out well and we have aimed for certain things and achieved them, we're likely to feel that our future decisions will work out well too.

13 Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, NJ: Prentice Hall.
14 Bandura, A. (1986). Social Foundations of Thought and Action: A Social Cognitive Theory. Englewood Cliffs, N.J.: Prentice-Hall.
15 Bandura, A. (1997). Self-Efficacy: The Exercise of Control. New York: W.H. Freeman.

2. Vicarious experiences

Our self-efficacy in relation to a particular challenge will be affected by the experiences of other people close to us. This factor is highly influential when it comes to childbirth. First-time mothers may be exposed to so many horror stories – women sometimes seem to delight in telling each other how awful their labours were! If a woman has been told repeatedly by her friends and relatives that labour is unmanageable without an epidural, or that breastfeeding is extremely painful, her confidence in relation to labour and feeding will probably be eroded. The experiences of those who shape her view of the world will vicariously undermine her self-efficacy.

3. Social persuasion

Nowadays, social persuasion operates in many forms – via the television, Facebook, Twitter, Instagram and less obviously, but equally powerfully, via what 'experts' tell us. We are all constantly being 'persuaded' of certain things by the way in which news is presented to us, by advertising and by the norms of the groups in which we move. If media and health professionals constantly present childbirth as a life-threatening experience requiring expert medical assistance, society's view of childbirth will evolve to see the act of giving birth as intrinsically dangerous and best managed by professionals well versed in pathology and emergency care. Women's trust in their own bodies and their self-efficacy for birth is diminished by this social persuasion.

4. Emotional state

Pregnancy is a profoundly emotional time when women and men start to redefine themselves as mothers and fathers. Growing understanding of the responsibility that they are taking on with a new baby heightens awareness of risk and also of opportunity – the opportunity to make a difference in the world by successfully nurturing a new human life. A woman's naturally heightened emotions in pregnancy may be unreasonably exaggerated if she is in very difficult and frightening circumstances, such as living in poverty, or in a country whose language she doesn't speak, or with an abusive partner. Being in a hyper-emotional state makes it difficult to make decisions and take control.

Increasing Self-Efficacy

The four factors outlined above – mastery experiences, vicarious experiences, social persuasion and emotional state – will all affect whether a pregnant woman feels she is able to make her own choices about having a baby and carry them through. So what can we do as midwives, or doulas, or childbirth educators to enhance her self-efficacy?

1. Mastery experiences

In antenatal classes that I led, a popular discussion centred on how you might prepare for an important interview. Suggestions included: reading up on the company, business or institution you're hoping to work with; talking to people doing the job you're applying for; making sure you know how to get to the interview venue; choosing the right clothes; having a good night's sleep, eating an energy-packed breakfast, practising relaxation and using positive affirmations ('I can and I will give an excellent interview'). All of these enable mastery of the interview situation – and, I used to point out, are equally applicable to preparing for labour! By helping parents-to-be understand that the challenges they have already met in their lives would help them face the new challenges ahead, I aimed to illustrate that they have had MASTERY EXPERIENCES even if not yet of labour and birth.

2. Vicarious experiences

It's often revealing to ask parents-to-be what their friends' experiences of labour have been. For example, to ask: 'How did your friends' labours start?' 'How long did friends' labours last?' Talking about other people's experiences enables educators and midwives to understand how vicarious experiences might be affecting parents' decision-making capacity. If a woman shares that her sister's labour lasted three days and her best friend went into hospital four times before being finally admitted in labour, you have the chance to discuss how all women's experiences of labour and birth are different and that a very long, slowly progressing

labour isn't necessarily going to be her experience. Unless you find out what are the vicarious experiences that are boosting or lowering a woman's self-efficacy, you're not in a position to help her develop a more rounded understanding of what labour and birth are like.

3. Social persuasion

Sharing positive birth stories is very important in addressing the often negative influence of social persuasion. Positive stories shared by a childbirth educator in an antenatal class ('Let's read Maria's story of her successful home birth') or by a midwife at a clinic appointment ('I've just been at the most beautiful birth…') can counter-balance the many horror stories that women have been exposed to. Similarly, watching a video of a labour where the woman strongly and confidently births her baby without intervention can provide images of birth to compete with the medical dramas that are pervasive in our television viewing. It's really important that we start to tackle social persuasion in relation to labour and birth by disseminating positive stories and images of powerful women who choose their own way to have a baby (whatever that way might be).

4. Emotional state

A woman's emotional state in pregnancy is inevitably complex. Some people are living in circumstances that mean they are emotionally very fragile, with their confidence levels and their self-efficacy low. There may be very little, if anything, a childbirth educator or health professional can do to address such deeply entrenched problems as poverty, destructive relationships, lack of education or inter-generational disadvantage. However, the consistent, sensitive support of a known and trusted adult in the life of a pregnant woman who is struggling with adverse circumstances can make a huge difference. And this is why continuity of carer, which enables the development of a trusting relationship between the woman and someone who can walk alongside her on her pregnancy journey, is so very important (and sadly, so rarely available). Having such a caring consistent relationship can boost a woman's self-efficacy in relation to labour and birth.

Information and Skills

Finally, I want to say a little about information giving in pregnancy. This is also an important aspect of self-efficacy because it's hard to feel powerful in a particular situation if you don't understand what's happening. Knowledge is Power. Information giving is a skilled undertaking; it's not a question of simply dumping a whole load of facts on a bewildered parent-to-be. People need the information they want at a time that they want it. So in an antenatal appointment or antenatal class, if we're discussing, for example, induction of labour, we can start by asking the woman or couple or group what they already know about induction. People – especially when they're pregnant and are highly motivated to learn – often know far more about labour and birth than educators and health professionals give them credit for. I generally find that the information parents share with me is largely accurate and telling them that they already know a great deal boosts their self-efficacy wonderfully! Armed with the educator's positive affirmation, they feel strong enough to correct any misinformation that they hold and to pay attention to essential new information.

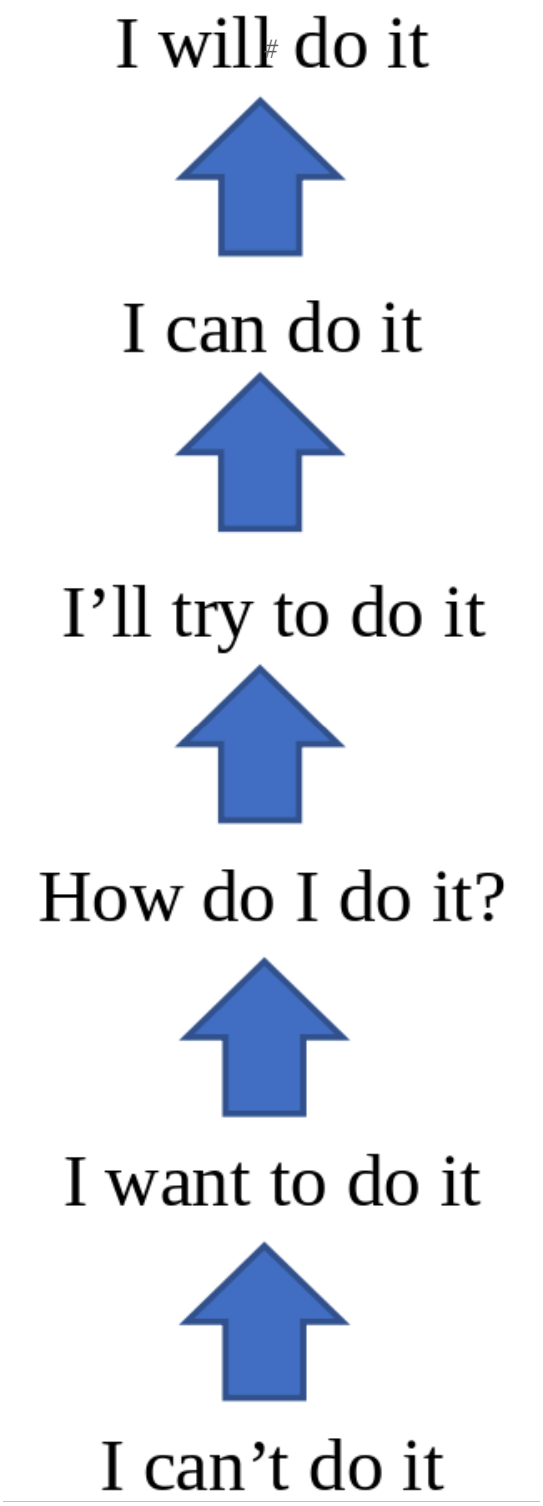
However, facts aren't enough to boost a woman's self-efficacy to labour and give birth as she chooses. She also needs skills to work with her body. This is why it's so important to offer women and their chosen birth companions the opportunity to learn and practise a variety of skills for labour - upright positions, calm breathing, massage, positive affirmations, visualisations and relaxation. If her choice is to aim for a straightforward vaginal delivery, she needs to acquire the skills to facilitate this.

Conclusion

This article has summarised the factors that influence an individual's self-efficacy in relation to particular circumstances and has suggested ways in which childbirth educators, doulas and midwives can help pregnant women move up the self-efficacy scale and experience a birth which enables them to embark on motherhood with confidence and positive mental health.

THE SELF-EFFICACY SCALE

(based on an idea from https://coachcampus.com/coach-portfolios/power-tools/robyn-goddard-self-efficacy-vs-self-doubt/)



Article

What can we learn from listening to our internal monologues?

by Sophie Martin

We all have continuous internal monologues running day and night.[1] Much of what the voices in our heads say is a reflection of our subconscious, a constant behemoth of an undercurrent, processing thousands of pieces of information every day, whilst our conscious mind skitters along the surface. Our subconscious is often only dredged up in our dreams: weird mish-mashes of half-processed content from our day, matched onto experiences both past, present and possible. This subconscious monologue is a powerful tool, something that enables us all to make snap judgements that contain a myriad of personal biases. Bias gets a bad rap today as it is often associated with discrimination: biases linked to ethnicity and gender usually have negative or controversial connotations. But these snap judgements and pattern-matches are an endlessly useful strategy to inform our evaluations of one another: What does this person think

1 Andreas S. NLP Techniques – Help with Negative Self Talk – NLP eBook from Steve Andreas [Internet]. YouTube. 2021 [cited 8 February 2021]. Available from:https://www.youtube.com/watch?v=JiVEfkUIuMI

of me? Can I trust them? Am I safe? Could just being aware of our own internal dialogue help us strip back our own and others' conscious judgements to address our deeper needs underneath? This subconscious storytelling, our sixth sense, our 'gut feeling' has been key in our evolutionary history.

And it is also key to our health. Studies have shown that outcomes are influenced by the stories we are told, and we tell ourselves, overt and implied, about our well-being and care. Some pathologies are so ingrained in the inner conversation that we become the pathology itself: 'I AM depressed', 'I AM high risk'. It is well known that doctors who build a good rapport with patients promote their health and well-being[2], and that the side effects of drugs and placebos are strongly influenced by the assumptions of those who have been blinded to what the little pills they're prescribed actually contain[3].

So what narratives can be active in the perinatal period, and how are these shaped by interactions with our care providers? Are they effective in supporting our emotional, and therefore physical well-being? Most women and families take their cues from medical professionals when developing their inner discourse around pregnancy, even mirroring doctors' and midwives' language closely. It could be argued that rather than a medical event, childbirth is first and foremost a rite of passage but differs from other life changes because it often takes place in a medical setting. Spiritual and other celebratory aspects are often overlooked, and the meaning-making can take on a risk-based approach. It'd be strange to book a wedding and alongside making all the plans for the beautiful touches – favours, signage, chair-covers, flowers – picturing your perfect day in your mind's eye, to be told '**it's only going to get worse**' or **'you should think about your safety**' or feel like you have '**carried the weight of words**' while carrying your baby[4]. If that were the case maybe folks would think twice about getting hitched in the first place. Phrases like this can pervade the subconscious of the mother, and be deeply unhelpful.

Pregnancy and childbirth also differ in that, despite much care taking place in a medical environment, no innate pathology is involved: in the majority of pregnancies under midwife led care, no disease is being cured, no malfunctioning part removed. The trickle-down effect of consultant led care, quantifying risk rather than qualifying it, and a move away from case-loading, means the relationship between a woman and her healthcare providers might be a distant one, with decisions based upon protocols rather than her personal informed choices. It is also often the case that mothers invest much time and emotional energy in communicating with medical professionals, in an environment where supportive and informative interactions can degenerate into a risk-minimising, box-ticking exercise. Far from the midwife or obstetrician listening as a friendly and helpful ear on an equal footing, they can appear dictatorial, patronising, even hostile. There must be some contributing factors to the tribalism that can arise between women and families and their caregivers, some influence that is responsible for corrupting erstwhile questioning, courageous and confident mothers into litigious and fearful patients, under the risk-mongering care of practitioners urging birth partners to '**talk some sense** into their nearest and dearest.

It can take courage and a certain amount of space and time (and legal backbone) to speak honestly and openly about some negative experiences in the NHS, and to examine the internal dialogue of those operating within the system, free from the burden of future reprisals. An example of this is former obstetrician Adam Kay, who in his frank, funny and horrifying account of working in the NHS, shines a light onto the struggles of caring for birthing people and families in a climate of unacceptable staffing pressures[5]. In contrast to midwifery-led care there can be a higher level of perinatal pathologies for women under obstetric care, as they can comprise mothers with complex needs and co-morbidities, mothers and babies who, in the doctors' view, could potentially die on their

2 Ha J, Longnecker N. Doctor-Patient Communication: A Review. The Ochsner Journal 2010 10(1):38–42. Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184 (accessed 16 February 2021).

3 Govender S. Is the Nocebo Effect Hurting Your Health? WebMD. 2021. Available from: www.webmd.com/balance/features/is-the-nocebo-effect-hurting-your-health#1 (accessed 8 February 2021); Geddes L. 'Nocebo effect' cause of most statin side-effects, study suggests. The Guardian, 15 November 2020. Available from: www.theguardian.com/society/2020/nov/15/nocebo-effect-cause-of-most-statin-side-effects-research-suggests (accessed 8 February 2021).

4 All quotes in bold italic type are anonymous excerpts from a discussion on Facebook on 13 January 2021 in response to a request made by me with respect to language use in maternity care and its impact on women.

5 Kay A. This is Going to Hurt: Secret Diaries of a Junior Doctor. 1st ed. London: Picador; 2018.

watch. Trapped in a narrative of death lurking behind every cubicle curtain, the precious and vulnerable lives in their care, and without the time or emotional space to connect with birthing people, is it any wonder that 'you can't pay any attention to the (wo)man behind the curtain, your own sanity relies on it'[6] whilst at the same time '...couldn't think about anything bad ever happening again... women were having unnecessary caesareans... but if it meant everyone got out of there alive it was worth it'[7]. Surely, this is a strategy for self-preservation and risk control, to neither acknowledge the mother as a person nor allow her to assume responsibility for her choices, for fear of the worst becoming a reality. Given the climate of fear, we can appreciate that the subtext to many medical conversations – and even consultants' self-talk – is laced with implications for safety, heavy with inference on parental responsibility, heavy with risk, fear and just bloody wretched for all concerned.

So how to use this tool of subconscious messaging, of instant judgement, to help support not only our well-being, but change the conversation entirely around perinatal healthcare? Is this too monumental a task? Firstly it's okay not to burden ourselves with this, at times, herculean undertaking. To go as far as bringing our own monologue into the bright light of day, scrutinising it, augmenting unhelpful aspects, letting it go, that in itself is work enough. But as Kay says, 'why would any sane person do that job for anything other than the right reasons?'[8]. The lack of appreciation by the system, the demands on personal time and the arguably pitiful salary mean that the medical staff we have left could possibly be our greatest gift. Are there strategies that already exist to uncover the unmet needs beneath the self-talk, align diverse points of view, and promote empathy, understanding and health of both mother and doctor?

There is precedence for creating a framework in which potentially conflicting interests can communicate effectively to mutual benefit. AIMS is not alone in its longstanding work for the rights of birthing people[9]. Birthrights, for instance, has applied the lens of human rights to perinatal care to allow mothers to stand on the shoulders of legal giants, and discuss their pregnancy choices as equals with even the most exhausted and risk-averse of consultants[10]. We can also delve deeper into the underlying needs of both pregnant women and healthcare providers by assuming every interaction is at its most basic either a 'please' or a 'thank you' exchange. This changes an induction booking from a ***'kick start a car'*** into a 'PLEASE, let me try to explain this with a simple metaphor', '***incompetent contractions***' and ***'don't endanger the life of your baby'*** to 'PLEASE, don't either of you die'. If these requests were acknowledged more openly, it could become easier to empathise with one another.

This lack of trust and respect that can occur between women and their care providers can foster an atmosphere of doom and gloom, and overlooks the productive and trusting relationships that do develop, in spite of the strain on time and resources.

This lack of trust and respect that can occur between women and their care providers can foster an atmosphere of doom and gloom, and overlooks the productive and trusting relationships that do develop, in spite of the strain on time and resources. What a gift for the health of the mother, unborn baby and her healthcare professionals, when they are supported to enhance one another's internal dialogue! What change in subconscious narrative might take place, and thus augment nuance and inflection during discussions? What wonderful trickle-down effects might we expect for families and maternity services as a result?

This work originates within us, and begins with interrogating the voices we all hear from within. Unwrapping the layers of the metaphorical onion (rotten now from overuse) we can choose to use our discoveries of underlying needs beneath our internal discourse to re-frame our own narratives, and thus conversations with others. Joe Griffin and Ivan Tyrell in their thesis on the human condition postulate on nine 'givens' that we need to live

6 Kay, This is Going to Hurt, p. 258
7 Kay, This is Going to Hurt, p. 258
8 Kay, This is Going to Hurt, p. 261
9 Ashworth, E., 2020. *AIMS Guide to Your Rights in Pregnancy and Birth*. 1st ed. Association for the Improvement of Maternity Services.
10 #BasicBirthRights – Birthrights. 2021. Available from: www.birthrights.org.uk/campaigns-research/basicbirthrights (cited 16 February 2021).

a fulfilled life: security, attention, autonomy, intimacy, community, privacy, status, competence, and purpose.[11] With our eyes opened to this knowledge about which needs might be unmet in our perinatal circumstance, we might seek to prod our care-givers, partners, and families into action, and open their minds to diverse outcomes other than the binary of "life and death".

We might seek other tools that exist to promote understanding to benefit the health of both parties, and put any conflict into perspective. Marshall Rosenberg's ability to reconcile two apparently black and white points of view was honed during 1960s race riots in America, using a model he developed called 'non-violent communication' (NVC)[12].

[Rosenbeg] reasoned that needs of different parties are never in conflict, with relationship breakdown ensuing only when the possible strategies for meeting needs clash.

According to his model, individuals are encouraged to cultivate self-compassion, to honestly express how they feel, and to listen empathetically within four criteria: observe, note feelings, discover deeper needs, and finally make requests of the other person He reasoned that needs of different parties are never in conflict, with relationship breakdown ensuing only when the possible strategies for meeting needs clash. According to his model, individuals are encouraged to cultivate self-compassion, to honestly express how they feel, and to listen empathetically within four criteria: observe, note feelings, discover deeper needs, and finally make requests of the other person[13]. Rosenberg noted successes even when one party is neither motivated by compassion, nor aware of NVC: if we ourselves are able to 'stay motivated solely to give and receive compassionately, and do everything we can to let others know this is our only motive, they (the other party) will join us in the process'[14]. There are also clear benefits from NVC in medical settings, one doctor commented 'NVC helps me understand what patients' needs are and what they need to hear at a given moment... I feel more energy and joy in my work as I become increasingly engaged in NVC'[15].

It is noticeable then that, in sharp contrast to what at times can seem to be an all-pervasive climate of fear and pathology around the perinatal period, there can also be a myriad of ripple effects from outstanding, or even just 'caring' care. This is witnessed by women in very clear terms: when *'language used made me feel strong and capable', 'how great I was and that I could do it'*, and *'they (the midwives) were just there to help and support'*. This is what can be achieved when we have gained a better understanding of the deeper meaning-making in what we say. Mothers and care-givers can grasp the opportunity to support one another to not only endure pregnancy and the perinatal period, but to re-phrase their internal monologues to marvel at the amazing work the mother's body is doing, and as a result be more easeful, safe and well.

The rewards for us all when we cultivate healthful internal monologues are great, and their positive powers far-reaching. Listen up.

Quick-fix guide to re-framing your self-talk

1 – Helpful or unhelpful: Are your internal narratives bringing positive changes and feelings that are helpful? Or are there unhelpful themes that can be harmful to ourselves or others?

2 – Pick out three 'feeling' words, adjectives that sum up unhelpful themes in your internal story, for example 'tense, anxious, fearful'

3 – Interrogate these adjectives to find opposites that ring true to us. It's important that these are free from negatives or quantifiers ('less anxious' or 'more relaxed' do not count) or time phrases ('relaxed later' and 'brave next week' don't count either). Following the examples above, the three opposite words might be 'relaxed, calm, courageous'.

11 Tyrell I, Griffin J. What are the 'human givens'? Human Givens Institute. 2021. Available from: www.hgi.org.uk/human-givens/introduction/what-are-human-givens (accessed 16 February 2021).
12 Rosenberg M. Nonviolent Communication: A Language of Life | Center for Nonviolent Communication [Internet]. cnvc.org. 2015. Available from: www.cnvc.org/training/resource/book-chapter-1 (accessed 16 February 2021).
13 The NVC Model | Center for Nonviolent Communication. cnvc.org. 2020. Available from: www.cnvc.org/learn-nvc/the-nvc-model (accessed 16 February 2021).
14 Rosenberg M. Nonviolent Communication: A Language of Life | Center for Nonviolent Communication. 2015. Available from: www.cnvc.org/training/resource/book-chapter-1 (accessed 16 February 2021).
15 Rosenberg M. Nonviolent Communication: A Language of Life | Center for Nonviolent Communication. 2015. Available from: www.cnvc.org/training/resource/book-chapter-1 (accessed 16 February 2021).

4 – Deeper needs: how do these tie in with the nine human givens? It could be that feeling anxious might reflect a lack of emotional security, for example. This can help us to communicate our needs clearly to ourselves and others, e.g. 'I want to know that I can choose to relax, and feel secure'.
5 – Reflecting on others' language: Can we pick out adjectives that hint at others' self-talk themes? Can we work opposite adjectives into our responses to show we understand their subconscious needs?

Sophie loves supporting women to birth and mother with pride through yoga, feeding and trauma support, and most importantly tea and biscuits. She lives in Berkshire with her partner and two young sons.

Bibliography

Andreas S. NLP Techniques – Help with Negative Self Talk – NLP eBook from Steve Andreas. YouTube. 2021. Available from: www.youtube.com/watch?v=JiVEfkUIuMI (accessed 8 February 2021).

Ashworth, E., 2020. AIMS Guide to Your Rights in Pregnancy and Birth. 1st ed. Association for the Improvement of Maternity Services.

#BasicBirthRights. Birthrights. 2021. Available from: www.birthrights.org.uk/campaigns-research/basicbirthrights (accessed 16 February 2021)

Geddes L. 'Nocebo effect' cause of most statin side-effects, study suggests. The Guardian. 2020. Available from: www.theguardian.com/society/2020/nov/15/nocebo-effect-cause-of-most-statin-side-effects-research-suggests (accessed 8 February 2021).

Govender S. Is the Nocebo Effect Hurting Your Health? WebMD. 2021. Available from: www.webmd.com/balance/features/is-the-nocebo-effect-hurting-your-health#1 (accessed 8 February 2021).

Ha J, Longnecker N. Doctor-Patient Communication: A Review. The Ochsner Journal. 2010; 10(1):38-42. Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184 (accessed 16 February 2021).

Kay A. This is Going to Hurt: Secret Diaries of a Junior Doctor. 1st ed. London: Picador; 2018.

Rosenberg M. Nonviolent Communication: A Language of Life | Center for Nonviolent Communication. 2015. Available from: www.cnvc.org/training/resource/book-chapter-1 (accessed 16 February 2021).

The NVC Model | Center for Nonviolent Communication. 2020. Available from: www.cnvc.org/learn-nvc/the-nvc-model (accessed 16 February 2021).

Tyrell I, Griffin J. What are the 'human givens'? Human Givens Institute. 2021. Available from: www.hgi.org.uk/human-givens/introduction/what-are-human-givens (accessed 16 February 2021).

Article

Yoga: A time for me and a time for my baby

by Cathy Welch

While I was ruminating about what to write for this article, a text popped up on my phone with a baby announcement from one of the women who recently attended my Yoga for Pregnancy (YfP) classes over a number of months, initially in person and then online. Her final sentence read:

"It was such a positive experience and all your coaching with breathing and moving through contractions helped enormously so thank you so much."

Campbell and Nolan[16] have explored reasons for women attending yoga classes during their pregnancies and a high priority for the women who participated in their study was to gain confidence in their ability to manage the sensations of labour. This small study found that improved self-efficacy was considered to have played a leading role. It gave me pause for thought as I reflected on why I teach Yoga for Pregnancy classes and whether the feedback from women before and after their babies are born is congruent with my aspirations for their experiences.

I have to admit that teaching these classes is a highlight in my week – sitting in a circle of women (literally, or currently metaphorically), each with their own story, sharing their hopes and dreams, their needs and desires, and feeling that I can create a safe and supportive environment that will enhance their well-being, feels like an honour and a privilege, much more than just a job teaching yoga. This supportive social space is considered one of the key contributory factors to improved mental health in pregnant women,[17] [18] alongside the specific yoga practices of breathing, physical movements and meditation/relaxation.[19] Evidence continues to grow that yoga has a positive effect on the hypothalamic-pituitary adrenal axis through stimulation of the vagus nerve, which reduces cortisol levels and thus, by implication, potentially improves women's health and that of their unborn babies.[20] But do the women who attend Yoga for Pregnancy classes know this? I doubt it. Most women are there because they have been to yoga classes in a previous pregnancy, because a friend has recommended it or because their midwife may have suggested it as a way to combat anxiety.

I sometimes start a session by asking women to share what they get from the classes and without fail their reasons feel perhaps nebulous and intangible. They include: time for the mother; time to think about her pregnancy; time for her to relax and switch off; helping her to sleep; improving her comfort and easing her niggles. Once their babies have been born, women may share feedback on social media or via evaluation forms and similar themes arise:

"Yoga classes gave me time to focus on me and my growing bump and postnatal yoga allowed quality time to bond with my baby."

"It was such a nice me time."

"Mum and baby yoga was a lot of fun, me and my daughter got a lot out of it."

16 Campbell V.R. & Nolan M. (2019) 'It definitely made a difference': a grounded theory study of yoga for pregnancy and women's self-efficacy for labour. *Midwifery* 68 (2019) 74-83.

17 Bribiescas S. (2013) Yoga in Pregnancy. *International Journal of Childbirth Education* 28(3) 99-102.

18 Campbell V.R. & Nolan M. (2015) A qualitative study exploring how the aims, language and actions of yoga for pregnancy teachers may impact upon women's self-efficacy for labour and birth. Women and Birth (2015). Http://dx.doi.org/10.1016/j.wombi.2015.04.007

19 Sheffield K.M. & Woods-Giscombé C.L. (2016) Efficacy, Feasibility, and Acceptability of Perinatal yoga on Women's Mental Health and Well-Being. *Journal of Holistic Nursing* 34 (1) 64-79

20 Kwon R., Kasper K., London S. & Haas D.M. (2020) A systematic review: The effects of yoga on pregnancy. European Journal of Obstetrics & *Gynecology and Reproductive Biology* 250 (2020) 171-177.

"I found the yoga really helped with my SPD, and was the one chance each week for me to relax and concentrate on myself and my bump."

"The yoga exercises were great for helping to keep my body supple during pregnancy."

"...benefit of sharing experiences with other local women."

Sometimes we share tears, often we share laughter. Women experience loss, heartbreak, joy and elation. They love the opportunity to be with other women in order to share stories and learn about themselves. They carry what they learn into their daily lives – adapting to their ever-changing bodies and, "Preparing for something I can't prepare for". For many women their yoga class is the 'drug of choice'. At a time when they may be deciding to avoid most medications, certain foods and alcohol, and curtailing their normal exercise routines, yoga becomes something women feel ready to embrace. It gives them confidence in their ability to cope and, when labour begins, it is another tool in their kit for working with whatever happens:

"It helped me during a long labour to stay calm."

"'Breathing techniques learnt in yoga definitely helped get me through the stress of labour and making some tricky decisions."

"The breathing exercises really helped with my homebirths."

"I used several of the breathing techniques during my labour which helped me to control the pain and achieve the delivery that I wanted."

In reality, however the labour and birth progress on the day, whether it is a planned caesarean or a birth at home, and whatever challenges the recovery presents and regardless of the reality of caring for a newborn baby (or two!), time and time again the women talk about how the breathing they learnt in yoga has helped them through the perinatal period. They highlight the sharing with other women, the gentle caring and consideration they receive in classes, and the growing understanding and knowledge about their own bodies that they gather along the way.

So, while acknowledging that not every woman who attends classes falls in love with their Yoga for Pregnancy sessions, many do – and consequently many women feel stronger, more confident and filled with self-belief. There is nothing more rewarding than welcoming them back with their babies for 'mum and baby' yoga sessions, for their next pregnancy and even after their child-bearing time is over, when yoga becomes their way to maintain health and well-being for many years to come.

"(The) knowledgeable and gentle approach made me feel like I was in safe hands, and the group was very welcoming. At the class we discussed lots of different aspects of pregnancy, labour, delivery and motherhood in a safe environment which gave me the confidence to choose my own path. Several of the women were attending the classes for their second or third time, and I'll certainly plan to go again if I have another baby."

Aims for the Yoga for Pregnancy sessions

- To build women's confidence and trust in their innate ability to give birth to their babies resulting in an increased number of straightforward vaginal births where women can work with their bodies in a way that leaves them feeling empowered and fulfilled.
- To give women a wide range of practical yoga-based skills to help them adapt to pregnancy, to work with their bodies during labour and birth and to aid recovery after their babies are born.
- To give women an opportunity to share ideas, experiences, views, feelings and concerns within a safe and comfortable environment.
- To give women the space and time to just 'be' with their babies and with themselves
- To create a time when women can connect with their breath, their body, their emotions and their minds through yoga practice.
- To inspire women to want to continue yoga practice after their babies have been born.

At a time when they may be deciding to avoid most medications, certain foods and alcohol, and curtailing their normal exercise routines, it becomes something women feel ready to embrace.

Cathy Welch has been a childbirth educator for over 25 years. She is passionate about supporting women's health and well-being through yoga and homeopathy in Wiltshire.

Article

Mothers are doing it for each other: A conversation with The Motherkind Café

by Katharine Handel

Illustration by Katherine Crawford, "Salutogenesis."

The Motherkind Café is an Oxfordshire post-natal peer support group where women who are worried about their mental health after having a baby can come and talk about it in a supportive and non-judgemental environment. The café offers both monthly "circles," which are facilitated discussion groups on a particular topic or theme to do with motherhood, and drop-in sessions. It was founded in 2019 by Emily Malden and two clinical psychologists, Guin Webster and Rebecca Knowles-Bevis.

Today, I am one of the café's co-ordinators along with Emily and Katherine Crawford. Although The Motherkind Café has had to change its format during the COVID-19 pandemic, it has continued to operate via a private Facebook group and Zoom support meetings.

The three co-ordinators at our first birthday party in January 2020

I thought that the model of mothers helping other mothers by drawing on their own experiences was a great example of salutogenesis, so I had a conversation with Emily and Katherine about the history of the café, what it means to us, and what we'd like to achieve with it in the future.[1]

Emily Malden: I set up the café because I wished it had existed when I had my son. I wanted an informal space where it was ok to say you were really struggling and where you could hear that there were other people who had struggled too. I'd read a lot online about women who'd had difficulties with their mental health when they'd had a baby, and I'd meet people with older children who would admit that they had found it hard at the beginning, but nobody who I met who was in the same phase as me was prepared to say they were struggling.

Katharine Handel: And didn't you also have problems finding somewhere you could bring your baby with you?

EM: Yes. I wasn't really eligible for any clinical support because they didn't think I was ill enough. I tried to find a group through MIND because I saw that they ran peer

support groups, but they didn't have any specifically for post-natal depression or post-natal mental illness. I know psychologists say that post-natal depression is still depression and the symptoms are very similar, but for me, my mental health was completely linked to the fact that I'd just become a mum, and I was really struggling with that concept. I felt there was a real lack of support for women with mental health problems that had specifically developed in the post-natal period, and though I was offered some groups or therapy, you couldn't bring your baby, and I couldn't leave him because he was so young at the time. So it was important to me that you could bring your baby, but that the focus would be on the mum's mental health.

Katherine Crawford: I remember seeing a call on social media for peer supporters to help set up a café with mums in mind which was specifically for mums who had found it difficult, who'd either experienced post-natal depression or who were just finding the transition to motherhood hard. I had post-natal depression with my second child and I just loved the idea of the café: I thought, "This is what I would have wanted when I was really struggling." From my own experience of peer support, it's so important to see people who have been in a really dark place who have survived it and who are ok; it proves they're human. I wanted to give hope to those mums, so I got in touch with Emily and I'm really pleased I did.

KH: I had been really wanting to do something for women in my local community for a while. Then I saw the Facebook advert and I felt like I could contribute something useful, as I'd suffered from depression for a number of years in the past and I was really worried that I was going to relapse when I had my son, though I was very lucky and that didn't happen. I remember messaging and saying "I've been depressed but I'm not currently depressed and I didn't have post-natal depression, is this enough?!"

EM: I'd say about a third of the women who applied to be peer supporters didn't identify as having had a post-natal mental health condition: they just knew that it was really hard and they wanted to tell other mums that it wasn't going to be hard forever. Everybody struggles, I don't really believe people who say they don't, but we're not allowed to say it.

KH: I think you need to hear somebody being honest first so that you feel comfortable being honest about what's happening to you.

KC: I think that's what makes it such an important place. At all the baby groups that I ever went to, you were so afraid of saying something like, "I'm not really enjoying this," because what if somebody rejected what you said? Whereas when you come to the café, once that door is closed, you can say whatever you like. We're not going to throw it in anyone's face. We're going to say, "It's ok to feel like that, and it's not going to feel like that forever." It really spoke to me that it was just mums. It's a protected space just for us. And seeing people relax when they don't have to be careful, when they don't have to really explain what they're finding difficult, is just lovely. God, I miss it.

EM: I miss it! This is making me miss it.

KH: Me too. I really miss connecting with other people. Remember that first session when we all got together to do the training and talk about the café? It was such a special day. We knew we'd all lived through our own horrible experiences and that we were there because we wanted to do something with that pain and turn it into something that would help other women.

KC: That's what mums do though, isn't it? They just plough through it, crack on.

EM: I think for quite a few of our peer supporters, it was empowering to think "I've got something I can do that is useful for other people," and I think that's part of what's great about it. And I think there's a very specific kind of support from people who've been through the same thing as you, and we've had people say that this helped them more than the clinical support they received. I don't mean that clinical support isn't really important, but in my case, I knew that I just needed to talk about what I was going through because I couldn't process it and I didn't feel like there was really anyone who understood. I think peer support is an amazing tool for helping people who are going through something really tough. Seeing someone who's been through the same thing as you on the other side of it is so powerful.

KH: I think sometimes with your mental health you need permission to say, "This is bad." You get that much more easily and much more non-threateningly from talking to one of your peers than you do from going to see a doctor. It feels like almost a stepping stone to either saying, "This is enough, this is what I need," or to recognising, "I need more than this." The validation of somebody else saying that what you're going through is serious is very valuable.

EM: Yes, I can think of specific examples of women I've spoken to for whom being at the café, hearing that other women had found it hard, and realising that they weren't alone was definitely enough. And I can also think of plenty of women who maybe hadn't fully realised that they were struggling because they had post-natal depression and they needed more help. Both of those instances can be seen in a positive light, because they both have very positive outcomes. The people who need the help can feel empowered to go and get it, and the people who don't feel the need to seek help elsewhere get something from not feeling so alone in struggling with motherhood, because like I said, I think everybody does.

KC: I think how you access the café is important as well, because although we have our safeguarding and our policies, the three of us are not qualified to say, "You have post-natal depression." What we can do is to say, "If you have it, or think you might, you are welcome here and nobody's going to say that you're ill or label you." From the outside, we just look like a playgroup. We've had many visitors who have taken a couple of sessions before they're happy to say that they're really struggling. You can't just keep going to the GP and saying, "I'm fine, I've made this appointment but I'm absolutely fine," but people can come to us for as many sessions as they like. I think that's a really nice way to be able to access informal support, there's no pressure.

EM: I think one of the things I was really keen on was that it should be a drop-in, no referral. So you can just decide on the day if you want to go. And there's no criteria for coming, you don't even need to feel like you have anything at all, you just need a space to talk about what you're going through. I know that baby groups are a vehicle for social interaction with other mums, but they seem to have a big focus on the baby, or the mum and the baby, without any focus on discussing what's just happened to you.

KH: I think the café is the one place where you're yourself first and you're a mother second, and what's going on with you is the most important thing. It's about you, and that's something that you don't get very often as a new mum.

KC: Also what I really like about the café is that you feel a bit looked-after, you're always welcome, somebody makes you a cup of tea. You don't realise how important that act is until you've had your identity stripped, you've just had a major life event that could have included surgery, and sometimes nobody even asks you how you are!

EM: And that's what we care about, because we know your little baby is loved and held and fed, and we have no doubt that you're doing a brilliant job as a mum, but what's important to us is how you deal with it. That question just didn't feel like it was being asked enough.

KC: I think our circle sessions are great as well. I'd never ever heard of anything where you could come as a mum to a session where there would be no bubbles involved and no-one would be offering to do sensory play; instead, it would be an adult conversation. I really enjoy those talks where you have a room full of women having a really deep conversation.

EM: Yeah, about things like identity, or how a baby changed your relationship with your partner, or with your mother, or with other members of your family. They were amazing. They've always been our most popular sessions. I think what's great about them is that they give people a space to have an in-depth conversation: it's an open floor for a really interesting discussion, a safe and confidential space for a discussion about something interesting, about really massive things that are a part of being a mum.

KH: It's been a bit different this year, hasn't it?

EM: Yeah, because we've done a lot of online support, but we've had phases of not being able to actively support people in the way we'd like to and we haven't done as many sessions as we would have normally done.

KH: But what we've got instead is a real community on our Facebook group.

EM: Yeah, I agree. For ages I'd wanted to create a private Facebook group for the people who'd been to the café to feel a connection, and I'd always hoped that people would make friends through the café, so setting up the group this year has been great in many ways. It's got about 300 members and it's a nice community and a space where people can share things, so that's been a really positive outcome of being online.

KH: What I really like is that we've seen women who we supported when they were having a tough time supporting other women in the group as well: women who came to us when they were really struggling with their mental health now respond to people who are in the same position as they were, and they can add their own wisdom, so we're seeing the community supporting itself.

KC: There have also been some conversations when we've

talked about recovery and hearing people mention the café is a really special feeling. It makes me feel quite smug, in a really nice way.

KH: What are our hopes for the café, going forward?

EM: I just really hope to be able to see people face-to-face again soon. More broadly, I'd like to be able to sustain it for as long as possible and empower other women to want to keep running it. In the short term, we're looking to train a new group of volunteers, some of whom have been visitors to the café, which will be lovely, because we don't really know what it's like to come to the café as a visitor, whereas they do. I'd love to be able to have a couple of sessions that run in different places throughout the county too. And to keep our online group running and have that as a space for people to talk as well. That's what I'd like for the next one to two years.

KC: I'd agree with Emily. I'd love to see it expand. In my pipe dream, we'd have a session running somewhere in Oxfordshire every day, so that somebody could potentially go every day and get that support from other mums, to create a network of mums who are looking out for one another and taking the strain of the loneliness and isolation you can feel. And not just in COVID times: being a new mother can be incredibly isolating whenever you do it. But I'll settle with trialling another location and continuing what we're doing. And publishing our book![2]

EM: I think I just want to keep the conversation open about mental health, particularly for new mums, but really for mums of all stages, and to battle some of the stereotypes and expectations of women as mums and about the way society tells us we're supposed to feel. I think anything we can do that's a little chip away at that massive block of expectation and pressure on women who've had a baby is a positive thing, and I'd love to just keep us banging that drum.

Katharine Handel is an editor and researcher. As well as being one of the editors of the AIMS journal, she is also one of the co-ordinators of The Motherkind Café and a contributor to the café's podcast and blog.
She lives in Oxfordshire with her husband and son.

References

1. For more about the café, visit our website at themotherkindcafe.org.
2. This book (which is currently in preparation) will contain stories contributed by members of the café's community about their experiences of feeding their babies and how that impacted their mental health.

Article

Introducing "They said to me": Giving voice to the voiceless

by Samantha Gadsden

'They Said To Me' is an awareness-raising platform, present on Facebook, Instagram and now a website, where women and birthing people can anonymously share their experiences of maternity services, giving voice to the voiceless.

It was founded in response to a perception of an ongoing and significant erosion of birth rights, with a corresponding increase in coercion and a rise in emotive language, and in women and birthing people being dictated to by their healthcare providers; less informed choice and more "you will comply" instruction, sometimes accompanied by threats.

"They Said To Me I am a danger to myself and my unborn child as the placenta fails after 40 weeks and I need social care to help me make better choices".

It appears that in the COVID-19 pandemic, birth rights were simply cancelled. It is becoming increasingly evident that the respect and ability to be centred in their own care and involved in decision making about themselves that all pregnant and birthing women and people deserve is not being accorded to them.

'The "positive story" narratives being posted by maternity care providers contrast starkly with stories of women literally having word battles with their care providers in order to prevent unwanted interventions. Others report feeling that they cannot speak out about their experiences of being separated from their birth partners, for fear of "letting the side down" if they don't have a smiling face on the ward.

Even in areas where home birth is still being supported, health care professionals may use a variety of reasons and excuses to talk women out of home birth, such as "your baby could die waiting for an ambulance".

"A consultant told me I would die if I attempted a home birth and my baby would die if I attempted a home birth. She also called my husband rude for standing up for my choices".

Fights between women and healthcare providers should not be happening. We are all supposed to be working together. Currently within the system, women are becoming more and more powerless instead of more and more powerful.

At 3:30 am on the 26th May, as I was answering another query from another terrified woman, I thought in despair, "I cannot hear another one of these stories without having somewhere to put it, it needs to be somewhere. I need to publicly share their stories in order to raise awareness and bring about change." This led to the birth of 'They Said to Me'.

'They Said to Me' uses the power of social media to gather stories and expose bad practice. It gives women a safe and anonymous space to share their experiences within the maternity services and receive empathic, responsive support, a voice and a community, and help to ensure that they are never silenced.

'They Said to Me' shares daily posts on Facebook and Instagram from women and birthing people about their experiences within a maternity system that is undeniably broken and that undeniably damages both those who work within it and those who have to use its services. Since its creation at the end of May 2020, 'They Said to Me' has had almost 4 thousand people 'like' and 4,350 people follow the Facebook page, and gained 2700 followers on Instagram. On Facebook in the four weeks to 13th February 2021, over 25 thousand users saw the posts and over 11 thousand engaged with them. On Instagram for the same period, the posts were seen by over 4 thousand accounts and were interacted with 2817 times.

"Thank you for your page, it is so powerful and angering to hear other birthing people's experiences".

Via our website, we now have a function to "share your story," enabling people to share much longer stories, including heartbreaking accounts of miscarriage, of dreadful experiences in early pregnancy units, of divide and conquer between parents.

"I knew I would be in for a fight but some of the things she said to me were just downright awful, she even tried telling my partner I was going to kill the baby for refusing a gestational diabetes test and said that if the baby was stillborn that'll be the reason why, even though it would go down as unexplained. I had to warn him beforehand she would turn to him, because I'm not backing down".

In the future, I would like 'They Said to Me' to become a community interest company and raise grant funding to support women and birthing people.

***Samantha Gadsden** is an experienced antenatal, birth and postnatal doula and educator, a hypnobirthing teacher and birth trauma worker. At her heart she is a birth activist. As well as being the creatrix of They Said To Me she runs the large and growing Home Birth Support Group UK, as well as 'the village and associated network of Due In and follow on parenting groups'. She is also co-host of The Birth Activist Podcast.*

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'They Said to Me' gives women a safe and anonymous space to share their experiences within the maternity services and receive empathic, responsive support, a voice and a community, and help to ensure that they are never silenced.

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Article

Challenging attitudes and language around Down syndrome: The lived experience of a proud mother

By Nicola Enoch

Improvements in the UK's maternity services all happen thanks to the efforts of a diverse range of people and organisations. In this article, Nicola Enoch tells AIMS about how she has drawn on her personal experience – where she discovered a need for improved information and support around Down syndrome – to move into the world of peer support, national policy work and campaigning. Nicola's inspiring account of her steadfast commitment and achievement serves as a reminder of just what 'ordinary people' can do and demonstrates the key role of those with a service user perspective in driving improvement and change.

Seventeen years ago, when pregnant with my second child, I was firmly of the view that I did not want a baby with Down syndrome – or as I'd have thought then, a Down's baby – a baby defined by and limited by its disability. When I reflect now, I can see how desperately ignorant I was, misinformed and misled. Society and medical practitioners led me to believe that one didn't want one of 'them', an unknown entity that we screened in order to avoid.

I'd found myself on the conveyor belt to termination – completely against all my hopes and dreams and absolutely terrified. Booked in for an amnio, my husband and I had never particularly discussed termination, but it was the unspoken default – what everyone did, what the medics steered you towards, aware it would all be dealt with quickly, discreetly and then we could try again for a baby who was healthy, no problems, and with no chromosomal abnormality…

Having suffered 4 miscarriages before our beautiful daughter Emily had been born, I had endured my share of pain and grief, and so, with fear of a miscarriage and in the hope that nature surely wouldn't be so cruel again, I decided to cancel the amnio. It turns out to be the best decision I've ever made. Although I didn't think that, a few months later, when my gorgeous baby boy Tom was a day old and a paediatrician awkwardly and clumsily expressed 'concern' that Tom may have Down syndrome and asked me if I thought 'he looked normal'.

My world fell apart. I regretted cancelling the amnio and feared our lives were now ruined. Emily no longer had a beautiful baby brother; he'd been replaced by a burdensome sibling. I couldn't envisage what Tom's life would be like as I had no knowledge or experience of Down syndrome – I imagined rejection, segregation, isolation…that Tom would have to go to a special school, that as a family our lives would be dominated by Down syndrome, a future full of medical appointments, awkward stares and embarrassment, people pitying us, specialist equipment. I feared we'd entered a world we'd been led to believe we didn't want to be part of, and so found ourselves considering having Tom adopted. It sounds extreme when I try to condense my feelings into a paragraph, but the fact is that complete fear and utter despair overwhelmed me.

I'd clearly rejected Tom and feared I'd never love him as I did Emily; but in time I fell back in love with him, and now I couldn't be prouder or love either Emily or Tom any more than I do. As Tom started to show me that he was nothing to be feared, not a risk or a burden but rather a wonderful little boy who made my heart swell with love and pride, I started to question why I'd felt such despair and fear. I realised how influenced I'd been by medical language and attitudes, by my lack of knowledge or contact with anyone with Down syndrome, by society's derisory and prejudicial views towards those with any sort of a learning difference and the blatant discrimination that is levelled towards those who are not perceived to be normal, to be acceptable.

When Tom was 18 months old I started a local support group, The Ups of Downs[1], in Warwickshire. Over the years I realised I was never meeting any parents who'd discovered whilst pregnant that their baby had Down syndrome, just parents who had all too often struggled in the early days as I had. It has been a long journey of discovery – realising how negative and discriminatory attitudes towards those with Down syndrome prevail in maternity services. For expectant and new parents, very little accurate information is provided, and inappropriate or non-existent support is given to parents when they are at their most vulnerable and in need.

And so, in 2017, I created Positive about Down syndrome[2] (PADS), initially as a website full of stories and photos. The stories are written by young people with Down syndrome and their friends and families, and the aim is to share the reality of our everyday lives. I hope that in this way we support other families with what they yearn to know: "What will our lives look like?"

PADS has a strong presence on social media and we have gone on to create online support groups for expectant mums[3] – whether they have a high chance or a confirmed result of their little one having Down syndrome – and a group for new parents[4]. These pages offer amazing support and I am immensely proud of them, as I can see, on an almost daily basis, how beneficial they are to our expectant and new parents. I don't want any parent to feel alone, to be scared of the future, when the reality is that there is nothing to be scared about, that a child with Down syndrome fundamentally has the same needs as any other baby. Whilst approximately 15 to 20% of babies with Down syndrome require heart surgery, the outcomes are generally very good. I am astounded at how strong and resilient most of our babies are! Just recently we had one little girl, Matilda, undergo open heart surgery, closing an ASD (atrial septal defect) and large VSD (ventricular septal defect) on a Wednesday morning. She was home Friday evening.

I also started to campaign and lobby for change as I became more aware of the lack of information and support for our expectant and new parents, along with discrimination towards Down syndrome. In 2019 at the Houses of Parliament, we published a research report – Sharing the news[5] – which corroborated the anecdotal stories. I was hearing of women being pressured to terminate, and decisions not to screen or to continue a pregnancy regularly being questioned and undermined, along with a shocking amount of ignorance, misinformation and lack of support.

Sharing the news

This is a survey of 1,410 women who have given birth to a baby with Down syndrome since 2000, conducted by PADS in 2018, in conjunction with Don't Screen Us Out (DSUO)[6] and the Down's Syndrome Research Foundation UK (DSRF)[7]. Responses reveal that there is a general assumption by medical professionals that an expectant woman will terminate when discovering her baby has Down syndrome. The report also finds that:

on receiving news that the baby had Down syndrome:

- 69% of women were offered a termination.
- After advising that they were continuing with the pregnancy, 46% of women were asked again if they wished to terminate.

on receiving news that the baby had a high chance of having Down syndrome (greater than 1:150):

- 91% of women were offered further tests.
- Of those who declined further tests, 44% felt under pressure to test further.
- After advising they were continuing with the pregnancy, 50% of women were offered a termination again.

antenatal screening:

- 41% of women were of the understanding that screening for Down syndrome was a routine element of their antenatal care.

- 41% of women advised professionals that they did not want to screen for Down syndrome.
- After advising that they didn't want to screen for Down syndrome, screening was mentioned again to 49% of women.

There has never been an RCOG (Royal College of Obstetricians and Gynaecologists) pathway for those women continuing a pregnancy with a high chance or confirmed result of baby having Down syndrome, only an RCOG pathway for those choosing to terminate: this speaks volumes about attitudes and priorities. In 2019, PADS was approached by St George's Hospital (Tooting, South London) to collaborate to produce such a pathway, together with the Down Syndrome Research Foundation and we were delighted to recently publish this[8].

In June 2020 we published #NobodyToldMe the truth about Down syndrome[9] – a collection of experiences written by young people with Down syndrome and their friends and families, and we are delighted with the response. We have already distributed over 2,000 copies. We gift a copy to all our expectant and new parents and have some funds to provide copies to maternity units. PADS has appointed a Maternity Co-ordinator as we are keen to build relationships with local maternity units, provide literature to signpost parents to our website and online support groups, connect hospitals with their regional support groups and provide training. We are presently collaborating with Health Education England to produce an eLearning module which we hope will be available before the end of 2021.

Seventeen years ago, I was terrified and felt desperately alone. Today, I often wonder how I could ever have considered our lives would be better without Tom. He has taught us all so much, and without a doubt has enriched our lives. It saddens me that on a daily basis, women in the UK are making life or death decisions without the information and support they deserve, that new parents are left feeling devastated and scared and that expectant parents are anxious and alone. PADS is here to support those parents, as well as educate and inform medical professionals about the reality of living with Down syndrome in modern Britain. We hope that both parents and professionals are empowered by such knowledge.

Nicola Enoch is a founding trustee of both The Ups of Downs and Positive about Downs Syndrome. For more than 15 years, Nicola has been passionate about improving the lives of those with Down Syndrome, and their families, and she has worked with a wide variety of stakeholders to achieve this goal.

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References

1 www.upsofdowns.co.uk
2 www.positiveaboutdownsyndrome.co.uk
3 www.facebook.com/groups/415274562687672
4 www.facebook.com/groups/2188980851370457
5 www.downsyndromeuk.co.uk/flipbook.html
6 www.dontscreenusout.org
7 www.dsrf-uk.org
8 https://www.stgeorges.nhs.uk/wp-content/uploads/2021/01/Personalised-antenatal-care-of-pregnancies-suspected-or-diagnosed-with-Down-syndrome.pdf
9 www.positiveaboutdownsyndrome.co.uk/nobodytoldme
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Article

Continuity of Carer and Social Support Network: Working together

By Anne Glover

As a doula, I am keen to embrace the ideology that women's chosen social support is important for the well-functioning of the maternity services, and also an integral part of a well-functioning continuity of carer model of care. I am writing this during a pandemic when birthing partners, doulas, friends and family are being prohibited from fully supporting women and birthing people during birth and postnatally. Some healthcare professionals are of the opinion that once Continuity of Carer is widely implemented across the maternity services, then there will be no need for doulas. In this article, I will explore why it is important for Continuity of Carer to work hand-in-hand with members of the social support network, which may include a doula.

Beyond the bounds of the maternity services, adequate social support is crucial to ensuring a positive transition to life with a new baby. Here, we explore how formal maternity services can work to facilitate beneficial social support networks, focussing on how the Continuity of Carer[1] model of care does this particularly well.

The Continuity of Carer model of care in maternity services places great emphasis on individualised care, to ensure that the midwife and her client can form an honest relationship allowing trust to develop, as dreams and vulnerabilities may be disclosed and discussed. It is a relationship that develops antenatally, during labour and birth, and extends into the postnatal period ensuring consistency and a sense of familiarity and respect. This is proven to be an effective way to improve health outcomes for both mother and baby. It is a professional relationship not only between a midwife and her client, but also with the client's chosen social support network, including family, friends and doulas, who may often attend medical appointments or consultations as a means of emotional support or as an advocate.

Social support network

Most of us thrive on being around other like-minded individuals, supporting each other in our life ventures and experiences, and this is no different when a family is preparing for the arrival of a new baby. As Maddie McMahon writes: 'Human beings are a tribal species, reliant on extended families and neighbours during times of extra work, upheaval, celebration and grief.'[2] Friends, family, neighbours and doulas all have different qualities and offer unique types of support. Ultimately, it is a woman's choice who she wants or needs to have around her during pregnancy and as she prepares for the birth and life with a new baby. However, informed choices are dependent on knowing the extent of choices available, and not everyone has access to a ready-made social support network. Social support is vital to help a family adjust to having a baby,

to offer practical support but also to support the family emotionally and promote their mental well-being. It is reassuring in times of life-changing events to know that you are not on your own and that you have a social network to turn to for guidance, sharing knowledge and experience, as well as the professional medical care from your midwife.

How does this model of care impact on a woman's social support network?

Women and families are at the centre of Continuity of Carer[3] and as service users they are an important part of implementing change in the maternity services. For maternity services to function well, there needs to be great satisfaction between midwives and their clients. We already know the improved health outcomes for mother and baby,[4] but there needs to be an appreciation that the Continuity of Carer model can benefit the well-being of the midwives and the team as well, so they can work to the best of their ability with great job satisfaction. Midwives cannot provide everything families need as some issues and needs are outside their remit, and this model of care will thrive if women have their own individualised social support network. For example, a postnatal doula can visit the family as often as they wish to assist with caring for the baby, caring for other siblings and pets, ensuring they all have nutritious meals, and perhaps sharing housework and laundry with the extended family. This can really help a family to adapt to having a new baby. If mother and baby are adapting well together with the support of a doula, then this will in turn ensure that the time spent postnatally with the midwife is more effective and successful for everyone involved. It's important to listen to the woman and trust her to know what she needs and who will best provide the support she needs as she prepares for birth and life with her baby. Nowadays, there are even greater demands on fathers and partners, so why not have as much social support as you can get? Continuity of Carer is not just for the mother, but for her partner, children, doula and friends, her whole wider social network.

There has been some talk in the maternity world about this model of care eradicating the need for doulas,[5] who provide continuity of emotional, physical and informational support to families throughout pregnancy, labour and birth, and postnatally. It really is a personal choice who should be in the support network. It could be family, friends and/or a doula. Doulas spend time getting to know everything about a family as they prepare for life with a newborn and offer hands-on support, as well as being there as an advocate if that is what the family wishes, building an intimate relationship. Evidence for doulas shows that the benefits of continuous support during labour and birth provide better outcomes for mothers and babies.[6] If more women are more satisfied with their birthing experience and outcomes, then there will be a reduction in the long-term cost to the NHS. It makes perfect sense, then, that continuity of care provided by both midwives and doulas working alongside each other, complementing each others' work, can only enhance the birthing experience for families.

An example of how a doula complements the Continuity of Carer model of maternity care

Sara Benetti, a doula from the North Coast in Northern Ireland, recently supported a first-time mum who opted for care from the Lotus Team:[7]

> *I heard about the Lotus Team in the summer and was delighted to recommend it to my clients, as I thought the opportunity to be looked after by a small team of midwives through pregnancy, birth and postnatally was a wonderful idea. Pregnancy can be stressful enough at times for families, never mind the additional anxiety and stress around COVID! My last client opted for the Lotus Team, and I was lucky enough to have already met her named midwife before, through our local Positive Birth Movement group. I already knew she would support her with balanced discussions around her wishes, and there was a lot of uncertainty around COVID, about place of birth (home, large busy ward or smaller local unit?), general worries about pregnancy and birth any new parent may have. Her midwife always took the time to chat with her and her partner without any rush, occasionally with me too. When labour started, I went to my client's home to support her there. We kept in touch with her midwife by message and called her when my client was considering going into hospital. As a doula it was heart-breaking not to be able to walk into the labour ward with my client and her partner and continue to support them there, but at the same time, it was so reassuring to leave them*

at the door where they were met by their own midwife, who then not only looked after them until the baby was born, but also sent me updates so I knew they were doing well. I was confident that they would have been fully informed and supported in whatever decisions they needed to make and that she would have reminded them that they could always take the time to consider options and even call me to talk things through if they felt the need. I felt we were a team and my clients surely felt the same. They felt they had support at every step of the way and that they were the protagonists of their own journey, which makes such a big difference too when things are not entirely smooth.

AIMS is keen to see the extension of this respectful Continuity of Carer model of maternity care becoming standardised across the UK. AIMS is certain that the more emphasis is put on individualised care and acknowledgement of women's choices to have their own social network around during a life-changing event, the more it will optimise the professionalism and well-being of the maternity services, and ultimately alleviate stress on women and the NHS. Often it is a doula who highlights the maternity choices available, and she can then encourage women to demand the Continuity of Carer model of care.

References:

[1] NHS England (2016) National Maternity Review: 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

[2] Maddie McMahon (2015) Splashing out on a doula. https://thebirthhub.co.uk/2015/07/21/splashing-out-on-a-doula/

[3] Kirstie Coxon and Hannah Jones (2016) Relationships: The pathway to safe, high-quality maternity care. Sheila Kitzinger symposium at Green Templeton College, Oxford: Summary report. https://www.rcm.org.uk/media/2962/skp_report.pdf

[4] Midwifery Continuity of Carer (COC) page https://www.rcm.org.uk/promoting/professional-practice/continuity-of-carer/

[5] More information on the role of doulas can be found on the Doula UK website: https://doula.org.uk/

[6] See https://doula.org.uk/research/

[7] For more on the Lotus Team, see Anne Glover (2020) Campaign update: Continuity of Carer, Northern Ireland – Trying to do it properly! https://www.aims.org.uk/journal/item/campaign-update-continuity-carer

Article

The science behind babywearing

By Neve Spicer

Neve Spicer is the founder and chief-editor of WeTheParents, the pregnancy and parenting guide. As the mom of three wild but wonderful children, she shares her hard-won experience and know-how with her fellow parents in the hope it will make the ride less bumpy.

Neve has created a wonderful infographic that provides a visual summary of the evidence of the benefits of babywearing for both babies and parents. This can be seen on the AIMS website, www.aims.org.uk/journal/item/babywearing-infographic.

You can find the T.I.C.K.S. rule for safe babywearing at babyslingsafety.co.uk (used with permission of the UK Sling Consortium).

Interview

An Interview with Soo Downe by the AIMS Campaigns Team

Interview by Jo Dagustun

Soo Downe

AIMS recognises that many different types of organisations, alongside many individuals, play an important part in the mission to improve UK maternity services for all. Academics, and the research work they do in universities, are an important part of the maternity services improvement community. In the UK we are fortunate to have a flourishing maternity research sector, including academics with a midwifery background who play an increasingly important role. In this interview for AIMS, Professor Soo Downe – who leads a thriving research team at the University of Central Lancashire – explains her role, how she manages to keep her work grounded and policy-relevant, as well as her position in England's national Maternity Transformation Programme's Stakeholder Council.

Can you please start by telling us about what drives your passion for maternity service improvement, and what first attracted you to getting involved in working with birth?

I first came across labour and birth when I was in the second year of my undergraduate degree (which was a degree in literature and linguistics: nothing to do with health care!). I happened to find myself in Boputhaswana, one of the South African homelands, at a time when apartheid was still prevalent. For complicated reasons I was staying on a maternity station run by nuns. There, I saw birth for the first time and seeing the women there give birth, it struck me (almost like a *coup de foudre*) that if we get birth right, we get the world right. And that is something I continue to believe to this day.

As a midwife and working professor at the University of Central Lancashire, what does an average work day for you look like?

Currently, under lockdown, my day probably looks very much like many other people's days! Getting up at about 7 in the morning, working through most of the day on the computer, linking up with people all around the world online. I may be dealing with a student query or meeting a student I supervise one hour. Then the next hour, I may be meeting with the World Health Organisation about a review or a study we're doing. Then I might be talking on Teams with some of our colleagues who are working on a large research programme – our NIHR-funded ASPIRE-COVID 19 study about maternity care organisation during the pandemic in the UK and the Netherlands. Then I may join one of the national policy meetings about a key issue that we feel to be particularly important at the time. If possible, I'll have a break for a local walk or a cycle – I am extremely lucky to have the Forest of Bowland down the road. Then I might be back in the evening to work on some presentations, or perhaps to give a presentation in a different

timezone, through the wonders of broadband.

Then there's organising our normal labour and birth international research conference, or our masters module on normal birth, or talking with team members about possible new blue skies innovations. (Team members are, for instance, working on studies using gaming and VR technology, thermal imaging and innovative media, linking all this with sociological or psychological theory in the domain of maternity care…) That is the really exciting part of research! Oh, and getting the email to say that a paper that you think might make a real difference has finally been accepted for publication, or that a bid for a project that you think might finally be The One to change the world is actually funded!

Can you tell us about the piece of research you've been involved in that you remember most fondly, and – if different – what element of your academic work you think has done the most for improving maternity care in the UK?

I suppose my first research study is one that I remember with some degree of fondness, although I also remember not really knowing what I was doing. It was a large survey of midwives to find out about the experiences of those who trained as direct entrants, at a time when it looked like direct entry was going to be vanishing from the UK. I decided to survey a whole range of midwives to find out if they were direct entrants or not, with questions about how they felt about their job or how they got into the job, and so on. I think, from memory, I got hundreds of responses back. Given that this was pre computers, analysing all those responses was a huge job. I only ever managed to write it up as a short piece in MIDIRS (Midwives Information & Resource Service) and always intended to go back to the data because it seemed to me there was an awful lot of extremely interesting information in there.

In terms of the work that we've done recently that made the most difference, the most influential is probably our reviews of what matters to women, undertaken for the World Health Organisation for their recent guidelines. The finding (which is not surprising to anybody really) is that women want and need a positive pregnancy, labour, birth, and postnatal experience. The findings were based on world-wide reviews of all the qualitative research published in each area in all languages and were instrumental in re-framing the WHO guidelines for maternity care, so that they now have the term 'positive experience' in their title. This does seem to have provided legitimacy to talking about the personal individual humanised aspects of maternity care globally, in parallel with all of the work being done by many people to identify, call out and reduce disrespect and abuse.

In England, we have just been marking the fifth anniversary of the 2016 Better Births report. In your opinion, how much of an impact has that report had in driving maternity service improvement so far, and what are you keen to see delivered still?

I was a member of one of the sub groups that preceded the Better Births report, namely the sub group on models of care. What that group worked out is that in order to really change the way maternity services are performed, delivered, managed, and practised in the UK (and possibly around the world), it was really important to completely start again with a blank sheet. So, rather than saying 'we have these buildings, we have this design, we have these referral patterns that are all based around how organisations function most effectively', it was critical to sweep all that away and to truly and authentically start with the woman at the centre and build the service around her.

There was a genuine enthusiasm in the models of care and the other pre-Better Births groups to do this. I'm now a member of the Stakeholder Council that advises the Maternity Transformation Board on what is happening on the ground and how to tackle possibly difficult bumps in the implementation road. We're all still saying you can't just bolt change on the top of existing services. You have to do it by making change happen at a very fundamental level, and this is a message which is proving very very hard to implement, perhaps not surprisingly. Probably, along with most members of the Stakeholder Council, I'd say that getting this right is all about having that difficult but essential conversation. Whether at government level, commissioners, CEOs of Trusts, Directors of Services, or at the level of practice, and maybe also learning from where people have done this well. There are examples of good practice that show it is possible to reconfigure effectively even during a pandemic. It is perhaps critical that we learn from these in order to be able to go forward.

As a member of the Maternity Transformation Programme's Stakeholder Council in England, can you say a little more about your role and what the group has achieved to date?

See above. The Stakeholder Council meets regularly, every couple of months, usually to discuss particular elements of the strategy and propose ways of enhancing progress towards fulfilling the Better Births goals. So I think what the Council has achieved to date has been to make sure that some of the targets are kept high on the government's agenda, both those associated with safety – like the care bundles – and, critically, those associated with personalisation (which is also actually safety), namely the continuity of care targets. These have of course been disrupted to an extent by COVID, but the Stakeholder Council has continued to work through the pandemic and has continued to say that these elements are critical and can't be dropped, because they are about the long-term wellbeing of mothers and babies and families. The other advantage of the group is how it brings together key players from a range of organisations, which helps with friendly and constructive conversations, even where the starting positions or the underlying philosophies of the individuals concerned might vary quite considerably.

You have written about a salutogenic approach to maternity care. Please could you explain what you mean by this and how this approach might lead to improvements in the maternity services? Could you also share some specific examples of where a salutogenic approach has been adopted to the benefit of maternity service users?

Salutogenesis is a concept developed by Aaron Antonovsky. He was a medical sociologist who, when dealing with survivors of the Holocaust, was surprised to find that some individuals were remarkably positive about life, given all they had been through. The theory is relevant to every life phase, from birth to death. The three basic concepts that make up what he called the overall Sense of Coherence for an individual are that life is meaningful, manageable, and comprehensible. The theory goes that if an individual possesses high levels of those three qualities, then their sense of coherence is high and their capacity to deal with complications in life is also high.

There is growing evidence in maternity care that people who start with a high sense of coherence in the maternity journey do better. Also, women who have positive birth experiences can enhance their sense of coherence into the longer term, even though Antonovsky originally believed that your sense of coherence was fairly fixed by your early 20s. Conversely, negative birth experiences can quite profoundly damage a person's sense of coherence into the longer term. Just before Antonovsky died, he was beginning to talk about salutogenic organisations and communities, and this really is where the application might be in maternity organisations and systems.

In this case, the salutogenic approach would say we have to pay attention to what makes things go well in maternity services as well as what makes them go badly, both at the level of the individual and at the level of the organisation. So, for example, an individual may have, on the face of it, certain risk factors, but may also have, for example, familial traits or experiences or histories that mean those risk factors are mitigated. An example in maternity care might be somebody who is at 41 weeks, but is otherwise well, and who has a family history going back generations of longer pregnancies with good outcomes. This suggests, for this particular individual, that giving birth beyond 41 weeks is genetic or physiological as opposed to being grounds for induction.

There are many other examples, of course. At the organisational level, as noted, above, the theory would suggest that what we should be doing is looking at organisations that manage both healthy women and babies and those with complications or risk factors really well. So you might look for an organisation, for example, (controlled for case mix), that has low rates of adverse outcomes, high rates of spontaneous physiological birth, high rates of maternal wellbeing, high rates of maternal choice being delivered (whether that's for elective caesarean or home birth), and high rates of staff wellbeing, with low staff turnover rates. What are they doing right that other places can learn from?

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

We have some of the best evidence, policies and targets for maternity services in the world. The challenge is to get this to drive authentic change deep into practice, so it becomes part of maternity services' DNA. Now is probably the

greatest opportunity we have had for decades to really get maternity care right by ensuring that we keep in balance BOTH optimal clinical care and outcomes AND genuinely humanised care throughout the maternity episode. It is also a time when such care is coming under sustained pressure from increasing bureaucracy, risk aversion, social media pressure, journalistic 'click-bait' sensationalism, and more and more pressure on time for care. The only way that this chance for authentic renewal can succeed is if midwives, service users, medical staff, policy makers, managers, commissioners, social influencers, media leads and others can genuinely cross the divide between each others' sometimes highly entrenched positions. We need to shift our gaze once and for all to the consideration of values based care provision, with attention to the life course implications of what is provided, said, done, and valued during the maternity episode.

In 2020, AIMS celebrated our first 60 years, and we are now looking towards the future. Can you tell us a little about what AIMS means to you, and where you think our efforts would be best placed over, say, the next five years?

Since I joined the Association of Radical Midwives (the ARM) in the mid-1980s, I have always seen AIMS as a sister organisation, working with the ARM to foreground what matters to women and other maternity service users, their babies and their families. The Trent survey on interventions in normal birth, published in 2001[1] and based on work that Beverley Beech and colleagues had published earlier in the AIMS journal, was a profound wake-up call to the RCM and other professional organisations about the state of normal physiological birth in the UK. Though the legacy of that work has been subject to severe critique recently, I stand by it. These findings show that every year, thousands of women and babies who would like to labour and birth physiologically are not supported to do so (this was also unfortunately mirrored in the recent NMPA (National Maternity and Perinatal Audit) data[2]). We now also have evidence from microbiome and epigenome studies, suggesting that this may have profound and long-term consequences on rates of chronic auto-immune disease over the life course[3].This cause is still an important one.

AIMS has always fought for the rights of women in maternity care, whatever they are, and the current focus on the terrible inequalities for Black African, Asian, and minority group women and babies is critical. Getting beyond simple platitudes and developing solutions that get to primary causes is just the kind of work that AIMS has always been at the forefront of. I see this as the other essential focus for AIMS going forward.

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1 Johanson R, Newburn M. Promoting normality in childbirth [published correction appears in BMJ 2002 Jan 12;324(7329):98]. BMJ. 2001;323(7322):1142-1143. doi:10.1136/bmj.323.7322.1142

2 National Maternity and Perinatal Audit 2019 Available at: maternityaudit.org.uk/FilesUploaded/NMPA%20Organisational%20Report%202019.pdf

3 Downe S. & Byrom S. (eds.) (2019) Squaring the circle: Normal birth research, theory and practice in a technological age. London: Printer & Martin Ltd, Chapters 13 and 14
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Article

Better Births – Five Years On

By Annie Francis

The National Maternity Review, led by Baroness Julia Cumberlege, was commissioned by NHS England in March 2015. Its report, Better Births, was published in February 2016, and its conclusions and recommendations continue to underpin maternity policy in England, under the banner of the Maternity Transformation Programme.

Five years on from the publication of Better Births, AIMS is pleased to share some reflections on the programme's implementation from Annie Francis, a member of the National Maternity Review Team as well as a continuing member of the Stakeholder Council.

I am sitting at my desk writing this on January 31st, 2021. It is the second anniversary of the closure of Neighbourhood Midwives and we are in our third lockdown of the COVID-19 pandemic.

Five years ago, as the National Maternity Review's report, Better Births,[4] was about to be published, I could never have imagined that this is where we would be. Back then, I was full of hope that the bold central vision of the report that 'most women would know their midwife by March 2021' was not only achievable, but could actually be made a reality. The difference this time was that lessons had been learnt from the days of Changing Childbirth[5] and that a comprehensive 'Maternity Transformation Programme' (MTP) was going to ensure that all 28 recommendations from Better Births would be implemented.

Back to 2021 and the million dollar question: Has the MTP succeeded and are we where we hoped we would be? Obviously, the last year has taken a massive sideswipe at so much – health and social care, education, the economy – and so it is impossible to ignore the impact of this on maternity. But even before the pandemic, there were plenty of signs that we might not be on track to achieve what was set out with such clarity and hope 5 years ago.

The key word for me is 'transformation.' It was acknowledged in the Better Births report that none of the changes being recommended would be possible within the 'current staffing models' and that moving to greater continuity would require more 'radical approaches'.[6] One such radical idea was the integration of alternative midwifery providers, with a proven track record of successfully offering almost 100% continuity of carer. There were two such providers operating at the time – Neighbourhood Midwives in the South and One to One in the North.

NHS personal maternity care budgets (PMCBs) were another radical idea from the review. These were intended to be linked to an accreditation system which would have enabled Neighbourhood Midwives and One to One to be available for selection directly by women,[7] given that our organisations had both successfully met the stringent requirements of an NHS contract and were already commissioned to provide NHS services. Fast-forward to 2021 and neither proposal has been rolled out – PMCBs are little more than a choice menu, where they still exist at all, and the accreditation system never moved beyond the planning stage.

The fact that neither Neighbourhood Midwives nor One to One has survived is, frankly, down to the many systemic barriers and challenges we both faced, none of which were successfully dismantled quickly enough. A

4 National Maternity Review (2016) 'Better Births'. www.england.nhs.uk/ourwork/futurenhs/mat-review
5 McIntosh T (1993) A celebration and a warning. AIMS Journal [online]; 28(2): www.aims.org.uk/pdfs/journal/483.

6 Better Births (2016), www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf p. 76.
7 Better Births (2016), www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf p. 118.

major factor was the lack of significant reform of the funding and commissioning structures within the maternity services. The emphasis on competition that was a central plank of the Health and Social Care Act 2012 meant there was no incentive for other Providers to collaborate with us. The bottom line was that every woman who booked with us was a loss of income for them and we simply didn't have enough clout or sufficient resources to hang on long enough for the system to recognise and embrace what we had to offer – with catastrophic consequences for both organisations.

Apart from the failure to successfully embed new providers, slow progress on improving postnatal care and the apparent disappearance of a rapid resolution and redress scheme, what of continuity of carer (CoCr)?

NHS England produced guidance for implementing CoCr in 2017 which included this definition:

> *First and foremost continuity of carer means that there is consistency in the midwife or clinical team that provides hands on care for a woman and her baby throughout the three phases of her maternity journey:*
>
> - *Pregnancy*
> - *Labour*
> - *The postnatal period*
>
> *Secondly, it enables the co-ordination of a woman's care, so that a named individual takes responsibility for ensuring all the needs of a woman and her baby are met, at the right time and in the right place.*
>
> *Thirdly, it enables the development of a relationship between the woman and the clinician who cares for her over time.*[8]

Despite the huge amount of effort, time and money that has gone into introducing continuity of carer (based on this definition) as national policy, the overall impression is of an extremely mixed picture. There are Trusts who have relished the challenge and made significant progress, while others (the majority?) still struggle to reach the initial target of 20% of women receiving continuity of carer. The concept of 'most women' has been downgraded to mean 51% (that isn't 'most' in my book) and the postcode lottery of access to continuity of carer teams is alive and well across the country. Taking a snapshot of where we are now, even the most generous minded would hesitate to call it an unqualified success.

There are many theories and explanations put forward as to why the implementation of continuity of carer has proved so resistant to universal acceptance and rollout. Shortage of staff, the risk of burnout and midwives not wanting to be on call are probably the most common reasons given. But these are the symptoms, not the cause. For me, it is 'New Public Management' (NPM) that lies at the heart of the problem. Introduced into the NHS in the 80s, it is an approach based on marketisation, metrics and bureaucratic management techniques commonly used in the private sector, and it is an outdated and poor fit for the complex world of healthcare.9

Recent reports – Mid Staffs, Morecambe Bay and now the Ockenden Report – all highlight the dysfunctional and toxic culture of the organisations they were investigating. It is my belief that in order to dramatically improve organisational culture, we must confront the need for system-wide change and recognise that NPM has failed. We need to look for more holistic and humane alternatives, such as the emerging Human Learning System (HLS). This is an approach based on human relationships at the heart of care provision, an environment of continuous learning and the mindful nurturing of healthy systems.[10] Until we do, we will continue to tinker at the edges of major reform – and there will be more such reports that will continue to uncover equally devastating findings.

The jury will be out for some time yet on how effectively the Maternity Transformation Programme has implemented the recommendations of Better Births, not least because of the devastating impact of the pandemic, but genuine and sustainable innovation will not take root in our NHS until we finally face the truth that the entire system needs root and branch reform.

For me, reflecting on the 2nd anniversary of Neighbourhood Midwives' closure, the future lies in the increasingly broad and growing network of like-minded individuals and organisations working to introduce a HLS approach into all public services – in my heart, I know that is where Neighbourhood Midwives would have found a home and thrived.

Annie Francis qualified as a midwife in 1998, is the former CEO and co-founder of Neighbourhood Midwives and a member of NHS England's Stakeholder Council.[11]

8 www.england.nhs.uk/wp-content/uploads/2017/12/implementing-better-births.pdf (p. 13).

9 George M (2017) The effect of introducing new public management practices on compassion within the NHS. Nursing Times [online]; 113: 7, 30–34.

10 www.humanlearning.systems/overview/

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

AIMS Commentary on the Ockenden Interim Report (10 December 2020)

By Anna Madeley

AIMS welcomes the publication of the interim Ockenden Report12 relating to 250 cases involving the care of mothers and their babies that have so far been assessed by the ongoing independent investigation of maternity services at the Shrewsbury and Telford Hospital NHS Trust (SaTH). Like the review team, AIMS is concerned that many of the issues raised are reflective of previous reports on poor maternity care in NHS trusts across the UK.

The review, which was set up at the request of Jeremy Hunt, then Secretary of State for Health and Social Care, is being conducted by a multidisciplinary clinical team of independent external reviewers, chaired by Donna Ockenden.

It is anticipated the final report will be published in the second quarter of 2021. However, as more families have contacted the authors (1,862 cases are in review in total), an interim report has been necessary to share the 'immediate and essential actions' for urgent implementation at the Trust and for reflection and, as the authors emphasise, for consideration across all NHS trusts in the UK. AIMS welcomes the decision to present these interim findings and recommendations.

The report is a sobering read, detailing – alongside recurrent themes – vignettes illustrating the organisational and systematic failures that have occurred. Good leadership and multidisciplinary team working across midwives, obstetricians, anaesthetists and neonatologists is a fundamental tenet of quality maternity care. Sadly, many of the vignettes and recommendations underline a failure to bring these disciplines together cohesively, particularly in relation to the escalation of concerns and the provision of compassionate care.

The report addresses the extent of Care Quality Commission (CQC) and local Clinical Commissioning Group (CCG) oversight of the Trust, where concerns have previously been raised; the review team is continuing to scrutinise these results and will present its findings in the final report. Additionally, the problems surrounding senior Trust leadership instability over the preceding 20 years, and the resultant view of many historical problems as 'legacy' issues, highlight the fundamental necessity to address safe and effective service provision, whilst learning from incidents through robust and thorough investigations. Sadly, the report highlights how the lack of such processes may have contributed to the failure to develop continuous service improvement.

Of particular concern to AIMS are those issues which are reflective of previous reports into poor maternity care in NHS trusts across the UK. Themes include a failure to complete initial and ongoing risk assessment of women and their babies, a lack of escalation of concerns by midwives and junior obstetricians where there is a deviation from the normal course of pregnancy, labour and recovery in the early weeks after birth, injudicious use of oxytocin in the management of labour, the drive to reduce caesarean rates at any cost, and inadequate bereavement care. In other words, there were failures in offering 'too much too soon' as well as 'too little too late'.[13]

12 'Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust', December 2020, www.ockendenmaternityreview.org.uk/wp-content/uploads/2020/12/ockenden-report.pdf

13 S. Miller et al., 'Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide', The Lancet, 2016, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31472-6/fulltext

The authors present seven Immediate and Essential Actions which they recommend that all maternity services across the UK consider and implement. These are:

Enhancing safety
Listening to women and their families
Staff training and working together
Managing complex pregnancy
Risk assessment throughout pregnancy
Monitoring fetal wellbeing
Informed consent

There is more detail about the recommendations for each of these actions in chapter 5 of the interim report.

AIMS considers it vital that all NHS trusts provide services that are committed to continuous improvement in safety, strong leadership with a workplace culture that challenges poor practice and cultures, and above all ensuring that women and their families are listened to.

Anna is a registered midwife and doctoral researcher in the field of maternity care. Previously Anna has worked as a midwife within three NHS trusts, establishing and leading a homebirth team in her last clinical role, and as a Senior Midwifery Lecturer prior to starting her studies. She continues to work as an Associate Lecturer in Midwifery across two universities alongside her research.

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Article

Getting to grips with the first Ockenden Report and what it means for the Maternity Transformation Programme

By the AIMS Campaigns Team

Donna Ockenden and her team's first – interim – report was published in December 2020. It starts to lay bare how the maternity services in the area 'served' by Shrewsbury and Telford Hospital NHS Trust have, over the years, surely failed far too many families. On one point of detail alone, it is shocking to read that women's deaths in some cases were not investigated, let alone properly investigated (para 4.71). What does that say about how we value the lives of mothers and babies, and those who come after them?

Despite pockets of excellence across the country, and despite the ongoing efforts of hard-working maternity staff, AIMS fears that the maternity services will continue to fail a significant proportion of families, in a myriad of ways that are discussed in, but also go beyond the scope of, the current report. That is why AIMS is a stakeholder in the effort to improve maternity services across the UK and has been for the last 60 years. Most recently, we have supported Better Births (2016) in offering a solid framework for the transformation of maternity services across England, and we continue to support its implementation. In this context, the first Ockenden Report certainly shines a light on a service which falls far short of the Better Births vision. AIMS is keen that the new evidence presented by the Ockenden team prompts renewed reflection on how well the existing Maternity Transformation Programme is working to put an end to the current postcode lottery that is today's maternity services, where families across England cannot be sure that they are receiving a high-quality service in line with the Better Births vision.

The first Ockenden Report is thus an important and welcome – if deeply troubling – document. It gives us confidence that the final report, due later in 2021, will further provide a compelling case to redouble efforts to implement the ongoing Maternity Transformation Programme across England.

So if this report is so useful, it is also important to consider how it has come about. AIMS believes that it was absolutely right that ministers eventually took action to commission this review into identified local failings: the allocation of sufficient public funds to support the work of Donna Ockenden and her team is key. But it is also important to note that this careful scrutiny is being enabled only through the efforts of local bereaved families. They are the ones – as others before them – who have continued in the worst of circumstances to insist on learning and action, to improve the maternity services for others. Yet again, this is a reminder that service user voices are a key element of the maternity improvement agenda: without the steadfast efforts of service user families repeatedly raising their concerns, the Ockenden Review Team would not be at work today. In that context, and in support of those families, AIMS believes that the strengthening of what we currently know as the PALS (Patient Advice and Liaison Service) function in hospital trusts is absolutely crucial and is pleased to see that this is a key element of the report's recommendations for national 'immediate and essential actions'. More generally, we wholly agree that how the maternity services listen and hear, throughout the maternity pathway, is critical to the provision of improved care and safety in maternity services.

But what of the role of others – both within the system and outside, whether individuals or organisations – to ensure that serious failings in our maternity services are addressed? What transformation needs to take place in order to ensure that in future others can play a more effective role in rooting out and addressing serious failure? Some patience is required here. AIMS will be looking carefully at the final report to see how others (maternity staff, managers, board members, etc.) – some of whom presumably also had concerns about the service in the geographical area covered by the Ockenden Review – were able to voice these. What were the barriers they faced to being heard, to being listened to? What elements of the system, in place to protect against such failings, seem to have failed us, and how? AIMS believes that such a focus will be hugely helpful as we move forward. We need to understand what structures to create and strengthen, in ways that embed transparency and accountability. We need to ensure that all scope for improvement in the maternity services is always honestly mapped, even if the task to respond to it seems daunting, and to understand how the actioning of that improvement needs to be sequenced over time.

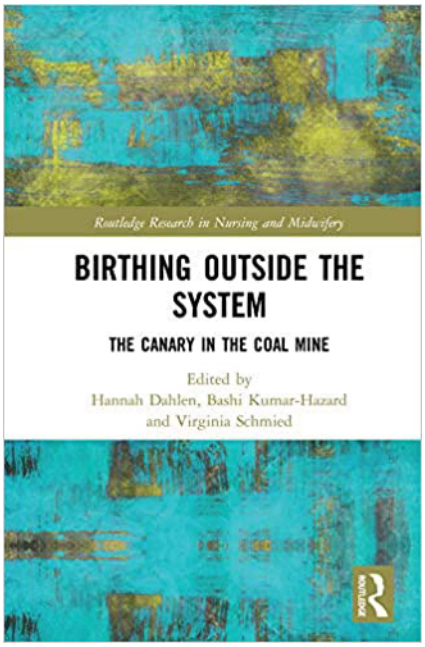
Crucially, AIMS believes that we need to see the final recommendations of this review rooted in a secure understanding of the basic physiology of birth and how this is best supported for a safe, healthy and positive outcome for all. We need to think about what is going well, and what not so well, during the whole maternity care pathway. So many of the vignettes presented in the first report seem to raise questions about the quality of care over the whole maternity pathway, questions that go far wider – for example – than skills in relation to foetal monitoring during labour.

In conclusion, this interim report, and the vignettes it presents, raises many questions. For our part, AIMS – as a critical friend – will be in touch with the review team to raise questions and also to offer our thoughts on the additional considerations that might helpfully be taken into account in the next stage of the review, so that it can properly, and most effectively, inform the ongoing maternity transformation process in England. We will make that contribution public. And we will also be offering a word of caution: despite the understandable, appropriate and searing call to immediate action, there are likely few – wholly effective – 'quick fixes' to be found.

Book Review

A Social History of Maternity and Chilbirth:
By Tania McIntosh

Published by Routledge
ISBN: 978-0-415561631
200 pages



A note from AIMS Book Review Editor, Jo Dagustun

Once in a while, birth activists around the world hear about a book in preparation that lifts our hearts. In late 2019, this was one such book, and it's a pleasure to offer here a review by two AIMS Volunteers: Gemma McKenzie (who is currently studying for a PhD, reads and produces academic texts for her day job) and Virginia Hatton (AIMS Publications Volunteer).

In offering this review, we wish to send a strong message of thanks to the authors and editors of this book for ensuring that this "serious academic text" is also highly accessible to – and useful for – those outside of the academic world who seek to "support all maternity service users to navigate the system as it exists, and campaign for a system which truly meets the needs of all" (wording taken from the AIMS mission statement, 2017).

As Virginia notes below, the price of this text is high: this partly reflects the extent of its content, but also the academic book market in which and for which it is primarily produced. It might be assumed that most readers will likely be accessing it for free via their university library. We very much hope that this does not put you off. We would instead urge you to request that this book is purchased by your local public library, so that it is easily available to everyone in your local maternity service improvement community, or perhaps opt to purchase the ebook over the more expensive hardcover version.

A review by Gemma McKenzie

Where to begin with this incredible book? I had initially believed it to be about freebirth and had envisioned an afternoon curled up on the sofa with a cup of tea and my YouTube log fire blazing on the TV while I indulged in an exploration of the subject. But this is not a book about freebirth; it is 450 pages of jaw-dropping, anger-inducing, galvanizing text that makes you want to get out of your armchair and join the battle to protect human rights in pregnancy and childbirth. The way in which autonomy, bodily integrity and abuse were explored made me want to dive into the pages for more information while simultaneously looking away in despair.

This is no holiday read to enjoy on a sun lounger; the book contains trauma, racism, misogyny and injustice, but is also peppered with rays of light that illuminate good practice and genuine efforts to improve the maternity system. It is also truly international and shifts discussion on birth away from the countries we are perhaps most familiar with – the UK, USA and Australia – and delves into the maternity experiences of women in the Netherlands, Hungary, Jordan, India and Russia. Alongside expected perspectives such as those of midwives, obstetricians and birth workers, the writing comes from a range of people including Aboriginal women in Australia, a lawyer, and an anthropologist.

Unusually for an academic book, the authors are painfully honest about their own birthing experiences. This serves to humanise them in a way we don't typically see in research texts. We see that the authors are real people who have experienced highs, lows, joy, loss and grief. Their lived experiences add depth to their academic work and we can then better understand the passion behind their words.

It would be impossible for me to present all the precious nuggets of information contained in this book. But there are a few things that stand out. One is the term 'bait and switch', which appeared in chapter 10 with regards to birth choices in Eastern Europe and Russia. This is a term I had never heard before, but it means that prior to labour, health care professionals falsely assure women that their birthing preferences and requests will be met. The 'bait' is the false assurance that ensures that a woman complies, and the 'switch' occurs when the woman arrives at the hospital where she finds that those requests and preferences will not be honoured. Although this was written about Eastern Europe, I know from my own birthing experiences that this tactic is alive and well in the UK. I find it incredibly useful to know that there is an actual term and available vocabulary to describe this behaviour, and that it has been recognised as a phenomenon that needs to be challenged.

There were also passages in the book that made me stop in my tracks due to their poignancy. These were moments when I wanted to slam my finger down on the page and shout 'Yes – I agree entirely!' Whilst I could probably quote huge sections of the book, I will limit myself to three short examples. The first comes from the chapter by Kaveri Mayra and Bashi Kumar Hazard. Writing about the Australian system, they state that:

> *Women are groomed to seek permission in relation to their own bodily autonomy. (p.203)*

In a second example, author Bec Jenkinson writes:

> *Being able to decline recommended care is an acid test of woman-centred care… (p.321)*

And finally, in reference to the 'trick question' of what are people's rights during birth, authors Farah Diaz-Tello and Bashi Kumar-Hazard respond:

> *…the most important right possessed by a person giving birth is the right to be afforded all the same rights with which every other human being is endowed. (p.283)*

I could go on and probably list another 20 quotes. But I won't. Instead, I will urge you to get hold of this text and read it from cover to cover. I guarantee there will be sections in this book that will stir your emotions and stimulate your mind. If you have given birth, there will be passages that you will be able to relate to and other areas where you will be exposed to totally new ideas. I have read hundreds of articles

and books on childbirth and maternity care – but without doubt this is one of the best.

Supplementary review by Virginia Hatton

I had the good fortune to start reading this book over Christmas and I wholeheartedly echo Gemma's judgment that this is an essential read for birth workers and birth activists. The intertwining of personal birthing experiences of the authors with sensitively conducted interdisciplinary research sets a new standard for books about birth and maternity care.

This book gave me a new understanding of birthing people and midwives' autonomy, and the language and tools to support their autonomy in my own community.

What is autonomy?

> *We all need to feel a sense of control over our own lives, or at least, our own behaviour. Autonomy can equate with individual choice, but is more complex than merely selecting from available options and is not necessarily individualistic. When autonomy is satisfied, we experience willingness, volition and responsibility for our own behaviour.* ***When autonomy is frustrated, we have a sense of being controlled by outside forces or of losing the ability to determine our own behaviour or what happens to us.*** *Women who free birth point to feelings of autonomy when they describe themselves as both responsible and able to make decisions and be in charge during their births. (p.49 emphasis added)*
>
> *Autonomy, competence and relatedness are not just the needs of a handful of women. They are t****he innate requirements of all women.*** *(p. 50 emphasis added)*

Before reading this book, I associated 'autonomy' with words such as 'confidence', 'empowerment', and 'informed decision making'. I thought of autonomy as something that birthing people 'exercised'. I'd never thought of it as something to be 'satisfied', as in the quote above. Reading this book deepened my understanding of how autonomy is upheld in UK human rights law and central to national maternity strategies. It also increased my awareness that autonomy is not only something that women exercise, but also something that can be taken away by health care providers and midwives. Examples of this include lack of choice in decision making, lack of consent for procedures and coercion (including social services threats, 'dead baby card', influencing family members, repetitive discussions of risks)[1]. Therefore, whenever these situations come up in meetings and communication I have with my local maternity services, I'm going to start reminding those involved that these actions also took away the birthing person's autonomy, something the law protects and that maternity care is meant to satisfy.

My only criticism of the book is that it is expensive, and this could limit access to the important messages it holds. I'd encourage AIMS members to see if their local libraries can purchase a copy or access it through an interlibrary loan. In addition, the many health care acronyms from around the world at times posed a challenge to myself as a lay reader. However, this was far outweighed by the benefit of hearing diverse voices from many countries, particularly ones we do not read about as much in UK birth literature.

As an AIMS volunteer it was also heartening to see the AIMS Journal cited in the references and to know that our time and effort as volunteers in keeping the Journal going is contributing to these important international conversations about birth. I highly recommend this book and look forward to discussions about it with other AIMS members in the future.

References

1 Birthing outside the system, p. 83

Article

What has the AIMS campaigns team been doing?

What we've been working on:

- A response to the draft NICE guidelines on Neonatal Infection www.aims.org.uk/campaigning/item/nice-neonatal-infection-guideline-comments and Shared Decision Making www.aims.org.uk/campaigning/item/nice-shared-decision-making-guideline-comments
- Updating the coronavirus webpage www.aims.org.uk/campaigning/item/coronavirus and template letters www.aims.org.uk/campaigning/item/template-letters with new guidance for England, Wales, Scotland & Northern Ireland, plus guidance for parents of babies in a neonatal unit
- A new series of AIMS Position Papers - watch this space!
- Continuity of Carer: relaunching our policy/campaigns team to focus on how AIMS can best contribute to policy implementation
- Ockenden: We have two initial responses - Getting to grips with the first Ockenden Report and what it means for the Maternity Transformation Programme and AIMS commentary on the Ockenden Interim Report, and are working on a further detailed AIMS response. We are also reviewing how local Trust Boards are considering the report and the 'immediate and essential actions'
- ButNotMaternity Alliance: Working with other organisations to lobby for partner attendance to be enabled throughout the maternity services
- Correspondence with the chair of the Maternity Transformation Programme Board, Sarah-Jane Marsh, requesting a progress report on the barriers and opportunities presented by existing NHS financial policies as we seek to transform maternity care through the introduction of a relational model of midwifery care (Continuity of Carer).
- Correspondence with NHS England, where – under the banner of modernising the NHS – we have argued that it's time to ditch the terminology of 'shared decision making', and invited Sir Simon Stephens (CEO) to support us in this campaign.
- Correspondence with the Health and Social Care Select Committee on the issue of 'normal birth': we argue that the maternity services need to step up to be 'Better Birth' compliant and to always offer physiology-informed care, and we have invited Jeremy Hunt MP, current chair of this Committee, to support this agenda. Find our letter here: www.aims.org.uk/campaigning/item/letter-to-jeremy-hunt-normal-birth.

Conferences/meetings attended:

- 15th International Labour and Birth Research Conference, 2-4 December
- NMPA Clinical Reference Group, 3 December
- Leeds School of Art online open lecture, 9 December
- NPEU Virtual Conference, 10-11 December
- London Maternity and Midwifery Festival, 12 January
- City Research Seminar on Decision making during labour in midwifery-led units, 18 January
- NHS England's Maternity Transformation Programme's Stakeholder Council, 21 January
- Midwifery Unit Network seminar on decision making in practice, 26 January
- All Ireland Maternity & Midwifery Festival, 9 February
- Continuity of Carer Implementation: the Oldham Journey, 12 February

What we've been reading:

- Guidance from all four nations of the UK on partner attendance in maternity care during the pandemic. See our coronavirus birth information page www.aims.org.uk/information/item/coronavirus for further details.
- Guidance from the British Association of Perinatal Medicine on parents attendance in neonatal units.See our coronavirus birth information page www.aims.org.uk/information/item/coronavirus#post-heading-17 for more information

- MBRRACE perinatal and maternal surveillance reports www.npeu.ox.ac.uk/mbrrace-uk
- Ockenden Report part 1 www.england.nhs.uk/publication/ockenden-review-of-maternity-services, published December 10, and follow up responses from NHS-E&I
- Article "Homebirthing in the United Kingdom during COVID-19" journals.sagepub.com/doi/full/10.1177/0968533220955224 by Romanis E.C. & Nelson A. Medical Law International 20:30, 183-200 September 2020
- The 2nd edition of Margaret Jowitt's book Dynamic Positions in Birth
- Findings of the WRISK report "Users' experiences of COVID-19 maternity service changes" wrisk.org/uncategorized/the-wrisk-covid-report version 2 December 2020
- Article "Consent in pregnancy - an observational study of ante-natal care of Montgomery: all about risk?" BMC Pregnancy Childbirth 21, 102 (2021). doi.org/10.1186/s12884-021-03574-2
- Article 'Unpacking the complexities of de-implementing inappropriate health interventions.' Implementation Sci 15, 2 (2020). doi.org/10.1186/s13012-019-0960-9

What we've been watching:

- Netflix "Pieces of a Woman" - a sensitive Netflix original film featuring a home birth and a neonatal death. UK charity SANDS have created a short video to accompany the film, including a Q&A with the scriptwriter Kata Wéber and lead actor Vanessa Kirby, drawing out how SANDS hopes that this film will help to 'break the silence' of the taboo that is baby loss. You can find the SANDS video on their website here: Pieces Of A Woman | Sands - Stillbirth and neonatal death charity[1]
- The film also deals with issues relating to the experiences of Agnes Gereb, and you can read more about Agnes Gereb here: www.aims.org.uk/campaigning/item/agnes-gereb
- Thanks to the Campaigns Steering Group – Nadia Higson, Debbie Chippington Derrick, Anne Glover and Jo Dagustun – and the following contributors:
- Work around Shared Decision Making, including the NICE guideline: Jo Dagustun and Belinda Brooks
- NICE Guideline on Neonatal Infection: Tasha Knights, Rachel Boldero and Anne Glover
- NICE Guideline on Caesarean: Tasha Knights, Rachel Boldero and Debbie Chippington Derrick
- NICE Guideline on Postnatal Care: Julie Milan, Holly Gresswell and Nadia Higson
- 'Black Mothers' research summary: Hannah King and Dessie Lovelace-Hanson
- Position Paper on Freebirthing: Nadia Higson, Jo Dagustun and Gemma McKenzie
- MBRRACE report on perinatal mortality in twin births: Shane Ridley
- Ockenden Response work: Jo Dagustun and Anna Madeley
- Letter to Society and College of Radiographers (SCoR) on partners and scans: Emma Ashworth and Nadia Higson
- Updates to the webpage 'Coronavirus and your maternity care' and AIMS template letters: Nadia Higson
- Continuity of Carer Campaign: Jo Dagustun and Naomi Tolsen

Please don't hesitate to get in touch with campaigns@aims.org.uk if you would like to be involved in any AIMS campaigning activities.

References

1 www.sands.org.uk/pieces-of-a-woman

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