AIMS JOURNAL

Breaking Down the Barriers to VBAC

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Editorial

Breaking down the barriers to VBAC

by Emma Ashworth

It is estimated that 29.7 million births occurred globally by caesarean section in 2015 which is around double the number in 2000. This shows an alarming increase in the use of caesarean section worldwide.1 In the UK, caesarean births have increased from 19.7% of births in 2000 to 26.2% in 20152 and some hospitals have a much higher rate than this.3

A large proportion of caesarean births are due to repeat surgeries after previous births by caesarean section. While these are commonly called 'elective', this does not necessarily mean that it was elected by the mother as the option that she wished to choose – although for some, it will be, and this must be supported. For many pregnant women, little or no support is given to them if they want to give birth vaginally after previously having had one or more caesareans and even though the word 'elective' may be used, this refers to the fact that the caesarean was planned, not that it was chosen by the woman.

With more than 1 in 4 births in the UK now being by caesarean there are some pressing medical and ethical concerns about the current status quo. While it is extremely important to work on reducing the numbers of women having a first caesarean (unless that's the right decision for that mother), improvements to how women are supported to have a VBAC are desperately needed.

With all of this awareness of a caesarean "epidemic" why are so many women left unsupported and scared if they want to attempt a vaginal birth after a caesarean? Women are commonly and actively discouraged from giving birth in a midwife led setting (home or birth centre) when preparing for a VBAC despite the research showing that home VBAC has a much higher chance of spontaneous vaginal birth (82.6%) when compared to birth in an obstetric unit (53.7%).4 The same research also showed the proportions of women having ventouse, forceps or caesarean births in the planned home VBAC group were lower than in planned obstetric unit VBAC group.

While it is never possible to cover all aspects of a topic as wide as birth after caesarean, we have done our best to cram in as much as we can. We also hope to explore the topic further in forthcoming Journals.

This Journal focuses on VBAC from some of the possible different perspectives and experiences, in order to offer pregnant women and people who are considering the option of VBAC support and information, and to raise awareness among birth campaigners of the barriers to VBAC which still remain.

As it is AIMS' 60th anniversary year, we are starting with a reflective look at AIMS' influence on the support available in the UK for pregnant women and people who want to have a VBAC. Debbie Chippington Derrick, AIMS' Chair of Trustees and Volunteer and AIMS member for over 30 years, who has herself experienced a home birth after 3 caesareans, walks us through some of this history. Sarah Le Quang Sang shares her very personal reflections on her plans for a home birth after a previous caesarean (HBAC), which she has developed into a powerful performance piece.

Our research reviewer, Gemma McKenzie, has looked at a rare piece of research which evaluates women's experience of planning a VBAC. What we hope is that this research will

help to inform midwives and doctors on the importance of their interaction with women because, so often, how medical staff do interact and support women planning a birth after a caesarean, and how this affects outcomes for mother and baby, is given low importance compared to medical interventions.

We were very disappointed to read the report from Leeds, in Yorkshire, where the NHS Trust there is putting serious barriers up for women who want to have a VBAC. We hope that raising awareness of the situation will give them cause to reflect and change.

Finally in the last of our themed articles we have the powerful birth story of Eden, shared by her mother, Katie Hickey, whose experience of planning Eden's birth led her to being instrumental in the production of this edition of the AIMS Journal.

We are grateful to Katie Olliffe for her article on compassionate communication, which continues our ongoing efforts to help everyone involved in maternity to communicate more effectively with one another – a key principle, we feel, in improving the experience for everyone.

Maddie McMahon has opened her heart to us describing how being believed when abuse or an assault occurs is essential to the person who was hurt – both inside and outside the birth room, and Verina Henchy and I have looked at how we might communicate better to health care providers what abuse looks and feels like so that they can work to change normal practices which are actually abusive.

England's first Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent, has kindly agreed to be interviewed by AIMS for this Journal, and she gives us her thoughts on how the implementation of Better Births is going. Thanks to Jo Dagustun for arranging this interview with Jacqueline.

Jo Dagustun has a top tip on how to freely access newspaper articles which are hidden behind a paywall – hugely helpful to those of us who just want to read the occasional article from particular outlets without necessarily supporting them financially! Jo has also been busy with book reviews, and this time it's the fabulous 'Give Birth Like a Feminist' by Milli Hill.

So all in all, this is definitely a more-than-one-cuppa Journal. There's certainly something for everybody so please, do share it, talk about it and make sure that as many people as possible benefit from the information in it! And don't forget, the Journal is only possible thanks to those of you who have joined AIMS as members. If you are able to, your financial support makes all the difference to us being able to continue to produce this amazing content – that and our wonderful authors.

Until next time,
Emma Ashworth
Journal Editor

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Article

Reclaiming Birth after Caesarean

by Debbie Chippington Derrick

In this 60th year of AIMS it seems fitting to reflect that when the organisation was founded in 1960, caesarean section rates were about 3%[1], and for the vast majority of those women these surgical births would have been real lifesavers for mothers and babies. At the time vaginal birth with the next baby was actually quite usual in the UK, even though this was not the case in other countries such as the USA. In the US, repeat caesareans were being recommended for many women, and the medical profession were deeming a labour following a caesarean a 'trial of labour'.

As the caesarean rates rose, reaching around 10% in the UK in the mid-1980s, more and more women were having caesareans that they felt were avoidable. Women started to share their experiences of birth after caesarean and the term VBAC (Vaginal Birth after Caesarean) came into existence, challenging the term 'trial of labour'.

There were several critical books published during the 1980s which provided VBAC information and challenged the concept that birth after a caesarean had to be a medically managed birth. These books also put the risk of uterine rupture into perspective. The first of these to have an impact were 'Silent Knife' by Nancy Wainer Cohen and Lois J Estner (1983) and 'The Vaginal Birth After Cesarean (VBAC) Experience' by Lynn Baptisti Richard and contributors (1987). The publication of these books coincided with my own need to understand what had happened to me. I was lucky to be able to network with other women struggling with the same issues. We questioned what we were being told and discussed what this meant for us.

AIMS was key in enabling an understanding of women's rights during birth after caesarean in the UK, enabling informed decision making for a group who were being led to believe they had no alternative but to submit to the will of doctors for the births of their subsequent babies.

In the *AIMS Journal* in 1990 there was a series of five stories about VBAC and Caesarean Birth[2], which included Gina Lowdon's account "I have a baby, but I've never given birth....". It was articles of this sort about caesarean birth and VBAC that were helping other women to question what they were being told by their doctors and midwives. Gina went on to have a home birth after caesarean birth (HBAC) with her second baby. The birth of my third son, a HBA3C featured in the *AIMS Journal* in 19963, a birth which would not have happened without the support of others which gradually led me to the realisation that I could not successfully labour and birth my baby outside the privacy of my own home.

Without the support of AIMS many women would not have had the information they needed to be able to stand their ground and to reclaim control over their bodies and their births. Support at that time was found in books, articles, at conferences, local support meetings and by phone. With the advent of email and websites that information and support was able to reach much further and AIMS has continued to be important in providing critical information and support about the rights to make informed decision about VBAC and HBAC through our books, website and Journal, as well as through our helpline.

This Journal provides an update on how women who have had a previous caesarean are faring within the maternity service in 2020. It seems clear that 30 years on the struggle still continues.

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Article

Manifesto for the performance of vaginal birth after (VBAC) at home (HBAC)

by Sarah Le Quang Sang

To the medicalised institutions, their medical staff and the health governmental bodies

ARE YOU LISTENING TO ME?

NO I am not high risk

NO I will not go to the labour ward

NO I will not be immobilised by continuous monitoring

NO I will not labour under time pressure

NO I will not be bullied by you

NO I will not be given a trial of labour

I WILL LABOUR!

Giving birth is an ancestral ritual which has been performed at home by women for centuries.
An act which has ensured the survival of the human species.

Women and daughters have witnessed the act of giving birth for millennia. Women can perform the art of giving birth and everyperformance will be unique.

Giving birth is a creative act.
The ultimate act of transformation.

A VBAC at Home is a political act which shifts the power from an obstetrically-led medical institution to a woman-centred care approach.

Labour is a durational performance: starting spontaneously with an unexpected duration.

A VBAC at Home gives time for the performance of labour. There is no failure to progress, only failure to wait! Patience and respect for the process is practiced.

A VBAC at Home requires participants to support the performer throughout the act of birth.

Midwives, partner, family members, friends will be chosen in advance by the performer to participate in the event.

A VBAC at Home enables the performer to control her birth. She is informed and capable of making the right decisions for herself and her baby. She rejects the politics of fear and failure institutionalised by hospital birth.

A VBAC at Home should be available to all women without resistance. All women are eligible for care and should be in control of their choices without judgement.

I AM STRONG

I AM CAPABLE

I TRUST MY BODY

I TRUST MY BABY

The performance of VBAC at Home is not a medicalised event. It is a holistic act celebrating life itself.

VBAC at Home is performed without the traditional medical props.

NO Forceps

NO Ventouse

NO CTG

NO Cannulas

NO Augmentation Drugs

NO Amniotomy

NO Epidural

The performance of VBAC at Home challenges the current medical hierarchy of birth.
Verticality is replaced by horizontality.

The performance of VBAC at Home reframes birth as an event in a woman's life in her domestic environment. There is no drama.

Giving birth is a woman's right of passage into motherhood. A physical and mental journey leading to an act of transformation. Such a journey requires preparation and planning, knowing that unforeseen circumstances can change the course of actions.

A birth plan is a manifesto of personal preferences.

In the performance of VBAC at Home, hospitals and obstetrics interventions are for emergencies only.

Giving birth is an innate performance. A primal aptitude buried deep inside every woman.

The performance of VBAC at Home redefines risk. Risk is not measured as a possible scar rupture but as avoiding another assisted birth and future mental trauma associated to this experience.

The performance of VBAC at Home promotes independence.

INDEPENDENCE in the choices the performer makes about her birth.

INDEPENDENCE from hospital's policies.

INDEPENDENCE from unnecessary medical intervention.

The performance of VBAC at Home respects the culture of birth and the art of midwifery.

The performance of VBAC at Home is an act of activism.

Sarah Le Quang Sang discusses her Manifesto on her website, www.areyoulisteningtome.com

Photo of Sarah Le Quang Sang courtesy of Tom Elkins[1]

1. *www.threepractices.com*

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Research Review

A narrative analysis of women's experiences of planning a vaginal birth after caesarean (VBAC) in Australia using critical feminist theory.

Hazel Keedle, Virginia Schmied, Elaine Burns and Hannah Grace Dahlen

in **BMC Pregnancy and Childbirth (2019) 19:142**
www.ncbi.nlm.nih.gov/pubmed/31035957

by Gemma McKenzie

What is this study about?
This is a study about women's experiences of planning a vaginal birth after caesarean section (VBAC) in Australia. The paper reports on the second phase of a three-phase study. In this phase, the researchers explored women's experiences, thoughts and feelings after antenatal appointments and after the birth.
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Who took part?

Pregnant women who had experienced a caesarean in their previous pregnancy were recruited via a flyer on social media. Eleven women completed the study.

How did the researchers explore women's experiences?

All of the participants downloaded an app onto their smartphone. They were encouraged to audio or video record their thoughts and feelings within 24 hours of an antenatal appointment. Women were not to record the specifics of their interactions with health care providers (HCPs), nor the details of HCP names or facilities (i.e. hospital or clinic names). Any mention of these were deleted by the researchers.

Six weeks after the birth, the participants were interviewed either over the phone or face-to-face. These interviews were semi-structured, which means that the interviewer had some very basic and broad questions (in this case just five). This provides the interviewee with the opportunity to discuss their experiences in reasonable depth. The interviews lasted between 45 and 90 minutes.

The researchers then analysed the women's narratives and noted the common themes that appeared within the stories.

What did the researchers discover?

Although all eleven women planned a VBAC, only six gave birth this way (one experiencing an instrumental birth) and the other five had repeat caesarean sections.

Four themes were identified that played a role in whether women felt resolved* or disappointed following the birth of their baby. These included, having:

1. Confidence in oneself;
2. Control;
3. Supportive relationships with HCPs;
4. An active labour.

The researchers discovered that although these factors were all independent, they had a cumulative effect. In other words, high levels of all four of these factors, resulted in women feeling resolved* after their birth regardless of whether they had a VBAC or not.

*The authors defined feeling 'resolved' as 'to settle or find a solution to a problem or contentious matter.'

What were women's stories?

The paper provides some of the stories that women gave to researchers and describes them under the above themes.

1. Control

The authors demonstrate the fight that women have in planning a VBAC by using the example of Tonia. Tonia struggled to find the support she needed from HCPs. She wanted to decline vaginal examinations (VEs) due to being raped when younger as she knew they would be triggering and would stall her labour. However, when she showed her obstetrician her birth plan, he would not agree to this and Tonia felt that she was being treated like a statistic and not an individual. When she went into labour, she was manipulated into a VE, but still managed to have a VBAC.

2. Confidence

The authors use Isabella's story to reflect the impact confidence had on her ability to have a VBAC despite strong opposition. Her obstetrician told her that if she did not agree to a repeat caesarean at 37 weeks that the hospital would not provide care for her. However, Isabella hired a doula and sought support from her midwifery team with whom she had developed a good relationship. She knew that they would support her regardless of whether they agreed with her choices.

Isabella endured negativity from the obstetrics team including one doctor asking, "how would I feel if I had a hysterectomy and dead baby as a result of my choices?" Nevertheless, she laboured at home, and when she arrived at hospital, she gave birth vaginally within twenty minutes. Isabella's doula later commented positively on how her midwife had actively buffered Isabella from any unnecessary interference from staff.

3. Relationship with HCP

Bianca's story was used as an example of the benefits of a good relationship with a HCP. Bianca had a private midwife who had experienced her own VBAC, which, Bianca felt, may have helped the midwife to be very supportive of her decisions. She trusted this midwife and experienced Continuity of Carer. Bianca had a VBAC in the hospital after five hours of labour.

4. Staying active and upright

Dehlia's story reflects the importance of staying active and upright during labour. She had a supportive obstetrician and

midwife who were confident in her ability to have a VBAC. She laboured in the shower and managed to birth her 4.9kg (10.8lb) baby vaginally. Dehlia was convinced that she would not have been able to do that if she had opted for an epidural.

AIMS Discussion

This is a valuable study that explores VBAC from the perspective of women planning to birth in this way. The obstetric and midwifery literature tends to omit women's voices and to concentrate on numbers and statistics. This research is therefore a very welcome and useful contribution to the evidence base.

After outlining the participants' narratives, the authors then discussed some of the academic theories underpinning women's experiences. This included concepts such as power relations in the birthing room and the patriarchal nature of the maternity system. We agree with the authors' arguments on these points. Importantly, from a feminist perspective, the obstetric system is patriarchal in that it was created by men based on men's interpretations of women's bodies and how they should and should not labour and birth. The foundations for this system were laid before women were even allowed to become doctors. In contrast, while the midwifery profession's origins were based on woman to woman care, the dominant authority of men in society means that midwifery has come to be seen as the inferior profession. In addition, in more recent years, due to the pathologisation and medicalisation of pregnancy and birth, midwifery is becoming ever closer to obstetrics as women's bodies are viewed as sites of risk that need to be managed and controlled.

This becomes evident in Keedle's study. Women are 'fighting' to give birth vaginally. Vaginal birth is the default outcome for all pregnancies, therefore serious ethical questions should be raised when women have to 'fight' to enable their bodies to carry out a normal bodily function. While AIMS fully supports repeat caesarean sections for those women who wish to make that birthing decision, vaginal birth should not be denied to women who want to attempt VBAC. In fact, we would question why any HCP believes they have a right - or the ability - to 'prohibit' or 'disallow' a woman to give birth vaginally. Equally, threatening to withdraw care from women who want to VBAC is bullying and nullifies any woman's informed consent to surgery as she would have been coerced into agreeing.

The final point we would argue is that Keedle's four themes reflect what all women need to ensure their best chance of a vaginal birth, and to be satisfied with the experience, regardless of the eventual mode of birth. It is frightening that in 2020, researchers are still trying to prove that a woman having control during labour and birth, staying upright, feeling confident and having good relationships with her HCPs are the most important factors for a good outcome. We can only hope that as more research exploring women's experiences of birth is produced, that a shift will take place that puts women at the centre of birth,

Article

Leeds Trust fails to follow National VBAC Guidelines

by Helen Cox

Leeds Trust are denying women who are planning a vaginal birth after a previous caesarean (VBAC) the best chance of a successful vaginal birth.

RCOG1 recommends that women who have previously had a caesarean are offered an appointment with an obstetrician in order to discuss their plans for birth. This is an opportunity for health care providers, and women who have had a previous caesarean, to talk about their options for birthing their baby. In some areas of the country these clinics are midwife-led, with a linked obstetrician should the need for additional support arise.

Women accessing care via the Leeds NHS Teaching Hospitals are increasingly reporting being coerced into aligning their plans for birth with the preferences of the obstetrician counselling them, in what is, in Leeds, an Obstetrician-led clinic. Women have reported being told of babies dying because of the birth choices made by their mothers, horrific and shockingly detailed descriptions of

the mechanisms through which their babies might die (including ways which are not related to VBAC), partners in the appointments are being asked if they are happy with the decisions their partners are making – with an indication of the doctor feeling that the women's decisions are not safe. Many women are reporting that they are being told that they are not allowed to birth in the place or in the way they wish to, and they are being told that they may not use a birth pool as pain relief and comfort in labour.

Quite aside from the obvious confidentiality breech when women are told of specific cases, this is unacceptable. The need to offer women information about the perceived safety of different birth places and choices does not give carte blanche for health care providers to frighten women into submission, which is what women are reporting. To withhold the availability of a form of analgesia, labouring and birthing in water, is unethical and does not align with research evidence or the most recent NICE guidelines relating to VBAC ((NICE) 2019), which state, "Support informed choice of a full range of options for pain relief for women who have had a previous caesarean section, including labour and birth in water."

It is necessary to offer women information about the relative outcomes for vaginal birth vs. caesarean birth due to the possibility of uterine rupture, which is increased in women planning a vaginal birth after previous caesarean compared to women who haven't had a caesarean. The RCOG state that:

"Women should be informed that the absolute risk of birth-related perinatal death associated with VBAC is extremely low and comparable to the risk for nulliparous women" ((RCOG) 2015)

This does not align with an approach of telling women of cases when babies died, or describing the minutiae of how babies may die. This moves from a conversation aiming to enable women to make an informed decision to coercion, and breaches the codes of conduct that both doctors and midwives must adhere to.

Leeds NHS Trust, unlike other trusts of its size and many much smaller, has never had a consultant midwife. Now that we've lost the services of the Supervisors of Midwives, and in the absence of a consultant midwife, women report struggling to access support after antenatal appointments in which their plans have been blocked. Some are referred to a Birth Matters clinic, the remit of which involves birth debriefing and planning, but with waiting lists of weeks or months and the requirement to re-book in to see an obstetrician in order to attempt to negotiate access to birth pools or non-obstetric settings, this pathway is not functioning effectively.

The new 'alongside midwife led unit', the Lotus Suite, at Leeds General Infirmary, is a less clinical-looking area than the main obstetric ward, which has been achieved by installing a set of doors which block off the bottom three labour ward rooms, and redecorating them. Six months ago, these were labour ward rooms, and women having a VBAC were among those using them. A set of double doors and a coat of paint later, women are now being told that it is unsafe for them to birth in this area of the labour ward, despite the fact that we know how important a calm and relaxing environment can be to a successful and positive physiological birth. They report being told that they must birth in the more clinical looking obstetric rooms just up the corridor, with access to the Lotus Suite rooms blocked by the requirement to speak to and negotiate with the right consultant.

Why is it that in one of the UK's largest teaching hospitals, supporting around 10,000 births per year, women are subjected to this pressure to conform to care that doesn't reflect the best available research evidence or the NICE guidelines? How can a hospital which should be leading the way in VBAC care be going backwards in its support for women? And most importantly, what are the Leeds CCG (Clinical Commissioning Group) and Trust management going to do to change this situation?

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Helen Cox is a pseudonym.

Article

The Birth of Eden

by Katie Hickey

My labour with my first baby, in 2016, was long and didn't have that slow build you get told about in your antenatal classes! As soon as my contractions started they were intense and coming every few minutes. I was vomiting a lot and this made me feel very tired as I couldn't keep down any food or water. I had planned to have a home birth and when the midwife arrived, despite 12 hours of intense labour my cervix was about 1cm dilated. After 26 hours at home and being around 4-5cm dilated we finally agreed to be transferred to hospital as the midwife said I wasn't making any progress.

If I'd known then what I know now I would have given myself more time and not allowed my doubts and fears to take over. This is so hard to do when you've not been through labour before and especially when you have a midwife you've never met and worse still a midwife who doesn't seem very supportive of homebirth! The rest of my labour ensued in the predictable, all too common, cascade of intervention. My waters were broken, I was put on a continuous monitor, I had an intravenous drip of synthetic oxytocin to try and make my contractions more frequent and more "effective" and I had an epidural. After many more hours my cervix remained at 5-6cm dilated. The doctors had been mentioning caesarean section for a while but I held off as long as I could. I finally agreed to give birth abdominally in theatre, 36 hours after my labour had started. I felt ready by this point after trying everything the hospital had to offer, I just wanted my baby to be born and really there was no other way at this point.

It was soul destroying to have "failed" at something that felt so important to my identity as a woman. My recovery was long and painful, breastfeeding was difficult and I kept feeling as though I was failing at all aspects of motherhood for a long time. I wanted to blame my midwife for being so cold, for not giving me space and for filling my mind with doubt. I will never forget when the ambulance arrived to take me to hospital, I broke down in tears and said, "I couldn't do it." I had already given up which I am sure played a large part in me ending up with a surgical birth. A lot of time and a lot of reflection made me realise that in fact it wasn't the "fault" of my midwife. I had to accept responsibility for part of my birth story as well. There were multiple factors that led me to an abdominal birth all contributing to that final outcome, the unsupportive midwife was just one of those factors. If only it were as simple as to blame it on one thing but that is very rarely the case.

I'd often dreamt of what my second birth would be like and how things would be different. After my first daughter was born I decided to take a break from my career as a vet and become a doula in the hope I could help other families have a more positive journey into parenthood than I'd had

I'd often dreamt of what my second birth would be like and how things would be different. After my first daughter was born I decided to take a break from my career as a vet and become a doula in the hope I could help other families have a more positive journey into parenthood than I'd had. I also wanted to learn about birth and the maternity system as I knew this would benefit me in my next birth. I supported several VBAC births and spent time learning about what works well and what gives women the best chance of having a successful VBAC. I witnessed first hand the bullying and intimidation tactics laid on by some medical professionals and sadly being confronted by ignorance and fear by many medical staff. I understood just how vulnerable pregnant women are and especially if their first births did not go smoothly there is extra fear and worry that the next birth will go badly or even worse.

I started becoming interested in free birth and I read a lot of birth stories and listened to podcasts discussing free birth. I could see that a lot of women were choosing this path out of fear, fear of the over medicalisation of their birthing process. This seems such a shame that no matter what path many women chose, fear is often the overriding factor in their decision making. I felt quite drawn to the idea of free birth but given my medical background and also witnessing some difficult situations as a doula I felt that choosing a free birth was not the right option for me. I wanted to have peace of mind that there would be a medical professional close at hand if there was to be something wrong especially with my baby.

It then became the most important part of my birth preparation to seek continuity of carer. I know that having continuity from my midwives and continuity from my doula would give me the best chance of having a successful vaginal birth (I know this from experience and it is also backed up by research!). If I knew the team that would be with me during the birth I knew I would not fear unnecessary intervention because we would have the opportunity to build a relationship and discuss my wishes and preferences before the day my baby was born.

My local hospital had recently put together a home birth team of 6 midwives that offered continuity of carer. I had done some research before to see who was in the team and what sort of experience they had. There were a few very experienced midwives in the team and some younger midwives that hadn't attended a homebirth VBAC. I spoke to the team leader and made a request for my named midwives to be the 2 most experienced midwives in the team. I knew from the research I'd done that they had the most experience of homebirth and a very strong belief in birth being a natural process. They also had the confidence and experience to talk about hospital policy but always give me the final choice in making decisions even if that went against hospital policy.

When I was looking at building my birth team I had considered all my options. I looked into hiring an independent midwife with a doula or without a doula and in the end what felt right for me was sticking with my NHS midwifery team and having a doula as well.

When I was looking at building my birth team I had considered all my options. I looked into hiring an independent midwife with a doula or without a doula and in the end what felt right for me was sticking with my NHS midwifery team and having a doula as well. It was important that I had a doula that felt comfortable helping me and my husband with advocacy and helping to keep the morale high when things got tough. I decided that the right doula for me was Becky. A very well known retired midwife who spent her career helping women have as normal births as possible, often at home and often when they had pre-existing conditions that may have meant homebirth wasn't "recommended" by hospital policy. Becky set up the Albany midwifery practice and their outcomes are far better than current NHS homebirth statistics. My midwifery team knew Becky well and had worked with her in the past as well. It was in fact a senior midwife from my hospital that recommended I contact Becky in the first place and how right she was!! Becky was a vital part of my team and with her midwifery background I felt at ease that she would help protect me from being railroaded by medical caregivers during the birth.

Once my team was established I felt a huge weight off my shoulders. I could relax into the pregnancy and feel relaxed going into the birth because my biggest fear was not being allowed to labour in my natural way because my natural way may not "conform" to the hospital policies of labour after a previous caesarean section. It was only with hindsight that I was able to see how crucial this had been to my successful VBAC at home. Without the team I had I know my second labour would have ended the same as my first, in a caesarean birth.

I trusted my birth team, I was able to explain what roles I wanted them to play and my tolerances for medical presence including monitoring my baby's heart rate and how I felt about having vaginal examinations etc. I knew my team were on my side. We all wanted the same thing which was to keep everything as normal as possible unless there was clear evidence that there was something happening that needed a more medicalised approach.

My labour began on Tuesday afternoon. My doula, Becky, had popped over for a cup of tea and a chat and whist we were sipping tea I was having some very mild contractions whilst bouncing on my birth ball. I tried to shrug them off as Braxton-Hicks but Becky knew it wouldn't be too long until she heard from me again. Sure enough they started to get more frequent overnight but still mild. I started the TENS machine overnight and tried to get as much rest as possible.

Wednesday morning came around and my contractions ramped up. I was finding it quite challenging to cope and they felt very intense but were still fairly irregular with regards to frequency. Sometimes they came every 2-3 minutes and other times there was a longer gap. We called my mother-in-law to collect our eldest daughter as I felt I just needed to focus on myself and I wasn't able to give her any attention. I also needed my husband to be with me and do things when I needed rather than having him looking after our toddler.

I had given a lot of thought to having our daughter present at the birth and I had really wanted her there. We talked to her about it nearly every day and I had showed her birth videos and shown her some of the noises I would make when I was in labour so she could be as prepared as possible. We knew she was only 5 minutes down the road with my mother-in-law so she could be brought back quickly if we wanted her to come back. Fred inflated the pool around 10am and Becky came and joined us shortly after that.

Becky suggested that Fred fill the pool as things could go quickly given this was baby number 2. I said I didn't want to get into the pool "too early" something you hear midwives saying all the time and it was a residual fear I'd carried from my first labour. Becky reminded me I was a very sensible woman and if my contractions slowed down after getting in the pool I could always just get out! Right she was. Getting into the pool didn't slow down my contractions but I did feel much more comfortable.

My wonderful birth photographer Hannah joined us shortly after Becky and started documenting the birth journey. I moved a bit around the flat from my bedroom where the pool was, to my daughter's room and the living room.

My contractions stayed intense and I'd been in contact with my midwife Mary early on in the day. She had a day off but she was going to come and see me anyway and my second midwife Sue was on duty as well. It felt like everything was falling into place. My entire birth team was there for me, that was a huge relief.

The plan I had agreed with my midwife was that I wasn't going to call her to come to be with me until I felt I had started pushing. Again this was due to my fears that if I had midwives there too early it would somehow slow things down or "start the clock" of how long I would be "allowed" to labour. Mary was visiting the Horniman Museum on her day off and that was opposite where I lived. She offered to come and check on me but I knew I wasn't at the pushing stage. I felt guilty that she may have to travel all the way home and then come out to me later and all this on her day off so I agreed for her to come over earlier than I had originally intended. I liked Mary very much and I trusted her so I had confidence that having her there, even though it was earlier than planned, wouldn't derail my progress.

Once she arrived and saw how strong my contractions were she called for the second midwife, Sue, to join her. Little did I know in the living room all the birth equipment had been laid out ready on the dining table. By this point I had kept myself hidden in the bedroom as I knew privacy and space were crucial to helping my labour progress.

After several hours and contractions starting to space out somewhat Mary offered to do a vaginal exam. By this point I had 3 very experienced home birth midwives in the flat and they had all expected the baby to have been born by now. It was approximately 6pm and I'd been contracting intensely since the morning and mild contractions since the night before. I agreed that a vaginal exam would be useful. I wasn't completely against vaginal examinations, I think in the right context they are a useful tool but often a tool that's overused and definitely incorrectly interpreted in a large number of births! During my first labour I had a midwife that caused a lot of pain when she tried to do a vaginal exam at home and I was quite scared of going through that again.

Hannah my birth photographer held my hand as I laid on my bed and Mary carried out the vaginal examination. I trusted Mary and I tried to relax as much as possible but I was clearly stressed and also distressed about lying on my back on my bed. It was all too close to my memories of my first labour. It felt suddenly as if I was going down that same path again….failure…to…progress…

Mary said I was 3cm dilated. I felt like I had wasted their time! Everyone was in my flat waiting for this baby to be born and by the looks of things that wasn't going to happen anytime soon!! I had tried earlier on in the day to do a VE myself and to try and assess my cervix myself but I couldn't reach it and now that made sense. It was too far back for me to reach myself especially with my pregnant bump in the way.

In the moment I tried really hard to remain positive. I said everyone needed to go home and luckily because I was less than 4cm dilated the midwives were able to leave without breaking their protocols. In midwifery definition I wasn't "in labour" yet!! It bloody felt like it though!!

Becky and Hannah stayed for a little longer than the midwives and Becky finally went home to bed around 9pm. The plan was for everyone to "pace themselves and get some rest." This sounded all well and good for everyone except me! How exactly was I to pace myself and get some rest? Not very easy when you're contracting and having a major crisis of confidence. Around 11pm I called Mary, my midwife. I said that maybe I should just cut my loses and go to hospital now. I could get some pethidine and have a sleep (like everyone else!) or maybe I needed an epidural in order to rest. I just didn't want to repeat the story of my first birth and labour for days and then end in an emergency c-section.

Mary was very calm and she said if I wanted to go to hospital I definitely could do that but in the meantime had I tried practicing my hypnobirthing? When she asked that I could have thrown the phone against the wall. Hypnobirthing? What good was that going to do?? Honestly! As if it was a magic cure that would help me cope as much as hard drugs? I don't think so! But you know what? She was right. I hadn't even tried using hypnobirthing techniques. I hadn't listened to any of my tracks I had just got stuck into a negative rut, and I'm a hypnobirthing teacher! This just goes to show it's not always easy to practice what you preach.

Hypnobirthing? What good was that going to do?? Honestly! As if it was a magic cure that would help me cope as much as hard drugs? I don't think so! But you know what? She was right...

I hung up, got out of the birth pool (where I had gone to try and sleep as it was the most comfortable place). I piled all my pillows onto my bed against the headboard and knelt over the pillows with my headphones in listening to my VBAC hypnobirthing tracks. I did that all night until the morning and Mary was right. It helped massively. Mary had managed very tactfully to talk me off the ledge. She knew me, she'd spent time with me throughout my pregnancy and she knew how much this VBAC meant to me. If I had called just any midwife who didn't know me do you think I'd have been given the same advice? I very much doubt it.

It was now Thursday morning. My contractions were very spaced out. Sometimes 15-20 mins between each one. This enabled me to eat and get some sleep. Fred and I were alone, he was trying to get me to eat as much as I could stomach, which was a couple of biscuits and sweet tea, bananas or some toast here and there. It was important to try and eat and to stay hydrated. I drank a lot of water, sugary tea and sports drinks. It was a beautiful sunny day.

We went for a walk in the woods behind our flat. I practiced my spinning babies (https://spinningbabies.com/) exercises. Did as much of the miles circuit (http://www.milescircuit.com/) as I could bear and we had sex twice. I can't say any of it was very enjoyable but I certainly wasn't going to give up without having tried everything I knew of!

I was in contact with Mary throughout the day and she was checking in on the phone about my babies movements. She offered to come and listen to baby's heart in the afternoon but I said I could feel baby moving loads and there was no point coming back until things were really progressing. I really felt like the baby was trying to move into a different position to help birth more easily. I had tried again to asses my cervix myself and by Thursday afternoon I could feel the baby's head quite easily so that was encouraging that my cervix had ripened enough to move forwards and everything felt a lot lower.

We called my mother in law and asked her to bring our daughter back. She'd been gone for 2 whole days now and that felt like too much. I wanted her back. As soon as she got home my contractions ramped up. I had 2-3 hours of what felt like constant contractions. I let Becky and Mary know but then the contractions became very spaced out again after that time passed!

It was now bedtime on Thursday night. Fred went to bed and I got into the birth pool (we had emptied it cleaned and refilled it by this point). I started sleeping in the birth pool and was being woken up with each contraction which suddenly felt more painful than before. I woke Fred up and told him to call Becky (my doula) to come back. I had no idea where I was at in terms of progress but I felt that I didn't want to be doing it on my own anymore. I wanted my doula back to hold my hand. Becky came straight over and as soon as she arrived I started to feel the contractions were different and I felt some pressure in my vagina. Becky watched me for 2 more contractions and we knew then that things were really happening. Fred called the midwives and said I was pushing and to hurry.

The pushing felt great. Everyone had told me that it felt like doing an enormous poo but honestly it didn't feel like that. It just felt like pressure in my vagina. I could feel the head and I could feel progress AT LAST. I had complete clarity. I felt strong and I felt confident. If Becky hadn't been there with me I'm not sure I would have been so calm, she really helped me. She told me to take things very slowly, not to rush and to just breathe and blow.

The head was visible after only a couple of pushes and we called the midwives back to let them know. Sadly Mary wasn't working that night but I knew the midwife on her way and I knew she was lovely as well. The midwives knew they weren't going to reach me in time for the birth so we called 999. I had agreed with Fred in advance of the birth that if we were ever in a situation where the baby was going to be born before the midwives arrived we would call an ambulance. I wanted that reassurance that if either of us got into difficulty we would be able to go to hospital as soon as possible. The paramedics arrived within seconds it felt like. They were extremely respectful and waited outside my bedroom until my baby, Eden, was born. Once Eden's head was visible Becky came round and whispered into my ear, "You aren't going to have another caesarean" We had discussed during my pregnancy her saying that to me when the time came and she remembered. It was amazing.

Having Becky as my doula was just perfect. Given her experience as a midwife she was able to keep me calm through the pushing stage and she was also able to speak openly to the paramedics who had never seen a baby born into water. Eden slipped out easily and was born in her sac! Fred caught her and with Becky's help he passed her between my legs and into my arms. Becky had to help get her out of the sac, she was so slippery I couldn't grab hold of her straight away but as soon as I hand her in my hands I sat back and put her onto my chest. She was so pink and so soft. She was completely calm and I was in complete ecstasy. I felt a huge rush of love and overwhelming gratitude to have been at home, in our birth pool to give birth to our second daughter. Everything in that moment felt completely perfect. It was the birth I had dreamt about.

The midwives arrived not long after Eden was born. I just held her and soaked up what had just happened. The midwife asked if I wanted to get out of the pool to deliver the placenta and I declined. I didn't want to go anywhere. About 45 mins after birthing Eden I felt some contractions again and gave a push and the placenta slid out easily. We cut the cord about an hour after Eden was born and we got out of the water.

I couldn't believe I had done it. I DID IT. Never in my all my birth preparation had I thought my fears and doubts would be so strong during my labour. I was ready to give up on more than one occasion. I know that without the incredible team around me I wouldn't have had the beautiful outcome I did. Also I know if I had gone to hospital there is close to zero chance I would have given birth vaginally. I broke all the "rules": I laboured for a long time, I didn't have continuous monitoring and I gave birth unmedicated in a birth pool all after a previous caesarean birth.

I can never thank the Lewisham Poppie Team enough for the continuity of carer they allowed me. Thanks to that continuity my midwife, Mary, was able to connect with me and care for me in a way I didn't have in my first pregnancy and birth. The combination of continuity from my midwives and my doula Becky undoubtedly resulted in the birth I wanted.

I hope this story gives confidence and some guidance to all women planning to birth their babies. Seek continuity, ask for it, demand it. You won't regret it and it is likely to impact your pregnancy and birth in many ways.

Photo and video credit to Hannah Palamara (*www.hannahpalamara.com*)

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Article

Compassionately Communicating

(Non Violent Communication (NVC)) as a Birth Worker

by Katie Olliffe

Early in my career as a trainee doula, one of the first births I attended turned out to be one of the hardest births I've ever supported for various reasons. The midwife seemed to have difficulties accepting my presence. I worked so hard to make a connection with her, however, after a few hours of trying, I eventually admitted defeat. There is only so long you can attempt to communicate with another person, receiving only one word answers! Instead I turned my efforts to attempting to keep the birth environment a positive space, which was sadly almost impossible. The labour and birth was faced with various challenges, and the strained relationship between the midwife and I was a huge and unnecessary hindrance. I was attempting to support my clients with the birth wishes we had researched extensively during our antenatal preparation. Some of my client's wishes were different to the advice of the midwife, health care professionals and hospital guidelines. It was an incredibly difficult situation with a theme of very defensive communication.

I left that experience with a heavy heart, feeling misunderstood, angry and frustrated. It was concluded by the midwife and some of the health care providers that they believed I had been 'strongly influencing' my clients. To be accused of something by assumption and partial observation by people that clearly were not interested in understanding my role in the birth space was not an easy situation to be in.

One of the first things we learn in our doula training is to actively listen: Listening intently for information that may help us to understand our clients. This can then effectively help us to signpost appropriately to existing evidence and information and to provide individualised support and encouragement so our clients can make their
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own informed decisions. So not only was it hard to be accused of influencing or advising, but by default it felt incredibly patronising to the birthing couple. The birthing couple had spent a long time exploring their birth wishes, with the mother making decisions for herself, and after a very exhausting birth experience they were not in a position to dispute this belief. Part of the process of being mentored as a doula is the opportunity to thoroughly debrief experiences with a more experienced doula. My wise and experienced mentor listened, empathised and later asked me to consider why the midwife might have felt the way she did about my presence? I am a natural empath, I found it very easy to consider why she may have felt negativity towards me. I imagine some midwives find it incredibly challenging to form a relationship with someone who is in active labour, because most midwives in our current system will never have met the birthing person during the antenatal period. A birthing person in active labour can be very much focussing on the task at hand. To then observe the relationship between another birth support person that has had an opportunity to form a relationship and understanding of that family prior to the big day must be very challenging. Working out where you fit within that, particularly if you do not understand the role of a doula must be incredibly difficult. So for me finding empathy retrospectively was easy, however the much harder part was working out what exactly I could have done differently.

I am also often in situations where the way that I communicate is the difference between a positive or negative appointment or birth environment. So, I started to research evidence-based ways of communicating in conflict situations which led me to a book called Non-Violent Communication (NVC) by Marshall Rosenberg.

A big part of my role as a doula is to research evidence and to find useful information. I am also often in situations where the way that I communicate is the difference between a positive or negative appointment or birth environment. So, I started to research evidence-based ways of communicating in conflicting situation which led me to a book called Non-Violent Communication (NVC) by Marshall Rosenberg. Studying this way of communicating has been incredible and life changing and has supported me endlessly over the years, not only in personal relationships but especially in my work.

The fundamentals of NVC are this: Every person shares a similar set of needs. A need for honesty, feeling cared for, supported, feeling able to contribute and a desire to be included. NVC supports you to hear any judgements you might be making and to hear the judgements of others. It then supports you to focus on the underlying needs that may be influencing those feelings or judgements. NVC encourages us to actively listen to others, to enable us to identify differing needs and for the practitioner to listen to their own inner dialogue and chatter, and to meet it with self-compassion and kindness. This process can then support outward compassion and kindness to others. It can also support your ability to hear the unspoken dialogue of multiple people.

During a family's birth journey there are often four different dialogues going on:-

That of the birthing parent or couple
The midwife/health care practitioner and hospital guidelines
The silent dialogue of the baby
The doula or birth support partner

For example:

Birthing Family: Planning a vaginal birth at home, this is a second baby, the couple experienced a positive first birth experience which has led to a very positive approach in the preparation for the second birth. The pregnant woman is aware that the hospital protocol suggests induction between 39 and 40 weeks gestation as she is over 40 years old. The birthing family has spent more than six months getting to know their doula, together exploring her birth wishes. The doula has shared loads of books and evidence based articles. The doula has spent lots of time listening to her talk about her hopes and wishes, really listening out for things that may be triggering or worrying. They spend lots of time imagining and visualising together and of course have talked intently and imagined what it might be like when

they finally scoop their baby into their arms. They have finalised two sets of birth wishes or care plans that cover spontaneous labour, induction and birth with medicalised support. This birthing mother's preference is to avoid induction because their first baby was born in a birth pool in the birth centre. From that experience the birthing family have learned that finding a setting that feels safe and private for her to birth their baby in is really helpful to the birthing hormones she will experience. Additionally, Mum wants to birth at home because her 2 year old needs Dad around at bedtime and she feels she will feel safer knowing that her 2 year old has support. She feels confident that she will have support from her doula and midwives and she has decided she doesn't want to have routine vaginal examinations unless she requests them. She is aware that the induction process is likely to involve more vaginal procedures than spontaneous labour might. Approaching 39 weeks of pregnancy she feels well and baby's movements are normal and if this were to change she would of course adapt her wishes. Together the family and doula have read the guidelines from the Royal College of Obstetricians and Gynaecologists around maternal age and recommendations.

Consultant Obstetrician: Has various families this week that have been recommended induction for various reasons. She undertakes approximately three planned caesarean births a day plus whatever emergency procedures may come up. She has performed two caesareans and supported three induction conversations already this morning. She has a younger trainee consultant working with her this afternoon. She is running to a tight schedule. She has five families in her care this afternoon for conversations about inductions and elective caesarean and needs to run through recommendations and procedures with each of those families, what to expect and their expectations. She speaks very fast, she is assertive, she is efficient, but she appears abrupt and practical and at times insensitive. One of the families is coming in to be monitored and to make a decision about homebirth or induction and has very specific birth wishes, preferring to decline induction. The consultant feels that induction is the safest option given that there are risks associated with age and gestation and she finds this family's decision to be frustrating, and inconvenient. She doesn't really understand their choice, particularly as she has recently supported a family that resulted in a poor outcome for baby and mother. The mother's choices and wishes are going against hospital protocol and the protocol or guidelines exist for a reason. If the consultant supports their requests and there were to be complications later on with either mum or baby, questions might be asked of her. Why had she supported not following hospital guidelines? How could she justify this? Her perception is that her practicing license could be compromised if she hasn't followed protocol and doesn't have a good explanation for doing so. It seems evident that there is a need for this doctor to feel in control of both the situation and of the potential consequences to herself.

If the consultant supports their requests and there were to be complications later on with either mum or baby, questions might be asked of her. Why had she supported not following hospital guidelines? How could she justify this?

The Baby: Hasn't started the birthing process but is getting ready to. All baby's needs are being met in mum's womb. Recently the womb space has been contracting gently. Baby is gradually getting used to the tightenings. The mother's cervix is softening. Baby is head down, sometimes applying pressure to the cervix and sometimes not as this is mum's second baby. There is a complex physiological puzzle going on in order to prepare baby for its journey in the world. The baby feels safe. The physiological hormones support the baby to prepare for birth and for baby's entrance into the world. A gentle entrance into the world will support baby in adapting from the familiar womb environment that he experienced over the last 9 months to its new world outside of the womb. Once baby has entered the outside world his new favourite place will be on his mother's chest. Ideally for this transition to take place smoothly he needs uninterrupted skin to skin so he can follow the scent and crawl to his mother's breast, his next safe space.

The Doula: Is very much thinking about the birthing family's hopes for a home birth, is thinking about the last

induction she supported that had been long and challenging for the family and her. Tries to keep an open mind and argues internally that she has also attended very positive inductions. Is wondering if the evidence that supports the guideline is really that black and white? This mother literally turned 40 three weeks ago and has otherwise experienced a healthy pregnancy. She cannot stop thinking about the physiological process that prepares the baby for birth and the information that she researched that told her that a substance called surfactant, and the protein within that, in migrating to the uterine walls may be involved in causing labour to start. She knows that this substance is critical in lung development and for baby to breath outside the uterus. This all makes so much sense and she marvels at how wonderful our bodies are and finds it hard to push the intrinsic puzzle to one side. She reminds herself that she must keep the birthing family's wishes and the safety of the family as a whole in the forefront of the dialogue.

Three out of four of the above dialogues are obviously my perception of the different stories.

As a doula, my role is to hear and understand all of the dialogues, and to listen compassionately to my own inner dialogue and ensure the support and guidance that I give is not being influenced by my own fears or unprocessed experiences. From that, I have to somehow ensure the voice of the birthing family is heard and, as much as possible, that they can work towards their goals and birth wishes in an environment where they feel respected, heard and included in the decision making. I need to do so without my own personal agenda, sometimes outside of the advice of the hospital or medical teams and their guidelines, if this is the parents' wishes. Often, the parents' decisions are different to the choices I might personally make if I were to be in the same position.

Using NVC means I am able to hear the family's needs and acknowledge that the family are entitled to make their own, researched and informed choices. Using NVC means I am able to decipher the needs of the consultant, the midwife, the protocol or guideline of the hospital and which also means I can introduce their perspective to the parents and support them to understand why a consultant may be appearing to be insensitive, hurried and uncaring and how we might navigate that. NVC gives me the ability to hear any judgements that come up in my own mind when I'm listening to others speak and to use language that acknowledges everyone's needs. To empathise with my clients, to have empathy for the needs driving the behaviour of the health care providers that enter my clients' antenatal or birth space. This does not necessarily mean I agree with or condone the behaviour of others, but that I will seek to understand and try to explain what may be driving their behaviour which can sometimes make life easier for the birthing family to understand.

So when approaching the above situation, this is an example of how that might look with our ordinary human reactions and thought process:

The birthing family have an appointment with the consultant obstetrician. They are approaching 39 weeks and have read lots of information including guidelines to support them to make an informed choice. They have decided that they would like to wait until labour happens and birth at home and are hopeful that because of the healthy pregnancy to date, and the very recent 40th birthday, that the obstetrician will be objective and will support their wishes. However they are also concerned that she might not. The obstetrician arrives a few minutes late, looking flustered and introduces herself. The couple introduce themselves and their doula. The consultant eyes the doula and then smiles and says "I've never met a doula before but I've heard all about you". The couple feel uncomfortable. The doula is used to it. The doula sits quietly making notes of the conversation at the couple's request. The consultant opens the discussion by saying "so I understand you are over 40 years of age, and we would recommend booking you in for induction if you're labour hasn't started by around 39 weeks, which looks like we are approaching fairly soon".

The expectant family begin to ask a few questions. They start with, "Can you explain why this is the recommendation?" The consultant interrupts them to say "The risks associated with stillbirth double for mothers over 40 and of course we want to minimise the risk of any harm to your baby and to you."

At this point the heavily pregnant mother starts to feel deflated and to become tearful. Her partner comforts her and feels angry. He senses that they might have a battle

to achieve support for the mother's decisions, and he isn't sure that this conversation will be conducive to continuing to feel safe with their wishes. The doula, hearing this explanation and seeing the mother's response, immediately feels protective and defensive. She thinks that this language is not acceptable, that it sounds coercive and not informative enough. Angry thoughts are running through her head.

The father says, "At the moment my wife feels well and is very keen to have a homebirth for multiple reasons." the consultant looks sympathetic, but she is thinking, "Why would you even consider taking ANY risk?" She says, "Yes, I understand, however I am sure you would not want to expose your unborn baby to elevated risks of stillbirth." She begins to tell a story of a birth she attended recently that ended with a poor outcome. The doula wants her to shut up and is thinking this is not relevant or an individualised approach. The doula sees that the doctor is not even listening to her clients or trying to understand the mother's birth wishes. This is fear-based scare mongering.

So, in the scenario above, where NVC is not used, you can see lots of judgements and thought processes that are angry, defensive, and blaming. If we entered this space and said our judgemental thoughts out loud such as, "The language that you are using is coercive. It is entirely irrelevant to this individual family that you attended a birth with a poor outcome," you can imagine how the dialogue might continue. It is likely the consultant would feel angry for being spoken to in this way and defensive in her response. Now, as a doula using NVC, I meet those value feelings or judgements that arise with compassion. I hear the consultant's dialogue and whilst feeling the feelings above I also try to consider "why?" Her disclosure that she recently attended a birth with a poor outcome, which could be considered irrelevant, incomparable or coercive and fear inducing also indicates to me that her intention to protect others from any negative experience is coming from a place of fear, a desire to protect others and informed by her previous experiences which she may not always have the opportunity to unpick and offload. In this moment I am able to silently acknowledge her fear, to perhaps share with this family later.

My thought process begins to focus on the family's goals and to how I may be able to guide the consultant back to a place of individualised care, and from there to her hearing why homebirth feels safe to this birthing family. I am also keen to hear her explain the statistics so that the perceived risk that informs this guideline can be absorbed and explored together. I am hopeful that this might reassure the consultant that the birthing family are making an informed choice. I also hope that she may repeat from the guideline that the perceived risks of stillbirth starts low at 1 in 1000 in aged under 35 to 2 in 1000 in aged over 40 so whilst the words "risk doubles" is accurate, it is a risk that starts very low and doubles to another very small number. I think about how I can word a sentence that ensures that the consultant feels that her words have been heard, but that also achieves the goal of getting the conversation onto useful information that will support the birthing family and for the consultant to hear that it is the birthing family's wishes - that the mother is making informed choices rather than being influenced by me.

So using NVC I would say "I'm so sorry to hear you recently supported such a challenging situation. These experiences must be a very difficult part of your work. Thank you for explaining the hospital guidelines and your recommendations" (so I am acknowledging her experience, not dismissing it and acknowledging the guidelines). Then, addressing the birthing family, I would say "Perhaps moving forward you would find it useful if we could talk about the statistics that inform the guideline so that you can more easily put the information into context?" The birthing family respond to say, "Oh yes, we have read them but it would be useful to look at them together."

The Consultant replies, "Of course, let me pull up the RCOG guidelines." I continue to address the birthing family and ask whether they would also find it useful to talk about their preferences of how they would like to move forward. I would continue throughout the dialogue to keep the conversation on track towards the goals of the birthing family and with the birthing family expressing their wishes for themselves with my mediation.

If everyone feels heard, and each individual hears someone acknowledging their feelings, we can often approach the sometimes conflicting needs of parents and the maternity unit and work together towards a mutually acceptable resolution with positivity. Rarely is someone being 'difficult' or 'challenging' for the sake of it or with the sole intention to

cause us personal pain. There will always be a feeling or a need which is driving their behaviour and communication. If we can identify, validate and listen we can often move on to finding a resolution. Sometimes it can take some time, and in some scenarios giving that time doesn't feel possible to explore out loud. However, by understanding the process of NVC you will often find that the way you navigate information in your own mind will often support you to feel less anger and frustration towards others, particularly in situations where you do not necessarily agree.

Non Violent Communication can conjure up images of people communicating violently by default! I have always preferred to explain NVC as Compassionate Communication. The word compassion helps me to take responsibility and ownership for my own feelings and acknowledge which feelings belong to others. I wholeheartedly encourage everyone in the birth world to check it out as a way of communicating or interpreting situations.

I am a big advocate for the Hearts in Healthcare movement,[1] a community of health professionals, trainees and patient advocates who are champions for compassionate care with some amazing goals, such as encouraging health workers to reconnect with the heart of their practise and allowing compassionate caring to rise above institutional rules and limitations. There are also some great books and introductory videos for NVC on You Tube which enable you to self-study this method of communicating.[2]

Katie Olliffe lives in Cambridge. Mother to 2, Step-Mother to 3, partner to Rich. Birth and Postnatal Doula, Doula Mentor and Trainer. Teacher of Compassionate Communication, Writer and Roller-skater!

1. *https://heartsinhealthcare.com/*
2. Giraffe and Jackall l anguage explained by Marshall Rosenberg *www.youtube.com/watch?v=A-6zkwqjDVI*

Article

Being Believed: Obstetric violence in the age of #metoo

by Maddie McMahon

The story of the female holiday maker in Ayia Napa, Cyprus, who was raped and then not believed has brought back some strong memories and emotions for me. It's more than 25 years ago now, half a lifetime. And yet, the fear and fury can still be brought to the surface.

This poor woman has been traumatised twice. It's not just the men who raped her who are perpetrators. The police did not listen. They coerced and gaslighted her, imprisoned and prosecuted her. They are perpetrators of violence against her.

I know.

I know how it feels to feel small. And powerless. I know how it feels to be told, in no uncertain terms, that you don't matter, you are unreliable, that you are not worthy of belief,

trust and support. I know. It is a deepening of the initial trauma that has ripple effects across your whole life.

He pounced on me in the dark, violently attacked and tried to rape me. It seems madness to use the word lucky, but I was. Adrenaline made me angry and strong. It doesn't always do that. Sometimes it makes you freeze. I was able to grab him where it hurts most and twist with all my might. It gave me a chance to do the other thing that adrenaline is there to fuel – run. When he saw me escaping towards my block of flats and help from neighbours, he grabbed my dropped bag and ran off himself.

Because he stole my bag, the police branded his crime a 'mugging'. I was told by the police and many other people that I had been 'silly', 'stupid', 'idiotic' and 'asking for it' to say goodbye to my boyfriend at the top of the steps and walk the 100 yards across the Roman amphitheatre to my flat, alone. Like the girl in Cyprus, I was a Brit abroad, young and fearless, with a new boyfriend. Like her, I was branded because of my gender and nationality. Like her I was expected to swallow what happened, chalk it up to experience and keep my mouth shut. To my shame, I did.

I've been reflecting this week on what a lifetime of this shit does to a woman. A lifetime of being made to feel small. Of being told that we must not take up space – either physically or in any other way. We are made invisible; vanished and vanquished on a daily basis. What does it do to us to feel so powerless year after year? To be minimised and given such a minuscule amount of agency?

For me, it has folded me up inside and quite literally bends me double. The anger and sense of bitter injustice has sat, in the pit of my stomach, for so long, fermenting. The irritable bowel I've suffered for years is the physical manifestation of that emotion. It makes me fear conflict and I find it difficult to know how to safely express my anger. I have been taught since childhood that I must not express strong emotions. The result is that I sometimes struggle to know how to safely and appropriately express and channel my fury. It means that if I am threatened, my reaction may be hard to fathom and unpredictable.

Mostly, my sense of justice is enhanced. I cannot bear injustice and my whole working life and volunteering activities are based around that feeling.

This week I am reflecting on what the layering of injustice, insult and assault does to women. It heaps trauma upon trauma and ironically makes it more likely that we become victims again. I see it in the birth room all too often. A lifetime of being taught to put up and shut up, not make a fuss, not be visible or take up space, results in birthing people who are unable to speak up. It feels easier to submit to the painful, embarrassing examination than to speak the words that twist and turn in their guts, yearning for expression. It's easier to smile and comply.

A lifetime of being taught to put up and shut up, not make a fuss, not be visible or take up space, results in birthing people who are unable to speak up. It feels easier to submit to the painful, embarrassing examination than to speak the words that twist and turn in their guts, yearning for expression.

'Well I'm sure the doctors had your best interests at heart',
'They wouldn't have done it if they hadn't needed to',
'I think you're exaggerating',
'Maybe if you hadn't acted that way or argued with them...',
'You've got a healthy baby, that's all that matters',
'You're OK, try not to think about it'.

What do these phrases and others like them do to us? Any psychologist will tell you. Denial of trauma deepens it. It opens a wound and digs around in it painfully. It doesn't just try to erase the trauma, it annihilates us. Our very sense of self can vanish. We are effectively rubbed out.

A few weeks after the attack in the amphitheatre, I 'came to' and looked around me. My new boyfriend was still there. Patiently waiting. He believed me. He didn't say it was my fault or imply I carried any responsibility. He didn't make quips about the dress I was wearing. He didn't beat himself up about not walking me home. He understood that the only blame to be attributed was on the perpetrator. Rape and sexual assault ONLY happens because people commit those crimes. Full stop.

Having that firm and steady validation protected my mental health. It stopped me falling down any rabbit holes

of self blame. He enabled me to take up space in the world and own my experience. He didn't try to make me small by silencing me because my words made him uncomfortable. For that, I am eternally grateful.

Yesterday, talking to my counsellor about all this, he pointed out that my body language had changed as he validated my emotional experience. From folded in on myself, I stretched out, took a deep breath and took up space.

We have to stop telling women they are mistaken. We have to stop telling them that others have it much worse. We have to tell them they are seen, heard and believed. We have to show them that they can unfold, open up and take up the space they deserve. Being pregnant is about getting bigger, not smaller. Birth is enormous; it is something of value that should not be diminished. Our stories deserve to live on, take flight and grow.

Am I really comparing the birthroom and the amphitheatre, I hear you ask? I know that it is vanishingly rare for malice to be lurking in the birthroom like it lurked on those Roman steps. But people can be hurt by people who are intending to help. People can be hurt by those who are hurting themselves. Fear, exhaustion, ignorance, pressure, haste and thoughtless routine practice can all cause harm. These days, it's unlikely that women will know those caring for them in labour. It makes it so much harder for midwives when they haven't built a relationship with the birthing person. They have no opportunity to peek into the lives of the families they care for. They rarely witness our heart's desires and the demons we battle.

But when a person comes out of a birth emotionally damaged; when they talk about the way they were treated and touched. When they describe being pressurised and coerced by people who seemed cold and distant, it doesn't matter if the abuse was intended. It still happened. The parent who is traumatised feels that way. Whether you believe them or not, is irrelevant.

In fact, if you really don't believe her, can I suggest you keep your mouth shut?

Maddie McMahon is a doula, doula trainer, breastfeeding counsellor and author. She has 2 teenage children and lives with her family and a small, black and white cat, in Cambridge. She blogs on birth, breastfeeding and feminism at www.thebirthhub.co.uk.

Article

Abusing language

by Emma Ashworth and Verina Henchy

If you're around birth for long enough, you'll hear women tell you that they have had vaginal examinations without consent, perhaps as a form of coercion. It seems that women are frequently told things like "We need to know 'where you are' if you're to be admitted to the hospital/given access to the pool/given an epidural or even gas and air". In some case there is no explanation or justification.

Sometimes when woman consent to a vaginal examination, they will also be given a stretch and sweep or have their waters broken with the justification of , "I did it while I was there".

If a person uses coercion to gain access to someone's vagina in a non-medical setting, the law recognises that as assault. If a person does a medical procedure it is well accepted by the medical establishment and the law as assault and medical malpractice. Yet for some reason it has become common practice for doctors and midwives to expect access to the vaginas of pregnant or labouring people.

When this was raised at a recent meeting between maternity service users and a hospital trust, senior midwives were extremely upset. The context for this discussion was a group activity called the 'diamond nine' exercise. Nine real life statements collected from service users were written on cards and members were asked to lay them out with the most serious concern at the top and the least serious concern at the bottom.

"I agreed to a VE and without my permission, my midwife gave me a 'stretch and sweep" was placed at the top of the diamond by one group. When asked why, they said that this was the most serious concern because it was common practice and it was an act of abuse.

Senior midwifes were upset not because they were being advised of women suffering abuse under their watch, but because *"the midwives have a hard enough time of it, without being accused of abusing women"*.

At another meeting where there was a discussion of women who were declining care, a doctor asked how health professionals could be protected when women make unsafe decisions. Is this the crux of the issue in that midwives and doctors believe that women are not able to make safe decision about their bodies and so they feel they must do interventions, such as a vaginal examination, even if the women fails to consent?

Doctors and midwives need to be able to accept two things.

- That birthing people make decisions that are right for them based on many things and are the only persons who can do so; and, rarely, will these decisions be highly risky when all aspects are considered.
- That even if a decision is highly risky that person has an absolute right to be supported in that decision.

So, is the use of the term abuse in this situation an understandable concern? Should campaigners use different language when talking about this issue with midwives in order to not have them defensively shut down the issue as they don't see themselves as 'abusers'?

Language is hugely powerful, and hearing ourselves being accused of something that does not represent our internal sense of self is generally going to lead to us being defensive. Equally, women who have been assaulted want to, and have the right to, hold ownership of their description of what happened to them. As birth campaigners – and many of us are victims of these assaults – how do we tread both these lines in a way which supports everyone being heard as well as keeping everyone listening?

Perhaps, we need also to be asking why the system is forcing midwives and doctors to be more comfortable with assault than with supporting someone to make decisions about their care which currently fall outside normal care. What is it about the culture of our maternity institutions which is supporting this sort of practice which AIMS was founded 60 years ago to try to address?

I think that it is important to use the words that women use to describe their experience of what happened to them, and we should not shy away from them. Assault, abuse, attack, violence… these are what women experienced, and it is not acceptable to downplay that in order to try to avoid upsetting people, even if the intent by the health care provider was not to assault, abuse, attack or be violent. However, there are ways to use these words which do not in turn mean that the midwives feel under attack themselves, meaning that they are then more likely to reflect on their own practice and how it feels to be a woman in their care.

These practices, which are assault, are also the normal way of working in many units. Very often maternity staff, who may be extremely gentle and kind people, have simply never had it pointed out to them that what they are doing can cause extreme trauma. They may feel extreme pressure to conform to what is expected by the institution, pressure that may make them concerned for their job or professional registration. This does not mean that they are 'bad people'. It means that human psychology is such that the everyday normalisation of the abnormal can simply mean that even the best people do not realise, or feel unable to do anything about, the destructive power of their actions.

Very often maternity staff, who may be extremely gentle and kind people, have simply never had it pointed out to them that what they are doing can cause extreme trauma.

Let's look at how communication may be improved. If a birth campaigner says, "I want to talk about how the midwives and doctors in the trust are assaulting women during their births", instantly the maternity staff's minds jump to a different type of assault, something that they consider that they would never do. As they are thinking of something awful that they know would not be something they could ever consider doing, they are not going to be open to reflecting on the fact that their practice is actually abusive.

Instead, consider saying, "I want to talk about practices which are considered within the hospital to be completely normal, and I totally understand that they are being done with the intention of caring for the woman, and yet many women are experiencing these as being very traumatic. We

know that many midwives and doctors are simply following common practice, and I know that you would all be horrified to hear that some of what feels really routine to you is causing many problems, but women are being traumatised and they need you to hear what their experience is so that this can be changed."

The health care providers may still respond defensively, and even begin to explain why it's important that these routine assaults happen. It's fine to listen to their responses so that they know that they're being heard. However, if they do this, they haven't yet understood the situation, so perhaps you could respond with something like, "I completely understand, however it's not always the checks themselves that are the problem. What we need to talk about is how women experience them when they're not given enough information to make an informed decision - a decision to decline or accept what is being suggested without feeling coerced."

When trying to work on communication, there's a fine line to tread. People's experiences must not be downplayed, but to be heard we need to be really careful about how we speak. This might be considered to be 'tone policing'. I would hope that I would never do that – everyone has the absolute right to speak about their experience as they wish to. But when it comes to communication, when we are trying to be listened to and understood, how we will be heard is vital. This does not mean pussyfooting around, nor downplaying the seriousness of the assault – no – that would be entirely inappropriate. But it does mean thinking about how to best put across our words in a way that the other person will actually listen. When we do this, we can really reach out to the other person and communication can start to happen. Equally, the onus is also on health care providers to listen to and respect the experiences of women as being the experiences that they actually had, even if that's hard to hear.

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Interview with Professor Jacqueline Dunkley-Bent

Interview by Jo Dagustun

For this issue, as we mark the 4th anniversary of Better Births, the AIMS Campaigns team were keen to invite Jacqui Dunkley-Bent to introduce herself to our readers. Whilst in post as Head of Maternity, Children and Young People at NHS England, 2019 saw Jacqui appointed as England's first Chief Midwifery Officer, a move widely welcomed by birth campaigners. Since then, Jacqui has been playing a key role in the Maternity Transformation Programme across the country, as well as dealing most recently with the latest maternity scandal to hit the headlines, the sadly avoidable deaths of babies in East Kent.

We invited Jacqui to tell us a bit about herself, to share with us her ambitions as England's first Chief Midwifery Officer, and to offer us an update on progress on a key AIMS campaign priority, the implementation of a relational model of maternity care for all women across England. Here are her written replies.

1. When did you first know you wanted to get involved in birth issues, and why?

I think I was very young, in my pre-teenage years. There was no particular trigger or influence. A seed was sown in my mind. I trained as a nurse and then a midwife and here we are today.
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2. What are you most proud of in your career to date?

Where can I start? There are so many great things that give me a sense of pride. In no particular order, I am proud of the student midwives, student nurses and medical students whom I have taught and encouraged over the years; so many mums/partners that I have supported through their pregnancy, childbirth and postnatal experiences; and the fact that I have never forgotten - or lost my determination and ambition - to do what's right, to treat everyone as how I would like to be treated and to champion those whose voices are seldom heard, including women, midwives, support staff and doctors. I am also proud of my achievements in clinical practice, education, research, leadership, management and healthcare policy. As a clinical midwife, becoming expert in waterbirth, fetal surveillance, perineal repair and pelvic floor integrity, caseload midwifery for women pregnant as a result of rape, who had experienced domestic abuse and mental ill health, aqua natal instructor and therapeutic holistic masseur practitioner. As a midwifery lecturer, I am proud of having developed and led on student midwife simulation for obstetric emergencies, and the development of midwifery curricula. As a manager in a new organisation, I'm proud of having met with 70% of midwives, nurses, doctors and support staff who worked in the directorate I managed, and women and children who used NHS services, to seek their views about the future of their service, and of having led two large teaching hospitals through CQC inspections.

3. What is one of the most difficult things you have ever done?

There are so many things that have been difficult but I would describe my journey as relatively easy, because I am more courageous when I am driven by a moral imperative to do what's right - frequently a lonely place to be. But to be specific, developing a maternity triage service with no budget is something that I would put on the difficult, but achieved, list, and also successfully completing my doctorate at a time when my father was dying.

4. You hold the post of England's first Chief Midwifery Officer – congratulations from all of us at AIMS! Can you tell us something about what you have achieved in your first year in this role and about your ambition for the future?

I am proud to be England's Chief Midwifery Officer and I have 3 key ambitions. First, for England to be one of the safest places in the world to be pregnant, birth and transition in to parenthood, giving children the best start in life. Second, to lead by example, whilst developing a leadership structure for the midwifery profession that is credible and safe. This includes increasing midwifery numbers. Third, to influence perceptions of midwifery, so that midwifery is a career of choice for children and young people, creating a culture that encourages midwives to remain in the profession, and influencing the perceptions of the public and the media so that the contribution that midwives make to improving outcomes for mums and babies is commonly known and understood.

5. Given the focus on the need for effective multidisciplinary team working, do we also need a Chief Maternity Officer in England?

The national clinical director fulfils this role and we work closely together to improve outcomes for mums and babies.

6. For many years now, AIMS has been campaigning for all women to benefit from a relational model of maternity care (where every woman has a midwife who she can get to know and trust, and who can support her through her pregnancy, birth and beyond, regardless of her circumstances or where her baby is to be born). How far do you think that the Maternity Transformation Programme will meet that ambition and what do you think are the key challenges ahead?

I am the national lead for this policy ambition. Together with the policy team and progressive midwives and leaders, we are gaining momentum with the ambition for most women to have continuity of carer by 2021 and for 75% of BAME women and women who are socioeconomically disadvantaged to have continuity of carer by 2024. This way of working requires transformation of services and how we provide midwifery care. We have developed a plethora of initiatives, guidance, tools and frameworks, offered one-on-

one support, created policy levers through the NHS contract and planning guidance, and - most recently - incentivisation through the NHS Resolution maternity incentive scheme, all to support the implementation of continuity of carer. The RCM has been supportive and has developed an amazing continuity of carer game and an i-learn module. I remain optimistic!

7. AIMS is celebrating its 60th birthday this year. Looking forward, how do you think that the service user community, AIMS included, can most effectively contribute to ensuring that the maternity services in the UK are as good as they can possibly be?

My biggest ask is for AIMS and the wider service user community to support the implementation of national maternity policy. Better Births, the report of the National Maternity Review, is approaching its 4th Birthday in 2020, and 2021 will see this programme transition into the NHS Long Term Plan. I am proud of the maternity chapter in the Long Term Plan and we can all play a part in making our maternity services world class.

AIMS Comment

AIMS hopes that Jacqui's optimism that "we are gaining momentum with the ambition for most women to have continuity of carer by 2021 and for 75% of BAME women and women who are socioeconomically disadvantaged to have continuity of carer by 2024" proves well-founded. Many people have been confused about what is meant by "most" but it seems to be being interpreted as over 50%.

AIMS has previously reported concerns about the lack of transparency surrounding implementation and progress to date, which makes it difficult to judge whether we are truly on track to meet this goal.

According to the latest National Maternity Survey by the Care Quality Commission (CQC) *www.cqc.org.uk/sites/default/files/20200128_mat19_qualitymethodology.pdf* for example, in February 2019 'Fewer than one in six women (16%) said that any of the midwives who cared for them during labour had been involved in their antenatal care' and and only 9% 'said that at least one of the midwives who cared for them postnatally had also been involved in both their labour and antenatal care'. Four years on from the publication of Better Births, it is clear that much remains to be done and increased momentum is essential if we are to meet the 2021 and 2024 ambitions. Beyond these ambitions, AIMS will continue to press for a truly relational model of maternity care for all women.

Memo:

The ambition to achieve a higher proportion (75%) of Continuity of Carer for certain groups of service-users goes beyond the plans discussed in the context of the Maternity Transformation Programme, and first appeared in the NHS Long Term Plan. This section of the NHS Long Term Plan can be found here (*www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/stronger-nhs-action-on-health-inequalities*, paragraph 2.28 and has been discussed in the AIMS Campaign update here (*www.aims.org.uk/journal/item/coc-campaign-update*). The new ambition set out in the Long Term Plan followed the publication of the MBRRACE report in 2018 (*www.npeu.ox.ac.uk/mbrrace-uk/reports*). AIMS supports this new ambition as part of a wider initiative to address the health inequalities in outcomes for both mothers and babies in these groups. For more on this, see "MBRRACE and the disproportionate number of BAME deaths: Why is this happening and how?" (*www.aims.org.uk/journal/item/mbrrace-bame*)

Article

Cracking the media paywall: how to access newspaper articles for free!

by Jo Dagustun

Everyone working to improve maternity services knows very well how the mass media is a really important force in the debate about the state of our maternity services (and not always for the positive). Our access to the newspaper coverage of birth issues is thus increasingly key to our role as successful birth activists. But have you ever seen a headline to a newspaper article that you'd really like to read, only to find that the full text is hidden behind a paywall? If this is a problem that you encounter, then this short article is

intended to help you.

Did you know that many local authority library services in the UK have signed up to the PressReader platform, which allows anyone with a local library membership to access a huge number of newspapers, at no additional charge? You can use PressReader in your local library, if they are offering the service, on the library's own computers, or on your own computer or device, most likely via your local library's website, but ask the staff in your library if you need more help.

To sign up to the platform, all you need is your library card number and PIN. If you don't have a library PIN just ask at your library. This is the same PIN that you may have used to go online to renew books, or to access library computers. Once signed up you will have access to the full texts of over 7000 newspapers and magazines from around the world, including local newspapers from around the UK. There are lots of further features on the platform to explore too, which can help you keep track and share what you have read. Given these features, you might also choose to use the platform to read and keep track of articles that are not behind a paywall.

Reading a newspaper online is not quite the same as reading the article in print, granted, and I found that the platform took me a while to navigate. But once you've got a basic understanding of the site layout and functions, it is a fantastic way to crack through that paywall.

So what are you waiting for? I'd really recommend that you check out what your local library is offering its members today!

Notes

If you'd like more information about the company that runs PressReader, you can look here:
https://about.pressreader.com/about-us/

For access to academic research articles that sit behind a paywall, please see this AIMS Journal article:
www.aims.org.uk/journal/item/access-to-research-scheme

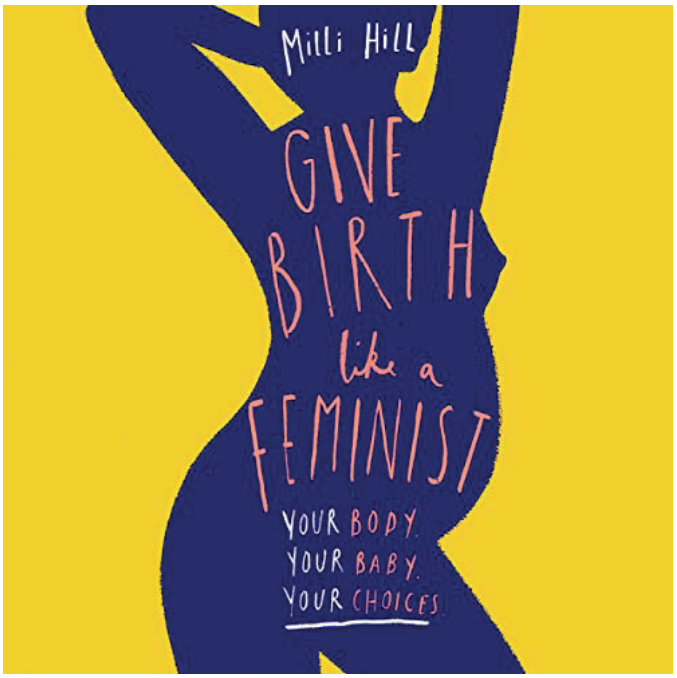
For birth activists interested in how the media covers childbirth, you might want to read a recent edited collection of essays on the topic, Midwifery, Childbirth and the Media, edited by Ann Luce, Vanora Hundley and Edwin Van Teijlingen (2017, Palgrave Macmillan). Find more details about the book on the publisher's website:
www.palgrave.com/gp/book/9783319635125

Book Review

Give Birth like a Feminist. Your body. Your baby. Your choices.

by Milli Hill

HQ 2019
ISBN: 9780008313104
304 pages
Publisher's recommended price: £14.99



Once in a while, a new book is published that seems integral to the mission of AIMS: 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.

This new book from Milli Hill – founder of the Positive Birth Movement (*www.aims.org.uk/journal/item/positive-birth-movement*) and author of the popular The Positive Birth Book (*www.aims.org.uk/journal/item/book-reviews-29-2#3*) – certainly seems to fit that description, talking directly to pregnant women about their own forthcoming births but also encouraging them to become active and campaign for 'a different kind of maternity experience for women of the future'. Commencing with a look at the vexed issue of " 'Am I allowed?': The Birth Room Power Imbalance", Milli's well-researched book covers a wide-range of issues relevant to understanding why she identifies birth as a feminist issue and why she thinks we need to start talking about it in those terms. We invited a group of AIMS volunteers to share their views about it: thanks to Maddie McMahon, Rachel Boldero and Marein Schmitthenner.

Can you describe this book in just a few words?

Rachel: Empowering, modern, powerful

Marein: The new feminist mother's manifesto

Maddie: It's YOUR body

What is the main message you took away from this book, that you would like more people to hear?

***Maddie**: Every birthing person has choice, and right to consent or decline, and that - sadly - informed decision making is often not being facilitated as it should.*

***Rachel**: You own your body and your decisions*

***Marein**: That we cannot improve the maternity system and the way it works (or doesn't) for mothers, babies and families, unless we address the underlying problems of power imbalances (not just in the birth world) and the lack of respect for women, who are still too often viewed as weak, unreasonable and unable to make decisions (for themselves and their babies) independently.*

Who should read this book?

Marein: Birthworkers, feminists, pregnant women, activists, gynaecologists, obstetricians, decision makers in the health service, and everyone else!

Maddie: Despite those who may feel the topic is a niche issue, I think this book needs to be read by everyone! Whether you are pregnant, already a parent, a health professional or interested in the cutting edge of real-world feminism, this book will provide food for thought.

Rachel: I personally think it's an important one for pregnant women and their partners, plus anyone who is considering having a child in the future. The sooner we can spread these messages the better in my view, before individuals become completely coerced into thinking a different way by what they see in the media and so on. I also think that it would be very useful as a mandatory read for student (and qualified) midwives, and it's an important book for doulas too.

The book is quite UK-focussed: do you think it would make for good reading outside the UK?

Rachel: Yes, we should be sharing learning and learning from others

Marein: It would absolutely make for important reading outside the UK. I am involved in the European Doula Network, and I know from first-hand experience that doulas, birth workers and mothers everywhere suffer the same (or worse!) discrimination and this affects their birth experiences.

Maddie: Yes, the themes are universal. Whilst this book focuses mainly on the problem of too much intervention too soon, the issue of too little intervention too late is also discussed: the lack of timely intervention for mothers having childbirth difficulties in developing countries is also an important feminist birth issue, so I think this book should have wide appeal.

What chapters/ parts of the book did you find most valuable?

Marein: This is a tough choice. They are all very valuable. To me, though, Chapter 7, 'Birth Rights and Women's Rights are Human Rights' is the most important chapter. It ties together all the different parts of the book and explains why a woman's rights in the birth situation are so intricately connected to her fundamental rights as a human being. Understanding the legal position is very important in our fight to make sure these rights do not just exist in theory, but are lived experience every day for all women. And very worryingly - in the light of recent increasingly misogynist policies around the world - we know that existing legal protections must be fought for tooth and nail, in order that they we don't lose them.

Rachel: I found the section discussing vulnerabilities following sexual abuse or trauma very insightful. I appreciated how the book addresses this issue full on. Also on the issue of race: Milli makes it clear that we need to make sure the maternity services are really listening to ALL service users.

Maddie: There are many, but I think there are some points that Milli makes with such clarity, in a field that can be rife with emotion, binary discussion and out-and-out warfare. For example, the point that, whilst the safety of the baby is very, very important, a live baby should not be the pinnacle of a woman's expectations. In fact, it should be the bare minimum. After reading this book you could not fail to have understood that a woman's experience of childbirth matters too; not for any fluffy, hippy reasons, but because her mental and physical health actually matter, to her, her family and wider society.

At the end of the Letter to Pregnant readers, Milli suggests eight things that women can do to give birth like a feminist. What did you make of that? Is there anything you'd like to add?

Maddie: I can't answer this. It is all spot on.

Marein: I loved that list. It's all-inclusive, proving Milli's immense knowledge of the birth world and its problems, and how to overcome them, one woman at a time, but also with activism. These 8 points are a fantastic list of how to fight discrimination, improve maternity services for all and find your voice!

A postscript from Jo Dagustun, AIMS Book Review Editor

I had a really interesting reaction to this book. As soon as I'd read the first few pages, I felt hugely privileged to have access to one of the final pre-publication proof copies. After having read it cover to cover I kept it in my bag in the days that followed, carrying it around with me everywhere, retrieving it at any appropriate opportunity to show people that I'd just read this amazing book and that it was coming out soon! (This included my local libraries, to ask them to order copies.)

Straightaway, I knew that if asked to pick a favourite extract, I'd select a few words from Milli's excellent focus on encouraging all pregnant women, as they approach birth, to claim their right to 'be the key decision maker over what happens to their body, and to be listened to, and treated with respect'. I particularly liked the first of Milli's eight tips in her 'letter to pregnant readers' that closes the book:

"Be an adult … Refuse to be infantilised, patronized or mansplained in your maternity care … stand up for yourself – just as you do in other areas of your life."

My (strictly unofficial) hunch is that this book would have won first place if AIMS had run a 'best new book for birth activists' competition in 2019. It is a highly-accessible and up-to-date account of contemporary birth culture in the UK, and is perfect for anyone wanting to brief themselves as they become part of the UK's flourishing maternity service improvement community. I've been part of this community myself since 2008, and I can attest to the fact that Milli's book covers well the key events, issues and debates of the last decade. As AIMS Book Review Editor, this is a book that I'd certainly like to encourage all AIMS volunteers - and others in the birth improvement community - to read. Thank you so much, Milli, for writing this valuable book.