AIMS For a better birth...

The International Labour and Birth Research Conference 24th – 26th April 2023: Charlotte Edun reports on this recent conference in Grange over Sands

AIMS Journal, 2023, Vol 35, No 3



By Charlotte Edun

Arriving at the first day of a conference is usually quite a lively affair, a mix of meeting colleagues, perusing the programme, finding coffee and seats and settling into the atmosphere. Arrival at this 15th International Labour and Birth Research Conference, however, prompted some more sober consideration even before StJohn Crean (pro-vice Chancellor of UCLAN) opened the conference at 8.45am. As we walked along the promenade on our way to the Grange Hotel, my AIMS colleague reflected on the poignant location of the conference, in the shadow of failings in maternity care at Furness General Hospital.[1] We were then greeted at the entrance to the Grange Hotel by security guards, who had been invited following threats of disruption from families concerned that papers and themes in this conference put mothers, babies and families at risk. In light of this, Conference Series Chair Soo Downe's opening question to the conference was important to establish the focus of the conference: *what do women want and need to make birth better for them*? From the outset this conference fixated not on particular ideologies or approaches, but on the directly expressed needs and desires of women having babies. By the end of the conference it was clear that these needs and desires remain consistent across the globe, despite the variances in available resources and outcomes we heard about

from numerous UK and international speakers.

The conference schedule promised three packed days, each with six streams of presentations, workshops, symposia and creativity, reflecting experiences of and research into pregnancy and birth across the world. Speakers presenting findings from research projects in Australia, Canada, Denmark, India, Ireland, The Netherlands, Norway, Poland, Spain, the UK and the United States to name but a few. These presentations brought flavours of the varied factors influencing - and hampering - improvements in maternity services across the globe, and were an important reminder of significant differences in experience and outcomes for mothers and their babies. Dr. Alexandre Dumont (*Optimising decision-making for mode of birth in low- and middle-income countries: experiences from Argentina, Thailand, Vietnam and Burkina Faso)* drew attention to a factor influencing maternal decision-making in Burkina Faso which is largely not a concern in the UK; women in Burkina Faso are not supported by known birth partners because they labour and birth in multiple occupancy rooms where space is at premium and dignity and privacy is considered in the context of the many, not the individual. Dr. Rose Laisser's paper (*Implementing the WHO labour care guide in Tanzania*) brought a sombre reminder that motherhood and early childhood remains a significant risk; in Tanzania the mortality rate for children under the age of 5 is 47.1%.

Despite these stark differences, sessions suggested international similarities too. Consistently, presenters described that the facilitators of meaningful and sustained improvements to maternity care include engaged senior leadership, supportive supervision and appropriate and relevant organisational policies. The potential for the role of the consultant midwife as influential change-maker was highlighted by Lucy Bradley *(A phenomenological study: How are UK home birth midwives supported in autonomous decision-making when caring for women with additional needs?)* and Florence Darling (*The influences of facilitators and barriers on the implementation of a physiological approach)* and in conversation with conference delegates.

Sessions from the UK focused the mind on the value of and improvements seen thanks to personalised care (which in my mind takes me straight to continuity of carer, this link reinforced by Dr. Alexandre Dumont who cited a Palestinian study suggesting that continuity of carer reduces caesarean birth rates. I continue to seek this paper). Professor Alex Heazell (*Reflections on the UK East Kent review)* gave important consideration to the findings, meaning and next-steps from the Kirkup report, including the remit and role of the professional bodies involved but ineffective in East Kent Hospitals University NHS Foundation Trust (a concern echoed by AIMS[2]). Dr Juliet Rayment (*The Re:Birth Project: Looking for a shared language)* reflected on learnings from the Re:Birth Project, and its aim to develop a set of language principles for use in both healthcare communications and individual care. The findings are important to hear; that service users want terms that are descriptive and technically accurate, and also non-hierarchical and non-judgmental; that language needs to be clear, unambiguous and consistently understood by diverse groups; and that different people use language in different ways, and a 'good faith' approach is important. This last point was reflected in Mary Longworth and Karen Roberts' session (*Words midwives use with women)* where they shared findings evidencing that there is not a 'one-size-fits-all' solution, because while some language is appropriate and acceptable to some, it can be unacceptable

and upsetting to others. Each of these papers made the case for not only personalised care, but for *continuity of carer*, that vital relationship in which trust and good faith is established between mother and midwife over time, so that a shared understanding and language can develop.

Soo Downe's opening question will ring true for anyone aligned with AIMS' purpose and principles.*What do women want and need to make birth better for them*? It's a question that has been asked many times over the decades, and certainly since the establishment of AIMS in 1960. Much time, effort, energy and resources have been invested, and still women's aspirations and fears are obscured by factors and perspectives which are unrelated to women's experiences. So it was heartening to find the service user voice well represented at this conference, with keynote speeches from Siobhan Monteith (*Amazing Grace: Birthing the dead*), and Michelle Quashie (*Personalised care planning: the need to listen to all women*), and an outstanding, standing-ovation provoking presentation from Kaveri Mayra*(Birth mapping – a visual arts based participatory research method embedded in feminist epistemology.* You can see her 'Three minute thesis here, but please be aware she talks on themes of disrespect and abuse which you may find upsetting). Both sessions reminded conference delegates that beyond the objective factors that can be recorded, measured and thematically analysed by academics, are a breadth of complex, human factors that affect what women want and need in their pregnancies and births. These factors can be dynamic, extensive and historic, encompassing the birth, life and death experiences of extended families, as well as more immediate and obvious elements such as relationships with health care professionals. These sessions encouraged the conference to expand ideas and definitions of what 'optimal birth' may mean, encouraging us to consider 'optimal for the circumstances'.

For me, these three sessions from Kaveri, Michelle and Siobhan summed up much of what was discussed at this conference. Better still, the key points they presented largely answered Soo Downe's opening question. *What **do** women want and need to make birth better for them?*It seems as though dignity, humanisation, relationality and respect are the keys. This is not a simplistic answer, nor is it a call to reject or de-prioritise medical support when it is required. Rather it is an opportunity to move beyond the troublesome 'either/or' dynamic of the 'Birth Wars', to flatten the hierarchy and ask: How can we make birth safe *and* respectful? What could a maternity care estate look like, if it were designed to provide genuine breadth of choice[3] to suit the diverse needs and attitudes of all the women accessing it? What needs to change in attitudes, aptitudes and ambition to provide women with what they consistently want?

The concerns of protesters in advance of this conference were, as far as I understand, that we delegates fall for the naturalistic fallacy that everything natural is better, that all women want little or no intervention, and that the pursuit of physiological birth is so important it can be elevated above avoiding risk. However what we heard over these three days presents a more nuanced picture. We do know that women have an overall preference for physiological birth, however, we also know that when this happens alongside disrespectful, suboptimal *care*, it is experienced as traumatic. We also know that despite the overall preference for physiological birth, women *can* experience interventions as positive and empowering, when they happen alongside respectful woman-centred *care*. The link here is *humanisation* of the processes and period of pregnancy and birth.

For me, it was a long drive home, which gave me plenty of time to ponder all I had heard and observed over these three bright Spring days in Grange over Sands. My first reflection was prompted by the question from the conference committee about how this Series can and should move forward. I think it's an interesting observation that these matters of what is 'normal' in birth and what matters to mothers are represented in an International Labour and Birth Research conference, rather than in the midst of the many obstetric and midwifery conferences. It does prompt a thought about whether those conferences are asking the question Soo Downe opened with. If they are asking that question, but through a different lens (the medical model), then I wonder how it is that these things have come to be so significantly separated. It seems as though what women want and need is not considered to be connected to outcomes (qualitative or quantitative).

My second reflection was on how ideas of dignity, humanisation and relationality can be used to our benefit. Could this allow the pendulum to swing away from the focus on how birth happens (which is unhelpful and divisive for some), towards a narrative of respect for the female body and the vital work it does in pregnancy, birth and breastfeeding. Could this help move our attention (back) towards women's feelings about and experiences of their bodies, and the complex (but undisputed) connection between mind, body and environment, which is the reality of birth. Could this be the basis for a more realistic conversation about how women's bodies function and the common factors that make birth positive? Could this enable us to place humanisation as the primary necessary support to birth *however and wherever it happens?* Could this be an area of common ground that meets the needs of those concerned about the conference, those who don't find the content important enough to attend, and those of us who enthusiastically follow research in this area?

Author bio: Charlotte Edun is a doula, MNVP lead (Maidstone and Tunbridge Wells NHS Trust), researcher at the School of Nursing, Midwifery and Health at Coventry University and AIMS volunteer. Her areas of interest are decision making, health literacy and physiology informed care.

---

1 Guardian (2015) Morecambe Bay report exposes 'lethal mix' of failures that led to baby deaths

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

2 AIMS (2022) AIMS statement on the Kirkup Report

https://www.aims.org.uk/campaigning/item/kirkup-report

3 Editor's note: 'genuine breadth of choice', as opposed to the rhetoric of choice