AIMS For a better birth...

All on the same side?

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www.caesarean.org.uk co-founder Gina Lowdon explores the concept of choosing a caesarean

Sadly, women are often portrayed in the media as being on opposing sides: on the one side are the 'natural' childbirth 'earth mothers' lobbying for women's right to birth at home or in a birth pool, for intervention-free birth in hospital, and for support for breastfeeding; and on the other side are those reported as being 'too posh to push', who want caesareans and epidurals on demand, and who see vaginal birth in any setting as an horrendously frightening, painful and degrading experience, and definitely one to be avoided.

At best these two groups are seen as being on opposite sides of the same coin, at worst they are seen as being mutually exclusive and as having demands and ideas that are in direct opposition. However, they have much in common and are not nearly so far apart as to render impossible shared campaigning objectives.

To state the obvious, all women would like to go through a straightforward, positive experience of bringing a healthy baby into the world. Where women differ is in their beliefs about how best to achieve such an experience; those advocating home birth are at the opposite end of the birthing spectrum to those preferring an elective caesarean. What few seem to realise is that both ends of this continuum share the same under lying principles, and it should be possible to join forces and speak with one voice representing and supporting the needs of both groups (and, indeed, all those in between).

To understand how and why the perceived opposition has come about we have to step back in history. Have the aspirations of women changed and are campaigning objectives still in line with what women really want?

Throughout the ages, right up until relatively recently, birth was a normal life event; women became pregnant, in due course they went into labour, gave birth and continued with their lives. There were no intellectual 'choices' to be made, no complex options to be weighed up; it was simply a case of following life's natural flow of events. Women just had to hope and pray that all would be well.

For most women the birth proceeded normally without major complications and although women could give birth unaided, many preferred to have the companionship and help of other women and/or a midwife.

There is evidence that providing women were able to eat well throughout their lives and pregnancy,

maintain good health throughout, and providing their living conditions were of a reasonable quality, then around 95% could expect labour not to present any major hazard.[1, 2, 3, 4] This figure may seem high, but it must be remembered that throughout history for the remaining 5% or so, complications were such that death was a real possibility. There were also communities who did not have enough to eat or whose living conditions were deplorable and therefore in those communities pregnant women were at much higher risk of general poor health, mal-formed pelves, and consequent higher rates of complications of pregnancy, labour and birth.

Birth was something to look forward to, but it was also something to fear.

From Birth at Home to Hospital Delivery

Before the bir th of the NHS in 1948 it was usual practice in the UK for babies to be born at home and midwives were employed either privately or by local council authorities as providers of community services; midwifery care was seen as a community service rather than a health service. The move away from domiciliary delivery (as home birth was termed) to hospital delivery which was already well under way at that time, accelerated with the advent of the NHS; midwifery provision moved from local councils to the health service provider (the NHS), and the emphasis changed as birth became acknowledged as a health issue rather than a normal life event.

Also, and this was crucial for the way birthing practices developed, birth came under the control of doctors and male dominated obstetrics. Doctors had been taking an interest in childbir th for some decades but the move from home to hospital brought the birthing process into the realm of male doctors and medical science, and away from women and midwives and their more socially caring approach. This change was gradual and insidious, but it has been inexorable and has resulted in a complete change in the way birth is approached, seen and understood by our society.

By 1958 the percentage of bir ths still taking place at home had reduced to 36%, by 1970 the rate was down to 13% and by the early 1980s was down as low as around 1%[5] The driving forces behind the declining home birth rate are complex, but contrary to popular belief there is no evidence that the move contributed to improved health outcomes for mothers or babies. In fact there are strong arguments to support the relative safety of home birth.[6]

By contrast, at the opposite end of the childbirth spectrum rates of caesarean section were increasing. In the first decade of the twentieth century only 74 of 15,222 deliveries were by caesarean section[7] In these early days of caesarean section a woman was lucky to survive at all, so it was a measure of last resort. By the 1940s numbers of caesarean deliveries were increasing as improved surgical techniques, blood transfusions, anaesthetics, and the introduction of antibiotics reduced the risk of maternal mortality, making the operation more acceptable to the medical profession.

By 1958 2.7% of births were by caesarean section, but with increasing confidence and much improved survival rates the caesarean rate had doubled to 5.3% of births by 1972[5] This was still at a level that

reflected the number of life-threatening problems that might be encountered in a generally healthy population. 1, 2, 3, 4 However rates of caesarean delivery across the western world continued to rise. By 1985 the caesarean section rate in the UK had doubled again to 10.5%, and by 2001 there was a further doubling to 21.5%.8 The latest figures (2007) indicate that the rate may have stabilised at just over 24%9 However, if the pattern here in the UK follows that of the USA, this plateau will be short lived and followed by a continued rise.

So how did women feel about the changes reflected in the statistics?

1960s: The Rise of the Interventions

The move from home to hospital as the prominent place for most births was well under way by the 1960s, and with it came a shift in perception. The birthing process and experience ceased to be seen as a normal life event of personal, social and community importance; instead it was viewed as a medical condition and a time of great risk. There was also a shift away from predominantly pastoral care by women (midwives, family and friends) to medical care and conditions of labour that were controlled by men of science (doctors, obstetricians and paediatricians).

Although caesarean rates were increasing they were still low, reaching just 5% by 1970. At that time therefore they did not present a cause for concern for the majority of women, reflecting as they did the level of complications generally encountered. Despite greatly improved outcomes and much lower death rates caesareans were still only carried out when absolutely necessary. Childbirth had never been without its risks and complications and the roughly 5% rate reflected public experience and expectations of trouble. At that time there was no suggestion therefore that caesareans were done inappropriately.

The move to hospital-based, doctor-led care however gave rise to a whole host of medical inter ventions which affected much larger numbers of women and which therefore did present a whole raft of concerns. Particularly unpopular amongst the early interventions (with both mothers and midwives), were shaving of the pubic hair and enemas to purge the back passage; practices which were believed to reduce infection rates, but which were shown to be ineffective at best10, 11 and which gradually fell into disuse following assertive campaigning by childbirth organisations.

Many women did not like the way they were treated in hospital; there was a lack of privacy, a lack of respect and there were degrading and unpleasant procedures that had to be endured in order to access the perceived greater safety of having medical expertise on hand, and babies were often separated from mothers and placed in nurseries. No-one at that time questioned the validity of the presumption that hospital birth was safer ; it was simply accepted as fact.

The Birth of Childbirth Organisations

The strength of feeling against the prevailing conditions was demonstrated by the formation, in the late 1950s/early 1960s of various user groups including: the Natural Childbirth Trust (1956) which became The National Childbirth Trust (NCT); The Society for the Prevention of Cruelty to Pregnant Women

(1959) which became the Association for Improvements in the Maternity Services (AIMS) in 1960 and the National Association for the Welfare of Children in Hospital (NAWCH 1963) which became Action for Sick Children.

The NCT focused on educating women to increase their confidence in the natural birth process and enable them to be more self-sufficient so they would not feel the need to avail themselves of hospital care. Their philosophy was based on the teachings of Grantly Dick-Read who had demonstrated that by understanding and working with the natural birth process complications could be kept below around 5% in healthy women.1

AIMS was more concerned with the way women were treated in hospital, which Sally Willington, founder of AIMS, considered amounted to cruelty to women, hence the initial nomenclature of AIMS. The general perception that hospital birth was safer was not in contention at that time and one of AIMS' early campaigns was for more hospital beds so that women who needed, or wanted, to give birth in hospital could do so.

Throughout the 1960s experience of birth in hospital left much to be desired. Rates of caesarean section were increasing but they were still low enough not to present an issue for the majority of women. The medicalisation of birth that came with the move to hospitals however brought a range of inter ventions which became common place and, with the possible exception of pain relief, universally disliked, such as pubic shaving, enemas, induction, augmentation, episiotomy. Campaigning by user groups focused on trying to persuade the maternity services to treat women and their babies more humanely.

The interventions themselves were accepted as necessary to preserve health and life and the concern, as it has been earlier with the number of hospital places, was the shortfall in service provision - all women who would benefit should have access to modern medical care, particularly pain relief.

1970s: The Demise of Home Birth

By the early 1970s it became clear that the option of home birth was being phased out. As fewer women gave birth at home more women were subjected to hospital protocols. Many who would have laboured perfectly well in the familiar environment of their own home attended by a known midwife found hospital labour wards impersonal, unpleasant and unsettling, with the result that their labours stalled or slowed down and became subjected to the growing range of interventions, including caesarean section. Not surprisingly, intervention rates of all kinds rose as the birth process became increasingly medicalised and mechanised, and rates of caesarean section soon followed suit.

For a large propor tion of women this was incomprehensible. Although many women had been led to believe hospital was safer for them and their babies, many others could not understand what the fuss was about; the vast majority of women had managed just fine since time began. Hospital delivery was proving to be inconvenient, unpleasant and degrading and did not seem to have much to offer women who maintained confidence in the natural birth process and had no reason to expect difficulties, particularly if

they were for tunate enough to live in an area covered by a known and trusted midwife or had the option of a good local GP unit.

There was alarm at the phasing out of home bir th as an option for women, and Margaret Whyte took a lead by raising awareness of this situation in 1972 when she set up the Society to Support Home Confinements. Following her lead AIMS too became interested in the issue and began campaigning for the right of women to have a home birth. Whilst those women who needed or wanted to give birth in hospital should be able to do so, so too should women be able to give birth at home as they always had done through the ages. Despite all efforts and the great many women who still preferred to give birth at home, home birth rates continued to fall, dropping to less than 1% by the early 1980s.

Such initiatives were backed by substantial numbers of women; those who felt strongly enough to 'create a fuss' and make their views known. At that time there were no groups of women arguing against natural birth, at home or in hospital: that argument was being raised solely by the medical profession.

During the 1970s the dangers of home birth as perceived by many in the medical profession and increasing numbers of the general population began to be called into question. Although the Peel Report of 1970 12 had implied that hospital birth was safer, it was criticised for the lack of evidence to support the implication. Archie Cochrane was one of the first critics in 1972 in his book 'Effectiveness and Efficiency'13 and much later, in 1990, Marjorie Tew gave a detailed assessment of the statistical evidence in her book 'Safer Childbirth' 6 indicating the relative safety of home birth. Unfortunately, despite consistent and clear evidence to the contrary, home birth continues to be viewed by the majority as inadvisable at best and highly risky at worst.

Throughout the 1970s and 1980s awareness grew among childbirth organisations that the option of safe and peaceful birth at home had been all but lost, stolen away by false promises and misconceptions concerning safety. Campaigning objectives focused on trying to recover the more gentle approach to birth that had served women so well for millennia. Hospital birth with its potentially lifesaving medical technology was acknowledged as being necessary for those who were in need, but awareness was growing amongst campaigners that inappropriate use of the growing range of interventions could bring harm as well as benefit.

Not all women were aware of the bigger picture but a significant number were. Those who felt traumatised by their experiences, who searched for information, who questioned the appropriateness of their care, found out that medical science was often far too enthusiastic and impatient, leading to injudicious use of interventions. But these women were far outnumbered by those who remained uninformed and who were left with the belief that unpleasant though hospital birth was, it was necessary for safe birth.

1980s: Caesarean birth becomes established

As rates of home birth hit their lowest levels by the early 1980s (around 1%), rates of caesarean section

were becoming a concern. A decade earlier, 1970 had seen the USA and the UK with similar caesarean section rates of around 5%.5 By 1978 the rate in the USA had tripled to 15.2% and women were starting to question the need for so many operations and began to fight back. The American organisation C/SEC Inc was founded in 1973 by women who suspected their caesareans had not been necessary and by 1981 one of C/SEC's founders, Nancy Wainer Cohen, was hard at work on 'Silent Knife: Caesarean Prevention and Vaginal Birth After Caesarean'. 14.

Silent Knife was published in 1983 and questioned every aspect of caesarean birth, including the inherent risks of this surgery to both mother and baby, the psychological affects on mothers of operations carried out for dubious indications, and the strength of the resultant scar which was shown to be considerably less prone to rupture than women had been led to believe. Silent Knife was an important book that gave women research-based facts and marked the beginning of the VBAC (vaginal birth after caesarean) movement in the USA.

Caesarean rates were slower to rise in the UK and, unlike in the USA, VBAC had always been accepted practice, but childbirth organisations were being contacted by increasing numbers of women who were unhappy and even traumatised, not just by their experiences on labour wards, but also by the resulting caesarean sections, and who were suffering a range of long term physical and medical consequences as well as trauma.

Not all women were unhappy with their caesarean births. Many were grateful that such a life preserving and relatively safe procedure was available. Although an unfortunate few found themselves facing short - and long - term difficulties as a result of their surgery, most caesarean mothers and their babies came through without encountering significant problems.

But, as the rate of caesareans increased, so did both the need for information and awareness that caesarean birth was not always problem-free. Whether women were at peace with their caesarean experience or not, many sought answers to a variety of questions. Unfortunately, a great many were not able to find the support and information they needed.

Established childbirth organisations had been focused on healthy women and the unpleasantness of interventions imposed on women on labour wards. It was widely believed that caesareans were only carried out when necessary and beneficial and were therefore strictly the domain of the medical experts. Lay organisations considered it neither appropriate nor wise to appear to be giving out information that might remotely be considered as 'medical advice' and thus considered caesarean issues as being outside their remit. Even childbirth preparation classes were criticised for not covering caesarean sections which were viewed solely as a medical emergency (rather than a birth).

Just as in the 1950s, 1960s and 1970s women expressed their views and attitudes by forming groups, sharing and disseminating information and experiences. Due to the lack of support from the established childbirth organisations, from 1981 onwards caesarean mothers began getting together to form self-help groups which Sheila Tunstall coordinated into the Caesarean Support Network.

As the caesarean section rate continued to climb to over 10% in the UK15 by the end of the 1980s, so too did the numbers of women dissatisfied and even traumatised by their caesarean experiences. The caesarean rate was now twice the general level of complications that people had been used to, but the prevailing view that every caesarean was carried out because there was a good cause meant there was widespread lack of understanding of the problems, and puzzlement over how any woman could view a procedure that must have saved her baby so negatively; it was simply not politically correct or acceptable to express negative feelings relating to caesarean operations and these women struggled to find support.

This period marked the start of the divide between those women who either gratefully accepted the necessity for their caesarean births and/or viewed them as an escape route from a bad vaginal birth experience, and those on the other side of the coin who suspected surgery had been resorted to inappropriately. By the end of the 1980s the operation was sufficiently commonplace that general information was more widely available as women shared their experiences and knowledge, but negative emotional responses were still frowned upon and largely misunder stood.

By 1990 caesarean bir th was well established with rates of around 11%15 whilst home birth rates remained negligible at around 1-2%.16 For the vast majority of women home birth was simply no longer an option to be considered seriously, it was no longer a part of the lived experience of the general population or part of current culture. Birth was no longer accepted as a natural life process; it was now firmly established as a fully medicalised event suited only to a hospital setting.

1990s: Evidence-Based Practice - a new campaigning tool

The 1990s was the decade where user groups turned to research evidence to support their campaigning objectives. Women had never been healthier, nor living conditions better, but as rates of interventions of all kinds, including caesarean sections, continued to rise alarmingly it became abundantly clear that substantial numbers of women were suffering the consequences. Birth had become a matter for medical science (irrespective of how healthy the woman was) and childbirth organisations could no longer confine their activities to the ever dwindling proportion of women considered 'normal' and 'healthy'; the 'medical domain' nettle had to be firmly grasped.

During the 1990s medical research and scientific evidence became more widely accessible and provided invaluable support for many of the arguments childbirth campaigners had been putting forward for decades as well as a firm basis on which to challenge medical opinion. Evidence showed that inter ventions of all kinds were not only unpleasant and often used unnecessarily but that they also had significant adverse effects.

Research evidence supported both the instincts and the lived experience of many caesarean mothers, demonstrating little improvement in outcome statistics when caesarean rates rose above 7% and recording evidence of associated risks for both mothers and babies.[11] (However, the full spectrum of adverse affects for an individual baby of not being born vaginally may still not be fully understood as more recent research findings indicate.)[17, 18, 19]

The general public however remained largely unaware of such risks and continued to believe that inter ventions were always beneficial and that every caesarean must be a much needed life-saver. A significant proportion of women too, were left believing that events on the labour ward and in the operating theatre had been unavoidable and that without the aid of medical science their babies may not have been born safely.

The VBAC movement comes to the UK

By the mid-1990s the caesarean section rate reached 15%[20] in the UK - the same level reached in the USA some two decades earlier that had prompted the formation of C/SEC and the publication of Silent Knife. It seems a 15% caesarean section rate marks the point where levels of discontent result in women fighting back - the VBAC movement became firmly established in the UK.

Childbirth organisations continued to receive the steady flow of enquiries from caesarean mothers expressing a need for information and support that had begun in the early 1980s, but with the move towards research-based campaigning the barriers presented by the perceived medical nature of caesareans were overcome and women started to find their concerns being taken on board.

Consequently, understanding of women's negative reactions to caesarean surgery grew and became accepted by the established childbirth organisations as realisation dawned that those preferring to avoid surgery and the 'cascade of interventions' that all to often led to the operating theatre, were fighting the same battles as those preferring birth at home or intervention-free birth in hospital; albeit with the added complication of a scarred uterus.

The division of caesarean mothers into those at peace with their caesarean births and those dissatisfied and even traumatised by their experiences that had begun to be apparent in the 1980s became more pronounced as the VBAC movement gained pace.

VBAC activists were uncovering research-based information that questioned the need for so many caesarean operations and challenged the basis of decisions taken by medical experts. Many mothers who

were at peace with their caesareans felt threatened by this new information since the only way many were able to cope with all they had been through was by continuing in the belief that it had all been necessary (and thus justified) for the health of their baby.

The 1990s saw VBAC campaigners and childbirth organisations with shared campaigning objectives highlighting inappropriate care, poor access to information and inadequacies in service provision that rendered women powerless victims of an unnecessarily medicalised system. However their approach was widely misunderstood by the general population and many caesarean mothers whose faith in medical expertise and continued belief in the dangers inherent in the birth process remained unshaken.

Clinical indications for caesarean section such as 'failure to progress' or 'cephalopelvic disproportion' (small pelvis, big baby) carried the not so subtle implication that interventions and caesareans rates were the result of some failing on the part of childbearing women. The medical profession were certainly not open to the idea that problems were the result of ill-advised forms of care and the vast majority of women were not ready to doubt the advice of their doctors.

Many caesarean mothers were therefore simply not ready to question the basis of their caesarean experience; some saw their caesarean as an escape route from a horrible vaginal birth experience and indeed many others had undergone caesarean sections for wholly appropriate reasons. The natural response of many of these women to the VBAC campaigns was a general perception that they were being blamed for bringing their experiences on themselves due to some personal inadequacy or failing; they felt under personal attack.

VBAC campaigners where branded as 'anti-caesarean' and childbirth organisations were frequently accused of failing to fully support all caesarean mothers, and of only valuing those women who were able to give birth 'properly' in some masochistic, competitive, Amazonian way; those who didn't were left with the distinct impression they were not 'real' women.

The Advent of Maternal Request for Caesarean Section

Caesarean mothers who felt negatively about their childbirth experience broadly fell into two groups: on the one hand were those who valued the natural birth process, who doubted the supposed benefits of their caesarean section and who were highly motivated to avoid repeat surgery in future, and on the other were those with no confidence in the natural birth process who considered their caesarean a welcome relief from a harrowing labour and who were therefore determined to avoid a similar experience in any future pregnancies by undergoing elective (planned in advance) caesarean births.

As the 1990s came to a close with caesarean rates in the region of 20% and rising, the widespread debate that had been taking place throughout the western world reached a general consensus that caesarean section rates were too high and should be reduced. Consequently the maternity services came under pressure from childbirth organisations, health service providers and government bodies to reduce the number of caesarean operations taking place. Some obstetricians became reluctant to agree to

caesareans in the absence of a clear clinical indication and women expressing a strong preference for caesarean birth began to encounter a lack of sympathy for their needs and refusal of their requests. For those who simply could not face the prospect of a vaginal birth or who perceived it as being detrimental for their baby, the denial of their only other birth option was alarming.

Established childbirth organisations began receiving increasing numbers of enquiries from women distraught at being forced to labour against their will as their escape route was closed off. The majority had already been through a traumatic experience and found the thought of repeating it terrifying; others had heard many horror stories from friends and relatives and dreaded a similar experience. Unfortunately however, whereas it had once been unacceptable to express negative feelings regarding caesarean birth, the pendulum had swung and by the end of the 1990s it was no longer acceptable to express a preference for caesarean birth. Yet again, a significant group of women were finding support and understanding difficult to find.

Media coverage of the issues was particularly unhelpful with confusion over the term 'elective caesarean' which was interpreted by many journalists to mean the caesarean was 'chosen by' or 'opted for' by the women themselves, often implying there was no underlying clinical indication. (The term 'elective caesarean' simply means 'planned in advance' as opposed to 'emergency caesarean' which in its original sense means that the indication 'emerged', that is, it was 'unforeseen' or 'unplanned'.)

The phrase 'too posh to push' coined shortly after the birth of Victoria Beckham's son in 1999 added insult to injury implying as it does that women requesting caesareans were not prepared to demean themselves by going though labour.

It was also an inaccurate analogy since by all accounts Victoria did have a clinical indication for caesarean section - her son was a breech presentation and she would have been strongly advised by her private obstetric-led care to have a caesarean. With her second pregnancy it is very unlikely that a VBAC would have been encouraged in the private obstetric sector. A more accurate phrase would have been 'conned and cut' since new evidence shows that breech babies can safely be born vaginally and that VBAC generally carries lower risk than planned repeat caesarean, but Victoria was doubtless misled as are so many women in similar situations.

Caesarean mothers on both sides of the divide deplored the media misunderstanding. Those at peace with their caesareans had not undergone their operations for frivolous reasons of fancy but for clear medical indications on the advice of their obstetricians and for the well-being of their babies. Those unhappy at having undergone surgery were indignant at being portrayed as having supposedly chosen a procedure they had definitely not wanted, had been given no choice over and the necessity of which they had come to doubt.

There was widespread misunderstanding of both the extent and the driving forces behind maternal request for caesarean section and a consequent lack of respect and consideration for the perspectives of those women who were genuinely expressing a preference for caesarean birth.

The New Millennium: Birth as a Medical Process

By the dawn of the New Millennium, birth as experienced by women in all western cultures had been transformed. The collective consciousness was generally unaware of the inherent benefits to both mother and baby of a truly natural birth process; those had become secrets known only to a dwindling number of mothers and grandmothers. With the passing of the decades the memory of straightforward, gentle, safe and caring birth at home was fading; confidence in the ability of women to give birth remained at an all time low. Intervention-free birth or birth at home was no longer an option for consideration by the majority of women - they simply didn't know it existed.

What the collective consciousness was only too well aware of were the difficulties experienced by women on our labour wards. Birth was no longer a normal life event but a medical condition requiring monitoring and intervention prescribed by doctors in hospitals. Women had been taught to fear birth, to believe that interventions were necessary to safeguard their babies. Indeed fear of birth had become endemic in western cultures; birth outside hospital, away from potentially lifesaving medical intervention was almost universally considered to be dangerous and irresponsible despite evidence to the contrary. Hospital labour wards had a virtual monopoly and control over public perception of the birth process.

Monopolies are rarely conducive of diversity and provision of good service. The medicalisation of birth requires that women are processed through a system focused on checking, measuring and managing - all highly scientific and clinical, and all carried out in the name of safety. Scant, if any, consideration is given to the way the 'system' impacts on women psychologically.

The role of midwives had also changed. Most midwives had become obstetric nurses, trained to carry out checks and make notes, and to ensure the woman's labour did not deviate from ever narrowing criteria considered to represent 'normal'. The emphasis was now on detecting abnormality rather than safe-guarding normality. Disenfranchised midwives had been leaving the profession in droves for decades and the resultant shortages of experienced midwifery staff further exacerbated the inadequate care received by labouring women as hard pressed midwives endeavoured to over see several women simultaneously, rendering impossible the sort of individualised care that used to be central to the midwife's role.

Whilst labour wards claimed to offer increased safety, they did so at the expense of individualised care. Had one-to-one midwifery care by a known midwife followed women from the home into hospital things might have been different, but hospitals were the domain of doctors and disease, not midwives and normal life processes. Hospitals are about rotas and shifts, measuring and monitoring, statistics and clinical indications, none of which allow for the timings and individuality of the rich variety of normal, natural healthy labour.

By the New Millennium caesarean rates were approaching or exceeding 20%[20] Medical advances had greatly reduced surgical risks and complications making caesarean birth a viable alternative. Short and long term consequences were relatively uncommon, poorly understood, and generally unnoticed by all but those women unfortunate enough to suffer from them. Caesarean birth now offered women an alternative to the labour ward experience of vaginal birth - and increasing numbers were considering it the lesser of two evils.

Today: The Divide Deepens

As we reach the end of the first decade of the 21st century caesarean rates appear to have stabilised at just over 24%, [9] although the pessimists among us expect them to rise again as they have done in the USA. Despite the best efforts of lay and midwifery groups and considerable support from various government documents,[20, 21, 22] home birth rates have only rallied marginally to around 3%,[23] and rates of interventions have reached unprecedented levels. It has been estimated that fewer than 10% of women now experience a birth process free of interventions.[24] Every day, healthy women who have passed a problem-free pregnancy enter hospitals in spontaneous labour and leave some while later having undergone major abdominal surgery, yet this state of affairs is regarded as acceptable and even expected.

An ever dwindling number of women are now having a positive experience of giving birth. The phrase 'normal birth; has become synonymous with a highly managed medicalised labour that nonetheless results in a baby being born vaginally without forceps or ventouse. 'Normal' it may well be in these troubled times, but clearly this idea of 'normal' bears no relation to the normal functioning of a woman's body in labour. Women themselves are also becoming less aware of the difference between 'normal' and 'natural' - it is not unusual for a woman to state she does not want another 'natural' birth when in reality what she has experienced is what passes for 'normal' birth today, which is far from natural and equates merely to the avoidance of a surgical or instrumental birth. Most women no longer know what a truly natural birth can be like.

In little more than half a century birth has been transformed - and its new form is not very pretty. Birth used to be a normal life event which took place in familiar and comfortable surroundings at a pace that was tailor-made to suit the needs of the individual woman and baby. Birth used to take place in privacy, with only those invited by the woman present. Birth is now a fully medicalised, impersonal event allowing little privacy, which takes place in unfamiliar and uncomfortable surroundings at a pace dictated by

medical experts based on statistics. Women have little or no say in who will be present, who will attend them, what is done to them during the process, and indeed in many cases the steady stream of health professionals may remain nameless.

Quite simply birth on today's labour wards just isn't 'nice'.

It isn't nice having someone put their hand in your vagina in order to carry out a vaginal examination. It isn't nice having needles stuck into you for the purposes of injections, canulas and drips. It isn't nice being given drugs to make your uterus work faster. It isn't nice being trapped on your back in a bed when you want to move position to ease your discomfort. It isn't nice having no-one pleasant to talk to because the midwife (if she is actually in the room) is too busy with machines and paperwork. It isn't nice being bored while you lie there waiting for something to happen. It isn't nice being worried, anxious, frightened, because no-one cares that you are feeling superfluous to this whole process. It isn't nice being left with damaged genitals resulting from rushed births, enforced pushing and general ill-advised care. And it is absolutely horrible having someone mutilate your genitals in the name of an episiotomy.

Believing that all this is done in the name of safer birth does not make it any nicer or any less degrading. Let's be absolutely clear here, women only put up with it all because there is a baby to safeguard. Without the expectation of a baby no-one would be prepared to endure such an experience.

It is abundantly clear that all women still want the same things in pregnancy and birth that they have always done - a comfortable pregnancy, a straightforward birth without problems and without pain, and of course most importantly, a healthy baby. Women are prepared to sacrifice a huge amount for their babies, something which is taken unfair advantage of by many health professionals.

Modern medicine has failed in its promises to women and unfortunately, like the proverbial runaway train, the medicalisation of birth shows no signs of slowing down. The approach to care that women find so unpleasant but which so many feel they have no option but to submit to for the welfare of their babies, continues to become more entrenched and intractable.

The gulf has widened between those women who understand the benefits of the natural birth process and those on the other side of the coin who can't even imagine them, for whom 'normal' birth equates to the labour ward definition of 'vaginal' and from which major abdominal surgery has come to offer an attractive route of escape.

All on the Same Side - Building Bridges

Despite the apparent gulf, these two groups of women are not really so far apart; they are all on the same side. Both ends of the spectrum share the common aim of trying to avoid what passes for normal birth on hospital labour wards. In these modern times there are two ways of avoiding a difficult and unpleasant vaginal birth experience: one is to have a good vaginal birth experience and the other is to have a planned caesarean section. Childbirth organisations and campaigners need to be aware that representing all women now includes those for whom a good experience of vaginal birth is no longer an accessible option

and who therefore need the alternative of planned caesarean section.

And that is the crux of the problem - not how a woman sees caesarean birth, but how a woman perceives vaginal birth.

For those who have been campaigning over recent decades the knowledge that vaginal birth can be safe, pleasant and something to treasure and look forward to is unquestionable; it is plain, obvious fact. But for a growing number of women vaginal birth is perceived as unpleasant, frightening, imper sonal, degrading, dirty, painful and dangerous. It is an indictment of our maternity services that conditions women endure during labour in western cultures are so dire that women are prepared to undergo major abdominal surgery in order to avoid it.

Campaigns for improvements in maternity care need to take into account the needs of women at both ends of the birthing spectrum.

Campaigning to reduce unacceptably high caesarean section rates should take care to focus on unwanted caesareans and to avoid closing off the much needed escape route for women unable to consider vaginal birth positively. There needs to be much greater awareness and acknowledgement that psychological need is a clinical indication for caesarean section. Women who are expressing a preference for caesarean birth deserve to have their psychological needs assessed and respected. They are expressing real fears, real concerns. Too often genuine psychological need is brushed aside and dismissed as unfounded, frivolous 'maternal request'.

Campaigning for one-to-one midwifery which has the potential to transform the experience of giving birth for women, should also acknowledge that those women with real medical concerns may appreciate one-to-one care from a specialist doctor as well as a midwife. Time and time again it is evident that those women who have built up personal relationships with their health professionals fare better - whether they are healthy women getting to know their midwife, whether they have a serious medical problem requiring the expertise of a doctor or obstetrician, or whether they are one of the unfortunate few coping with a tragedy.

Campaigning for choice over place of birth should openly acknowledge that women plan home births on the basis of perceived greater safety and a more appropriate model of care, and that women expressing a preference for caesarean section also do so on the basis of perceived greater safety and a more acceptable model of care. Who is right or wrong on the basis of general statistics and medical evidence is not the issue; each woman makes a highly personal decision based on her intimate knowledge of her individual circumstances which are likely to cover a considerably wider spectrum than is taken into account by statistics or medical professionals.

Those at both ends of the birthing spectrum need to take care when campaigning that they are not calling for measures that restrict the options of those at the other end of the continuum. Women rarely, if ever, make frivolous 'choices' when it comes to birth options. Decisions are always based on an intimate knowledge of their own personal situation and needs, even in cases where it might not be immediately

apparent.

Whatever the current campaigning objectives, until such time as the birth process is again reclaimed by women as something to look forward to, something unique and special, something perceived as a rare opportunity to be embraced and coveted, until our culture regains the knowledge and understanding of what birth used to be and can be again, then it is likely that women will continue to seek to avoid it in favour of the alternative our technological culture has provided - caesarean section.

Could there be any worse indictment of the care provided by our obstetric-led maternity services?

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