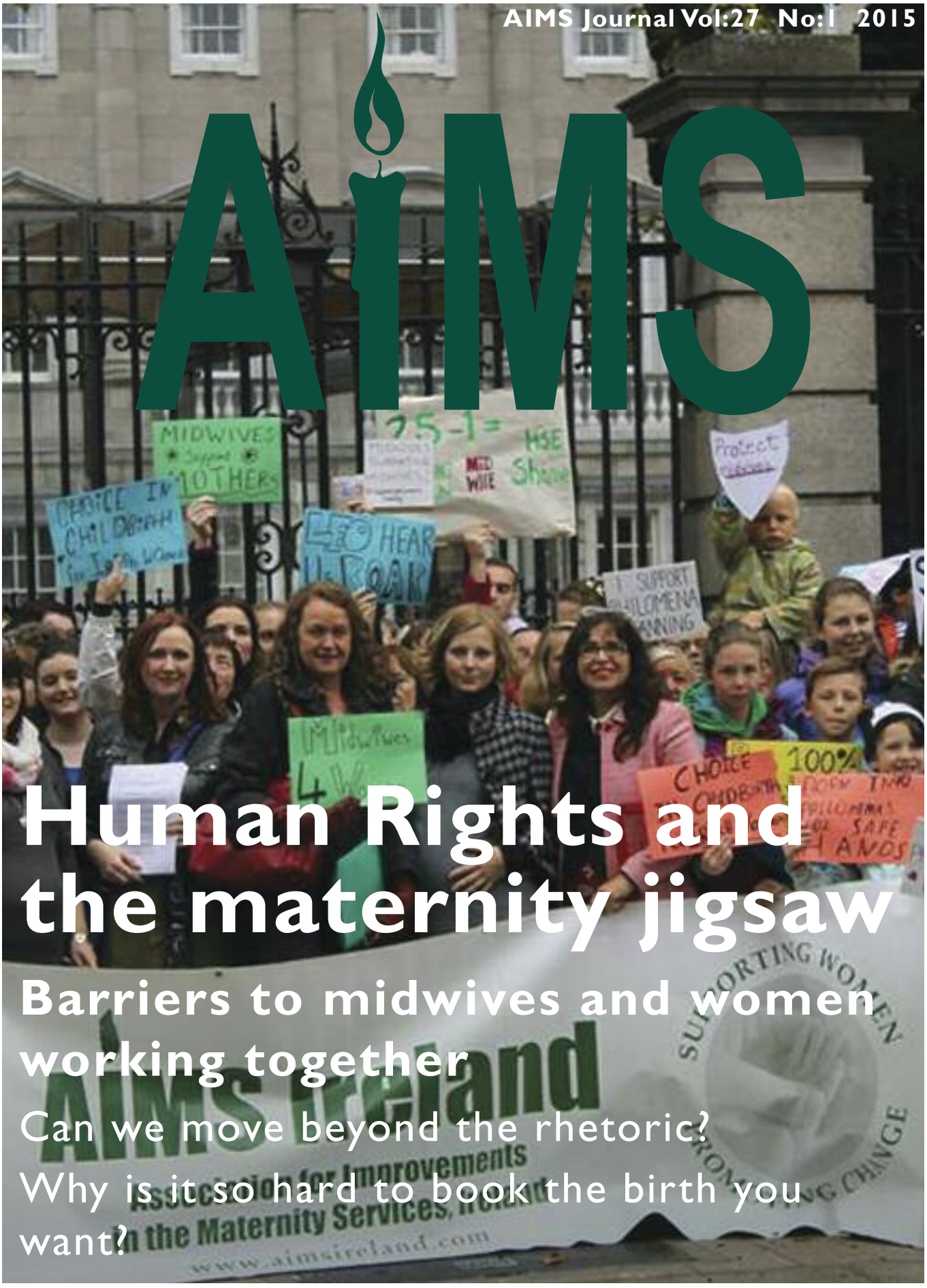
Association for Improvements in the Maternity Services

AIMS Journal Vol:27 No:1 2015

AIMS



Human Rights and the maternity jigsaw

Barriers to midwives and women working together

Can we move beyond the rhetoric?

Why is it so hard to book the birth you want?

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Diary

AIMS meetings

Friday 24 April 2015
Sheffield

All AIMS members are warmly invited to join us. For further details, to let us know you are attending or to send apologies please email secretary@aims.org.uk

AIMS talks

Mavis Kirkham
Friday 24 April 2015
7 – 9pm
Showroom 5
Showroom Cinema
15 Paternoster Row
Sheffield S1 3BX

If you are interested in attending please email talks@aims.org.uk

Please always check our website or contact us to confirm details as sometimes these change.

Royal Society of Medicine
Mental health in the perinatal period:
Mothers, fathers and babies
26 March 2015

and

Changes in maternity care:
are you ready, willing, and able?
3 June 2015
Wimpole Street, London
WIG 0AE
email maternity@rsm.ac.uk

University of Salford
Women and midwives together:
Developing great maternity services in Greater Manchester
27 March 2015
10.00 - 2.20 Free event
Aimed at pregnant women, parents, grandparents, midwives and managers.
Speakers include, mothers and fathers, Beverley Beech, Lisa Bacon, Burton Midwifery Service, Isle of Man SoMs.
Children welcome.
www.eventbrite.com/e/maternity-conference-27th-march-2015-tickets-14918736342

Doula UK Conference 2015
Positive birth supporting families
Ramada Sutton Coldfield
24 March 2015
doula.org.uk/content/doula-uk-conference

University of Central Lancashire
Normal labour and birth
The Grange Hotel Conference Centre, Grange Over Sands, Lake District
15 - 17 June 2015
Please contact Liz Roberts
telephone 01772 893809
email
healthconferences@uclan.ac.uk
www.uclan.ac.uk/conference_events/normal_labour_birth_2015.php

Association for Improvements in the Maternity Services
founded in 1960
by
Sally Willington 1931 – 2008

AIMS

campaigning for better maternity services for over 50 years

AIMS

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Vol:27 No:1
ISSN 0265 5004

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Printed by
QP Printing, London
Tel: 020 3332 0102

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Cover Picture:
AIMS Ireland demonstrating in support of Philomena Canning
© Jene Kelly

Contents

What human rights legislation means for AIMS

For over 50 years AIMS has campaigned for women's rights. The committee has always been made up of lay people, coming from a wide variety of different backgrounds, but all with the same strong sense that women have the right to decide how they want to give birth to their baby.

Earlier on this year, as readers know, AIMS made its application for Charity Status, explaining the range of work that it does. The first application was returned to us by the Charity Commission, because it wanted AIMS to prove the statement in its constitution that it promotes human rights. We set about explaining our work in a human rights context, something we hadn't explicitly done before. In doing this, we realised just how much we are aligned with human rights legislation and our second application was successful.

In Britain, sections of the press like to pour scorn on human rights; certain political parties would like to reduce the powers that they give; British Sovereignty is said to be at risk. But the reality is that human rights are a cornerstone of a healthy democracy, they can enable people to have a voice, they should be universal in their application, belong to everyone, and should set down the standards below which no government or institution should fall. Human rights are thus a basis for redressing the often unequal relationship between ordinary people and those in power.

In broad terms, everyone has a right to appropriate health care, but securing that right in maternity is problematic, as AIMS knows all too well. Physical, emotional and spiritual health should be a right for every mother – it should mean birthing her baby in the best possible circumstances. 'At least the baby is alright', a statement women often encounter after a traumatic birth, is not acceptable.

Informed decision making means that women must have all their options explained to them and then they, and only they, decide. It might not be what the doctor orders or the midwife advises, but that is her right, and AIMS will help her uphold that right. The right to refuse medical treatment or intervention, to informed consent, and to privacy and modesty are enshrined in law. Every woman has the right to support for the birth she wants, and she also needs to be heard when she is asking for help and when she feels that technology and intervention is the best thing for her. AIMS works hard to ensure that a woman's decisions and needs, as she defines them, are at the forefront of care and for adequate support to be provided when technology and interventions are used.

AIMS – celebrating Beverley's birthday before Sara Wickham's talk. Talk report on page 20

Over the years AIMS has:

- campaigned for the right to informed consent after all options have been explained
- highlighted the dangers of court-ordered caesareans
- worked to reduce forced vaginal examinations
- been there for women who are being bullied, threatened and coerced into birth procedures they don't want or need
- raised awareness of post traumatic stress disorder caused by birth trauma
- fought against verbal and physical abuse by doctors and midwives and social workers
- campaigned against forced episiotomies
- spoken out and monitored abuses of human rights (such as when women were shackled giving birth in prison, and when Agnes Gereb a Hungarian midwife was held under house arrest)

AIMS participates, as much as possible, in national debates, government policy making, guideline reviews, consultations and with other UK and international organisations campaigning for human rights.

AIMS stands for Association for Improvements in the Maternity Services. In our ideal world, maternity services would be able to plan for and accommodate all the different needs of women and the decisions they can make in pregnancy and childbirth. The health care workers (doctors and midwives) would be respectful and non-judgmental; they would put the woman's needs above their own; they would work to ensure that they support the mother, not seek to control her; they would understand risk and learn how to explain it.

Human rights legislation, when used to its fullest, can make this happen. All health care workers have professional obligations under their registration that mirror human rights legislation. They are all required to make each woman and her baby the focus of their practice.

If you are pregnant – know your rights and seek help in securing them. AIMS will help you.

Shane Ridley

Beyond human rights

Nadine Edwards discusses how human rights are only part of the jigsaw of care

AIMS has long championed women's rights within maternity care. Beverley Beech's first book in 1991 *Who's having your baby?* was warmly welcomed by a broad audience. We have recently launched the newest edition of its successor, *Am I Allowed?* – one of AIMS' best selling books.

AIMS has campaigned on maternity issues for many years, for example, initially for more hospital beds for women who needed specialist care during birth, then for women to have easy access to homebirth, for partners and companions to be enabled to accompany birthing women in hospital, for women to receive full information and to be supported in their decisions, even when these are at odds with professional advice, policies or guidelines. It has explicitly drawn on women's rights to support these campaigns throughout its history, but exercising rights is part of a jigsaw in which some of the pieces are less obvious than others.

An important debate has taken shape in which some question the discourse of rights, pointing out that rights have been developed and function within the prevailing values and beliefs of privileged peoples in rich countries.[1] This makes them both rigid and vulnerable, specific and vague, apparently set in stone and changeable. Rights are hard won and constantly under threat as has been apparent in some of the discussions held at the first two international conferences on Human Rights in Childbirth in the Hague in 2012 and in Belgium in 2013,[2] as the outcome of Dubska v Czech Republic[3] demonstrates and as described by Gill Boden on page 10 in her article on resisting the filming of birth in Wales. It is abundantly clear that no 'right' is set in stone but subject to shifts and changing beliefs of those in power and that the rights of pregnant women change according to mainstream values about women and birth. In the UK all bottles of alcohol bear the symbol of a pregnant woman with a red cross through it and in 2014 a pregnant woman was taken to court for drinking alcohol: on this occasion the court ruled against the council that took this action. However, last year Lynn Paltrow and Jeanne Flavin published a damning report about 413 arrests of and forced interventions in the US on pregnant women between 1973 and 2005[4] showing how the fetal rights movement is growing apace and threatening the integrity and health of women and babies.

In Australia, researchers found that doctors and midwives agreed that *'For the safety of the baby, the maternity care team sometimes need to override the needs of the woman.'* Although the law in the UK, Australia and most other rich countries upholds the pregnant woman's right to refuse treatment '*even if this choice could cause the fetus harm or death [...] some lawmakers believe that no right is absolute and that a person's autonomy is no exception to this*' (see page 22).

Similar reports in the UK have reached AIMS; reports of forced caesarean and of referrals to social services when women exert their right to autonomy and do not comply with medical advice. Beverley Beech's article on page 12 shows the enormous and unaccountable power over parents and children held by social services since the case of baby P.

And of course, even when women are aware of their rights, asserting these can be complex. For example, women usually know that they have a right to a homebirth, but, when faced with unsupportive doctors, midwives or family, may not want to exert that right: women wanting to give birth to a breech baby vaginally might know that this is their right, but that is hollow unless there are practitioners in their localities who are skilled in supporting vaginal birth (see page 18).

AIMS uses the language of rights to attempt to ensure that all pregnant women are treated with respect and that their agency is supported, but we offer support as well as information: support that is so vital if women are to receive good care, feel listened to and be enabled to make decisions for themselves and their babies that reflect their priorities and values.

AIMS knows what this caring might look like in maternity services: Kathryn Gutteridge and Becky Reed described this eloquently at the Royal Society of Medicine's conference Back to the Future (see page 19). While the models were different (a local birth centre and caseloading), the listening to, respect for and focus on each individual woman and family was the same.

Human rights have helped us in our endeavours to improve maternity care, but on their own will not secure good care for each woman. In line with the new NICE Guideline (see page 21), health care providers need to embody caring and respect towards women, babies and families in their care and this will happen best when they in turn are supported by the structures and systems around them. Adequate support for staff cannot occur in a profit driven, privatised health care system, ever more inaccessible and complicated commissioning structures, a powerless Department of Health in England, where midwives struggle for adequate pay (see page 27) and respect for their own judgement and practice (see Colm OBoyle's article on page 15) and where women's rights to autonomy are challenged and overridden every day throughout UK maternity hospitals, as Helen Shallow describes on page 6.

Nadine Edwards

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The paradox of too much or too little care

Helen Shallow reports on the International Confederation of Midwives Congress

I was extremely fortunate to be funded by the University of West of Scotland (UWS) recently to attend the 30th International Confederation of Midwives (ICM) Congress in Prague. As I share my reflections on the Congress I will, at the same time include the story of what happened to a woman I know, who gave birth during my time at Congress. I believe her story is a relevant and poignant example of where contemporary UK NHS midwifery and obstetric care has failed yet another new mother and why, despite a live mother and baby, how the woman feels after the birth of her baby matters.

In the following account of key lectures from the ICM Congress and themes from the concurrent sessions on women and human rights, I have linked the story of Sarah (pseudonym) as I believe her story is a painful example of where maternity care in high-income countries causes harm to women. My thoughts about the Congress and the mother's story have created a troublesome paradox, which needs to be teased out.

The ICM Congress

At Congress there were 3800 midwives from all round the world attending keynote lectures and a variety of workshops and concurrent sessions led by researchers and specialists in their field. Notably there were very few non-midwife delegates.

The statement that 92% of maternal deaths occur in the 73 lowest income countries with only 42% of the world's medical nursing and midwifery staff came as no surprise, but still leaves me feeling a sense of guilt and undeserved privilege, living as I do, in a high-resource country like the UK. One could question why any of us complain about maternity services in the UK when so many women in low-income countries cannot access maternity care at all with devastating consequences. However, there is a real and present issue in the UK and other high-income countries whereby valuable resources are overused due to a highly risk averse culture. Why we should question UK maternity care, was discussed by Lisa Kane Low (Associate Professor of Midwifery, University of Michigan) in her keynote speech.

Lisa argued that access to health care is not just an issue confined to low-income countries. North America is one of the richest countries in the world; nevertheless there are inequities and access issues for many families who cannot afford private health care insurance. We know that in the UK there are health inequalities and women who are most disadvantaged generally have the worst maternal and neonatal outcomes. Lisa went on to say that the disparity of inequity goes further, in that two thirds of the world's adult population control only 2% of the world's wealth.[1] Yet how we use those resources in maternity care in high-income countries illustrates why we do have something important to say about improving maternity care in the UK. Lisa noted that the current *'template of technology'* results in increased surgical births and the *'misapplied use of technology'*. Therein lies the paradox of over use in resource rich countries (such as ours) and underuse in resource poor countries where for example, the secure supply of a modicum of basic drugs such as antibiotics, a safe blood supply, and appropriate technologies such as hand-held battery-operated dopplers along with more secure employment conditions for healthcare workers, would and should save lives. However as Marjorie Tew showed in 1990, the belief that technology is the only answer is misleading.[2] A major theme of the conference focused on commitments to address inequalities in health caused by poverty, hunger and inadequate health and education infrastructures that we know would impact positively on overall health outcomes for women and families in resource poor countries.

Sarah's background

Sarah is a 42 year old first time mother. I first met Sarah over 20 years ago. We had long lost touch until very recently when I received a call asking if I could keep an eye on her as she was now pregnant and living in the area where I work as a consultant midwife. Sarah had returned from London at 36 weeks, to have her baby in her home area. From the outset Sarah knew I could not commit to being her midwife as plans for the ICM and a holiday had long been made. I offered her support as a friend and in my professional capacity I helped her to communicate her place of birth intentions, as the obstetric team had challenged her decision to birth in the birth centre.

As you read Sarah's account please bear in mind that during the human rights session at the Congress, Hermine Hayes-Kleine, a human rights lawyer from the USA, noted that even though women make up over the half of the world's population and have a *'right to the highest attainable standard of health'*, many women do not have healthy births. Hermine concurs with the WHO definition of health, whereby women have the right to health, which is more than just a live baby but also includes physical, emotional and spiritual health.

Sarah had been well throughout her pregnancy. In London at around 35 weeks her abdomen measured larger than expected and she was referred for a scan. The scan showed 'mild polyhydramnious' (extra fluid round the baby). The accuracy of amniotic fluid

measurement is questioned by some authors and as a measurement alone is not sufficient evidence on which to recommend induction of labour.[3] Nevertheless a 'helpful' GP put the idea in Sarah's head that it would be better for her if she went into labour at 37 weeks. How, I wondered, was she supposed to do that without intervention? I talked it through with her and suggested that as the extra fluid was mild it may resolve and as she had another scan scheduled that would become evident.

Karen Guilliland, ICM board member and Chair of the Human Rights session, noted that we have become a *'fetus centric'* world that compels us to see through the woman to the baby and, as a result, we are not putting mothers first. When society does not put mothers at the centre – we as midwives will (and do) also find it difficult to be woman centred. As soon as we cast doubt on the wellbeing of her baby a woman finds herself trapped in the web of 'what ifs' even when there is no immediate threat requiring action.

Everything else about Sarah was normal except, according to NICE criteria, her age.[4] Sarah commented that she knew at some point she would *'have to have the age debate with the doctors'*. Sarah was well and her baby's growth was fine and yet the obstetrician in London had already undermined her confidence by talking about the 'age issue' and 'need' for induction at 38 weeks.

Sarah deferred the decision in the hope that the local obstetricians would be more enlightened. In the event, at the next scan at just over 37 weeks, the fluid levels were back to normal, however, the sonographer noticed an anomaly with baby that could not be fully explained until after her baby was born. Sarah was again advised she should go to the labour ward, and again induction was recommended. The conversation went something like this: *'Was this due to the anomaly seen in baby?' No it wasn't. 'So why then?'... 'Well, just in case, your age, your history of increased fluid...' ... 'but that's resolved', 'yes','so I would still like go to the birth centre'. 'Well, we'll just do a stretch and sweep today' her reply being 'no thanks'.* Later Sarah described how the offer of a cervical stretch and membrane sweep sounded like she was being *'offered a cup of tea'* and the doctor appeared confused when she declined.

In the Human Rights lectures, Hermine Hayes-Klein outlined a legal definition of informed choice. The woman is informed of all of her options. She can be advised by the professional what he/she thinks she should do and why. Then the professional must support the woman even if she goes against their view. If a professional does not support in this way it is not choice. Health care professionals cannot say *'I'm the expert and you cannot decide.'* Choice goes beyond clinical evidence. No-one but the woman has all the information in the context of her life and family.

Sarah was well informed and had confidence in her ability to birth her own baby and yet it was becoming clear to me that she was facing the oh-so-familiar and difficult obstacle course that has an incremental demoralising effect on a woman's confidence, as of course, her baby comes first.

Just before my departure to Prague I spoke to a paediatrician and was assured that the anomaly may well resolve and that the only plan would be to scan the baby six weeks after the birth. I communicated with the birth centre manager and Sarah's consultant obstetrician that Sarah would be going to the birth centre when her labour started. She planned to await spontaneous labour and she fully understood the indications which could lead to transfer to labour ward. As Sarah's story unfolded we kept in touch via email intermittently as reception was not always possible.

Speaker after speaker at Congress talked about putting women at the centre of care. *'Women',* they said, *'need to be key decision makers as it is they who take their children into adulthood'* (Professor Lesley Page). Irrespective of country or level of income the rights of women to sexual and reproductive health and self-determination are seen as paramount. That every pregnant woman should have care by a trained and skilled midwife was seen not only as the *'best value for money'* (Frances Day-Stirk, President of ICM), but as the best option for women in terms of outcomes. It would appear that government and non-government organisations are no longer advocating that all women must birth on an obstetric labour ward and yet for many complex reasons, including the fear engendered in women, midwives and doctors, this continues apace.

Whilst in Prague I continued communication with Sarah as and when I could. She had reached her due date and all was fine. The plans were going well and she was just waiting in happy anticipation. At the end of the Congress, we all went our separate ways, my husband met me in a rented camper van and we drove off quite literally into the sunset.

Speaker after speaker at Congress talked about putting women at the centre of care

Email communication became more erratic but Sarah remained on my mind. I sent reassuring emails not knowing if she would receive them, in a long distance attempt to keep her confidence up, knowing the pressures she had been facing. Then when she was just five days past her estimated due date her waters broke. She emailed:

'Things have taken an unexpected turn! Waters broke last Thurs eve so I was then on the clock in terms of being able to have natural labour at the birth centre. Went in to birth centre on Friday was having regular contractions and the view of the doula and midwife was that I was in labour. I

got into the pool and continued having contractions through the night – pretty strong and regular. But then seemed to slacken off and VE at 4am showed I was only 2cm dilated!!! Was then given 'til 11 to see if more progress could be made. Increased by 1cm so decision to transfer to labour ward.'

Sarah wrote this email after transfer and an epidural had been sited and she said she was waiting...

My spirits sank as I read Sarah's email. Fresh out of Congress with renewed hope, to hear that Sarah was 'on the clock' and the race was on to see if she could get into labour within the prescribed timeframe, was disheartening and reaffirmed all that is wrong in contemporary maternity care. No surprise when I read that, exhausted, she had *'succumbed'* to the epidural and was waiting, and I knew what she was awaiting, but hoped against hope that I was wrong. Nevertheless I sent a resoundingly positive message of affirmation and support from us both and we anxiously awaited news knowing that her baby's birth was imminent.

At Congress one of the overwhelming messages was that midwives need to act autonomously and that women should be key decision makers, but here we had a woman with a midwife and her doula in attendance, who all appeared unable to protect Sarah by challenging a seemingly intractable system that does not allow for professional autonomy or individual decision making. The utilitarian one size fits all model was well into play. Despite the rhetoric of choice and empowerment, no-one was empowered in this account, least of all Sarah.

women should be key decision makers

A tense 24 hours passed before we could access our email again. I sent my husband to retrieve it, as I could not bear to, fearing what I anticipated but hoping to be wrong. The look on his face said it all on his return. This is what Sarah wrote:

'Hi Helen baby was born at 10.23 this morning. 8lbs 4ozs. Had to have a caesarean, as despite being in a perfect position and me pushing effectively she would not come out fast enough. There have been so many timeframes in this pregnancy that I appreciate are about reducing risk but have made things stressful. Forceps didn't work so I had to have a section. Am disappointed that I had almost every intervention but realise how unpredictable birth is...'

So how was it then that I could predict it, even though I hoped so much to be wrong? So the baby could not come out fast enough. Fast enough for whom? Sarah felt she understood that the actions taken were all about reducing risk but reducing risk to whom? Her baby was

So how was it then that I could predict it, even though I hoped so much to be wrong?

in a *'perfect position'*. No one could have done more than Sarah to ensure she and her baby remained healthy throughout her pregnancy. As soon as her waters broke naturally she was virtually destined towards caesarean section due to the time constraints placed upon her to perform accordingly. Where were her advocates when she needed them most? Sarah thanked me for my support, but I was not able to be there when she needed that support the most. The evidence around spontaneous rupture of membranes and risk of infection has changed over the years and the NICE intrapartum guideline currently recommends 'offering' immediate augmentation or after 24 hours after ruptured membranes; and yet the NICE guideline on antenatal care used to state that there was no increase of infection up to 96 hours after ruptured membranes. I cannot see where and how this evidence was superseded by newer evidence that shows expectant management to be more risky.[4] So where was Sarah's right to base a decision on this somewhat conflicting information when her labour started to be managed? I am not inferring that anyone deliberately set out to cause harm. On the contrary, I am sure everyone felt they were doing their very best for Sarah under the circumstances. Unfortunately the prevailing circumstances are those described by Lisa Kane Low and so many others at Congress, when she described the alignment of high income to increased technological know how and over use, linked with fear of litigation, and underuse where it may be needed but is not available or easily accessed in low income countries.

'However, in most cases, there is no absolute indication. The decision to perform a caesarean section involves balancing multiple risks: short- and long-term, maternal and foetal, for and against performing the procedure. ***Judging the balance of these risks for an individual woman in many ways requires more skill than performing the procedure.'***
(Editor's emphasis)

Smith GCS (2014) Variation in Caesarean Section Rates in the US: Outliers, Damned Outliers, and Statistics. PLoS Med 11(10): e1001746. doi:10.1371/journal.pmed.1001746

So, surely, in order to support healthier births and improved outcomes in all settings, we need to look beyond the rhetoric of risk, which stifles women's potential, and implement known solutions to improving women's health while at the same time providing more honest education that strengthens self efficacy and empowerment. All women have the right to be properly equipped both mentally and physically to play an active key role in self determination that impacts on improved health both physically and emotionally as well as spiritually; not just for her but for the wellbeing of her whole family.

In Elizabeth Prochaska's (English barrister and a founder of the organisation Birthrights) lecture on human rights violations I would suggest that several of Sarah's human rights had been violated as follows:

- Non consented care – what is consent when fear is engendered by non compliance
- Misinformed care – not outlining risks of augmentation after ruptured membranes or risks of time constraints
- [possible] Discriminatory care – 'She's done all the classes and you should see her birth plan!'
- Abandonment – epidural sited and waiting.....

In conclusion

Sarah's story parallels some of the themes that came from the ICM Congress. It painfully demonstrates the contrast between the reality and the rhetoric. I know without a shadow of a doubt that it could have been very different for Sarah. She may have had a caesarean anyway but she may well have not. We will never know that. What we do know is that she stood little chance against the hegemony of risk averse management of labour that puts the needs of the professional and the organisation before the needs of women 'just in case'. She wasn't given the time to enable her body to continue to do what her body had already started to do after her membranes ruptured spontaneously. The hormone drip and the epidural, the stress and the feeling of disempowerment ultimately led to her not being able to birth her baby unaided. In short, we have a live mother and baby but we also have a new but *'disappointed'* mother who will need time and support to assimilate what has just happened to her and to know that she is not to blame.

Helen Shallow

Helen is currently registered at UWS for her PhD study exploring what happens to women when their labour starts.

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Luke Zander and Michel Odent at the Maternity and Newborn Forum, 25 November 2014, report on page 19

© Becky Reed

The filming of birth

Gill Boden looks at the human rights issues around maintaining women's privacy and dignity

Giving birth is usually a private act attended only by invitation, and there are many good reasons why this should be the case. While the recent fashion for hospital birth in some parts of the world has modified the notion of privacy by extending it greatly, this nevertheless remains most people's belief and wish.

Sometimes women allow photos or films to be taken for private use or sometimes to be shared with those they choose but the recording of birth for commercial gain is not something we are used to. This does not mean that it has never happened before: Jennifer Worth, for example, recalls her shock as a young and naïve midwife in her autobiography, Call the Midwife, when she realises that men were paying to watch birth taking place in a brothel in a particularly 'seamy' part of East London.

This changed with One Born Every Minute, (OBEM), a television programme, which became a 'must-watch' for pregnant women in the UK: birth became regular prime-time family entertainment. Our attention was drawn to it by midwives unhappy about the kind of midwifery portrayed as the norm, but also by women who were dismayed to find scenes showing unkind treatment by staff, disrespectful spouses acting up for the cameras and women clearly in distress. One scene in particular caused great concern: a very young woman refusing a vaginal examination but her wishes being ignored so that she was in effect assaulted in front of the camera for our entertainment. At this point I wrote to the Royal College of Midwives (RCM) and spoke to the Nursing and Midwifery Council (NMC). Realising from my own experience of childbirth that many health professionals have perforce become accustomed to the lack of privacy almost inevitable in a hospital setting I carefully worded my question to the NMC. I asked what action a regulator would take against a Head of Midwifery who was found to have put a one-way mirror into a birth room and charged people for watching women giving birth, which is in effect what was happening in Southampton and Leeds. I can report that, worded in this way, my question caused some consternation and I was promised that the matter would be taken up with the Department of Health.

In AIMS we have been unhappy about this programme since 2012: not for the first time as Channel 4 once screened live births and we wrote to ask whether they would stop this if, as is possible, the first death occurred on screen; the series subsequently stopped, but OBEM has been without a doubt the most high profile programme.

There has been controversy, and many maternity units have not agreed to filming taking place in their unit. Gwent, for example, was one of the first to be approached and refused, others did not, but up until now there has not been a series filmed in Wales of OBEM. I want to tell the story of what has been happening in Cardiff since talks took place between Channel 4 and the Cardiff and Vale Trust during early 2014. Many midwives and obstetricians privately expressed their unhappiness, but employees of the trust were unwilling to make their views public: possibly because of an unwillingness to confront senior management but also, I think, because of a difficulty in framing their objections. As some said, the women filmed have given their consent and made the choice, so, as health professionals, their job is to accommodate the women's wishes and overcome their own discomfort. I was asked to write on behalf of women using the service. I did so, invoking a midwife's duty of care to ensure privacy and dignity and the difficulties raised when commercial motives conflict with this; I also mentioned bad publicity for midwives and I pointed out that a woman, especially having her first baby, might not have been made aware that the presence of a film crew might be expected to have an impact on the progress of her labour and so her consent might not be properly informed. I received a reply noting my concerns. Talks however seemed to go on. I wrote again, this time invoking the law and this is an excerpt of my letter:

… I'm very glad that you are taking a cautious approach to filming OBEM and taking the views of service users and midwives into account. I won't repeat the views of the two main childbirth organisations as I am assured that you are aware of them, but I would like to bring in the dimension of equality.

The Public Sector Equality Duty obliges LHBs [Local Health Boards] *to promote equality for people with protected characteristics both in employment and provision of services, and pregnancy and maternity is a protected characteristic. It is arguable that for a maternity service to ask a woman shortly before giving birth at its hospital to agree to being filmed could result in a negative impact at a vulnerable point in a woman's life. I understand that all women would give their individual consent but the fact that the LHB/NHS has invited the programme makers may suggest to the woman that there will not be negative impacts on her or her family: this of course cannot be guaranteed. A 'legitimate objective' could override any negative impact but I can't imagine what legitimate objective could be cited here. Do you have an equality impact assessment and does it suggest a possible legitimate objective?*

OBEM has already been filmed in at least two maternity units in England and while there has been considerable disquiet there has not been a legal challenge, but in Wales the Public Sector Equality Duty is more demanding and complex than in England: the Welsh Government has decided to set the bar higher. I am aware that the EHRC [Equality and Human Rights Commission] *is exercised about the negative impact that certain programmes are*

having on sections of the community and are in discussion with OFCOM [Office of Communications] *about this at the moment.*

If you are still considering going ahead with the filming of this programme would you send me a copy of your EIA [Environmental Impact Assessment]*? You might also find it helpful to have a discussion with the EHRC about this matter.*

My letter does not mean to suggest that women cannot make their own decisions about who is present for their birth or who watches it subsequently. I feel strongly, though, that cash strapped hospitals should not make arrangements with film companies or any other commercial enterprise that women, some of whom will be vulnerable, have to refuse. To date there has been no filming of OBEM in Cardiff.

Gill Boden

A gathering storm

Elizabeth Prochaska looks at birth rights in the United Kingdom

Only five years ago, few had heard of the concept of human rights in childbirth. While access to life-saving maternity services had been cast in terms of maternal rights, human rights law had rarely been recognised as a source of respectful care or choice in childbirth.

Then in 2011, the decision of the European Court of Human Rights in Ternovszky v Hungary, enshrining women's right to choose where to give birth, ignited the human rights in childbirth movement that has now taken off around the world. Organisations have formed in Europe, the United States, South America and Australia to promote women's birth rights. In September, the World Health Organisation[1] issued a statement, inspired by the White Ribbon Alliance Charter for Respectful Maternity Care, on the prevention and elimination of disrespect and abuse during childbirth and recognised that dignified and respectful care are essential to women's health.

The attraction of human rights to campaigners seeking to improve maternity care lies in its universality and the practical, legal strength of human rights values of dignity, autonomy and equality. These values offer a powerful means to improve maternity care. The notion of dignity enriches relationships between women and caregivers by focusing on basic principles of human worth, autonomy, respect and compassion. As a legal principle enshrined in human rights law, dignity has real teeth, compelling respectful healthcare that takes account of every individual's choices. Human rights do not prioritise one way of giving birth over another – a decision to freebirth or a choice of caesarean section are both recognised as choices that reflect each individual woman's autonomy and vision of a good birth. As more recent judgments of the European Court show, including Konovalova v Russia[2] on the participation of medical students during birth, the fight for birth rights is likely to intensify and take in multiple aspects of women's birth experiences.

In the United Kingdom, AIMS has been promoting women's rights in childbirth for many years. Since 2013, it has been joined by Birthrights, which was founded with the explicit aim of using human rights law to promote the rights of pregnant and birthing women. In its first two years, Birthrights has advised hundreds of individual women and health professionals on the law relating to maternity care. Enquiries to Birthrights reveal that many women in the UK do not have access to services of their choice and face disrespectful and obstructive treatment when they challenge the care that they are offered.

The Birthrights Dignity Survey in October 2013 showed that childbirth can have a profound impact on women's self-respect and relationships with their babies and partners. As the White Ribbon Alliance[3] has said *'women's experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma.'* Respectful care during birth is fundamental to ensuring that women enter motherhood with resilience.

In 2015, Birthrights will continue to promote women's rights through advice, training and research. It is collaborating with Bournemouth University on a project to investigate the experiences of women with disabilities, who are known to face particular obstacles to respectful maternity care. In the spring, the British Institute for Human Rights and Birthrights will be publishing a Human Rights Guide for Midwives. The Guide will provide in-depth explanation of human rights principles and the law illustrated with case studies based on enquiries that Birthrights has received. It will be made available to every midwife in the country and training will be offered by Birthrights and the BIHR (British Institute of Human Rights) to NHS Trusts. The Guide and the principles it espouses offer one means for midwives and the women they care for to challenge the culture of depersonalised care and to put meaning back into that often hollow phrase, 'woman-centred care'.

Elizabeth Prochaska

Elizabeth is a founder of Birthrights, www.birthrights.org.uk

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Article

Guilty until you prove your innocence

Beverley Beech reports on why Child Protection does not work

Child Protection has become a monster that is slowly and assiduously gobbling up children, and especially babies. The measures taken to manage the imperative to deal with abuse of children in the home have paradoxically put at risk trusting relationships between parents and the professionals who could help them.

Mothers, especially in the very early months, have ideally been supported to protect their own children by their families, with the aid of known and trusted midwives, health visitors and other professionals. They have been helped when they cannot do so and only in the most extreme of circumstances relieved of this task. The pressures on the helping professions, the fragmentation of services and a risk averse culture have undermined this model. Multi agency working with the sharing of information about individuals and families has the potential to enhance the help supplied: however, this carries its own risks within a culture of enforced reporting of concerns and a systematic undermining of professional autonomy over the last decades. Defensive reporting of families by professionals who feel the need to protect their own jobs has become more evident. We have even seen clear evidence of punitive reporting by professionals who are put under pressure to persuade families into conforming without the power or the right to do so.

culture of enforced reporting of concerns and a systematic undermining of professional autonomy

While the NSPCC and other children's agencies are quick to publicise threats to children, they appear not to be interested in the families damaged by false allegations of abuse. While without doubt, there are families where the abuse of children is such that removing the children is the only option, other families, beset by poverty and stress, need real support. Added to that are those families where the child has an underlying health problem, wrongly assumed to be caused by abuse – such as the *'shaken baby syndrome'*.

Women have had their babies removed from them in the labour ward or within hours of the birth.[1] One mother had her baby taken before she had delivered the placenta. The action was on the spurious grounds of previous *'concerns'* and it took court action and eighteen months before she was re-united with her baby. Women have been reported for *'refusing an ultrasound examination'* or *'failing to attend an antenatal clinic'*. Neither of these services is obligatory, (and ultrasound may be harmful to the baby).

families damaged by false allegations of abuse

The right to a family life under Article 8 of the Human Rights Act is conveniently and repeatedly ignored.

While many professionals assure themselves that they are acting *'in the best interests of the child'* they seriously underrate the probability of serious long-term psychological damage for a child who has been removed from its home and cared for by multiple foster carers. In the early months babies become primarily attached to their mothers, they are not blank canvases: they are sensitive, aware, and intelligent human beings and no-one can ask them whether or not they were anxious about being suddenly removed from the person who has been their sole companion for at least the last nine months of pregnancy. The kind of long-term damage caused is suggested by the fact that the majority of teenagers in the prison system have been in out of home care and social exclusion units.[2,3]

The rights of parents to determine the care of their children are now undermined not only by the actions of professionals but within the public domain generally. In the case of Ashya King, a child with a brain cancer who was being treated in Southampton General Hospital, there was a disagreement between the parents and the doctors about the most appropriate treatment. The doctors told the parents that conventional treatment would leave their son with serious special needs so the parents decided to discharge their child (as they had every right to do) and take him to receive proton-beam therapy treatment in Prague – criticised by some as 'doctor shopping'. The reaction of the hospital doctors was to inform social services who immediately applied for

Clearly, no-one considered the emotional impact on a five-year old child isolated in a strange room attended by people who spoke a different language

Ashya to be made a ward of court. The police then issued a European Arrest Warrant. The press reported that his parents sparked an international manhunt after removing him from a Southampton hospital without doctors' consent,[4] despite the fact that they did not need the doctors' consent and had every right to remove their child and take him elsewhere for treatment.

One does not know what social services, the judge, or the police were told but they clearly had the impression that Ashya would be harmed by being removed from the hospital and driven across Europe. One hopes that in time those who misled the court into believing that the child was in imminent danger will be identified and action taken.

The family was tracked down in Spain. Ashya was taken to hospital and deprived, for five days, of any visits from his parents. How can a five-year old understand that his parents are missing because they were not allowed to see him, and what possible damage could they do were they allowed access? Clearly, no-one considered the emotional impact on a five-year old child isolated in a strange room attended by people who spoke a different language. Eventually, further court hearings occurred, common sense prevailed, and Ashya was taken to the Czech Republic to receive the treatment his parents wanted. Did anyone give a moment's thought to the impact this experience had on Ashya, his four brothers and sisters, and his parents? Whatever the rights and wrongs of his parents' actions, how could it be in Ashya's best interests to be separated from them in such circumstances?

In the appeal the Judge remarked:

'it is a fundamental principle of family law in this jurisdiction that responsibility for making decisions about a child rests with his parents. In most cases, the parents are the best people to make decisions about a child and the State – whether it be the court, or any other public authority – has no business interfering with the exercise of parental responsibility unless the child is suffering or is likely to suffer significant harm as a result of the care given to the child not being what it would be reasonable to expect a parent to give.'[4]

What is the financial cost of Child Protection?

Child Protection is a huge money earner and this means that decision making is not financially unbiased. Last year over 4,000 babies in the UK were placed on the 'At Risk Register' before they were born and hundreds are taken into care soon after. Without doubt some of those babies were truly at risk, but many of them were taken for very questionable reasons. Conflicts of interests, where decision-makers stand to benefit financially from the decisions they are making, can seriously bias decision-making.[1] Very large financial interests are in play. Williams[2] has suggested how some of these financial processes operate:

'After 20 years of outsourcing, the bulk of children's homes are run by private companies, with money sucked upwards into one or two private equity companies, GI Partners or Bowmark Capital or BairdCapital. Two-thirds of fostering provision is controlled by the private sector. Only 11% of children's homes are run by charities; the third sector started off quite big in children's care, as you'd expect, meeting local-authority contracts by spending their own reserves. Eventually, though, the private sector underbid them, and they went bust or moved into other services.

'Having whittled down the competition, the private sector became eye-poppingly expensive: £200,000 is actually a low estimate, based on overall spending of £1bn on 5,000 children in residential care homes in England. In 2009, it was leaked that CastleCare, which runs 40 homes in Northamptonshire, was charging £378,000 a year for a residential place. This would be money well spent if the care was brilliant, but it isn't. Only 2.5% of children's homes have an Ofsted rating of "outstanding"...'[2]

The cash flow does not stop there. Many psychiatrists, paediatricians and lawyers are earning huge fees giving councils the opinions they want. Give the wrong opinion and they are not asked again. Add to that the money paid to foster carers, care workers and social workers the costs are eye watering. Who benefits? Certainly not many of the babies and children. Indeed, if some of the money was spent on supporting families, it could have long term benefits for families and society, and cost less.

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once I have jumped through one hoop they give me another

Ashya's is a high profile case in a long line of babies and children having been taken from their parents on the spurious grounds of *'acting in the child's best interests'*. Last year AIMS advised a woman to go to France to avoid having her baby removed at birth. A warrant was issued and the baby was removed shortly after the birth in a French hospital. Fortunately, the mother had an excellent French lawyer and local support. She was encouraged to visit her baby for prolonged periods daily (unlike in the UK where too many social workers and foster carers do their utmost to restrict the mother's access) and was, some weeks later, permanently re-united with her child. The Court recognised that she posed no danger whatsoever to her baby. She had been able to show the court that the social services report was largely fictitious and over-dramatised – in short, social services lied. The French Judge was said to be appalled when she read what had really happened. Unlike social services in the UK, the French social workers were very supportive and have done all they can to help the couple deal with life in a country where they do not even speak the language.

This case is not unusual. It is common for women to be reported to social services when they do not *'comply'* with local services. In a recent case, the mother was reported for *'failing to attend'* an antenatal appointment. This was interpreted by the social workers as an example of the mother failing to put the best interests of her baby first, and justification for two years of monitoring, frequent unannounced visits, bullying and intimidation from her local social workers, some of whom were not even on the register. Fortunately this mother moved to another area where the local social workers immediately removed her from their list as they did not find any justification for their involvement. Hooray for them.

Our regular and increasingly frequent requests for help due to threats of referrals to social services are echoed by the work of Forrester et al[5] who found that:

'Overall social workers tended to use a very confrontational communication style. This was so consistently observed that it is likely to be a systemic issue. [...] insufficient attention has been given to the micro-skills involved in safeguarding children and this is an urgent priority for future work.'

Now that we have *'joined up'* services we have the unintended consequence of two professions not necessarily using each other's language in the same way. We have a combination of overstretched midwives without the time to develop a relationship with a woman during her pregnancy believing that if they have a *'concern'* they have to refer, without the resources properly to get to know or support the family, and social workers interpreting the *'concern'* as evidence of possible abuse. One tragic consequence is that while a woman is most at risk from intimate partner abuse when she is pregnant she is now likely to be afraid to confide in her midwife – for good reason. Too often the action is not to support the mother, to offer services that could help her situation and empower her, but to report, monitor, check, criticise, and change the goal posts as often as possible. As one mother remarked, *'once I have jumped through one hoop they give me another'*.

We must question whether our high levels of children in care and compulsory adoption [forced by the courts despite opposition from the parents] is really of benefit to the children and families involved – especially as more and more evidence of the subsequent abuse of *'looked after'* children is made public. Our social care system is not only broken, it is sick and it will not be cured until there is an overhaul that really puts the family at the centre of care; provides real care for those in need; provides an educated social services work force; and spreads the truly supportive initiatives that were developed in the USA,[6] initiatives which are beginning to be introduced in some areas of the UK.

Beverley A Lawrence Beech

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Human Rights in Childbirth Conference 2016

The organisation, Human Rights in Childbirth is hosting its 5th Human Rights in Childbirth Conference in January 2016 in India (its first conference took place in the Hague in 2012). Its mission is to *'advocate for the recognition – in policy and reality – of every birthing woman's fundamental human rights.'* More information about HRiC and what it does can be found at humanrightsinchildbirth.com.

Why is it so hard?

Colm OBoyle explains how the HSE removes agency, making homebirth in Ireland so difficult

Homebirth midwives in Ireland feel under threat.[1] This is due to a combination of historical factors and recent changes in legislation with regard to professional indemnification. For those unfamiliar with Irish health and maternity services, a very brief historical overview is necessary to situate midwifery and homebirth and give some context. With that background then, the consequences of EU requirements for clinical indemnification will be considered.

Organisation of health care

Ireland became a free state in 1922 and a republic in 1948, just at the point when the NHS was being inaugurated in the United Kingdom (UK). However Ireland's health services did not follow the UK, free at the point of use, model. The Health Service Executive (HSE) is the executive arm of the Irish health service and implements the policies developed by the Department of Health (DoH). The HSE charges for admission to accident and emergency departments and for hospital stays. General practitioners (GPs) are regarded by the HSE as private practitioners and, although the primary gatekeepers to all other health services, they also charge for visits. There is, therefore, no free national health service in Ireland.

There is a means tested medical card system that enables free access to GPs and public HSE services for the financially most vulnerable. Private medicine and private health insurance are and have long been integral to the Irish health service. There are some private hospitals in the State but most 'private' beds and services are located within public hospitals. Maev-Ann Wren[2] has written about how the private system can be characterised as parasitising upon the public health services.

How maternity care is organised

Maternity services similarly have been historically divided into public, private and semi-private care. Only recently (1991) have maternity services became freely available to all women, which means many women still use private health insurance to pay for obstetric antenatal care and private postnatal beds in public maternity hospitals.

Most babies in Ireland (over 99%) are now born in consultant led obstetric hospitals, and so maternity services are largely funded under the HSE acute hospital services sector. Early transfer home (ETH) and DOMINO (Domiciliary in and out) schemes, are not yet widely available and where they are, are often developed as a means to ease pressure on busy hospital services. There are only two small midwifery led units (MLUs) in the North East of the country. The National Maternity Hospital's (NMH) Community Midwifery Scheme provides a DOMINO and homebirth service but only in a small area of south Dublin. Primary care generally, but maternity services and community midwifery particularly, have been recognised as being sorely underdeveloped in Ireland.[3,4,5] With maternity services being so dominated by acute hospital provision there seems little scope for expansion of community midwifery except through the development of hospital outreach schemes. Unfortunately though, it is not easy to develop these schemes without diverting resources away from the already stretched hospital sector.

The Maternity and Infant Care Scheme (MICS)[6] which facilitates shared GP/hospital antenatal care is funded from the HSE Community (primary care) budget. Many women use this free and integrated GP service which includes a six-week postnatal check for mother and baby. There is, however, no national community midwifery service and so postnatal services are otherwise provided by public health nurses who have considerable other nursing service demands that take priority.

Homebirth provision?

Despite mid twentieth century health service policy recommendations for hospital birth, the public private mix within Irish health services provision allowed the payment of 'grants' to pay for homebirths. Fewer than 20 independent midwives, now known as Self-employed Community Midwives (SECMs) continued to provide homebirth services, but some (no one knows how many) women were unable to access a homebirth. In 2003, several mothers took the HSE (then known as the Health Boards) to court demanding homebirth services. The Supreme Court[7] ruled, however, that the HSE was not obliged to provide homebirth and, essentially, that they could deliver whatever maternity services they saw fit. The High Court in 2013,[8] reaffirmed that ruling stating that the HSE was not required to provide home VBAC not only on the basis of the 2003 ruling, but because the HSE could be obliged to accept liability for births it 'reasonably' considered a risk.

This summary of the historical context of midwifery, maternity and homebirth services in Ireland sets the scene for the next section which considers professional indemnification.

Controlling and restricting midwives' practice

This section brings together two elements, first the withdrawal of trade union indemnification for homebirth in 2007 and second the Nurses and Midwives Act which came into effect in 2011.[9] The mechanism that apparently 'rescued' homebirth midwifery in 2007 became, as a result of the 2011 legislation, a means by which homebirth midwifery practice could be systematically controlled and restricted.

In 2007, on the recommendation of its underwriters, the Irish Nurses and Midwives Organisation (INMO) trade union withdrew professional clinical indemnification for

Demonstration in support of Philomena Canning (SECM) – see also readers' forum (page 25) and news (page 27)

homebirth midwifery – just as the Royal College of Midwives (RCM) had done in the UK in 1994. In response to concerns at this withdrawal, the HSE in a rushed consultation set up a memorandum of understanding (MOU) with the SECMs which tied State indemnification of their practice to very low risk women only.[10] That consultation document is still not publicly available on the HSE repository site LENUS and many of the issues and recommendations raised in the consultation remain unresolved. The HSE homebirth criteria are more restrictive than those in the UK NICE Intrapartum Guideline regarding choice of place of birth.[11] For example, some women who are seen to have medium risk conditions are deemed by the HSE to be unsuitable for homebirth at all. Some women with other conditions require consultant obstetrician approval for a homebirth, which 'approval' is difficult to obtain. By restricting midwives access to indemnification, the HSE effectively forbids midwives from attending any woman not deemed 'suitable' by the HSE. The HSE thereby dismisses the principle of women's informed choice and entirely ignores women's reasons for choosing homebirth or avoiding hospital birth.

In addition, SECMs have now to have three years post-registration experience prior to HSE 'approval' but without any indication of the relevance of that experience and without regard to the fact that each midwife at the point of registration must be competent to care for healthy low risk women in any setting. To add further unnecessary obstacles to women's choice the HSE has decided that there must be two such experienced midwives at each homebirth. The HSE has steadfastly resisted SECMs' claim that three years' experience is excessive for a second or on call support midwife. By making its service entirely dependent upon the very small numbers of SECMs in the country (fewer than 20) and by requiring them effectively to 'double up' the HSE has seriously restricted women's access to its notionally 'national' service[12] as well as seriously restricting SECMs' ability to practice and earn a living. The HSE's stated commitment to choice and flexibility is entirely at odds with its decisions about SECMs' autonomous practice. The HSE acknowledges that there is neither adequacy nor equity in its homebirth service but presents this in terms of resource constraints and safety.

'... the provision of choice in relation to same must be balanced with an over arching concern for safe practice, acceptable levels of risk, evidence based care and resource constraints.

'It is acknowledged that the proposed system will not immediately provide for equity of access on a nationwide basis. However what it does do is provide a framework that can be applied to enable choice,'[10]

Ireland has been a member of the EU since 1970 and so is subject to various EU legislation including directives on midwifery education, regulation and other directives such as those regarding limits to working hours and professional indemnification. EU directive 2011/24/EU, on patients' rights in cross-border healthcare, requires health care professionals to have liability insurance.[13]

In 2011, the Nurses and Midwives Act once more recognised midwifery 'as a distinct profession' in Ireland. It however made explicit the requirement that midwives have 'adequate clinical indemnity insurance' (section 40:1a) and criminalised uninsured birth attendance by midwives, resulting in significant fines or imprisonment. Irish midwives (and nurses and doctors) working within HSE hospitals and services are indemnified through the State Claims Agency (SCA) Clinical Indemnity Scheme (CIS).[14]

Midwives, as independent practitioners, are no longer able to obtain indemnification through their trade union membership, or on the open market. Midwives can now only attend women if they accept the MOU and sign a contract to work within the HSE's 'National homebirth scheme'. Furthermore, as the scheme makes provision only for planned homebirth, women no longer have access to SECM-led antenatal, DOMINO or postnatal care.

Cost of compensation now limits birth choice

Financial considerations take precedence over women's decisions. Professional indemnification against claims of financial compensation for loss, has become integral to contemporary definitions of professionalism.[15] The consequences of concern for indemnification reflected in EU directive[13] and Irish legislation[9] were highlighted by High Court Judge Ms Justice Iseult O'Malley in the case between Aja Teehan, a mother seeking a vaginal birth after caesarean section (VBAC) at home (sometimes abbreviated to HBAC) and the HSE which would not provide for it.[8]

'As I see it, the issue of insurance is at the heart of the problem. In the modern era it simply is not possible for medical practitioners dealing with the field of childbirth, whether midwives or obstetricians, to practice without insurance. ... Once that is accepted as a factor, it follows that if a particular service is to be provided, someone must be prepared to bear the potential liability. ... if something does go wrong in childbirth, the consequences may be, not only immensely tragic in human terms, but also extremely expensive in financial terms.' (paragraph 90).[8]

Consideration of financial risk and loss now overlay the already pervasive discourse on clinical risks. Neoliberal market concerns have come, yet again, to be implicated in the control of individual and professional freedoms. In this case, it is the professional autonomy of midwives and the birthing autonomy of individual women that have been restricted. Of most concern, I believe, is that this restriction has been characterised erroneously, as being in the name of 'protection' of women. Compensation for loss cannot, logically, be considered a protection from harm in the first instance. Women's birth choices (dare I say rights?) have been further restricted by constraining those midwives who would facilitate their choice. Ironically, this constraint is couched in the name of protecting women's need for, and 'right' to compensation.

Women and midwives must stand together

What the legislative requirement for indemnification, and the HSE's monopoly on its provision, have done is to give the HSE almost absolute control over midwives' practice and on terms that neither serve women nor promote midwifery professional autonomy. The HSE has effectively driven a wedge between women who want homebirth and the midwives who would attend them.

I must declare that I am a member of the INMO midwives section, and have been a homebirth midwife (SECM) who has had an MOU with the HSE. I have also served on the HSE National Steering Committee for Home Birth (NSCHB), which 'steers' the HSE homebirth scheme that I have critiqued. It is despite my presence at these various fora and despite my, and many others' representations to the INMO, the HSE and the DoH, that the decisions about the initial withdrawal of indemnification and that subsequent arrangements for homebirth midwifery have taken place. I must accept some responsibility for being unable, then and now, to adequately represent women's, my own and broader midwifery concerns at these developments.

Given the very many and very public cutbacks to government spending including to the health services, the prospect of women's birth choices coming anywhere close to the top of the DoH and HSE agenda seems slim. It is important, however, not only to critique the status quo but to articulate an alternative vision. I believe women and midwives must continue to be represented at the level of maternity policy development. Midwives must continue to stand with women collectively in the perpetual search for decent maternity services.

Colm OBoyle

Colm is a midwifery lecturer in Trinity College Dublin with a specific interest in homebirth and was until recently, a homebirth midwife.

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Northern breech conference: Breech birth – making choice a reality

26-27 September 2014, Sheffield

A few months ago, whilst I was struggling to think of basic antenatal scenarios for teaching first year midwifery students, a colleague diagnosed me with 'obstetric thrush' and advised me to 'recolonise my midwifery flora'. After almost four years working primarily in a hospital labour ward it seemed that my brain had been saturated by thoughts of obstetric intervention. This troubled me, as I definitely view birth as a normal physiological process. I have a strong woman centered philosophy, with a staunch view of the importance of informed choice.

Luckily, I was already planning to attend the North of England Breech Conference in Sheffield the following weekend. It may initially appear that a conference about breech birth, defined in midwifery education as a 'malpresentation'[1] and taught widely as an obstetric emergency,[2] would seem a strange place to get back in touch with midwifery. However, I did exactly that.

Organised by the Sheffield Citywide 1-1 team, a small team of incredible midwives, with the support of their Head of Midwifery Dotty Watkins, and consultant obstetrician Julia Bodle (who I suspect was a midwife in a former life) the conference was, in a word, inspirational.

The midwives in the 1-1 team, Helen, Sarah and Nicola, with obstetrician Julia Bodle, offer a 24-hour on call service, for women who are planning a vaginal breech birth at term. This service ensures that women are supported by birth attendants who are skilled in vaginal breech birth, a key contributory factor in ensuring a safe outcome for mother and baby.[3]

Jane Evans and Frank Louwen, speakers at the Northern breech conference

© Ben Dresner Barnes

Perhaps the clearest message from the conference was the importance of this multidisciplinary working. Poor multi-professional team working and lack of communication have long been highlighted as contributory factors to substandard care in the past.[4] There were numbers of excellent examples of how midwives and doctors have been working in partnership with excellent outcomes.

The conference included inspiring keynote speakers, presenting and also facilitating hands on teaching sessions. We also heard directly from families who had been cared for by the Sheffield 1-1 team. It was very powerful to have women and their partners speak directly about their experiences of informed decision-making (before being referred to the Sheffield team, one woman's consultant obstetrician opened his diary and asked her on what date she would like her caesarean section). Hearing these families speak so openly and honestly about their experiences made the whole conference 'real' – women want and deserve choice, and should be the key decision makers in plans for birth.

Informed choice is not only a basic human right but has also been a government commitment in relation to maternity services for many years.[5, 6] In 2014, over twenty years since Changing Childbirth was first published, lack of informed choice for women with term, breech presenting babies is surely completely unacceptable. As Benna Waites, a clinical psychologist, so eloquently explained, it is a physician's obligation not to eliminate risk but to help people weigh risk, benefit and potential harm, informed by the best scientific evidence.[7]

The so-called scientific evidence informing care for breech presenting babies has a lot to answer for. The Term Breech Trial[8] meant that almost overnight women were strongly encouraged to 'choose' caesarean section as the safest thing for their baby. The flaws of the Term Breech Trial have long since been highlighted[9] and two prospective trials have since demonstrated that vaginal breech birth at term, in the right circumstances, is a safe option.[10, 11]

The conference was not about promoting vaginal breech birth, but sharing evidence and teaching the skills to give midwives and obstetricians the confidence to support women who do choose vaginal breech birth. Hearing experienced independent midwife Jane Evans speak so calmly and confidently about facilitating breech birth highlighted the importance of the midwifery profession maintaining the knowledge and skills required to support women who make this choice. Professor Frank Louwen, from Frankfurt, Germany, has been supporting women to birth breech babies in upright positions for the last seven years. His skills and knowledge were awe-inspiring, but equally importantly,

The Royal College of Obstetricians and Gynaecologists (RCOG) has said since 2006 that women should have the choice of a breech 'delivery' – but this often meant the woman lying down and having an epidural and forceps. It is currently considering evidence on the benefits of women giving birth to healthy, term breech babies in upright positions and its new guidance on breech birth should be out soon.

As well as the Sheffield conference, you might like to see this comprehensive write up of two other breech conferences which provides some of the thinking and research behind this potential sea change in practice breechmidwife.wordpress.com/2014/10/19/rcog-and-oxford-breech-conferences-october-2014/

the way he and 'his midwives' worked in partnership, with each other, and with women was evident throughout his presentation.

The message is clear. Midwives and doctors need to work together, to provide safe, multi-disciplinary care for women with breech presenting babies. We cannot make caesarean section, through our own skills deficit, the only viable option for women. Women need unbiased information and support from those involved in their care. This is the only way to keep safe vaginal breech birth alive, develop and maintain our skills, and make choice a reality again. Sheffield, I salute you.

Sophie Whitecross

Sophie is a midwifery lecturer at Swansea University, and also practices as a midwife in Swansea.

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Looking back to the future

Maternity and Newborn Forum, 25 November 2014, Royal Society of Medicine (RSM), London

Luke Zander opened the conference by telling those present that the purpose of the various fora set up by the RSM was to bring different voices into debates about specific topics and move away from the concept of expert/audience. Interestingly only the Maternity and Newborn Forum (set up in 1983) has survived, I suspect largely to do with Luke's passion and his interest in and respect for others' views.

Michel Odent gave an excellent presentation about how current research is challenging outdated views and practices. For example, we now know about the need for immediate emotional and physical contact between mother and baby after birth in order to promote bonding and health giving microbial transfer, and about the harmful impacts of unnecessary pre-labour caesarean section and uterotonics. He stressed that the birthing woman cannot be 'helped', as birth is an involuntary process, but that she must be protected from inhibitory factors. Becky Reed, Kathryn Gutteridge and Becky Brien then described models of midwifery care that do just this – in the case of the Albany Practice and the Serenity and Halcyon Birth Centres – spectacularly well. Susan Bewley continued the theme describing the skilled doctor as one rooted in relationships and life-long learning and urged us to move away from risk and blame. Cathy Warwick also advised a move away from rule bound practice and focusing on single issues – trying to 'fix' them, towards relationships and thoughtful care. Elizabeth Prochaska agreed that the only way to improve care is through social models of maternity care. Being *'stuck in a risk matrix'* prevents improvement and destroys clinicians' abilities to provide good, individualised care and undermines women's decision making. She suggested ways in which human rights can support women and midwives. Commissioner of maternity services, Diane Jones, gave an in-depth presentation on the extremely complicated commissioning structures which by comparison demonstrated why we need a publicly funded NHS with structures that support the care we know works, improves outcomes and is what women and midwives want: structures that local communities can feed into developing and that are understandable and fully accountable. The current commissioning system supports a fragmented, private system of health care. It cannot possibly support the kind of integrated care described by Becky, Kathryn and Becky, that all women need.

Nadine Edwards

Group B Strep explained

AIMS Talk by Sara Wickham, 26 November 2014, The Watershed, Bristol

A lively group of midwives, doulas and birth activists met to hear Sara Wickham introduce the new AIMS book Group B Strep Explained one cold winter evening in central Bristol.

Sara started her talk by thanking the whole team at AIMS who had worked so cooperatively to bring this new and long awaited book to birth. Always insightful, Sara started her talk with a critique of the hold the medical model has on our understanding and conceptualisation around the issue of GBS and birth. Challenging the widely accepted personification of the bacteria as though it were sentient and intentionally engaged in a war against women and babies, she discussed an article which pointed out the loaded and bellicose language we all use, often without considering the effect this must have on women and their supporters: language such as 'colonisation', seeing GBS as an 'enemy' with 'attack rates', seeking to 'colonise' women's bodies and 'kill' their babies.

Sara described how global rates of GBS carriage vary from less than 2% to around 23%, though why this should be is uncertain. In the UK, our carriage rate is 18.1%. Of the babies who are born to women who are carrying GBS, about 50% will carry detectable levels, but only one baby in 2,000 will develop a GBS infection. Of babies who develop an infection, as opposed to carrying detectable bacteria levels, with prompt treatment seven out of ten will recover completely, two out of ten will have long term issues arising from the infection and one in ten will sadly die as a result of it. This means that, overall, one in 20,000 babies will die from GBS infection. It is also important to note that, healthy term babies have a ten times lower risk of becoming ill than pre-term babies.

As Sara mentioned, global approaches to the GBS issue vary too. Some areas such as the USA and Australia favour a screening programme which tests all women to see if they are carrying GBS, while the UK has adopted a programme which seeks to identify women with risk factors.

Sara explained that as our understanding of our relationship with our microbiomes deepens, concerns are being raised both about the problems of widespread over-treatment of GBS in mothers and babies, which some would argue results in the unwarranted use of intravenous antibiotics, (sometimes outside clinical guidelines for spurious reasons unconnected with maternal and fetal wellbeing). As a society, we must also address the issue of developing antibiotic resistance in the bacteria. Few antibiotics are available to treat infections due to their overuse and no new antibiotics have been developed recently leaving a future treatment crisis on the horizon.

Women's experiences of poor communication from health care providers about these complex and poorly researched issues, reported harassment, bullying and simple incorrect 'shroud waving' strategies are a shocking indictment of contemporary obstetric practice. Giving women good quality, unbiased information about GBS including the risks and benefits of screening and treatment options, and the risks and benefits of declining prophylaxis, and then supporting the choices they make should be central to providing effective and appropriate care.

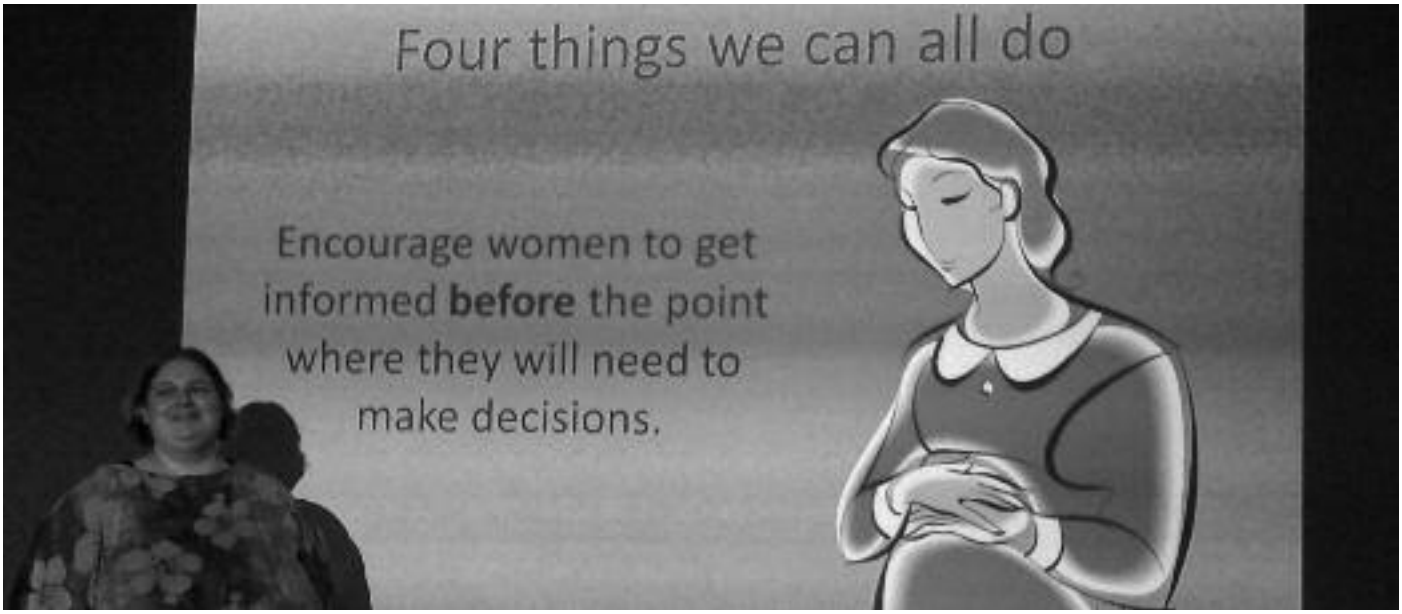
Sara quoted Ina May Gaskin saying 'It's easy to scare women. It's even profitable to scare women. But it's not nice, so let's STOP it!'.

Liz Nightingale, Meg Miskin-Garside and Sarah Ifill
Oxfordshire Midwifery Practice

This book is available on the AIMS website www.aims.org.uk in paperback and kindle editions.

For information on future AIMS talks, please email talks@aims.org.uk

Sara Wickham explaining Group B Strep



New NICE Intrapartum Guideline

Care of healthy women and their babies during childbirth

When I received a copy of this new NICE Guideline I resisted the urge to cartwheel around the room.

Two paragraphs jump out of this new Guideline:

'Explain to both multiparous and nulliparous women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby'

'Explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth'

NICE's decision to update the 2007 Intrapartum Guideline was based on developments in the NHS and the new evidence that has become available since then (such as the Birthplace Study www.npeu.ox.ac.uk/birthplace).

The Guideline is particularly strong on women's right to choose the place of birth. It says:

'Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.'

'Advise low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby'

Furthermore, it states that: Commissioners and providers should ensure that all four birth settings are available to all women (in the local area or in a neighbouring area).

The Guideline also addresses the uncertainty and inconsistency of care not only in relation to place of birth but also during the latent (early) first stage of labour, fetal assessment and particularly cardiotocography (continuous electronic monitoring of the baby's heartbeat) compared with intermittent auscultation (listening in to the baby's heartbeat at regular intervals) and third stage management. It recommends:

'Do not perform cardiotocography on admission for low-risk women in suspected or established labour in any birth setting as part of the initial assessment.'

'Do not perform cardiotocography for low-risk women in established labour.'

But the Guideline does highlight the circumstances when continuous cardiotography should be *'advised'*.

The recommendations for management of the Third Stage of Labour are also welcome, particularly, this statement:

'Physiological management of the third stage involves a package of care that includes the following components:

no routine use of uterotonic drugs

no clamping of the cord until pulsation has stopped

delivery of the placenta by maternal effort.'

It is worth stressing that the above recommendations apply to fit and healthy women, but there are instances where the Guideline covers all women:

'Maternity services should provide a model of care that supports one-to-one care in labour for all women and benchmark services and identify overstaffing or understaffing by using workforce planning models and/or woman-to-midwife ratios.'

Needless to say, the press focused on the 'small' increased risk of an adverse outcome for first babies born at home, which became the focus of public debate. So it is worth mentioning the findings of the Birthplace study of over 64,000 healthy women. This showed that for first babies there was a slightly higher risk when born at home of 9.3/1,000 compared to 5.3/1,000 born in a consultant unit (though the outcomes for freestanding midwifery units and alongside midwifery units for first babies were 4.5/1,000 and 4.7/1,000 respectively). These figures represent 91 adverse outcomes out of 15,000 births (52 adverse outcomes in the 10,541 first babies born in an obstetric unit and 39 adverse outcomes in the 4483 first babies born at home), but the figures only reached statistical significance because they combined, mortality with specific morbidities – such as a fractured humerus or clavical, meconium aspiration syndrome and brachial plexus injury. These are not necessarily life threatening events and if one looked only at mortality there was little difference in the comparison between home and hospital, and those differences did not reach statistical significance. In other words, the very small numbers of mortalities could have occurred by chance.

Importantly, the research also shows that healthy women birthing in obstetric units have a greater risk of having caesarean sections, episiotomies, forceps or ventouse and are less likely to breastfeed successfully – statistics that the press conveniently ignored.

The Guideline makes recommendations for action and it will be interesting to see how seriously the Trusts take these recommendations, and how soon change will occur. It has been 30 years since Marjorie Tew's statistical analysis revealed the safety of birth outside obstetric units. I hope we do not have to wait another 30 years before action is taken on these recommendations to improve care for all women.

If the NICE recommendations are acted upon, the majority of fit and healthy women will have, at last, care appropriate to their needs, and those high-risk women who need the specialised attention of obstetricians will stand a greater chance of getting it; but we should also be aware that there are many midwives who have practised, and trained, in obstetric units and have lost the understanding and skills required when attending normal births, so the Trusts will have to ensure that when they implement the NICE Guideline they also re-educate their midwives.

Beverley Beech

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Maternity care providers' perceptions of women's autonomy and the law

Kruske S, Young K, Jenkinson B and Catchlove A (2013) Maternity care providers' perceptions of women's autonomy and the law. BMC Pregnancy and Childbirth 2013, 13:84
doi:10.1186/1471-2393-13-84

Pregnant women, like anyone else, have the right to make decisions about their health care, including declining medical advice and treatment. They do not need to follow guidelines or policies. But what this means in practice is not necessarily well understood by doctors and midwives, especially if they believe that a woman's decision might harm her unborn baby. This research was designed to find out about doctors' and midwives' *'attitudes and beliefs towards women's right to make autonomous decisions during pregnancy and birth, and the legal responsibility of professionals for maternal and fetal outcomes'*.

Summary of the research

The researchers surveyed 336 midwives and doctors in Queensland, Australia about their views on decision making, women's autonomy and legal responsibilities for poor birth outcomes. Both groups showed *'a poor understanding of their own legal accountability, and the rights of the woman and her fetus*'. They believed the final decision should rest with the woman; but at the same time also believed that the needs of the woman may be overridden for the safety of the fetus. Doctors believed that they are legally accountable for the outcomes of women and babies, despite the legal position which makes clear that health care professionals are responsible only for adverse outcomes caused by their own negligence.

Because doctors and midwives can influence women's decisions, the researchers suggest that it is important to understand their perceptions of women's autonomy, so that women can be supported in their decisions.

The doctors and midwives were asked to rate their agreement with, *'In collaborative practice, working with primary carers, the final decision should always rest with the woman'* and *'Collaboration involves midwives and doctors working together but the doctor is the most competent in making the final decision'*. They all generally agreed that the final decision should rest with the woman, but midwives agreed significantly more often. But with the second statement, there was a significant difference between doctors and midwives: with doctors agreeing that they were the most competent to make a final decision.

They were also asked to rate their agreement with, *'For the safety of the baby, the maternity care team sometimes need to override the needs of the woman'* and *'Encouraging women to have more control over their childbearing compromises safety'*. Doctors agreed that the needs of the woman sometimes have to be overridden, while midwives were neutral. Both groups disagreed that woman having control over their childbearing would compromise safety, but midwives disagreed more often.

Lastly, they were asked to rate their agreement with, *'Legally, doctors are ultimately responsible, even in collaborative models'* and *'The current maternity care system allows all to be legally accountable for their own actions in a collaborative team'*. Midwives disagreed that doctors are ultimately responsible, but doctors believed that they are. Midwives expressed a neutral response to the second statement while doctors disagreed with it.

Both professional groups indicated that they supported women's right to autonomous decision making during pregnancy by agreeing that the final decision should always rest with the woman, but this was not supported by the conflicting view (or neutrality) that women's decisions could be overridden for the safety of the baby.

Previous research suggests that both midwives and obstetricians only support women to make final decisions about an aspect of their care when this agrees with their own preferences and this research supports this. The researchers comment that if doctors erroneously believe that they are responsible for outcomes following the woman's decision, and that if health practitioners do not understand that they are responsible only for the care their provide, it is difficult for them to support women's decisions that they disagree with. They suggest that *'care providers are poorly informed about this subject.'*

The research shows a *'clear ambiguity around clinicians' understanding and beliefs of women's autonomy and the rights of the fetus'* and it is suggested that *'some care providers may need to be supported to reflect on how aspects of woman-centred care may conflict with their broader values and beliefs on the rights of the fetus, and the legal and regulatory responsibilities of health professionals'*. They also call for guidelines to inform practitioners – especially when women make decisions which they disagree with – and *'policy direction on how these concepts can be applied in evidence-based, woman-centred care*'.

AIMS comments

It is no surprise that the study found inconsistencies among practitioners regarding women being decision makers about their care. Nor that midwives and doctors had different views. It does show us what women are up against if they want to make decisions outside the policies, guidelines and medical and midwifery preferences. Not only are they unlikely to get full information, but even if they do, they are unlikely to be supported in certain circumstances. This is an open access article and worth reading, as it shows the tensions around rights and autonomy.

Nadine Edwards

2010 National Maternity Survey

Lindquist A, Kurinczuk JJ, Redshaw, Knight M (2014) Experiences, utilisation and outcomes of maternity care in England among women from different socio-economic groups: findings from the 2010 National Maternity Survey. BJOG 2014. onlinelibrary.wiley.com/doi/10.1111/1471-0528.13059/full

This study looked at *'health care-seeking behaviour and experiences of 5332 women three months after they had given birth'*. It focused on the differences between their behaviour and experiences by socio-economic groups to try and better understand *'why socially disadvantaged women have poorer maternal health outcomes in the UK'*.

Summary

The results show that the poorer you are, the more likely you are to have missed out on care during pregnancy and after birth, and to report poor communication with, and disrespectful treatment from, health practitioners – and that this contributes to poorer outcomes.

AIMS comments

Like the authors of the Saving Mothers' Lives, and other studies and reports, the researchers recommend woman-centred care, accessible information and services, a change in culture and attitudes of health practitioners, greater continuity, better education and a shift of resources towards poorer women. Similar recommendations have been made again and again. Improving outcomes for women suffering disadvantages has apparently posed a puzzle for many years and services have attempted to redress the impact of inequalities. None to my knowledge have been as successful as the Albany Midwifery practice in south London. The women cared for by the Albany midwives were some of the poorest in England and are the very women behind the numbers in Andrea Lindquist et al's study who experienced poorer outcomes, and yet Albany mothers enjoyed some of the best outcomes in England, for over a decade.

But more than this, reports from the women show that they felt well informed, listened to, respected and empowered. They were able to exert the agency which is shown to be lacking in so many surveys and studies. For example, a young, teenage woman who had not previously engaged with the services was supported by the Albany midwives through her subsequent six births and another young woman was supported to make decisions and birth safely and well, despite both women having social and/or obstetric complexities.[1,2]

Social models of midwifery, especially caseloading midwifery works. How much research do we need before this is implemented so that the poorer outcomes for poorer women are improved? Of course midwifery cannot reduce the very real and growing inequalities, but they can make a significant difference to outcomes at birth, the women's experience and breastfeeding.

Nadine Edwards

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Measuring success

Albany Practice Outcomes 1997 – 2007

Spontaneous Vaginal Birth	80.4%	(UK 62.9%)
Caesarean Section	16.4%	(UK 25%)
Exclusive breastfeeding at 28 days	74%	(UK 21% at 6 weeks)
Perinatal mortality	4.9/1000 (Southwark 11.8/1000 average in 2005–7)	
Homebirth rate	45.1%	(England 2.67% in 2007)

Statistics with thanks to Becky Reed

Prevention and elimination of disrespect and abuse during childbirth

WHO Statement by *Lieve Blancquaert*

Every woman has the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth. However, across the world many women experience disrespectful, abusive, or neglectful treatment during childbirth in facilities. These practices can violate women's rights, deter women from seeking and using maternal health care services and can have implications for their health and well-being.

The statement illustrates a commitment to promoting the rights of women and to promoting access to safe, timely, respectful care during childbirth. It calls for:

- *Greater support from governments and development partners for research and action.*
- *Programmes to improve the quality of maternal health care, with a strong focus on respectful care.*
- *Greater emphasis on the rights of women to dignified, respectful healthcare through pregnancy and childbirth.*
- *The generation of data related to respectful and disrespectful care practices, systems of accountability and meaningful professional support.*
- *The involvement of all stakeholders, including women, in efforts to improve quality of care and eliminate disrespectful and abusive practices.*

The statement has been endorsed by a range of organisations worldwide.

www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth-data/en/

Royal College of Obstetricians and Gynaecologists guidelines: How evidence-based are they?

Prusova K, Tyler L, Churcher A and Lokugamage AU (2014) Royal College of Obstetricians and Gynaecologists guidelines: How evidence-based are they? J Obstet Gynaecol. 2014 Nov;34(8):706-11.
doi: 10.3109/01443615.2014.920794

The Royal College of Obstetricians and Gynaecologists (RCOG) publishes guidelines in order to assist clinicians with decision making. The present study aimed to assess how many of those guidelines were backed up by best quality medical evidence.

Summary of the research

The researchers analysed the RCOG's 'Green-top Guidelines.' Each of these guidelines deals with a specific topic, and contains recommendations, which have been graded according to the quality of medical evidence backing them up. Prior to December 2007, the grades ranged from A to D, and after this date from A to E. In both cases the best kind of evidence was generally considered to be a randomised controlled trial (A), although post December 2007, this could also include either a meta-analysis or a systematic review. The lowest level type of evidence was considered to be based on the clinical experience of the guideline development group.

The researchers found that prior to December 2007, only 8% of the Green-top obstetric guidelines were based on the highest level of medical evidence, whereas 41% were based on the lowest type. Post December 2007, 8% were based on the highest level of medical evidence and 40% on the lowest. Of the gynaecology guidelines, before December 2007, 18% were graded A and 40% as D. After this date, the figures were 13% and 42% respectively.

The researchers concluded that the evidence backing up the majority of RCOG guidelines is based on clinical experience, expert opinion or low quality studies.

AIMS Comments

Although the researchers' conclusion is sobering, there are some general points worth noting. Firstly, attempting to categorise the evidence with a simple A to D/E grading may be too crude to truly assess the quality of the evidence. Secondly, conducting randomised controlled trials within some areas of obstetrics and gynaecology may cause practical and ethical dilemmas. For example, given that women have been led to believe that longer pregnancies are dangerous, how many would feel confident to be part of a trial that attempted to see what happens when a pregnancy goes beyond 42 weeks? Thirdly, this study does not consider the midwifery guidelines produced by the Royal College of Midwives (RCM).

The researchers also pointed out that the existence of research in a particular area does not necessarily guide best practice. For example, following a review, the Cochrane Collaboration[1] concluded that it could not recommend the use of partograms as part of standard labour care. However, partograms are still considered fundamental to clinical practice and are regularly used.

Given that the majority of the RCOG guidelines are based on expert opinion and not the highest quality evidence, this begs the question of how much weight practitioners are putting on those guidelines. Do they understand and take into account the grading system? Although the RCOG suggests that clinicians should do otherwise, are medical professionals simply following the guidelines blindly, seeing them as rules that must be rigidly upheld? Are the guidelines being followed as a form of defensive medicine, even if a practitioner feels an alternative course of action would be preferable? Are they discussing the quality of the underpinning evidence with pregnant women so that they can make the best decision for themselves and their baby?

The researchers' conclusion is also relevant to a pregnant woman who is told that, for example, the RCOG guideline recommends a caesarean section in her situation. She may presume that this recommendation is based on hard evidence. This has implications for informed consent.

A further issue with the heavy reliance on small numbers of experts' opinion to form guidelines is the risk of bias and consequently of error.

Interestingly, a similar study was carried out in the US.[2] It found that only 25.5% of the American College of Obstetricians and Gynecologists' guidelines were based on the highest level of medical evidence and that 34.8% were based on the lowest. The study also noted that when the RCOG recommendations were compared to the American College's, only 28% were the same, 56% were not comparable and 16% were opposite. This raises the question of accuracy, and also the issue of whether there is such a thing as 'best practice'. Might it therefore be preferable to focus on woman-centred rather than guideline-centred care? Health practitioners would then be able to draw on the best up-to-date research and also use their professional judgement to help women make their own decisions.

Although initially shocking, the results of this study only paint part of the picture. To get a more accurate perspective, we need to consider whether there is any feasible way of creating more robust research, how exactly clinicians are using the guidelines, and whether this is ultimately having a negative effect on women, their pregnancies, babies and births.

Gemma McKenzie

Gemma is a mother of three and about to embark on a PhD researching informed consent within the maternity services

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Denial of human rights

Susannah Sweetman describes the impact on individual mothers and babies

When Irish Self Employed Community Midwife (SECM) Philomena Canning's insurance was suspended by the Health Service Executive (HSE) on 12 September 2014 (see page 27 for more information on this), I was 29 weeks pregnant with my fourth baby. Philomena had been our midwife for my second and third child – we felt absolutely confident and secure in her care.

Although I was concerned to learn of the suspension, I naively assumed that it would be reinstated within days. After all, no charges had been brought against her, no harm had come to any of the women or babies in her care, and 29 pregnant women, all of whom met the stringent criteria for homebirth, were depending on her ongoing care – surely that service could not be withdrawn without reason or explanation – right? It quickly became apparent that this was exactly what was happening, and by 29 September, when Philomena's application for an injunction to prevent withdrawal of her insurance was refused by the High Court, I began to realise that all of my choices and control over my maternity care had also been withdrawn.

To be severed from Philomena's care was like a bereavement – I was distraught at the thought that she would not be present for the birth of our baby. I was suddenly thrown into insecurity over who would provide care for my baby and me, and where I would give birth. Apart from the daunting prospect of attempting to build a relationship with a different SECM at such a late stage in my pregnancy, I also knew that even having that opportunity would be unlikely – all of the SECMs are working at full capacity, and most are booked out for months in advance. There is one DOMINO scheme in Dublin that provides a homebirth service, but they were fully booked, and I live outside the catchment area (by less than a kilometre). The SECMs were sympathetic, but unwilling to take me on – not only because of existing bookings but because they felt that taking on Philomena's clients would put them *'in the firing line of the HSE'*.

It was difficult to even contemplate having the baby in hospital. Had I been ill, I would have willingly sought the services of an obstetrician. But to be forced into a system that is known to be incapable of providing anywhere near an adequate level of support to women seemed absolutely ludicrous. Engaging with the HSE during these weeks was simply impossible. Phone calls and emails went unanswered, written correspondence went unacknowledged, questions were ignored. By refusing to engage with Philomena's clients in any constructive way, the HSE denied us a voice, reinforcing the sense that in the context of the Irish maternity services women are the least important 'stakeholders' of all. There was a clear assumption on the part of the HSE that we were a finite problem. After babies are born, place of birth is no longer an issue for the HSE; it is hard to be an activist when you have a newborn baby to look after.

The disengagement of the HSE from the women affected by Philomena's suspension amid mutterings of *'concern for public safety'* had the effect of pushing women into situations that are known to generate physiological and psychological morbidity related to childbirth. This is no secret, it is based on vast amounts of research freely available to the HSE which chooses to ignore it in favour of continued allegiance to a broken system. The HSE has done nothing to resolve Philomena's case, other than construct a situation in which cultural stereotypes of homebirth mothers as unreasonable women making unreasonable demands have been permitted to emerge and obscure the true picture: that is, the utter lack of support for homebirth, the lack of support for women, and the absence of any evidence against Philomena.

One commentary on the witch hunts of the Middle Ages argues that contrary to the belief that they were the result of mass hysteria, they in fact followed *'well organised, legalistic procedures (…) the witch hunts were well organised campaigns, initiated, financed and executed by the church and state'*.[1] It is not difficult to draw parallels between such an analysis and the HSE's behaviour in this case: its use of the legal system, the media, its selective use of research findings, the political alliances between institutions that render its power virtually impregnable.

My baby girl was born peacefully at home, on the 3 December, oblivious to the politics of her birth place. We named her Mila Morrigan, after the Irish goddess of war and birth, also known as Macha. Just as I had given up all hope of having a midwife at home, another SECM agreed to attend me, entirely thanks to the efforts of Philomena to find a midwife to take us on. At this immensely difficult time in her life, she has gone to war for her clients, trying to secure homebirth services for us all. The care was wonderful, calm and kind, and I could not have wished for a better birth for my beautiful girl. Still, I feel robbed of Philomena's care, and I know that she feels robbed of being there for us, as she has been of her livelihood, her profession, and vocation.

Shame on the HSE, and on the Minister for Health, and on all of those individuals who have contributed to this situation through their conspiracy of silence and inaction.

Susannah Sweetman

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Reviews

Group B Strep Explained

By Sara Wickham
AIMS 2014
Publisher's recommended price £8.00
ISBN 13: 978-1-874413-37-0
Available from www.aims.org.uk

When AIMS asked its members whether it should consider commissioning a new book on the subject of Group B Strep, I almost couldn't respond quickly enough to encourage AIMS to say 'yes'. Obviously enough people agreed with me, and the result is Sara Wickham's new book *Group B Strep Explained*.

In case you do not already know, Streptococcus agalactiae (the scientific name for GBS) is a bacterium which lives in a human host and is usually described as being 'commensal', that is, it usually does no particular harm or good. It is estimated that about 18% of UK women are 'colonised' with GBS, the majority of whom are probably blissfully unaware of this 'status', made even more uncertain because GBS can come and go over time and a positive test at one point does not equal a positive test on another occasion. What is certain, however, is that sometimes GBS can pass during birth from a GBS positive mother to her baby and that occasionally a baby will become extremely sick, disabled or die as a result.

There is a range of strategies for screening and attempting to prevent GBS disease used by different countries around the world, but the evidence on this is complex and debatable. In this book Sara takes nothing for granted. She questions and explains all the studies on the subject and sets out the benefits and disadvantages of having or declining antibiotics as well as how that might impact on planned place of birth or care during pregnancy. She is also careful to explain the current rationale for the UK's approach of not testing most women for GBS compared with the USA or Australia where testing for GBS during pregnancy is done routinely. Sara recognises with sensitivity all sides of the various debates and the book is appropriately peppered with reminders that GBS disease is potentially fatal whilst recognising the incredible rareness of this overall, especially for women having an otherwise 'normal' pregnancy.

The book is designed for everyone; from those with no prior knowledge on the subject to those who have read about GBS extensively. It is crammed full of medical evidence, carefully explained statistics and citations for further information making it, as far as I know, unique in bringing together a review of the latest scientific literature, as well as answering the real questions women have about their options. Overly-scientific and statistical language is avoided as much as possible but when it is used it is carefully explained and cross-referenced. My keenness on this book being written – and gratitude at the finished product – stems from my own experience of testing positive for GBS when pregnant with my first child in 2006. I suddenly found myself in a mysterious world of contradictory guidance and research papers, trying to use my GCSE-level statistics knowledge to understand relative risk factors, all too conscious the effect my decision might have on my baby and birth. I had meetings with midwives and obstetricians who did not know how to answer my questions. Fast-forward to 2015 and Sara Wickham's book. If I was pregnant now with a positive GBS result, it would be incredibly helpful. Whilst I would still have a difficult decision to make, the book would be a God-send to help understand the various statistics and recommendations generally thrown at all GBS women.

Sara states in her conclusion:

'I am almost certain that [the book] will be criticised in some circles because I haven't urged women to take every test possible and agree to intravenous antibiotics during labour. However, I hope I haven't made my reader think that GBS is something to dismiss, or that having antibiotics is always inadvisable.'

a well-balanced book which can be dipped into or read through as needed

In my view, Sara does not leave her reader thinking that GBS is something to dismiss. Far from it. However, what Sara does give her reader is a well-balanced book which can be dipped into or read through as needed. The very specific and technical nature of the book means that this book is not only for pregnant woman with a particular interest in GBS, but one that I would strongly recommend to doulas, midwives, obstetricians and paediatricians and to anyone else who supports pregnant women in any capacity and who wishes to be armed with quality and up-to-date information on this very important topic and the subject of decision-making in childbirth as a whole.

Ceri Durham

News roundup

Withdrawal of insurance for VBAC

In Ireland the private midwifery group, Neighbourhood Midwives posted on its website that: *'It is with deep regret that some clients that had hoped to be cared for by our service have had to be informed that this care cannot currently be provided by our service. This only applies to clients that previously had a caesarean section. […] The unfortunate withdrawal of insurance for HBAC is due to global policy change of the insurers for reasons external to the UK and Republic of Ireland.'*. The group stated that this was beyond its control and as AIMS has pointed out, this is one of the many problems with private health care and the introduction of insurance companies – which then dictate practice. Only a fully accountable, state funded health service can avoid this problem. www.neighbourhoodmidwives.com/hbac-insurance/

Midwife with excellent safety record suspended

Philomena Canning, self-employed midwife in Dublin, with 30 years experience, had her HSE indemnity revoked at the end of 2014 without explanation or investigation leaving 29 mothers in her care without a midwife. This followed two homebirths where the mothers were admitted to hospital after birth and later discharged. Both mothers and babies were well, and support Ms Canning.

Mothers, birth activists, midwives, and others were at the High Court hearing to support Ms Canning. Krysia Byrne of AIMSI (AIMS Ireland) said: *'We have had many cases of women being subject to horrible conditions and procedures under obstetric care, including the recent deaths that the press are still highlighting, yet the medical professionals in question are, for the most part, still in practice [...] yet a midwife with 30 years of safe births under her belt is removed from practice without any notice before an investigation even starts. It's a scandalous double standard.'* She continued: *'This HSE witch hunt cannot be allowed to continue.'* www.parent.ie/hse-witch-hunt/

RCM members vote to take industrial action

Last September, for the first time in its history, the RCM balloted its English members about industrial action, because of poor conditions and low wages: *'The RCM is campaigning for a 1% pay increase as recommended by the NHS Pay Review Body; an above inflation pay rise for 2015-16; and a commitment to future pay rises that will restore the value of NHS pay. Of over 10,000 midwives who voted, 82% were in favour of the strike.'* AIMS supported the RCM's demand for fairer rewards for midwives. Following negotiations with the Department of Health it appears that a settlement has been reached and that midwives, along with other health professionals, will receive a 1% pay rise and other gains. www.rcm.org.uk/news-views-and-analysis/news/industrial-action-suspended-as-rcm-and-other-health-unions-reach

Criminalising pregnant women?

The Court of Appeal ruled that drinking in pregnancy is not a crime. A council in the North West of England had taken a woman to court after her baby was born with Fetal Alcohol Syndrome as it hoped to claim criminal injuries compensation for the child. The British Pregnancy Advisory Service (bpas) and Birthrights intervened in the case because they believed it would establish a legal precedent which could be used to prosecute women who drink while pregnant and would do nothing for the health of alcoholic mothers and their babies.

This is a crucial ruling because it confirms, at least for now, that in these circumstances women must be able to make their own decisions about their pregnancies.

Hungarian midwife still facing court proceedings

Dr Ágnes Geréb was arrested over four years ago. She spent 70 days in prison and over three years under strict house arrest. This was relaxed slightly last year for health reasons.

Spokesperson Donal Kerry said: *'In the birth case incidents currently before the court all the birthing mothers involved support Ágnes and it is now expected that the court verdicts will be delivered sometime in 2015. […] In the meantime, national and international support has remained consistently strong for Ágnes and for the rights of birthing mothers and midwives in Hungary […] We will continue to keep all supporters updated on the situation of Ágnes as her treatment is also rightly seen to be inextricably linked to the future rights of birthing mothers and midwives in Hungary.'*

For information and to send messages of support: www.facebook.com/pages/Podpora-pro-%C3%81gnes-Ger%C3%A9b-Support-for-%C3%81gnes-Ger%C3%A9b/1395571794217 29

Blow for human rights

The European Court of Human Rights gave its judgement in the case of Dubská v Czech Republic in December. Birthrights commented that: *'The Court found that Czech legislation prohibiting midwives attendance at home births did not interfere with women's right to private life under Article 8 of the European Convention. The decision came as a surprise to maternity professionals and campaigners across Europe, who had welcomed the Court's previous decision in Ternovszky v Hungary which enshrined an obligation on the state to respect women's choice of place of birth.'*

A full commentary is available on www.birthrights.org.uk/2014/12/dubska-v-czech-republic-a-blow-to-womens-reproductive-rights-in-europe/

Supporting AIMS

AIMS has just become a Charity. It still has no paid staff – our committee and volunteers give their time freely. All monies raised go towards providing women with support and information, so do consider supporting us and please watch out for notices as we explore new ways of raising money to enhance our work.

How you can help AIMS

If you are not already a Member, you could join.

The benefits of Membership include four AIMS Journals a year – these provide valuable updates and information including research on childbirth and related issues. Authors of articles are from a wide range of backgrounds and countries, giving their insights, views and experiences.

Visit www.aims.org.uk

As a Member, you will be given access to the AIMS Members Yahoo Group. You will be able to stay in touch and have more of a say in what AIMS is doing. You will receive updates from committee meetings and early notice of events such as AIMS talks, as well as being able to contribute to discussions of current issues.

Join at health.groups.yahoo.com/group/aimsukmembers or email egroup@aims.org.uk

If all our Members just encouraged one other person to join, we would double our membership and income!

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Are you sure you have the up-to-date version?

Our publications cover all main aspects of pregnancy, including second and third stage of birth, breech birth, vaginal birth after caesarean (VBAC) and induction of labour. There are publications helping you to plan the birth you want – the best selling Am I Allowed? and What's Right for Me? Others cover the safety of childbirth, ultrasound, vitamin K and group B strep. There is also one helping you to make a complaint about your care. We sell other authors' books about homebirth.

Most of the publications are on Kindle. Don't worry if you don't have a Kindle, they can also be read on other devices. See **www.aims.org.uk/?aboutKindle.htm**.

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A really easy way for everyone to help AIMS is to order cards or notelets from our website www.aims.org.uk and consider giving the new canvas bag or mugs for presents.

A big thank you, whatever you can do!