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The Politics of Infant Feeding

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Editorial

The Politics of Infant Feeding

by AIMS Journal Editor, Emma Ashworth

For me, like so many breastfeeding supporters, there was a turning point that I can look back on with absolute clarity as the point where breastfeeding stopped being just a thing that I did, and became a passion. I read "The Politics of Breastfeeding" when I had already breastfed one baby and was pregnant with my second. I'd assumed that breastfeeding him would be as easy as my first, however it was anything but. Through the months of trial by tongue tie, cow's milk protein intolerance and the severe reflux that they both brought to our family, it was Gabrielle Palmer's book which was the key to me having the determination to stay the course (together with amazing support from wonderful breastfeeding counsellors).

The publisher states, "As revealing as "Freakonomics", shocking as "Fast Food Nation" and thought provoking as "No Logo", *The Politics of Breastfeeding* exposes infant feeding as one of the most important public health issues of our time." The extensive evidence base on the importance to the health of women and babies of breastfeeding is immense, despite the doubters who, like climate change deniers, attempt to undermine the facts with rhetoric and misrepresentation. Despite being published 10 years ago, it is as relevant today as it ever was, and Palmer's new book, "Why The Politics of Breastfeeding Matters" explains why these issues still need to be at the forefront of public awareness and Governmental support.

Of equal importance is the right of all people to decide what to do with their own bodies, and supporting everyone to make decisions which are right for them is at the core of AIMS' work. To be able to make decisions, we need evidence based information and therefore we are all indebted to Gillian Weaver and her colleagues at the Hearts Milk Bank for their research into breastmilk, as well as her many years of service to babies and families who need access to breastmilk which isn't their mother's own. In this edition of the AIMS Journal, Gillian shares with us an *update on the Hearts Milk Bank*, which is revolutionising the concept of donor milk banking.

Despite the dangers to public health of removing support for breastfeeding, the ongoing reduction in funding for these services continues. But not everyone is taking this lying down. Ayala Ochert inspires us all with The Better Breastfeeding Campaign" that she is working with, which helps local campaigners to protect or reinstate experienced and committed breastfeeding teams around the country. *Her article* is an essential read for anyone who is facing the issue of the loss of their local breastfeeding services.

The history of formula gives a fascinating insight into how the wants of business and the desire to find a market for a glut of milk overtook the needs, health and, in some cases, lives, of women and babies. Packaging which blatantly advertised its milk product as a baby food while also having, as a legal necessity, the phrase "not suitable for infants" in tiny writing, underlines the way that marketing of breastmilk substitutes continues right up to today. *A history of the Nestlé boycott* by Marta Busquets is followed by *an update on the current situation* by Patti Rundall of Baby Milk Action.

The need for excellent support for all women who want to breastfeed is brought to life in the *moving and insightful article by Philippa Lomas*. Philippa's experience of hypoplasia – sometimes known as "insufficient glandular tissue" – shows how expert, experienced and trained people are needed to pick up on more complex, less common issues.

As always in the AIMS Journal, as well as the on-topic articles we have gathered updates from around the birth world to inspire and support those of you who work so hard to improve the UK's maternity services. This edition looks at the dire situation with the *York homebirth service*, gives *AIMS' response to the Professional Standards Agency's (PSA) report on the Nursing and Midwifery Council (NMC)*, a report on the

Maternity Unit Network (MUNet) Conference and *some good news from Hungarian midwife and obstetrician Agnes Gereb*. We welcome an introduction from *The Association of Breastfeeding Mothers (ABM)* in our section dedicated to collaborative working by sharing what other maternity organisations are focusing on, and we have a lovely *homebirth story of baby Iris by Claire Pottage.*

Finally, many thanks to Sarah Kidson, Maddie McMahon and Jo Dagustun for three new book reviews for *our collection*.

I hope that you enjoy this edition of the AIMS Journal. As always, we welcome feedback, suggestions for Journal topics and most importantly writers! If you have written something that you would like to see published in the Journal (which hasn't been published elsewhere) then please do get in touch – *journal@aims.org.uk*.

To print this article directly from AIMS, please go to *www.aims.org.uk/journal/item/infant-feeding*

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Article

Introducing ABM: The Association of Breastfeeding Mothers

by Emma Pickett, Chair, ABM

The Association of Breastfeeding Mothers was founded in 1979 and gained charity status in 1980. Originally formed by a small group of women trained in breastfeeding support, our breastfeeding counselling course has now been joined by courses for professionals and partners and new members across the UK and beyond. Our foundation courses ('mother supporter' course for volunteers and foundation course for professionals) give a grounding in breastfeeding support, and our online courses are accessible through a range of devices.

Trainees can then go on to take our advanced courses which usually take around 18-24 months to complete – our breastfeeding counselling course for volunteers and advanced course for professionals (including those who may not have breastfed). Our online partner course is aimed at husbands, partners, friends and wider family and helps someone to support a new breastfeeding mum. It also contains tasks and activities a couple can do together to prepare for their feeding experience. Our training team consists of lactation consultants, health professionals, doulas and breastfeeding counsellors. We update the content regularly as evidence and new thinking emerges.

ABM breastfeeding counsellors take calls to the National Breastfeeding Helpline in partnership with the Breastfeeding Network as well as answering emails, calls on our own helpline, webchats and giving face-to-face support.

The ABM is part of the national conversation around breastfeeding. Recently we have contributed to a project developing guidelines on perinatal mental health for infant feeding supporters, attended sessions of the all-party parliamentary group on infant feeding and inequality, attended Baby Feeding Law Group meetings, contributed to NICE guidelines and been part of a conversation around the establishment of a Breastfeeding Alliance. As well as working closely with the Breastfeeding Network to run the National Breastfeeding Helpline, we are often around the table with La Leche League, NCT, and Lactation Consultants Great Britain (LCGB), whether it's at a meeting with UNICEF Baby Friendly, discussing Start4Life projects or debating breastfeeding rights in the workplace with Maternity Action and ACAS.

As a small organisation, we have particularly benefited from the development of social media in recent years, with more than 23,000 followers on Facebook alone. Our Pinterest page is a comprehensive database of breastfeeding resources with more than 70 separate boards. We also use social media to have daily conversations with our members and trainees. Our membership and our trainee numbers are the highest they have ever been in our 40-year history. We are able to provide a flexible response to national stories and contact our membership perhaps more easily than larger organisations might. The #FEEDME photo campaign we took part in along with RAN Studios saw our Facebook posts regularly reach more than a million views. This was a campaign focused on presenting positive images of a diverse range of London mums and we are looking to expand the campaign further in the future.

2018 has seen a change to our logo and website as we look forward to our 40th year in 2019. *www.abm.me.uk*
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Article

The Better Breastfeeding Campaign – Fighting for Breastfeeding Support

by Ayala Ochert

Last year, we launched the Better Breastfeeding campaign (*www.betterbreastfeeding.uk*) with the aim of getting better support for mothers who want to breastfeed. Breastfeeding rates in the UK are among the lowest in the world, despite the fact that most mothers here want to breastfeed. Surveys find that around 80% of mothers begin breastfeeding, but by 8 weeks around half of those have stopped breastfeeding completely. Yet 8 out of 10 of those who stopped in those early weeks said they would have liked to have breastfed for longer.

So it's really a no-brainer – help those mothers who want to breastfeed to continue, and breastfeeding rates will rise. But our campaign wasn't driven purely by a desire to increase breastfeeding rates, despite it being an important goal. I founded Better Breastfeeding with Professor Amy Brown and a group of passionate campaigners who all care deeply about mothers. I was inspired by various campaigns and campaign groups out there – #hospitalbreastfeeding (started by Helen Calvert), #MatExp, Milli Hill's Positive Birth Movement and the GP Infant Feeding Network (GPIFN). These groups were all started by individuals with a passion, and in our current age of social media it's possible for anyone to reach a big audience and to have an impact.

We are passionate about breastfeeding and we know how important it is to so many women. Breastfeeding means so much more to mothers than nutrition for their babies, and it can be devastating when it doesn't work out as planned. Studies show that mothers who plan to breastfeed but stop before they wanted double the rate of postnatal depression, and Professor Brown's research1 shows that some mothers experience symptoms of trauma and grief when they stop breastfeeding. You only have to talk to mothers, as we do, to hear how much breastfeeding means to them.

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Helping mothers succeed in their breastfeeding goals is highly achievable. With easy access to high-quality support from trained people, most mothers can breastfeed. (Even those who cannot breastfeed exclusively can often be helped to breastfeed partially, and other mothers can be supported to give their babies expressed breastmilk if direct breastfeeding is not possible.) What this means in practice is that mothers need access to trained peer supporters and breastfeeding counsellors from day one. These are mothers who have breastfed their own children and who are trained to help with babies who are struggling to latch, babies who aren't gaining enough weight and mothers with sore or damaged nipples, blocked ducts, mastitis or any of the more common problems they may experience. Peer supporters can also provide reassurance when breastfeeding is going well – very often mothers just need to hear 'That's normal' or 'You're doing a great job' or 'This is hard but it will get easier'. Sometimes, there will be a more complex problem, and those mothers and babies will need timely access to a lactation consultant. For example, if a baby has a tongue tie that is impacting their feeding or growth or causing

their mother extreme pain, that needs to be identified and treated quickly. No mother should have to wait weeks for access to a tongue-tie procedure when it's required. There are areas in the country, such as the London borough of Tower Hamlets, where you get an adequate level of support. But these places are now few and far between. Families living in the nearby borough of Redbridge used to have a similar level of support, but in 2016 the local council closed its baby-feeding support service. Now, the only NHS support in Redbridge is basic breastfeeding help from their midwives and health visitors. Their team of highly trained breastfeeding supporters was disbanded and that expertise has been lost. Sadly, this is a picture that we've seen repeated across the country. Many places had very little breastfeeding support to begin with, but those excellent services that did exist have been steadily eroded since around 2015 as a result of budget cuts and as public health responsibilities have moved from the NHS to local authorities in England.

Better Breastfeeding has been documenting these cuts over the last few years, and we've found that in 44% of local authorities in England breastfeeding support services have been reduced or closed completely (*https://betterbreastfeeding.uk/englandcuts/*). These are just the cuts that have been reported to us – we know there are more that haven't yet come to our attention (please let us know of any we've missed by emailing info@betterbreastfeeding.uk).

Many places had very little breastfeeding support to begin with, but those excellent services that did exist have been steadily eroded since around 2015 as a result of budget cuts and as public health responsibilities have moved from the NHS to local authorities in England.

It's a desperate situation, but our campaign is working hard to try to turn things around. At a national level, we have been working closely with other breastfeeding organisations to lobby ministers and talk to officials. We've also set up a network of Better Breastfeeding Advocates, who are helping us to campaign at a local level. We have nearly 180 advocates so far, and our aim is to have a group of advocates working together in each of the 44 regions in England identified by the government as Local Maternity Systems (LMSs). Each LMS has been tasked with delivering the government's Better Births strategy, and the official line is that improvements to breastfeeding are going to come about through this national maternity strategy.

The trouble is that the LMSs themselves have little idea of how to do this, and they haven't been told that breastfeeding is a priority, even though this is what ministers are saying publicly. So our campaign has produced a 'Guide to the guidance' on breastfeeding support that is aimed at LMSs and tells them everything they need to know about the national guidance that's out there – from the National Institute for Health and Care Excellence (NICE), Public Health England, United Nations Children's Fund (Unicef) and others. Our local advocates have been making sure that their LMS has seen the guide and they're applying pressure to try to ensure that good-quality breastfeeding support is part of their local Better Births plan.

Commissioners – in the NHS and in local government – are under pressure from many sides. They will listen to the loudest voices and, until now, breastfeeding campaigners have not been among those shouting the loudest. For the most part, we've been busy doing what we do, helping mums to breastfeed their babies. Our advocates are set to change this by making their voices heard at a local level. Not only will they be pushing for breastfeeding to be a central part of the new Better Births plans, they'll also be calling for it to be included in their local perinatal mental health pathway and in their local childhood obesity strategy. They'll even push for it to be part of the local council's environmental strategy (the more babies who are breastfed, the less plastic from formula packaging that needs to be recycled or sent to landfill).

One of the best ways to achieve this, we believe, is for each council area to have its own Infant Feeding Strategy Group, with representation from our advocates, working alongside council officials, midwives, health visitors, GPs, peer supporters and mothers themselves. Some areas have had these strategy groups for years; others are just being set up. Very often, it will make sense for the strategy group

to be part of the Maternity Voices Partnership or to work very closely with it. By ensuring that breastfeeding is at the heart of these local strategies, it should be much harder for councils to cut these services in the future. So this work needs to happen even in areas that haven't experienced cuts. In the current climate, no breastfeeding support service is safe from being axed.

If you would like to join us and become a Better Breastfeeding Advocate, please request to join at https://www.facebook.com/groups/betterbreastfeedingadvocates/. We share ideas and resources and will link you in with other campaigners in your area. Our advocates are also helping us to collect information to build a national picture of breastfeeding support, showing where it's good and where it's lacking. Our mapping toolkit will soon be available through the network, and the data we collect will be especially powerful for lobbying the government by highlighting the postcode lottery of breastfeeding support that exists.

What can I do?

If you know of cuts (or threatened cuts) to breastfeeding support in your area, or if your area needs to improve its service and you want to do something about it, here is a list of actions to take. There are no guarantees, but those areas that have successfully fought back against the cuts have employed these steps.

- **Act early.** As soon as you hear about cuts, or as soon as they're threatened, get into action. Join the Better Breastfeeding Advocates Network (https://www.facebook.com/groups/betterbreastfeedingadvocates/) and/or join the Breastfeeding Cuts UK Facebook group (https://www.facebook.com/groups/breastfeedingcutsuk/) for advice.
- **Get organised**. Create a campaign group and assign a task to each member. Make sure you have an effective way of communicating with each other.
- **Gather local voices**. Create an online petition and a social media presence and let as many local mums as possible know about the threatened cuts. Put mums in touch with their local councillors and MPs. Ask them to write with their personal stories (copying in the local campaign).
- **Get backing for your campaign**. Contact your local Maternity Voices Partnership (MVP), midwives, health visitors, GP groups and others and ask them to write a letter saying why the service is important. Write a briefing paper setting out the situation and explaining what the campaign is asking for and send it to every local councillor, to your local MP and to the commissioners responsible for the decision.
- **Contact the media**. Set a date for a public protest and make it a media-friendly event (with mums and babies who can pose for photos). Write a short press release about the situation with details of the protest and send it to all local media – press, radio, websites, TV. Send the press release a week in advance, and then follow up in a couple of days with a phone call to find out if they're interested in covering the story. Persistence pays off with busy journalists.
- **Speak up at your council**. Councils each work differently, but there will be a way of giving a short (5-minute) address at a council meeting. Look up which meetings will allow this. It may be a full council meeting or it may be a committee meeting, such as the Health Scrutiny Committee. Look up the council website to find the date of the next meeting and how to arrange a slot. It's often possible to send written questions in advance as well.
- **Don't let up**. Politicians will do everything they can to reassure and try to make campaigners go quiet. Don't let up until you're certain that the service has been saved.
- **Keep breastfeeding on the agenda**. Contact your MVP, LMS and the Health and Wellbeing Board. Push for the setting up of an Infant Feeding Strategy Board to ensure that breastfeeding is part of every relevant future strategy.

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(1) https://praeclaruspress.com/news-2/recorded-webinar-breastfeeding-trauma-by-dr-amy-brown/

Banking on Change at Hearts

by Gillian Weaver

Author Gillian Weaver has spent almost three decades immersed in the connected worlds of breastfeeding support and human milk banking. Together with Epigeneticist[1] and former Paediatric Surgeon Dr Natalie Shenker, she is now working to bring a change of approach to the provision of donor breastmilk and to lactation support. They co-founded the Hearts Milk Bank in 2016 which became fully operational in June 2017. They also recently launched the Human Milk Foundation, a charity that will help to support the work of human milk banks as together they expand assured availability of donor human milk geographically and to babies who previously would not have had access to donated human milk.

Milk Banks: A History

Human milk banks were introduced to the UK almost 80 years ago. The first was located at Queen Charlotte's Hospital in West London and officially opened in 1939. Others started to open throughout the UK after the 2nd World War and the numbers grew throughout the 1950s and 60s. The milk was collected from donors at home and the milk was heat treated and frozen in rudimentary freezers or used within 24 hours. Hospital based, less formal milk sharing operations began to take over and many mothers from the 70s and 80s who were resident in the postnatal wards will recall being asked to express milk for babies whose mothers didn't have enough, especially for babies on the neonatal unit and for twins and triplets. The milk was often used without any treatment but in many instances it was simply boiled in a saucepan in the ward kitchen.

However, change was afoot! Guidelines published by the then Department of Health and Social Security in 1981[2] recommended bacteriological screening and heat treatment of breastmilk, and the 1980s saw an end to the payment of paltry sums to the mothers who provided the milk. Purely altruistic donation became the norm and 'donor human milk' or 'donor milk' for short has since replaced the commonly used term 'bank milk'. The introduction of mandatory and more sophisticated heat treatments and extensive screening of donors also has its roots in the 80s as part of the aftermath of the global rise of HIV infection[3]. The development and marketing of specialist preterm infant formula milks and financial cuts across the NHS combined with concerns about risks of HIV transmission almost killed off milk banks across the UK as well as globally. Subsequently, however, published evidence of lower rates of necrotizing enterocolitis in preterm infants fed only human milk, including exclusively donor human milk, became available in the early 1990s[4]. This led to the overall numbers of milk banks increasing again including in the UK, with 17 fully operational by 2007. The publication of national guidelines in the 90s[5], followed by the NICE clinical guideline 93[6] in 2010, have standardized UK milk banking practices and led to greater quality assurance and improved traceability.

During the 1990s and into the new millennium there was renewed investment in milk banks; new ones were established and those that had survived the 80s decline, started to grow and expand their provision to include additional hospitals[7]. Donor recruitment, volumes of milk collected and processed and the provision of donor milk all increased year on year throughout the 90s and 2000s. However, current financial constraints within the NHS have impacted negatively on some milk banks and much needed investment has not been widely available. This has compromised the use of donor milk especially as, even for preterm infants, its use is not without critics within neonatal circles. The endorsement of national guidelines by the British Paediatric Association (BPA)[5] and then by the Royal College of Paediatrics and Child Health (RCPCH)[5], followed by the publication of the National Institute of Health and Care Excellence (NICE) Guideline CG93[6], addressed safety concerns but questions were

raised in the UK about the value of donor milk, about its cost effectiveness and the usefulness of human milk banks. Despite the growing body of evidence about the positive role of milk banks and donor milk (when used appropriately) in supporting lactation and breastfeeding the opposite has often been cited[9]! In addition, doubts about the evidence base with regard to donor milk and necrotizing enterocolitis have bedeviled milk banking for two decades now. Sadly research that had sufficient numbers of babies in it to get a clear result and that addresses the feeding regimes appropriate to UK preterm nutrition has remained elusive. Planned multi-centre trials may still take place, however many neonatal feeding specialists are reluctant to randomise infants to a diet that may leave them without any or little human milk if the mother struggles with establishing her milk supply. Study designs that take account of this are a possibility, but funding for a very large trial has not yet been found.

...the recognised benefits of donor milk compared to infant formula are fewer babies contracting sepsis and necrotizing enterocolitis, better feed tolerance and shorter hospital stay, and are unsurprising given the known contents of human milk and the good retention rates of immune components after the pasteurisation process.

On the other hand, the recognised benefits of donor milk compared to infant formula are fewer babies contracting sepsis and necrotizing enterocolitis, better feed tolerance and shorter hospital stay, and are unsurprising given the known contents of human milk and the good retention rates of immune components after the pasteurisation process.[8]

The use of donor milk as part of routine neonatal unit infant feeding protocols is associated with increased breastfeeding rates on discharge[9] as well as overall volumes of breastmilk intake[10]. Milk banking and donor milk proponents have long advocated its appropriate use as part of overall lactation support. They have similarly cautioned against using donor milk without also supporting women to express their own colostrum[7] (preferably within the first hour but at least within the first six hours) and without on going support for mothers to provide their own milk. When supplementing babies whose mothers are temporarily unable to provide enough of their own milk, the availability and use of donor milk is known to be interpreted by mothers as providing a bridge to breastfeeding and not, as the use of formula is perceived, as an end to it[11].

Improvements to Scotland's only milk bank had been supported by the Scottish government. Charitable funding had helped to develop a new facility in Glasgow and this enabled the development of a nationwide service in Scotland in 2013[12]. Donor milk supplies to neonatal units are now funded by the regional health boards of Scotland and a recent boost in funds from the Scottish government will enable more infants in hospital to receive breastmilk. The development of regional services has also made headway in the South West of England where the Bristol based Precious Drops Milk Bank received financial support from NHS England to increase provision of milk to neonatal units in Cornwall, Devon and Somerset as well as in Avon. The North West Mother's Milk Bank, formed after the amalgamation of the Wirral Mothers' Milk Bank and the Cheshire and North Wales Milk Bank, has grown year on year and continues to supply donor milk across the north of England and further afield if local milk banks are unable to meet demand. Their establishment of a number of depots in the north of England has enabled neonatal units to rapidly access milk when needed. However, elsewhere in England, local hospital based milk banks were often unable to fulfill local need. This was especially the case in London and the South East where suddenly milk banks were providing less milk to external Trusts, and assured supplies were becoming more difficult for neonatal units to obtain. It was not unusual for nursing staff to be spending several hours trying to locate supplies of donor milk and there were even examples of them having to take taxis across London to access small amounts of milk. Without assured access, the use of donor milk began to decline in the south east, and hospitals that had been planning to introduce it to neonatal feeding protocols had to place their plans on hold.

The Hearts Milk Bank

It was against this backdrop that the Hearts Milk Bank (HMB – *www.heartsmilkbank.org*) was founded in March 2016. It is a community interest company (CIC) that operates on a not for profit basis and was founded with the intention of bridging the gap in provision of donor milk throughout London and the South East. It is the first independent milk bank to be founded in the UK and received no NHS or government funding. **The Hearts Milk Bank has three aims, and the second two are what makes it stand out from other UK milk banks:**

1) The main aim of the Hearts Milk Bank is to provide safe and assured supplies of donor milk to any hospital neonatal or paediatric unit that is unable to access it from local hospital based milk banks.

2) A secondary aim is to promote and support human milk based research particularly into epigenetic studies of breast cancer but also in ethically approved areas of human milk and infant feeding. Areas for further research highlighted in both the NICE guideline[6] in 2010 and the BAPM report[12] in 2016 have not yet been addressed in the UK and the Hearts Milk Bank aims to facilitate these and other studies.

3)The provision of safe, screened donor milk to mothers whose babies are not premature or unwell, which, when combined with high quality IBCLC-led support ensures that women who do not wish to use formula, but (short or long term) need extra milk, can access human milk instead.

Support and mentorship from the University of Cambridge's Judge Business School and being awarded a very prestigious Mass Challenge prize in 2017, together with other business accolades, provided much needed reassurance that this was a sustainable and forward thinking model for human milk banking. Crowd funding and financial donations enabled the Human Milk Bank to start. The milk bank's proximity to local Hertfordshire and Bedfordshire SERV (Service by Emergency Rider Volunteers) provides a very important bonus as their volunteer motorcyclists are an indispensible part of the overall operation. The Blood Bikes, as they are known colloquially, have revolutionized human milk banking in the UK by providing not only free milk collection and delivery services but by being able to coordinate these in a way that frees up time for the milk bank administrative staff.

In addition to the co-founders, the milk bank benefits from staff with International Board Certified Lactation Consultants (IBCLCs), midwifery and hospital infant feeding specialist expertise and from pharmacy technician and breastfeeding support experience as well as from the expert advice panel that includes leaders in the fields of clinical microbiology, neonatology and breastmilk related pharmacology. A small group of greatly appreciated volunteers lend a hand with some of the administration and with marketing and promotion.

In the first 15 months of operation the Hearts Milk Bank has supplied milk to 27 hospitals with half of these unable to previously use donor milk due to a lack of assured access... The bank has recruited over 200 donors and is currently providing over 100 litres of milk a month to both hospital and community infants.

In the first 15 months of operation the Hearts Milk Bank has supplied milk to 27 hospitals with half of these unable to previously use donor milk due to a lack of assured access. More hospital neonatal units expect to introduce donor milk into their feeding protocols in the coming months. The bank has recruited over 200 donors and is currently providing over 100 litres of milk a month to both hospital and community infants.

Donor milk for babies who are not unwell

The provision of donor milk to babies at home came about as the result of having an ongoing surplus of milk, no shortage of mothers offering to become donors and increasing requests for milk from mothers unable or struggling to lactate. This led to the decision to provide donor milk, when available, to community based infants in circumstances where the request came via a health care professional and where the provision of donor milk

wouldn't undermine the baby's chances of receiving their mother's own milk. These include where the baby's mother has received an antenatal cancer diagnosis, has previously undergone bilateral mastectomy surgery, is taking medication absolutely contraindicated for breastfeeding (eg antipsychotic drugs) or is HIV positive and advised not to breastfeed. In all of these cases the donor milk is provided with the mother's health and wellbeing in mind in addition to the benefits of providing human milk for the infant. A final group of infants for whom in the future donor milk will become increasingly available via the Human Milk Bank are those who need a temporary supplementation whilst the mother's lactation improves and/or breastfeeding becomes established. It is envisaged that when used with the help of qualified and experienced breastfeeding supporters, the provision of a few feeds of donor milk will avoid the use of cow's milk formula and support the development of or return to full maternal milk feeds.

The Human Milk Foundation

The most recent news from the HMB is that the co-founders have collaborated with experts in the fields of cancer research and fund raising to create a new UK charity - the Human Milk Foundation (www.humanmilkfoundation.org). This has been established to support parents, facilitate increased supplies of milk to families who otherwise would not have access to human milk for their infants, to promote education around human milk and to promote and support research into human milk.

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www.bapm.org

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Breastfeeding with Insufficient Glandular Tissue

by Philippa Lomas

I was never confident that my breasts were 'normal' growing up. I was born blind and never went around feeling other people's breasts so I couldn't be sure, but from the fact that I never filled the top of a bra cup and from comments made by others about different women's breasts, I really began to wonder. I seemed to have very large nipples on the end of small tube-shaped sacks with a large gap between them. I eventually decided to speak to my GP about my concerns, even if it was just to be reassured that all was normal. The doctor took a look and said that he could see what I meant. For me, this was validation that I was not going insane. There was actually a problem.

I was told that I might be eligible for breast augmentation. I saw a plastic surgeon and he agreed. All the way along I told everyone, 'If I ever have children, I would like to breastfeed'. I was told that the surgery would be performed so that the implant was placed under the muscles, away from any ducts, and that the incision would be made on the underside of my breasts, preventing any nipple damage. The surgeon said, 'If you could breastfeed before the surgery, you'll be able to breastfeed after it'. No one had given my condition a name. No one had explained what the shape of my breasts before the operation might mean to breastfeeding.

Time passed, and the day after the surgery came. I remember lying on my hospital bed and the doctor who was on the ward that day came and pulled open the curtains round me. He had a few students with him. He addressed the students and said, 'This is the lady with tubular breast syndrome'. At the time I thought, 'So that's what it's called' but he offered no explanation.

The surgery improved my self-esteem immensely. I will always be grateful for the GP who listened and the resulting operation. I met my husband and got married shortly after the surgery. I became pregnant in early 2014 and was overjoyed. I told my midwife and health visitor about the name of my condition and the breast augmentation but they didn't seem to think it would be a problem. In December 2014 I gave birth to my first daughter, Karis. She latched on straightaway and I sat there marvelling at my baby and the fact I could provide everything she needed ... or so I thought.

Karis spent a lot of time at the breast. She fell asleep during feeds, and woke immediately to be fed again as soon as she was put down. Despite this, I thought breastfeeding was going well. I had been told that babies fed frequently at this age so I was not worried. Then, the dirty nappies stopped. Karis carried on putting on weight slowly, no one was concerned. After 9 days the dirty nappies resumed infrequently. The midwife discharged us and I was happy. Each time I expressed any concern about my milk supply, I was told that it was fine because I could squeeze drops of milk out. The health visitor was less happy. She disagreed with the midwife and came back 2 weeks later to do another weight check. She found that although Karis had not lost any weight, she had only gained half an ounce in those 2 weeks. She insisted that I should top up with formula. I felt like there was no point feeding her at all, like I was being told that my milk was worthless.

A baby-friendly feeding counsellor was called in and luckily she spotted a tongue tie. It was cut at 8 weeks. In the meantime, I died a little inside every time I gave a bottle of formula. I wished it could have been breastmilk. I expressed after every feed, in the middle of the night and every time Karis slept and I could put her down, but I never expressed more than an ounce at most. I began using a Supplemental Nursing System (SNS)[1] at 4 months. This meant the supplement could be given at the breast, filling the two purposes of stimulating my breast and feeding the baby. This bottle, with its two thin tubes hanging from it, was probably the thing that saved my breastfeeding relationship. Most professionals didn't even know what an SNS actually was and I had to explain it multiple times. This upset me because surely something like this should be the first port of call when a mother is needing to top up but still wanting

to breastfeed, and yet so many midwives are unaware of its existence. This is something that I feel should change. Fortunately for me, Karis never lost interest in breastfeeding with or without the SNS.

The feeding counsellor ... took a look and commented on the large gap between my breasts, and explained that she suspected mammary hypoplasia, otherwise known as insufficient glandular tissue or IGT. I would never make enough milk for my baby.

Time passed, and I continued to see the feeding supporter because I was still feeling so sad for having low supply. We tried dropping the supplements when the tongue tie was revised, but my milk supply only increased slightly. The health visitor asked questions about my surgery, but I explained that they had been so very careful that it would not have affected things. However, the feeding counsellor asked me what my breasts had been like beforehand, and I explained. She then took a look and commented on the large gap between my breasts, and explained that she suspected mammary hypoplasia, otherwise known as insufficient glandular tissue or IGT. I would never make enough milk for my baby. [*Editor's note: Please see the AIMS comment on mammary hypoplasia below this article.]* I couldn't do what I felt that every mother should be able to do for her child. I felt betrayed by my own body, and by the many professionals I'd shared my story with during and after pregnancy. Surely someone should have known! Someone should have told me! I felt guilty, angry and alone. Many people told me that 'Most women choose to give their baby formula, so why give yourself such a hard time?' but few people understood how heartbroken I felt.

Time passed and I became convinced that Karis was reacting badly to the formula. She was unable to poo easily and was extremely uncomfortable and windy, and she was often blocked up as though she was full of cold. Many of my family have dairy intolerance issues, so I mentioned it to a few of the health professionals that I was still in contact with. My concerns were dismissed as me finding another reason to complain about giving her formula. I was denied the option of receiving milk from a milk bank because most milk banks only supply donor milk to babies who are premature or have specific medical needs. [*Editor's note: Please see the article in this Journal about the Hearts Milk Bank which is working to overcome this issue.*]

At one year I took Karis off the formula and all dairy products. Overnight, I had a different child.

When I became pregnant again with my second daughter, I vowed to do everything in my power to make breastfeeding more successful this time! I researched and researched, joined a support group for women with low milk supply and bombarded them with questions. I took herbs that might be able to make me produce more milk by stimulating the breast tissue growth during pregnancy. I met with an International Board Certified Lactation Consultant (IBCLC) and put a plan together. I expressed from 36 weeks and built up a stash of colostrum for my baby. I convinced myself that this time would be different. I knew that I would have to supplement but thought it wouldn't be as much as last time. I thought that I knew what I was up against and that I was ready to face it.

When Cathy was born, she latched on straightaway, just like her sister. When she wasn't feeding I pumped. By the end of the second day she needed my top-up of colostrum. When this was all used up, she needed the backup ready-made formula I had packed in my hospital bag. From the minute she had the formula she had bad stomach ache and terrible wind. When I got home from hospital I called my IBCLC and she cut the tongue tie which I had already suspected. She explained to me how to express effectively to build up and maintain my supply. This was in contrast to midwives I encountered who were convinced I didn't need to worry and that I just had to have enough milk. I knew that I didn't. I found that I was having to explain my condition more and more to people, and listen to the platitudes of 'Many women worry about their supply, but most of the time it's actually fine, and if you cut out the formula your milk would increase' and 'You see, only a very small percentage of women actually really can't make enough milk, so it's highly unlikely you're actually one of them'.

Constantly having to explain that I had insufficient tissue to feed my baby made me feel like I was actually saying that I was an insufficient mother. I hated going out and having to publicly admit I wasn't enough by feeding my baby a bottle straight after a breastfeed or feeding with the SNS, in case someone asked about it.

Constantly having to explain that I had insufficient tissue to feed my baby made me feel like I was actually saying that I was an insufficient mother. I hated going out and having to publicly admit I wasn't enough by feeding my baby a bottle straight after a breastfeed or feeding with the SNS, in case someone asked about it. I'm sure people wondered why I bothered breastfeeding at all but I had learnt from my experience with Karis that it was not just about the milk. I clung to family and friends' reminders that whatever I could give her, no matter how small, was so very important. But still, I constantly totted up the number of ounces of supplement that day and each time I pumped I'd be discouraged by the pitiful amount in the bottles. I felt judged and was angry and frustrated with my own body and with the inability of anyone to do anything about it!

Formula really did not agree with Cathy. At night I was able to feed her myself and she was a lot more settled. Again, I was told that screened donor milk from a milk bank was not an option. I tried various types of formula but nothing helped much.

I went to my GP in tears and begged for domperidone in the hope that it would increase the little supply that I did have. At the back of my mind was the thought that if I could have produced all the milk she needed, Cathy would have been fine. The guilt was overwhelming. Eventually I asked a close family member who was breastfeeding if she would give me some of her milk. The transformation was almost instant. So then I went online to the Human Milk 4 Human Babies Facebook page[2] and found four other kind women who donated their milk.

Finally, our referral came through and the paediatrician prescribed a hydrolysed formula, which is formula made from cow's milk but with changes made to the protein to make it less likely to trigger a cow's milk protein allergy. This was too thick to pass through the tubes of the SNS, so I had to give bottles again. My heart broke every time I gave a bottle and a little piece of me died every time it was the thing that stopped her crying.

However, Cathy also never stopped wanting to breastfeed. She always asked me for milk first and when the bottle was done would return to the breast. She turned to the breast for comfort, for safety, for a drink after a snack or as a sleep aid. She is still nursing at nearly 15 months old! This continually fills me with joy and humility. It's something that I never thought would happen. I always thought she would give up putting so much effort in for such little reward given that I had stopped taking all herbal and medical remedies and had stopped expressing when she was 9 months old and my supply dropped significantly.

Cathy is a normal breastfeeding toddler and for me the story of our journey has a reasonably happy ending.

I wish there was more education given to midwives and all people who come into contact with breastfeeding mothers with mammary hypoplasia. Not only about the physical effects and the need to supplement but also about the mental effects on the mother who watches her dream of exclusively breastfeeding crumble into dust in front of her eyes and has to deal with the guilt.

There should be the option, for the baby's sake, to receive milk from a human milk bank, instead of having formula pushed at the first sign of trouble. Formula is not the answer to every breastfeeding challenge. Problem-solving with experience and knowledge is.

I am so grateful for my breast surgery, and I don't feel that it has impacted my breastfeeding journeys at all. I know in some cases surgery can have a negative impact, but for

me the operation was so well done that it was not the cause of my inability to exclusively breastfeed. It was the shape of my breasts before the augmentation that sealed the fate of my breastfeeding problems. Size doesn't matter, but the shape and structure may do. I urge you, if you're involved with advising or supporting breastfeeding mothers, please find out about hypoplasia so that you can provide appropriate individualised support or signposting.

I urge you, if you're involved with advising or supporting breastfeeding mothers, please find out about hypoplasia so that you can provide appropriate individualised support or signposting. Above all, please listen to women! While most milk supply concerns can be overcome, there are women with genuine health issues that cause naturally low supply who need specialist support.

Above all, please listen to women! While most milk supply concerns can be overcome, there are women with genuine health issues that cause naturally low supply who need specialist support. Before I found other women online who have hypoplasia I felt like I was the only woman in the world who couldn't breastfeed exclusively. Having to keep explaining hypoplasia to people made it much worse. I was fortunate to have a very understanding and supportive family network which encouraged and supported me to breastfeed as much as I could. Many women don't have this, particularly in this culture where breastfeeding is not normalised or commonly seen in public, so you could be the only person encouraging a struggling mum to carry on when all others are pushing for her to give up. You need to know what you're dealing with.

I wish that more milk banks were able to make screened breastmilk available to mums who need it, such as women with hypoplasia. It's the baby's right to have breastmilk and from my own experience the feelings of guilt increase, knowing that you have to feed your baby a synthetic substitute which may or may not agree with their digestive systems. Surely babies shouldn't be deprived of their right to be fed breastmilk just because they are not sick or premature? It shouldn't be another unspoken statement to the mother with low milk supply that the problem is hers so it doesn't matter.

References:

1) Further information on Supplementary Nursing Systems (SNSs): https://www.laleche.org.uk/nursing-supplementers/
2) Human Milk for Human Babies Facebook page: www.facebook.com/HM4HBUK/

AIMS Comment: Hypoplasia (Insufficient Glandular Tissue – IGT)

Hypoplasia is a condition where a mother's milk-making tissue in her breasts – the glandular tissue – has not developed as much as would be required to produce a full milk supply. Women who have hypoplasia may have already noticed, pre pregnancy, that their breasts look different from other women's. Common signs are breasts that are widely spaced, significantly unequal-sized breasts, and a tubular shape, sometimes with a 'bulbous' areola. During pregnancy, women with hypoplasia tend to notice that their breasts have not changed, or have changed very little, and they then find that their milk doesn't appear to 'come in'.

Many women with hypoplasia are able to offer some breastmilk to their baby and, with good support, some may be able to achieve a full or nearly full milk supply – but many cannot. Early intervention and support from an experienced, qualified person such as an International Board Certified Lactation Consultant (IBCLC) is vital to ensure that the maximum amount of a mother's own milk can be produced.

A note on language – the term 'insufficient glandular tissue', with the implication that a mother is 'insufficient' for her baby, can be very distressing. AIMS therefore supports use of the term 'hypoplasia' rather than 'insufficient glandular tissue' or 'IGT'.

More information:

https://kellymom.com/bf/got-milk/supply-worries/insufficient-glandular-tissue/

The Breastfeeding Mother's Guide to Making More Milk, by Diana West and Lisa Marasco: Find this book on Amazon

AIMS comment written by Emma Ashworth, BFC.
With thanks to Emma Pickett, IBCLC, for checking this information.

Beyond the infant formula business there is resistance

by Marta Busquets

Throughout history there have always been some babies who were not breastfed by their own mothers, for many different reasons. The main solution was found in a woman who was not the mother of the baby, often family members or friends; for instance, a woman breastfeeding her sister's baby.

Babies were only fed animal milk when human milk was not available. It was often milk from goats, horses or sheep, although, in the vast majority of cases, cow's milk. Around one third of the non-breastfed babies died, and the ones that survived were more prone to being sickly.[1]

Despite the clear evidence of the problems that non-human milk causes to human babies, in 1867 Justus von Liebig created and patented the first commercial infant formula and only sixteen years later there were 27 patented different brands and strong marketing pushing the products. What really started the revolution was the need to find a market for the now excessive quantities of cow's milk which was being produced, thanks to greater efficiencies in milk farming. The market needed to be created, and Henri Nestlé was ready to make it. He created a food called "Farine Lactée" which was made from wheat flour and condensed milk. Not surprisingly, Mr Nestlé was a grain merchant, so this product suited him well as an outlet for his grain, together with the glut of milk around at the time. "Farine Lactée" was heavily marketed as a healthy food for infants, alongside the claim that it had saved the life of a baby whose mother was unable to breastfeed him. Whether this claim is true, we don't know, but there were no advertising standards at that time…

GOOD HOUSEKEEPING MAGAZINE—THE HOME DIRECTORY 31

Baby Pieper
Hartford, Conn.

"RAISED ON IT"

NESTLÉ'S FOOD

A PERFECT NUTRIMENT FOR INFANTS, CHILDREN AND INVALIDS

Don't Wait Too Long Before You Wean the Baby

IF YOU do the little one is likely to be weak and anemic. Mother's milk is, of course, the best food for young babies, but the time comes when it isn't sufficient for the fast-growing body. Doctors say that this is when the baby is about six months old.

That's the time to begin using NESTLÉ'S FOOD, because NESTLÉ'S is so like mother's milk that the tiny stomach won't notice the difference.

At about the sixth month, then begin to give the baby NESTLÉ'S once a day in place of a nursing; then gradually increase the NESTLÉ'S until by the seventh or eighth month the baby is entirely weaned. Thus your baby will pass the most critical period of its babyhood, and not even notice it.

Don't tax the little stomach by changing abruptly to cow's milk. Milk as it comes from the cow, so often full of germs and heavy with indigestible curds, is not the food for a little baby; but cow's milk contains something life-giving that nothing else will supply and is the ideal food for the baby after it has been purified and made digestible. That requires a long, patient, scientific process which is all done for you in NESTLÉ'S FOOD.

NESTLÉ'S FOOD is the nearest thing in the world to mother's milk. It is the richest cow's milk from our own sanitary dairies, with the proteids made digestible and the sugar and fats rightly proportioned—all under scientific direction. And this splendid triumph of care and science comes to you as a powder. All you do is to add water and boil two minutes to make it ready for the baby—a bone-building, muscle-building, delicate and satisfying Food.

The coupon brings you a trade-size package of NESTLÉ'S FOOD free, so that you can see for yourself what other mothers have learned for forty years that NESTLÉ'S is the best substitute for mother's milk.

HENRI NESTLÉ, 70 Chambers St., New York. Please send me, free, your book and trial package.

Name _____

Address _____

Please mention Good Housekeeping Magazine when you write our advertisers

Advertising at the time not only made the dangerous and inaccurate statement that artificial formula was equal to mother's milk, it actually got to a point where it claimed that it was better or more convenient than breastmilk or breastfeeding. It was presented as a healthy choice (it is still marketed the same way today), with the description that it was a scientifically-made product which would resolve their invented claim that "*the time comes when it isn't sufficient for the fast-growing body*" (see image). By the early 1900s there was some indication that there was a desire to suppress some of the more outrageous claims about milk products marketed for babies, and the 1911 "Report on the unsuitability of sweetened condensed milk" was discussed in the UK's Parliament. Following this, the requirement to label condensed milk with "unsuitable for infants" was made law, but one manufacturer printed, "For Infants and Invalids" in huge letters, with the "unsuitable for infants" in tiny text.[2]

In the 1970s the rate of breastfeeding was extremely low - in the US, around 75% of babies were bottle-fed in

that period. During that time companies started expanding into developing countries with even fewer regulations and controls, which made more aggressive marketing possible. **Formula feeding increases the chance of illness and death and the chances are much worse for children in areas with unhygienic conditions, dirty water and families forced to dilute the formula because it's too costly. According to the United Nations Children's Fund (UNICEF)[3], a formula fed child in such precarious conditions is 25 times more likely to die of diarrhoea and 4 times more likely to die of pneumonia than a breastfed one. In the "developed" world, a formula fed child is also at a 25% increased risk of death compared to a breastfed baby.[4] Besides the death rates, formula feeding increases the risk of asthma, allergies, lower cognitive development, breathing infections, diabetes, cardiovascular disease, childhood cancer (in particular, leukaemia), chronic diseases and anaemia.**

Despite these risks, formula companies such as Nestlé disguised sales women as nurses, leading parents to believe that the artificial milk that they were selling was medically approved.

Despite these risks, formula companies such as Nestlé disguised sales women as nurses, leading parents to believe that the artificial milk that they were selling was medically approved. Following the theme of using medical staff to support the sale of formula, doctors have received commissions or presents for encouraging formula feeding and women have been given formula samples in hospital which interfere with their own milk production, thus creating an unnecessary need and making mothers dependent on the product. By advertising in medical centres and birth centres, formula appeared to be medically endorsed. Doctors started to see malnutrition, serious illness and death in babies with a frequency never before seen. They called it "bottle baby disease".[5]

Doctors started to see malnutrition, serious illness and death in babies with a frequency never before seen. They called it "bottle baby disease".

In 1973 a magazine called the New Internationalist was published. A booklet titled 'The Baby Killer' followed a year later. Both of them exposed these illegal and unethical practices to the public. This was the start of protests that led in 1977 to a Nestlé boycott, initially launched from the United States of America, but which was quickly picked up in other countries. The Nestlé Boycott[6] continues to be followed across the world to this day: as Nestlé is one of the biggest manufacturers of infant formula, and its marketing leads babies to be put at risk by claims that it makes, such as that its formula "protects babies".[6] Gabrielle Palmer's 'Why The Politics of Breastfeeding Matter' states, '*A Swiss action group called its version [of The Baby Killer] "Nestlé kills babies" […] Nestlé at first charged the group on four counts of libel: the title; the accusations of unethical practices; responsibility for death or damage to babies; and dressing saleswomen as nurses. By the final court hearing Nestlé had withdrawn all charges except for the title. The judge ruled this libellous because members of the Nestlé company had not actually killed babies; the mothers had done the killing when they bottle fed them with the artificial milks.*'

In 1981, all of the above prompted the World Health Assembly to establish the International code of Marketing of Breastfeeding Substitutes[7] which tries to establish ground rules regarding the marketing and promotion of such food products directed to babies and infants and limit the illegal and unethical approaches. Some of the items in the code have been introduced into UK law, including making it illegal to advertise or promote infant formula - which is why parents cannot buy discounted infant formula, nor get benefits such as supermarket reward card points on it.

Since then, different initiatives and regulations have been established internationally and locally to protect and promote breastfeeding from aggressive marketing, and to make formula risks available and known to the general public. For example, UNICEF, together with the World Health Organisation (WHO), launched the Baby-Friendly Hospital Initiative (BFHI) in 1991. In order for a hospital

to get accredited it has to ensure that it provides adequate breastfeeding support and respects the aforementioned International code of Marketing of Breast-feeding Substitutes. Thanks to these initiatives, breastfeeding rates have been slowly recovering in many developed countries over recent decades, even though formula companies continue violating regulations through sophisticated and subliminal marketing methods.

As well as the Nestlé boycott, we are seeing open discussions on the environmental footprint of formula production, since it produces high amounts of waste, greenhouse gases (remember that the cattle industry is the second largest contributor to such gases) and water consumption (a minimum of 4.000 litres of water are needed to produce just 1kg of formula powder).

According to the UK regulations, formula manufacturers cannot advertise formula for newborns, so they created different formulas according to age groups. By referring to Stage 2 formula ("Follow on") or Stage 3 ("Toddler milk") they can be advertised since it is aimed at babies older than six months – but the packages and merchandising are almost exactly the same as stage 1 formula, and in the adverts they very often use babies that appear to be under six months even though they will be older babies.

They have also once again expanded their business and unethical tactics to developing countries. But campaigners are fighting back. Such behaviour has sparked new boycott calls against formula companies in general and Nestlé in particular.[8]

As well as the Nestlé boycott, we are seeing open discussions on the environmental footprint of formula production, since it produces high amounts of waste, greenhouse gases (remember that the cattle industry is the second largest contributor to such gases) and water consumption (a minimum of 4.000 litres of water are needed to produce just 1kg of formula powder). Breastfeeding charities including *The Association of Breastfeeding Mothers*, *La Leche League*, *Breastfeeding Network* and the *NCT* continue to train people to a very high level to support women who want to breastfeed. These courses not only cover the practical skills of breastfeeding, and resolving breastfeeding issues with babies and children from birth to weaning, but include counselling training in order to help women to support their own goals. With these skills, and the sharing of these skills, we are reclaiming the woman to woman support and knowledge which has been, for so long, deliberately undermined by the formula companies.

But, the fight is far from over. It is important that governments, health agents, organisations and women keep demanding that regulations be respected and commit to contributing to a strong breastfeeding culture, including a social climate where women decide with all information available and babies are not victims of unethical marketing tactics. The Nestlé boycott continues, and AIMS is one of many organisations which ensures that no Nestlé product is used at any of its meetings, and many members also follow this ban in their own homes. Maybe you would like to join the boycott and ditch Nestlé?

Marta Busquets is a lawyer from Barcelona specialising in health and gender, and an advocate for women's rights, focusing on sexual and reproductive rights including breast-feeding.

Further reading:

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"Why The Politics of Breastfeeding Matter" Gabrielle Palmer, ISBN 978-1-78066-525-2 *https://politicsofbreastfeeding.wordpress.com/about-the-book/*

UNICEF on breast-feeding: *www.unicef.org/nutrition/index_24824.htm*

Risks of formula feeding by INFACT Canada: *www.infactcanada.ca/risksofformulafeeding.pdf*

Bottle Baby Disease: *www.jstor.org/stable/1965799?seq=1#page_scan_tab_contents*

Nestlé Boycott in the UK: *www.babymilkaction.org/nestlefree*

WHO Internation Code of Marketing of Breast-Milk Substitutes: *www.who.int/nutrition/publications/code_english.pdf*

Baby Milk Action Campaigns: *www.babymilkaction.org/news/campaigns*

Article

Baby Milk Action – The State of the States

by Patti Rundall

Recently Channel 4's Dispatches programme, Breastfeeding Uncovered, focused primarily on the lack of support for breastfeeding women in the UK which included a quick look at baby formula marketing.

The programme started by showing painful experiences which were disturbing to watch. It was easy to forget that the majority of women in the world can and do breastfeed with minimal problems. Yet the problems we saw were mostly avoidable and came down to bad advice or lack of appropriate support and the UK's dismal bottle and formula-feeding culture. Cow & Gate advert aimed at undermining breastfeeding. Features a woman with a baby and the caption, "I'm thinking of getting a t-shirt made - Danger! Sore boobs!"

The fact that we assume we need healthcare providers to attach a baby effectively and painlessly to the breast shows how much breastfeeding skill we have lost. Despite the *Baby Friendly Initiative* and our mother support networks run by local volunteers, or online, our national knowledge about something so basic and important is shocking. But it's not only our culture. Let's not forget the role of the baby feeding industry, who, on top of their marketing budgets, pour funds into what they call "education", the training of UK health workers and parental "advice", so much of which is misleading. Many key institutions, such as the Royal College of Paediatrics and Child Health and the British Society for Allergy and Clinical Immunology, or the Association of British Dieticians, take funding from formula manufacturers, forgetting that commercial meddling in public health and education carries a significant risk.

The quality of the partnerships or the long-term health outcomes for women, babies and families is rarely independently evaluated. Much of the inept care, misdiagnosis and implied product endorsement, the blanket warning against co-sleeping with your baby, the "hungry baby" and other myths such as that soreness and pain are inevitable in breastfeeding, can be traced, at least in part, to the baby food industry's door. And this is not unintentional. Indeed, it's at the heart of a global, centuries old strategy to grow a lucrative market by undermining and destroying breastfeeding. (See the article in this Journal by Marta Busquets on the history of formula for more information.)

"The US is an approximately $4billion market… I think there were three factors that fuelled our growth and one offset. So let's begin with the offset. We continue to see breastfeeding rates in the US climb through 2014. Now we'll be watching very closely to see whether the improvement in unemployment trends will cause this trend to abate somewhat. It's our hope and expectation that will be the case…" Kasper Jakobsen, Mead Johnson CEO, Feb, 2015

"*We were having a discussion among executives from various areas including India and other executives from Kenya and a small team from Europe [about] the products that would be most penetrative in these marketing areas and it was duly decided that infant baby formula would be probably the most receptive. Mothers are very emotional… We wanted to use a nursing mother with the youngest possible baby...*

The strategy was formed around the idea that mothers had better things to do with their time than nurse their babies. And also there was a cosmetic one that was in discussion too. And that was that we were appealing to the idea that if you nursed your babies that you might suffer from what is referred to as 'bosom sag' and that this would be obviated of course if you used these marvellous products... I don't recall anyone ever suggesting that the water be boiled or anything."

1989 interview with Harry, a retired advertising consultant about advertising project for Nestlé in the mid 1970s.

During the programme, the Dispatches team asked me to look at a range of Infant Formulas, Follow-on Formulas and so-called Growing up Milks that Kate Quigly, the presenter, had just bought. The packaging was covered in idealising images: teddy bears, shields, hearts and claims that were easy to shoot down. What I didn't expect was Kate to say that she had believed the "specially formulated for your baby" claim – and that maybe the formula was actually better than her own breastmilk. The industry would never admit to making such a claim and I had forgotten how clever and misleading that one is. They are, after all, describing a product that can stay on the shelf for up to two years and is traded globally to millions of parents for babies who live in vastly different environments. The only thing that was "specially formulated" for Kate was the marketing message. This is a tricky thing to say on British TV with so many parents using these products and believing what's said on the tin.

What I didn't expect was to hear Kate (Quigly) say that she had believed the "specially formulated for your baby" claim – and that maybe the formula was actually better than her own breastmilk.

The industry would never admit to making such a claim and I had forgotten how clever and misleading that one is.

There were astonished reactions to my statement that none of these products except the infant formulas were necessary, nor are they recommended by the UK or the World Health Organisation (WHO), and that all the formulas for babies over 6 months (products that look almost identical to infant formula) had been invented by the baby food industry with the direct aim of getting round the advertising bans that apply to infant formula. *Baby Milk Action* and *IBFAN* (the International Baby Food Action Network) have campaigned against 'follow on' formula since the early 1980s and have followed the bogus industry-funded science and political arguments at EU level. When Prof Michael Crawford at London Zoo analysed follow on formulas for us in 1984, he said they were more like rhinoceros milk than human milk! UK health visitors, alarmed at their composition, said they should be considered a "pudding". Baby Milk Action succeeded in getting the age of use raised from 4 months to 6 months for the UK and the 1986 World Health Assembly (WHA) Resolution said these products were not necessary. But the adoption of the Follow-up Formula Standard (Codex STAN- 156-1987) in 1987 ensured their global trade and unlimited misleading marketing ever since. While their composition improved in the EU the marketing got worse and sales boomed. It's been an amazing success story for pure marketing hype.

When Prof Michael Crawford at London Zoo analysed follow on formulas for us in 1984, he said they were more like rhinoceros milk than human milk! UK health visitors, alarmed at their composition, said they should be considered a "pudding".

Over the years, the WHO has issued several reinforcing warnings, but they issued guidance in 2016 saying that all formulas targeting babies 0-36 months function as breastmilk substitutes and are covered by the 1981 International Code of Marketing of Breast Milk Substitutes and subsequent relevant WHA Resolutions – a clear message that national controls should end this misleading marketing. *An important new paper highlighting this issue* has just been published by the WHO and UNICEF in November 2018.

So why don't all governments strengthen their laws and stop this nonsense? What happened at this year's WHA gives us a very current clue.

A front page, well-researched article in the New York Times, *U.S. Opposition to Breast-Feeding Resolution Stuns World Health Officials,* followed by 900 social media and 600 editorials, explained the story to millions of readers. **The US Government had threatened Ecuador with losing its "most favoured nation status" - as well as US military protection - if they continued to support a Resolution calling for more breastfeeding support and an end to misleading marketing. The New York Times described the US action as "tantamount to blackmail." President Trump's tweet that this was "fake news" ensured that the story went viral.**

No one could believe that a Breastfeeding Resolution – and a mildly worded one at that – could evoke such a fierce response. I had been at the Assembly, knew the key delegates, and a few weeks earlier had been invited by Ecuador to speak about conflicts of interest. So, I knew something of Ecuador's efforts to get consensus before the WHA and we all thought that this had been achieved.

When we arrived at the Assembly and realised what was happening we advised delegates to call for a vote. I remembered that during the 1994 WHA, the USA and EU – supporting their industries – had objected to a Resolution calling for an end to donations and discounted sales of formula to health care systems. **At the time, African delegates threatened to call for a roll call (a vote) and all sides withdrew their objections. Global consensus on WHO's International marketing code was achieved for the first time.**

President Trump may be just one person in the long history of opposition to the International Code by US Governments and the baby food industry since 1981, but perhaps by going just that bit too far he may have done us a favour in expanding awareness. Let's see. At least the USA media has woken up and a new Resolution on breastfeeding has been introduced into the US Congress proposing legislative action in the US at the federal level.

Of course, these political changes extend way beyond infant feeding but we all have a responsibility to stand up to such pressure. We could start by reminding the US population that it was US citizens' actions through the Nestlé Boycott and the 1978 US Senate Hearings, led by Senator Edward Kennedy, that resulted in the adoption of the international marketing code in 1981.

Today, the USA, like the UK, is reducing the care for breastfeeding mothers. But, unlike the UK, the USA is also calling for the wholesale removal and re-evaluation of WHA Resolutions and public health safeguards that WHO, UNICEF, IBFAN and all our partners have helped integrate into food standards and laws over many years. How can one country, especially the one that hasn't even ratified the *Convention on the Rights of the Child* (CRC), ignore democratic principles and throw its weight around in this way, forcing developing countries to welcome harmful products, lower safeguards and abandoning their indigenous food cultures? The long-term health implications are immense.

How can one country, especially the one that hasn't even ratified the *Convention on the Rights of the Child* (CRC), ignore democratic principles and throw its weight around in this way, forcing developing countries to welcome harmful products

Any strengthening of legislation on nutrition, food safety or child health is on hold because of Brexit. Theoretically UK baby food marketing legislation could be strengthened if we leave, but the safety and human rights safeguards enshrined in EU legislation could be lost. We could be forced to accept imports of formulas made with hormone-laced milk or high in free sugars. Whatever happens, let's not forget that the baby food industry will do what it can to expand its market, even if this means dismantling vital public health safeguards. Let's not forget this as we try to protect UK babies, and all those for whom breastfeeding is a matter of survival.

Baby Milk Action continues to rely on its members and donations to ensure that it can continue its work. www.babymilkaction.

To print this article directly from AIMS, please go to *www.aims.org.uk/journal/item/baby-milk-action*

York – It's not for women

by Emma Ashworth

The York Teaching Hospital NHS Foundation Trust has implemented two homebirth-related guidelines which are putting women, babies and midwives at risk.

The first guideline states that women are not permitted to decline care in their home and still have their midwife remain with them. The wording is, '*If you arrive at the home of a woman and she refuses to allow you to access her home or to provide care to her, you must explain that you will need to leave and explain this decision to her. You should inform the woman that you will be happy to return to provide care should she want you to do so. The conversation should be fully documented.*' (York Teaching Hospital NHS Foundation Trust, Home Birth Guideline Version No: 9, August 2017 – August 2020, page 7.)

The language in this guideline is ambiguous. It could be interpreted to mean that if the woman does not allow the midwife access to her home, and therefore does not allow the midwife to provide care, the midwife should leave. Another interpretation could be that if a midwife is not allowed into the home OR is allowed into the home but the woman doesn't accept their offer of checks or interventions, then the midwife should leave. In practice, it is this second interpretation which is being used by York midwives and midwifery managers.

Let's look at the consequences of this guideline. 'Care' could be any intervention or routine check such as vaginal exams, blood pressure checks, auscultation of the baby's heart, suggestions to change positions, advice to leave the pool or shower or bath. If women decline any of these interventions, they risk the midwife deciding that they need to leave the woman's home, as per the Trust guideline, abandoning her in labour and leaving her and her baby at risk of not having medical care should it be required. The midwife may be found to be negligent should there be a subsequent adverse outcome for the labouring person or their baby. Alternatively, the woman must accept an intervention which she may not want, which means that she has not freely consented (and therefore consent has not been legally obtained), and this leaves the midwife open to an accusation of assault, a criminal offence.

The second guideline states that if a midwife arrives at a woman's home and she is found to be 10cm dilated (bearing in mind that if the woman wants the midwife to stay she may be forced to have a vaginal examination), '*if the second stage does not appear to be progressing well and birth does not appear to be imminent*', the midwife should recommend transfer into the hospital for continuous monitoring of the baby.

In practice, women are being told that if they are found to be 10cm dilated at the point of the midwife's arrival, but are not yet pushing, they need to transfer in for continuous monitoring. There are a number of problems with this guideline. Firstly, it is clearly the case that assessments of labour progress and how close to birth the woman is are subjective, and usually inaccurate. This guideline increases the risk of women birthing on the way to hospital, with the inherent trauma that that often leads to, as well as the risks to mother and baby. Secondly, the recommendation is being given despite the fact that there is absolutely no evidence to say that continuous monitoring offers long-term health advantages to the mother or baby over intermittent monitoring. In fact, the evidence tells us that continuous monitoring simply increases the caesarean birth rate, causing significant harm to women, subsequent pregnancies and possibly this baby as well.1

Women have reported that they are scared that the midwives will tell them that they are fully dilated when they're not, to get them to go into hospital, and other women have discussed their worries of birthing their babies on the way to hospital, or having their labour stall at a critical time, leading to interventions such as artificial oxytocin or caesarean becoming necessary. These are extremely valid concerns – interfering with labour at this critical point can have very serious physiological consequences. Because of this, I have been trying to obtain a copy of the Trust's risk assessment covering the dangers to women and babies of transfer at this stage, but so far they have declined to share one or to confirm whether one exists.

This is an ongoing issue in York, and AIMS will update its members when there is more information about the situation.

Reference:
1. https://www.cochrane.org/CD006066/PREG_continuous-cardiotocography-ctg-form-electronic-fetal-monitoring-efm-fetal-assessment-during-labour

PSA's Lessons Learned Review: The Nursing and Midwifery Council's handling of concerns about midwives' fitness to practice at the Furness General Hospital

by Shane Ridley

In May 2018 the Profesional Standards Agency (PSA) published a Review *which highlights the lessons learned* about the Nursing and Midwifery Council's (NMC) handling of investigations into the clinical competence and integrity of the Midwifery Unit at Furness General Hospital (FGH) following concerns raised by, amongst others, the parents, the Cumbria police and the *Kirkup Report* (The Report of the Morecambe Bay Investigation chaired by Dr Bill Kirkup, CBE, published in March 2015). This Review makes a harrowing read. It is about 16 babies and 3 mothers who died. It highlights a catastrophic sequence of events where, effectively, no-one took responsibility to investigate concerns and to stop bad practice. It is quite clear that poor clinical practice had been witnessed where babies and women died who need not have died, and that some of the deaths occurred after it was discovered that there was a problem in this unit, including in the years after the Kirkup Report was published.

There is much shocking information about the deaths, the terrible experiences the parents have endured ... the useless investigations, the disrespectful midwives and above all the failure of the NMC to ensure the Fitness to Practice of midwives.

This Review concentrates on the NMC's '*approach to the value of evidence from and communication with patients and the NMC's commitment in practice to transparency*.' The Review is long and detailed and describes a time line from 2004 to 2017. I recommend that it is read in its entirety to understand the full failure of all the systems and organisations involved; you may find that you form a different view from that of the many press reports which have been made about various aspects of the many failures.

Section 2 of the Review describes the factual background, and how and when concerns were raised at the FGH. It describes the investigations and the inquests, and the involvement of the NMC and Care Quality Commission (CQC). Cumbria Police investigated clinical concerns which they passed to the NMC and the Ombudsman published reports of investigations, forwarding them to the Strategic Health Authority. The NMC received its first complaint about midwives at the hospital in 2009 and yet it did not complete the process of evaluating these complaints until July 2017, when the Conduct and Competence Committee heard the last of them - 64 in total. The time line in the Appendix of the Review makes for excruciating reading.

This section also describes the Local Supervisory System and the reasons for its subsequent abolishment in 2017, as well as changes to the NMC's Fitness to Practice system.

Section 3 details the babies and mothers who died and the consequences for the families. The names of the families and the midwives are not released, although they have been in the public domain many times. There is much shocking information about the deaths, the terrible experiences the parents have endured (including not being believed or having had their own evidence not being accepted in the investigations), the useless investigations, the disrespectful midwives and above all the failure of the NMC to ensure the Fitness to Practice of midwives. The midwives, too, were subjected to intense and unnecessary pressure over many years as the NMC failed in their responsibilities to undertake a timely and fair investigation. **What was not made clear in most of the media reports was how widespread the failures were. Failures were by no means isolated to the midwifery department - the obstetric team and indeed the Trust management all bear responsibility for these unnecessary deaths.**

In 2012, a Freedom of Information Act question about the Midwifery Unit at FGH disclosed that 19 claims had been notified to the NMC in respect of events from 1 January 2009 onwards and that there had been a sharp rise in claims in respect of untoward incidents after 1 January 2007. And yet it was not until June 2015, when the Kirkup report was published and further information received from the Kirkup Investigation team, that a full investigation into the standard of the supervisory reports by the midwives was undertaken by the NMC. Nine supervisory reports were considered by an expert. The investigation took such a long time not least because of difficulties obtaining information from the Trust and the NMC. These included supervisory reports carried out by a midwife in respect of four families. The midwife subsequently admitted her mistakes and agreed that she ought to be struck off. This case was completed eight years after a parent first raised concerns about the adequacy of the midwife's investigations and *five years after the midwife had retired.*

Section 4 of the Review focuses on the NMC's '*approach to the value of evidence from and communication with patients and the NMC's commitment in practice to transparency*', and what can be learned.

The Review has a series of comments and criticisms about what they found at the NMC but one of the most significant is the one highlighting its lack of clinical knowledge. This is even more profound given that the NMC argued the point with the investigators, maintaining that they didn't need midwifery clinical advisors. The Review finds that there was a lack of understanding of what the cases were about and why the issues had been raised. This was combined with poor record keeping and communication by the NMC to create a situation which led to disaster.

The Trust's Head of Midwifery (in Morecambe) told the investigation: *"I was dealing with screening people, or investigating managers, or fitness to practice investigators who have no midwifery background or knowledge. And I think that's the real gap in the NMC as well, that actually some of what we experienced might not have happened if we had actually had the midwifery practitioners doing that screening or the investigation."*

The Review also finds that the NMC did not engage properly with the families affected by the events, either in asking them for information, keeping them informed or indeed addressing their concerns. Rather than looking beyond the individual cases, it was found that too much emphasis was put on trying to win the case rather than look at the wider public protection concerns.

The NMC was not the only organisation to blame... The CQC must also shoulder some of it – it [*the CQC*] gave the Trust a glowing report, even though problems had arisen at that time, so further deaths may have been avoided had a more detailed investigation been undertaken by them.
Details of the alleged dishonesty and collusion by various individuals and organisations are contained in this Review.

The NMC was not the only organisation to blame; the immediate problems of a dysfunctional unit and questionable clinical competency should have been dealt with by the Trust. The CQC must also shoulder some of the blame – it gave the Trust a glowing report, even though problems had arisen at that time, so further deaths may have been avoided had a more detailed investigation been undertaken by them. Details of the alleged dishonesty and collusion by various individuals and organisations are contained in this Review.

The Review states '*We do not know whether any of these could have been prevented but, in our view, before 2014 the NMC did not take credible information which it received about the midwives at the FGH seriously or take action to satisfy itself that the midwives were fit to practice. Its handling of the cases before 2014 generally was frequently incompetent. Even after that:*

- *Cases took longer to be investigated than was necessary causing distress to families and registrants*
- *The full range of the conduct allegedly involved – clinical concerns, collusion and individual dishonesty – was not fully explored*

- *The families we spoke to were dissatisfied and our study of the files showed that all of the bereaved families were unhappy with aspects of the way in which they were treated or their cases handled by the NMC.*"

The Review has established that changes have been made and continue to be made within the NMC. The High Profile Cases Unit, the Employer Link Service and the Risk and Intelligence Unit will ensure a joined-up response to any high profile allegations. The Public Support Service is in the process of being established and will provide improved support for witnesses.

The Review states '*Ultimately there will be no substitute for an intelligent analysis of a complaint by staff who have the time, skills and access to the right advice to ensure that the right concerns are identified and taken forward. This means that the NMC needs to ensure that staff:*

- *Have the right expertise*
- *Are properly trained and supported*
- *Have access to expert advice, particularly clinical advice*
- *Are able to manage and criticise the work of external lawyers."*

The PSA have been very bold in publishing this Review and publically criticising the NMC. The final words in the Review advise the NMC to continue to address its shortcomings. AIMS hopes that the PSA will seriously monitor the new structures and objectives of the NMC to bring about a long-awaited change for the safety of mothers, their babies and midwives.

AIMS' comments on the Review

AIMS has said for many years that there has been a lack of midwifery knowledge and input at the NMC. AIMS is very pleased that this has finally been acknowledged and will be watching for an immediate improvement in this area.

Another important issue for AIMS is the length of time it took to deal with all the cases, which was astonishing. The families and the midwives involved were treated shamefully. It must have been a very difficult place to work in those intervening years and the management of the Trust and the Midwifery Unit must shoulder a great deal of the blame to allow this to fester for so long, putting not only mothers and babies at risk, but also the midwives themselves.

The PSA Review talks about external lawyers which were used by the NMC, and how this became a problem in that they did not have to share information with the External Investigations. AIMS notes that lawyer adverts were placed last year to be employed at the NMC and would be interested to know if all lawyer advice is now internal.

AIMS wonders if this damnation of the NMC's handling of Fitness to Practice will apply to other midwives who had cases brought against them? Will the RCM demand a review of all cases? AIMS knows of and supported many midwives who had cases brought against them during that time and who, in our opinion, were treated very badly by the NMC, eventually having cases dismissed but only after a hugely protracted process which cost the midwives severely, both financially and in their personal lives. Similarly, we supported families in other trusts where the NMC did not deal with their cases appropriately, leading us to wonder whether there are other "Morecambe Bays" just waiting to be uncovered.

AIMS will be interested to see whether the different structures and departments make a difference. We regularly respond to consultations and are signed up with Stakeholder interest at the NMC. We will be monitoring their progress, especially in relation to receiving complaints from the public.

AIMS has lessons to learn too, as will anyone or any organisation reading this Review:

- We are a lay organisation dedicated to improving maternity services for women.
- We work with, and support midwives who share AIMS' views of supporting women, and in doing so we will improve the maternity services.
- When AIMS comments on something in the future, you will know that we have taken time to understand the entire situation as it impacts on maternity services, and that if an AIMS voice can help to make a difference, we will speak.

To print this article directly from AIMS, please go to *www.aims.org.uk/journal/item/psa-review*

Conference Report: MUNet

by Debbie Chippington Derrick

The Midwifery Unit Network, referred to as MUNet, was set up three years ago. They are a European group which focuses on Midwifery Led Units (MLUS) whether they are Freestanding Midwifery Units (FMUs) which are in a separate site to the hospital and Obstetric Unit (OU), or Alongside Midwifery Units (AMUs) which are on the same site as the Obstetric Unit. They are currently in the process of becoming a Community Interest Company (CIC) with a management team who will work closely with advisers from City University. MUNet's mission is "To support and promote the development and growth of midwifery units (birth centres) throughout Europe, so they become the main care pathway for women with an uncomplicated pregnancy, providing holistic care to them and their families. To make midwifery units an easily accessible, mainstream option for women with uncomplicated pregnancies and their partners, through research, policy, leadership, quality improvement, training, influencing, information, support and networking activities."

This conference was very well attended and presented the report of MUNet's first three years' achievements and they also launched their new Midwifery Unit Standards.[1]

Debra Salmon, Dean of School of Health, opened the meeting. Baroness Julia Cumberledge then began by talking about Continuity of Carer, giving the sad example of one woman who had previously lost a baby, who then had to tell the same story over and over again as she kept seeing different midwives at her antenatal appointments. Julia said that Continuity of Carer means a safer service. She also discussed working with NHS digital to put electronic notes on women's devices with the aim of putting women more in control of their own care.

Sheena Byrom, MUNet Chair, reported on the first 3 years of MUNet. We were provided with a printed copy of the report (Midwifery Unit Network: the first three years) which is available from MUNet's new website.[1] Sheena talked about MUNet wanting birth centres to be the mainstream option for women, and not an add-on. She also said that MUNet are in the process of becoming a Community Interest Company (CIC).

Mary Ross-Davis, RCM Director for Scotland was up next. She spoke about the situation in Scotland where the key recommendation from the Scottish Maternity Review[2] included a named obstetrician & link GP for each team of midwives. She talked about the huge variation in services across the country with differences for rural & urban people, affluent & poor, etc. Scotland's homebirth rate is currently about 2.6%. Only six out of 18 OUs have a midwifery unit, but there are 19 FMUs. Changes of some OUs to midwifery units have not been positive as the changes were driven by a lack of staff, rather than because of any intended benefit for women. Some AMUs are currently closed due to staffing issues. There are no MLUs in the Glasgow area, despite this being where a significant proportion of the population live. Mary pointed out that one of the reasons that access to MLUs was limited is the very high induction rate, which is meaning that many women are then not eligible to give birth in them. In Scotland they are looking at changing guidelines on this issue although it was unclear whether this means fewer inductions rather than women who are induced being able to birth in the MLU.

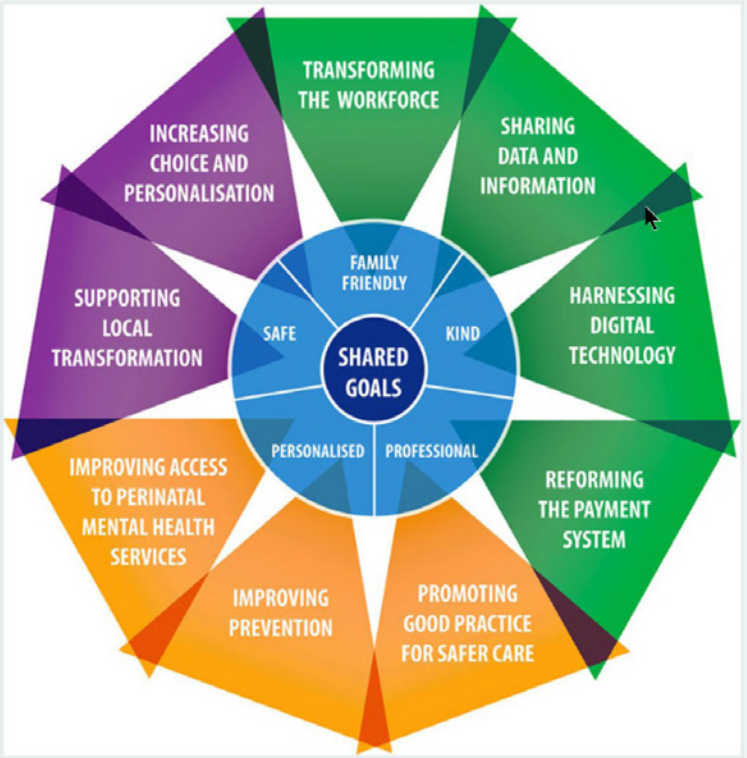
Maria Healey of Queen's University, Belfast, talked about the situation in Northern Ireland where there are five AMUs, three FMUs and one MLC (midwife led care). There are different access criteria for different units. They are working on improving guidelines for these units, as well as addressing the concern that women who were being referred for obstetric consultations were not returning to midwifery care when they should have been.

(AIMS have since found these link to the guidance which unfortunately does not fill us with confidence) *https://rqia.org.uk/RQIA/files/0b/0b9d5aee-0f80-47e6-8967-0c34216200af.pdf*

And this link gives more background – *www.rcm.org.uk/learning-and-career/learning-and-research/ebm-articles/planning-birth-in-and-admission-to-a-midwife*

Cate Langley, Consultant Midwife, Hywel Dda University Health Board & Marie Lewis, Consultant Midwife, Powys Teaching Hospital Health Board, talked about what is happening in Wales where every OU has an AMU, and there are 10 FMUs. Powys has no OU, but 6 FMUs where 1400 women - 30% of women in Powys - start labour. Decisions about where to birth are made by women when they are in labour. Midwives manage their own time, and they do not have set working hours, which allows them to manage being on call for women. They don't staff their birth centres, they staff the women! Cate talked about how midwives may be able to accompany women they are caring for when they go to the OU, although this isn't always possible given a transfer time of up to 2 hours. 50% of women have a midwife they know in labour. Marie Lewis talked about the Powys midwives' working patterns: No clinics, but individual appointments which can be cancelled and rebooked if a midwife is called to a birth.

Matt Tagney, the Programme Director of the NHS England Transformation Board praised the Better Births report and those who had been involved in producing it. He went through the recommendations in Better Births, highlighting Continuity of Carer, MLUs and safety, and how ambitious the safety targets are. He talked about the nine workstreams in Better Births which can be seen in the diagram below and further information is available on the NHS England website, *www.england.nhs.uk/mat-transformation*



There is a decision aid for first time mothers[3] and another for mothers of subsequent babies.[4]

Matt said that every area of the UK has provided NHS England with a plan to implement Better Births and claimed that that the CQC survey showed small, but significant positive changes. He stated that they had now achieved 9% continuity across London, but gave no further details about this, including what their definition of Continuity of Carer was. There are Community hubs which are beginning to link care around women, and he used the example of the new FMU in Salford. He did acknowledge that we still have a long way to go, that there are lots of challenges, but he said that he believes that the Continuity conversation has gone from 'can we make it happen', to 'how can we make it happen'.

Birte Harlev-Lam, Clinical Director, Maternity and Children, NHS Improvement, talked about the aim to improve maternity services in 136 NHS trusts, and two providers of services from outside the NHS (Neighbourhood Midwives and One to One Midwives). Her talk was not directly related specifically to MLUs, but was more looking at improving maternity care overall.

Birth Centre Beacon Site Awards

Mary Newburn, Executive Manager, Midwifery Unit Network started by pointing out that a quarter (24%) of Trusts in England have no MLUs, and that there is a large variation in how many MLU births take place in different Trusts, from only 4% up to 31% of births. She said that only 1 in 6 Trusts have both an FMU and an AMU, and while the number of AMUs has doubled between 2010 to 2017, there has been no increase in the number of FMU.

She talked about the awards that MUNet were making and emphasised that they were looking for a philosophy of care, listing the criteria:

- Significant number of births (FMU & AMU)
- A clear philosophy (personalised care, physiological birth, support for women and families)
- System for midwifery development, multi-disciplinary learning and case reviews
- A desire to share learning with other Midwifery Units
- Willingness to host visits and placements
- Participation in research and audits
- Service user involvement, partnership working, strategic development of midwifery care across the Trust/Board

- Positive communication and marketing

Awards were made to three units; Chorley & Preston, Halcyon & Serenity, and Lewisham.

Julia Cumberledge then introduced the award winners who each told us about the service they provide. She mentioned that one of the England football team had returned home because his wife was in labour with her third child – her third homebirth. She said that this could only happen when all the needs of a team member are being considered - crucial to building a strong and successful team.

The Award Winners:

Jo Goss, Matron for Midwifery-Led Services, Lancashire Teaching Hospital NHS Trust, gave a very lively talk about what they do well, including publicity. She said they have a diverse population, rural and urban, poor & affluent, different ethnic groups, etc. They have managed to get their FMU refurbished which has increased the birth rate there, and then developed an AMU. This is on the first floor, with the OU on a floor above, making it feel very separate. They have an integrated model with eight teams, covering homebirth and the MLUs. Last year their new staff were newly qualified midwives. They have individual plans for women who are making decisions that would not usually be recommended. She talked about training, multi-disciplinary work, networking, sharing learning and a supportive culture.

She was very clear that publicity can't be underestimated. They establish and maintain communication with the potential "customers" by going out into the community and holding open days. They also work closely with other organisation and agencies.

Tracey Thomas, Lead Midwife, Lewisham and Greenwich HNS Trust, talked about the Lewisham Birth Centre starting by saying that although the building is beautiful, the team is the important part, and that many of the original core team still work there. When they recruit it is not only on the basis of clinical skill, but on philosophy too. They need a commitment to a shared goal and asked who would want to manage a team of "Stepford midwives". She said that team work was essential and went on to explain that the midwives will not have met women before they come to the unit in labour, but their transfer rate is only 10% and 6% of women transfer for an epidural. What came over was that they are a team which not only works together, but they are also a social and supportive group.

Helen Giles, Midwifery Team Manager, Sandwell and Birmingham Hospitals NHS Trust, told us that Serenity Birth Centre has now been open eight years, and Halcyon's seven year lease is coming to an end soon and the unit could be under threat. Helen said that when Kathryn Gutteridge first arrived at the Trust the Health care commission had said that they needed to improve, they had a caesarean rate of 37%, and induction rate of 43% and 15-20 complaints per month. The staff moral was low and they had a 15-20% midwifery vacancy rate. She said that they needed to ask "why would any decent midwife want to work here at the moment". We have all seen the amazing midwifery unit that has come from out of the changes in Birmingham.

Helen also spoke about how they have redefined their criteria to include women with risk factors, with a positive focus on managing the risk. Women having a vaginal birth after a previous caesarean (VBAC), women with a BMI over 35, women with diet controlled gestational diabetes, women with hypothyroidism, a previous post partum haemorrhage (PPH), previous 3 and 4th degree tears, and previous retained placenta are not excluded. They have a guideline and a proforma for women planning a VBAC on the unit.

Sadly, despite the award made in July 2018, the Halycon was closed just three months later. The loss of the Halycon comes amid news of a number of other FMUs and AMUs which are being closed without proper consultation. Underuse is often quoted as a reason, but we know from enquires to the AIMS helpline that many women who want to birth in these units are being discourage or even refused access, and there is extensive feedback from local MSLCs that women are not being told by their community midwives that the option to birth outside the OU even exits.

Lucia Rocca-Ihenacho, Lecturer in Midwifery and NIHR Research Fellow introduced the NICE Birthplace Action study, which is looking at the barriers and facilitators for the implementation of the NICE intrapartum guidelines recommendation on place of birth for women with uncomplicated pregnancies. Members of the research team spoke: Ellen Thaels, Research Fellow and Laura Batinelli, Research Midwife said that to make change you have to have an impact on hearts and minds. They talked about what they did to improve the environment in one unit,

giving the whole team (including the cleaning staff) a practical challenge of making things look more homely and less medical. Before and after pictures were shown, which did show how much difference small changes could make. They looked at barriers and facilitators, and split work into workstreams to allow people to focus on a specific issue.

Lucia talked about the new Midwifery Unit Standards1, why they are important and what makes them work. They are rigorous, but inclusive with as wide an input as possible. There were stakeholder events and a systematic review of the literature, which only found 24 papers, and 3 PhD theses, and they interviewed those at Beacon sites. The twelve peer reviewers were also mentioned. Development challenges included gaps in evidence, how to rate different forms of knowledge and different terminology. There was a need for the standard to be applicable to countries who already have MLUs and those which don't. She said that in translating the document to other languages it will be very important to maintain the core meanings of the guidelines.

Research Midwife Denis Walsh, who was in the audience, asked about the future of FMUs – given that the number of these is not growing. Research Midwife Chris McCourt pointed out they were superior in terms of outcomes for women and that there is a need to translate the economic evidence, as there is a false assumption that because it is attractive it must be expensive. Julia Cumberledge thanked Denis for all his work in this area and went on to talk about the need for all four places of birth to be available everywhere, and that this would also mean that pressure was taken off labour wards. Lucia talked about the potential for FMUs being the centres of care.

A midwife from Warrington FMU reminded us that FMUs are the safest place for women to have their first baby according to Birthplace5. This important outcome does seem to be being quietly swept under the carpet, and we probably do need to keep reminding ourselves that for low risk first time mothers the outcomes for their babies were the same whether they birthed in an OU, AMU or FMU, whilst rates of transfer, epidural, caesarean, assisted birth, episiotomy, blood transfusion and admission to higher level care were lower in FMUs compared to AMUs and OUs.

They announced that the next MUNet conference will take place in Barcelona in September 2019.

Dame Cathy Warwick closed the conference. She reflected on the day with "Wow, a fantastic day" and that you have to be prepared to run with the people who have ideas and enthusiasm. She said that she had been glad that in her position at the RCM she had been able to help in the early days, but that it was the ideas and enthusiasm that made it happen. She said that it was exciting to hear Matt Tagney say that **we have to staff the women not the building**, and that we need to think more creatively about staffing. She gave an example: In Fort William's A&E, medical staff support the midwives. We need to be flexible and imaginative. She said that we had heard from academics, practitioners, policy makers, etc. and that there is a need to keep these different groups integrated, and that she really felt that this was coming through at this conference.

Julia Cumberledge concluded saying that MUNet should keep going, that they needed to make sure that they were well integrated alongside the other organisations working toward better maternity services and that she would like to see them do more about staffing and funding. But most of all to keep us motivated and thinking.

References

1. Midwifery Unit Network: The First Three Years: www.midwiferyunitnetwork.org/wp-content/uploads/PDFs/LY1308BRO-MUNEt-Three-Year-Report-PRINT-opt.pdf

2. Scottish Maternity Review: www.gov.scot/isbn/9781786527646

3. Decision aid for first time mothers: assets.nhs.uk/prod/documents/NHSE-your-choice-where-to-have-baby-first-baby-sept2018.pdf

4. Decision aid for mothers of second and subsequent babies: assets.nhs.uk/prod/documents/NHSE-your-choice-where-to-have-baby-baby-before-sept2018.pdf

5. Link to Birthplace https://www.bmj.com/content/343/bmj.d7400

Dr Ágnes Geréb Update (August 2018)

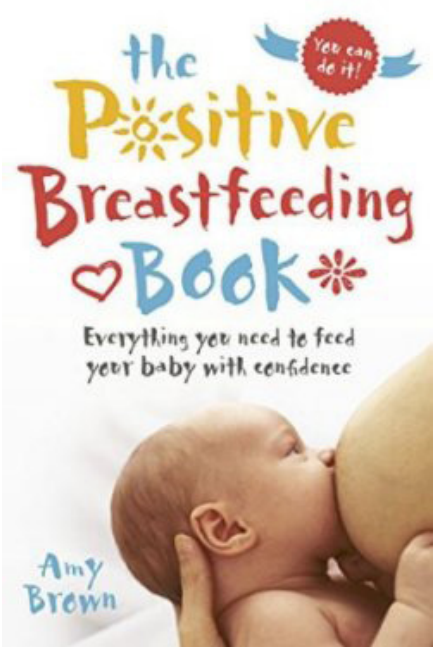
Nearly 8 years after her arrest and imprisonment of 5th October 2010, Dr Ágnes Geréb had her 2-year prison sentence (of February 2012) finally set aside by the partial clemency granted by Hungarian President, János Áder, on 28th June 2018. Confirmation has now come through that her 10-year work suspension has been calculated to end in February 2022, when she will be nearly 70 years of age. Fortunately, one of the benefits of the partial clemency is her right to secure a passport once again. However, her criminal status remains on record and she is obliged to pay the legal costs incurred by the State Prosecution Service in conducting their case against her.

Going forward it is both early and difficult to say what moves, if any, Ágnes may or can make with regard to securing an earlier return to her professional work. Or, indeed, how she would propose to deal with the legal costs facing her. Returning to her professional work arena currently remains a clear aim of hers. Whether she will have recourse to legal avenues in this regard still needs to be assessed. And, even if they exist, it may ultimately be considered more beneficial to pursue the matter through informal channels with the relevant Hungarian authorities. Equally, should Ágnes, her family and her advisers consider that there is a place for the international community to help in any matters, including erasing the burden of legal costs upon her then, of course, I would immediately reflect this back.

Meantime, Ágnes would like to thank AIMS and all AIMS supporters for their truly great support throughout this exceptionally long and challenging journey. She has remained remarkably strong and purposeful in her life and I expect this will continue to be the case.

Donal Kerry
International Spokesperson Campaign for Justice for Dr Ágnes Geréb
10th August 2018

Book Reviews



The Positive Breastfeeding Book: Everything you need to feed your baby with confidence

by Amy Brown

Pinter and Martin Ltd 2018
ISBN 978-1-78066-460-6
400 pages
Publisher's recommended price: £14.99

It was an absolute pleasure to read The Positive Breastfeeding Book by Professor Amy Brown. Not only did it deliver on its promise of being 'everything you need to feed your baby with confidence', it was an entertaining and informative read. This publication reflects the aims of the Positive Birth Movement, sharing stories, expertise and positivity. It also nicely complements The Positive Birth Book by Milli Hill, with a similar style and layout.

This book is both highly suitable and very useful for anyone interested in breastfeeding, whether an expectant or new mum, or mums already nursing a toddler or an older child, and their partners and family members too, as well as people involved in the world of breastfeeding support. It is full of information,

Amy builds a wonderful rapport with her readers, with her friendly style and excellent sense of humour throughout, and TOTALLY knows her stuff when it comes to breastfeeding. Right from the introduction, you get a good sense of Amy's style:

'Pregnancy and having a new baby is a strange time. You'll probably already know that total strangers appear to think you need to hear their deep wisdom on your body and your baby when you've just popped out for a loaf of bread. This won't stop any time soon, but you can work on perfecting a Paddington Bear Hard Stare.

Breastfeeding is one of those things that people love to give odd advice about, from the inaccurate to the downright bizarre. From how often you should feed your baby, to what's in your milk, to where your baby should sleep. Lots of people seem to have a strange distrust of breastfeeding, possibly because on one level it does all seem a bit like magic – you attach a baby to your nipple and over time they grow bigger and bigger. But the human race has survived this way for millennia. Why wouldn't it be possible? Why wouldn't you be able to? Many, many women have gone before you, breastfeeding in the most diverse circumstances. And you can follow them.'

Amy tackles a wide range of questions and scenarios, and does a great job of countering multiple popular myths about breastfeeding (and babies more generally). She educates and informs not only about breastfeeding, but touches on associated topics such as co-sleeping, babywearing, the fourth trimester and 'normal baby behaviour' too. Whilst clearly passionate about breastfeeding, Amy does a brilliant job of communicating a non-judgemental attitude and seeking to help others reach their own personal breastfeeding goals, whatever they may be. This book, and indeed the language used by Amy, is all about educating and empowering her readers.

Included throughout the book are lively and informative contributions from a wide variety of individuals, including midwives, doulas, breastfeeding counsellors, IBCLCs (International Board Certified Lactation Consultants), paediatricians and more, most (if not all) of whom have first-hand breastfeeding experience. I particularly liked, too, the final chapter which is full of words of encouragement from breastfeeding mums. In bringing in these additional voices, Amy presents succinct information from multiple other experts and their respective fields. Their contributions add to the reader's knowledge, and also – I feel – endorse the book overall. The quotes from breastfeeding mums are wonderful – in bringing a smile to your face, in 'normalising' what the reader may be feeling or experiencing, and adding to the sense of empowerment.

The book is very up to date, with good references to social media issues and LGBTQ+ considerations for example. It also usefully contains a wealth of trustworthy resources and suggestions for further reading. Signposting the reader to reliable information sources is so helpful, to help save us all from the perils of internet search engines that bring up all manner of mis-information. Not only are further information sources mentioned at appropriate junctures throughout the book, there is also a handy section at the back with this information organised by topic. There is also a useful page right at the front of the book setting out contacts for breastfeeding support and information: this is a perfect location for bleary-eyed mums who may be struggling. I would encourage anyone to reach out to these sources of support without hesitation – sometimes a friendly voice and some reassurance can make a world of difference – so I was delighted to see them in such a prominent position in this new book.

Breastfeeding can be tricky – in fact, really challenging at times for some mums – and this book acknowledges this. I am confident that the combination of factual information plus the positivity that exudes from Amy – and other contributors to this book – will help many a mum and her baby on their breastfeeding journey, well into toddlerhood and the pre-school years for some. Just as it says on the banner on the cover: 'You can do it!'

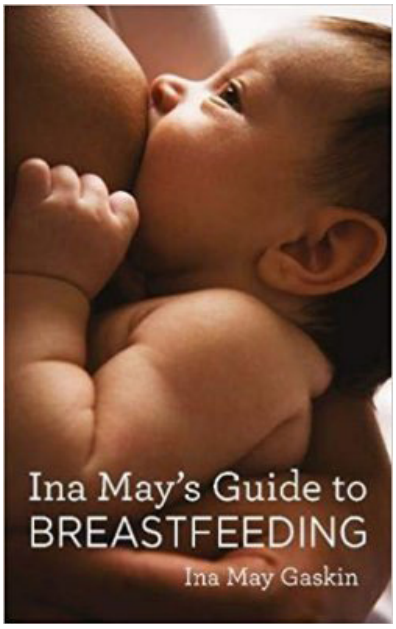
I will absolutely be gifting copies of this publication to some of my mummy and mum-to-be friends and recommending it to others also. It is a lively, fresh and easy-to-read text and ideal for the current generation. My perception is that this book may have a broader appeal than some other popular breastfeeding publications, and I would have no hesitation in widely recommending it. A heartfelt thank-you, Amy, for writing such a marvellous book.

Reviewed by Sarah Kidson, a trainee Breastfeeding Counsellor with the Association of Breastfeeding Mothers (ABM)

Ina May's Guide to Breastfeeding

by Ina May Gaskin

Pinter and Martin Ltd 2009
ISBN 978-1-905177-33-2
352 pages
Publisher's recommended price: £11.99



Ina May Gaskin is an iconic figure in the world of childbirth. I didn't discover her books on birth until fairly late in my own childbearing career, but even at that stage she was well worth reading. The accounts of her midwifery work are inspirational, and I truly believe that my own (and perhaps my friends') birth experiences would have been improved if we had read Ina May's writing earlier.

So when I heard about her new book on breastfeeding in 2009, 'dedicated to all those who work to raise the status of breastfeeding as a gift for future generations', I was keen to read and review it. Even though (or perhaps because) it was published towards the end of my own time breastfeeding my four children, I was eager to read what she had to say on this important topic and to find out whether it was a book that I could usefully recommend to others.

Reading the book at that stage, I did not find it of much practical benefit personally (although I have read reviews by many women who have). But I found that it contained a huge amount of incredibly interesting as well as highly practical material. Indeed, it is the sort of book that makes you think about changing career: there is still so much work to be done to normalise breastfeeding. But did I think that the book would be useful for other women, especially those nearer to the start of their breastfeeding journey?

I had two main concerns on reading the book.

- First, I was unsure about the emphasis that Ina May places on the usefulness of pregnant women expressing colostrum before giving birth (to be better prepared in the case of later difficulties); I worried that this – to me rather strange – advice might have the subtle effect of undermining women's confidence in their ability to birth a healthy baby successfully (*Editor's note:* This might be the case when it's offered as a blanket suggestion, although our knowledge is increasing about where this might be valuable in certain cases, for instance where the mother has diabetes and the baby may need additional colostrum at birth to raise blood sugar levels).
- Second, I was unsure about Ina May's emphasis on stocking up with breast-pumping gear, and so on, before the birth and on the activity of expressing milk more generally. I can accept that this advice might well reflect the needs of a US audience, where short maternity breaks from work are the norm, but I worried again that this acted to subtly undermine the benefits of unmediated attached breastfeeding. For a European audience, with access to greater maternity rights, some adaptations to the text would be useful. It is also probably worth noting here that the text is more generally heavily anchored in the North American context.

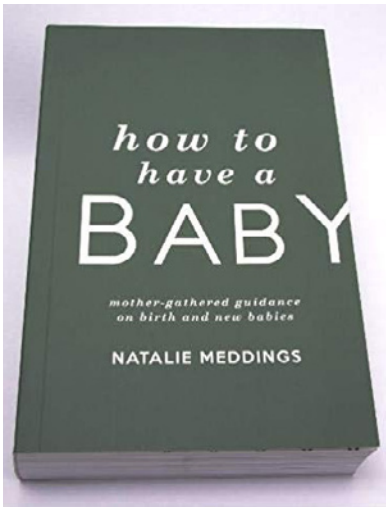
These concerns were serious enough for me to allow the task of a book review to fall off my to-do list for a few years. But that was an omission: this is a great book, worth shouting about. Subject to the provisos above, I'd like to wholeheartedly recommend the book to AIMS members as an excellent resource book (and a good read) for anyone interested in promoting the value of breastfeeding. It should be in every local breastfeeding library!

Reviewed for AIMS by Jo Dagustun

How to have a baby: mother-gathered guidance on birth and new babies

by Natalie Meddings

Eynham Press, 2017
ISBN 978-1527207363
389 pages
Publisher's recommended price: £11.99



Tucked up under a blanket on my sofa reading How to Have a Baby, by Natalie Meddings, the phrase that kept playing on a loop in my mind was 'fairy godmother'. Because this beautifully written and designed book is a blessing, not only on the baby but on the mother. Natalie arrives, I imagine, on a new mother's doorstep with magic wand in hand; ancient homespun wisdom on her lips. She is wisewoman and witch; keeper of the secrets and curator of the old knowledge: motherlore.

The theme of blessings returns at intervals throughout the book. Mothers tell their stories of words of blessing, hope and faith from families and friends. Blessings come in the form of top tips for birth and parenting. Gifts are given in the form of food, expressions of love and social cameraderie. This book doesn't profess to be an expert telling you what you should and shouldn't do. Natalie is all your mothers, your sisters, your aunties and your friends arriving bearing the gifts of their experience and wisdom. Nothing this book shares with us is useless; every page holds a nugget that could make birth or parenting easier or more beautiful.

Reading the section on labour I felt I could hear Natalie's warm, kind voice, holding my hand as she passed on the deep, intuitive knowledge that can only come from years spent accompanying parents through labour and birth. The phrases and analogies she uses to explain how birth works and how to ease the passage are ones I often find myself using as a doula, so I know from long experience that there is a deep truth and effectiveness in her words.

'How to Have a Baby' is much more than the formulaic baby manual books of mass appeal. It offers so much more than the usual fare of judgmental advice from nannies or conflicting opinion depending on which book you flick through. Although it is brimming over with practical suggestions and concise explanations of the physical and emotional progress of pregnancy and birth, the overwhelming feeling of this little tome is one of comfort and the tone is non-directive. The size, page layout, fonts and beautiful full colour photos all create a sense of calm, of peaceful contemplation and a connection with the miraculous process of growing, birthing and feeding a baby.

Like the repeated waves of labour, Natalie gently describes and repeats an elemental message: that we must feel safe to give birth and that therefore parents, particularly the birthing person, must be treated gently, with the utmost respect and kindness. With precision she paints a picture of the environment conducive to birth, paying particular attention to the birth companions. Because it is our lovers and handmaidens who create the safe space that allows,

"A mother [to] unwrap her body and produce her baby like a gift - just like that."

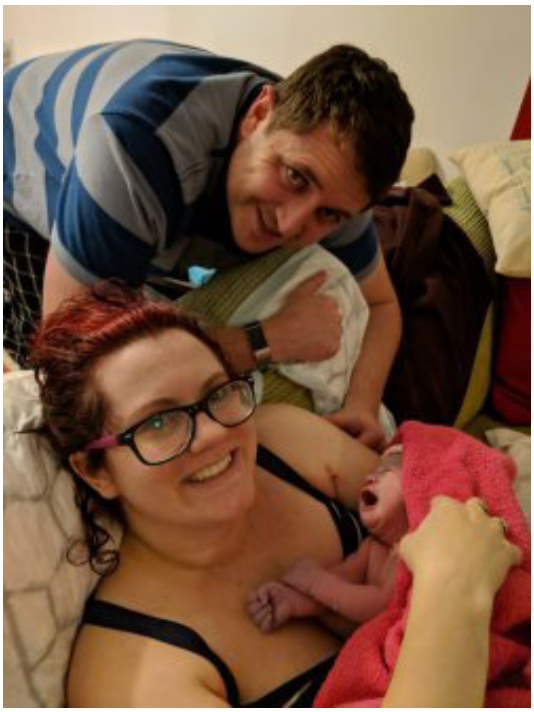
Doulas really are a combination of your best friend, your mum and your favourite auntie - without any of the possible attendant baggage. Natalie's writing makes this book a true 'doula in your pocket', bursting with homespun wisdom, simple recipes and reassuring words of comfort. Yet underpinning all this is a no-nonsense factual accuracy, with references to research and evidence-based guidelines that can aid responsible, grown up informed decision-making.

I truly hope 'How to Have a Baby' reaches a mainstream audience and becomes a classic. It deserves it. Yes, I'm quoted in the the book and yes, I count Natalie amongst my friends but I can honestly say that this review would be the same whether I knew her or not. I know I will want to lend this book to all my clients but I suspect I won't want to part with it. Looks like I'll have to buy a few more copies. I urge you to do the same.

Reviewed for AIMS by Maddie McMahon

Claire's birth story: The arrival of Iris

by Claire Pottage



As a fairly anxious person I found myself really enjoying pregnancy and embracing all that came with it. Early on I felt a home birth might be an option I wished to explore, but knew little about it and my partner knew even less and felt hesitant. We attended an information session by our local home birth team in Leeds, and listening to the options I felt this would be my preference and so did my partner. I was throughout though very open to being transferred to hospital at any point if I felt unsure and would not have been disappointed in any way with other birth options if these turned out to be the right thing- it was a very open birth plan.

I found having my antenatal care with the home birth team really personal and this helped me to enjoy my pregnancy.

My due date arrived on a Monday but with little sign of labour starting. I was a little disappointed but had really enjoyed spending my last few weeks of non-parent life catching up with the people I love and getting to know new friends made throughout pregnancy - and embraced a few more days! I decided against having any sweeps at this stage, but felt I might later in the week.

I did start getting a firmer Bump, and felt this was a sign and on Wednesday around 1:30am I felt I was getting surges. I know many people try to let their partner sleep but I was too excited and felt I needed his support with me even at this early stage. We called the home birth team at 2:30am, and had a good chat with them. They confirmed that it sounded like labour was starting and we talked about them coming to check how we were getting on in a few hours. Chris helped me put on the tens machine and we got into a routine of me standing for each surge with Chris in front of me holding my arms as I focused on my breathing whilst pressing the surge button on my tens machine.

In between each surge we were working our way through the Harry Potter box set! The books being something I always read when wanting to chill and as I know the story so well it didn't require much conversation, but got the oxytocin flowing!!

The first midwife's visit was at 5am. I had an examination and the midwife confirmed the head was in a good place and I had started dilating and was at 2cm. She really reassured me I was dealing with the contractions well and we all had a cup of tea and a lovely chat about birth but also about life and our families.

For the majority of the day I was getting a contraction every 5 minutes, but not any closer together, although they were increasing in intensity. My waters broke at 4pm and the midwife came back out to confirm this. She suggested I not have another exam as the contractions were still far apart and to carry on as we were, and again reassured me I was doing well with my breathing and this would be really helping baby progress on her journey. I took some paracetamol and we carried on with the next film!

As the night drew on, and we got to 24hrs since labour started, I was beginning to get tired, and a little frustrated that the contractions felt strong but were not becoming more frequent. The midwives had changed shift and another great midwife came over following our call to discuss this. She felt maybe the waters hadn't completely gone due to the contraction timings not shortening, so I had a second exam and this confirmed that my fore waters were intact, only my back waters had gone. We discussed some rest may be helpful for me so she suggested that I take some dihydrocodine and try and sleep. Chris and I then went

upstairs and fell quickly asleep in our own bed for around an hour and a half. At half one I awoke as my waters fully went.

I had a huge wobble at this point, and now knowing how things progressed I think this would have been my transition phase. Due to the shock of waking to the waters I started to shake and felt I couldn't stop myself and became concerned something was wrong. We rang the midwife and she reassured us that I was experiencing adrenaline so this spurred me on to get back on my breathing. Within half an hour this had worked and I was back in my pattern. Due to the prior progress the midwife felt I had some time to go yet and to continue to monitor the contraction times. At this point the contraction intensity was becoming hard, I found repeating affirmations really helpful: "The surges are being made by me so they can be handled by me".

I felt a strong urge to smell a towel that my mum had washed and which smelt comfortingly like my parents' house! I also asked Chris to fill the pool but at this point we had a bit of a comedy of errors, which didn't faze me at all as I felt in the zone! Chris was rushing to fill the pool and forgot to put in the liner- doh!! He then had to empty the first bits of water he had put in to be able to do it and in rushing missed the sink and flooded the kitchen! He was fantastic though and kept coming to me for our routine with each surge as he sorted the pool and it then got filled!

At this point I was finding the contractions intense and felt I needed the midwife with me. We called them and said I needed some support, but as they were at another birth which had become complex, we were told a team from delivery suite would be on their way to us, but, they said there was still plenty of time - little did we all know this might not be the case! I asked Chris to ring again as my up breathing was no longer working and I had a strong urge to breathe down, make a low noise and push, however at 3:45 the first midwife and a student midwife arrived. I remained fairly oblivious, repeating my affirmations through the surges and blocking everyone else out. The midwives supported my routine with the surges, and then they suggested that a position change from standing may help, so I knelt on the sofa with Chris in front of me working with me and focusing only on me. As I started to push the midwife massaged my perineum with warm water as I hadn't been able to get in the pool as I had felt I was managing the contractions better standing up (poor Chris after all his pool efforts!!). Within a few more pushes Iris was here!!

They turned me so I could sit and handed her straight to me. We all marvelled at how much hair she had! While I birthed my placenta one of the midwives set up for Chris to cut the cord and then have skin to skin with Iris. This was amazing to watch- and Iris tried to latch onto his hairy chest!!

We then spent the next two hours sitting with the midwives, (of which there were four as our home birth midwife wanted to see us herself before the end of her shift) and drank cups of tea while I was helped to latch Iris on for her first feed. I was also checked and I didn't need any stitches or have any tears, just small grazes.

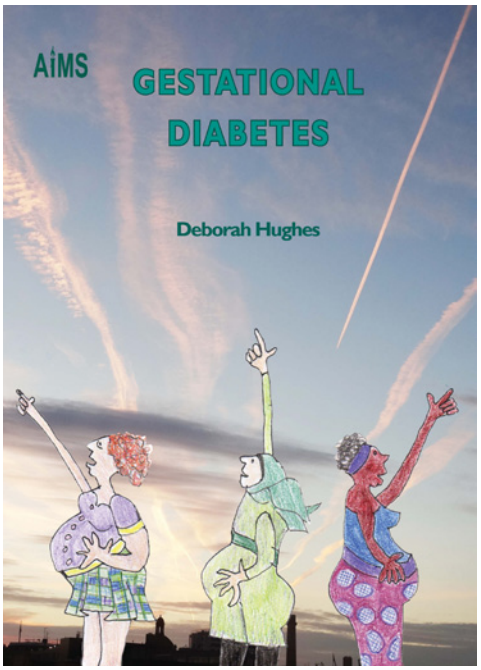
Our home birth midwife discussed who we would see when over the next few days, but reassured us if we needed anything to just call them. And we called both Iris's Nannys and Grandads to lets them know she was here!

Feeling open to change and being calm helped me have a really positive birth experience and helped me start my first few days of being a mummy with a positive mind set. Without the support of my partner Chris this wouldn't have been possible - birth partners have such an important role on the big day!

AIMS

There for your mother
Here for you
Help us to be there for your daughters

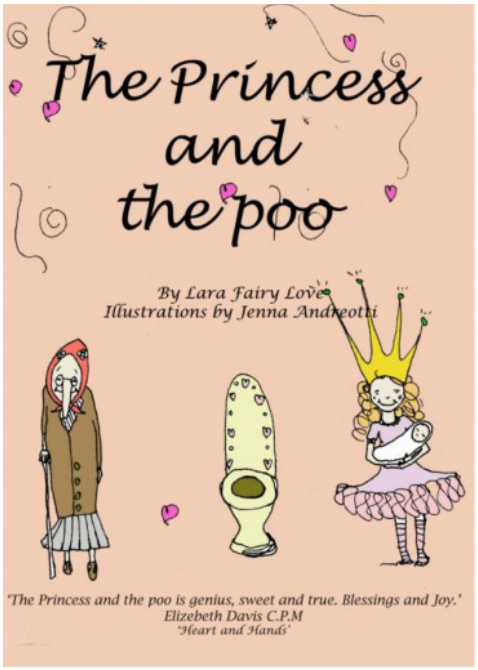
AIMS Books



We are incredibly lucky to have Deborah Hughes (BA (Hons), RM, MA, PGDEd) expertise on the subject of Gestational Diabetes. AIMS knows that many women are being diagnosed with Gestational Diabetes or are faced with the decision to be tested for it, without having all the information they want. Midwives, student midwives, doulas, hynobirthing practitioners and all others who work with women now have a significant resource. Jennifer Williams insightful illustrations and infographics, adding humour and making this complex subject more accessible.

Avaiable from AIMS bookshop
www.aims.org.uk/shop/item/gestational-diabetes,

£8



AIMS is thrilled to support the publication of The Princess and the Poo. We came across the book a while back and thought that it's a wonderful book for children and all who read it. Lara Fairy Love, its author, wants to encourage children to think more about the way they were born in the hope of inspiring more peaceful births. She says that if more people knew it did not have to be such a scary process, more would give birth at home. Jenna Andreotti provides the amazing illustrations.

Available from AIMS bookshop
www.aims.org.uk/shop/item/the-princess-the-poo

£5