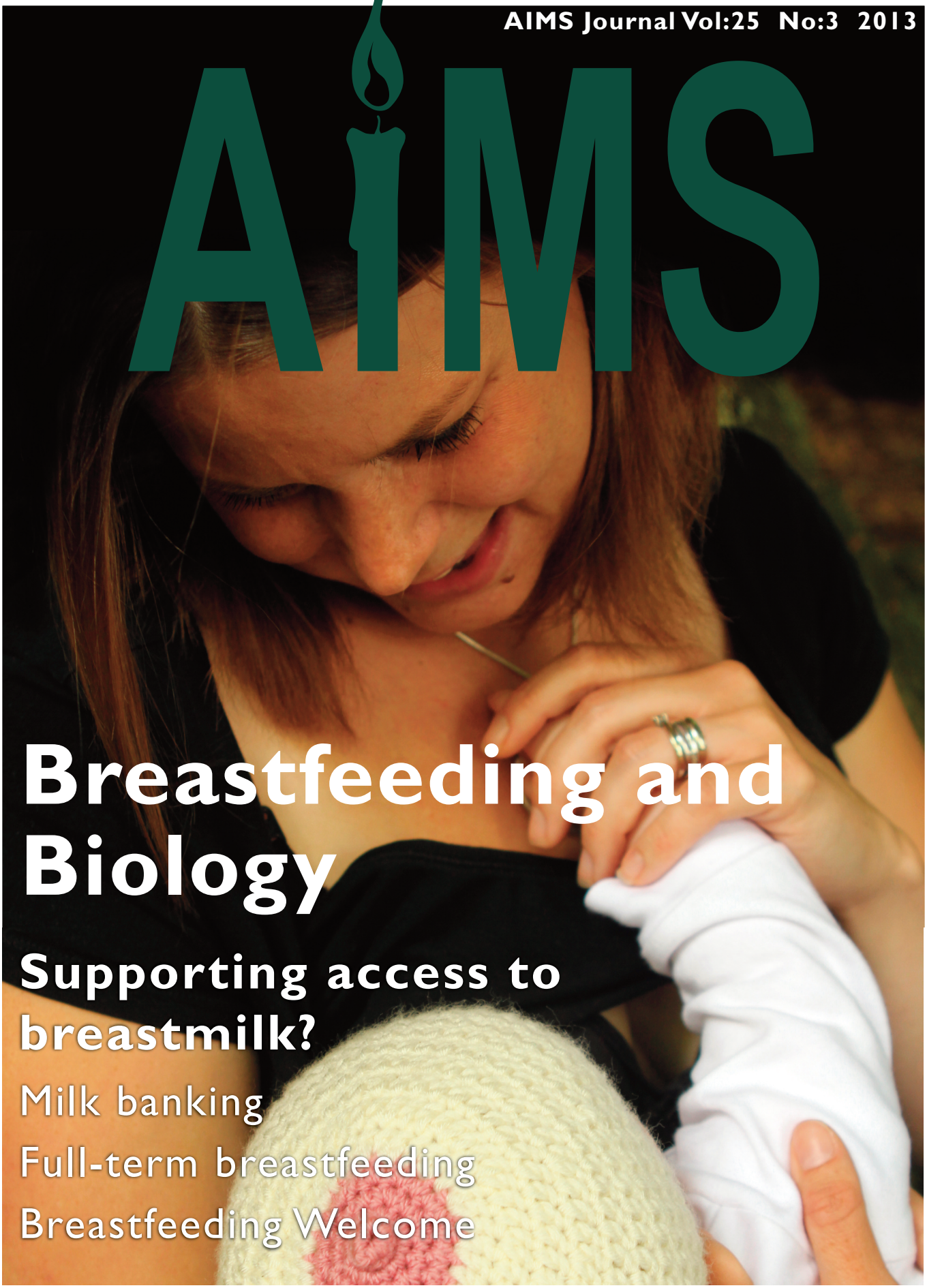
Association for Improvements in the Maternity Services

AIMS Journal Vol:25 No:3 2013

# AIMS



# Breastfeeding and Biology

## Supporting access to breastmilk?

Milk banking

Full-term breastfeeding

Breastfeeding Welcome

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# Diary

## AIMS AGM

Saturday 2 November, York
All members welcome
email: secretary@aims.org.uk

## AIMS Meetings

Friday 24 January 2014, London
Friday 21 March 2014, Cardiff

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

## Birth Rights in the European Union

Mobilizing Change
Monday 4 November 2013
8:30 – 18:00
Duinse Polders in Blankenberge, Belgium
humanrightsinchildbirth.com/conference/

## All-Party Parliamentary Group on Maternity

Maternal Mental Health
Wednesday 6 November 2013
2.30 – 4pm
House of Commons.
email Public.Affairs@nct.org.uk for further details

## RCM Annual Conference 2013

Wednesday 13 – Thursday 14 November 2013
The International Centre Telford
The RCM Debate - Do women have the right to give birth where, how and with whom they choose?
www.rcmconference.org.uk

## AIMS Talks

We are in the process of arranging a series of talks for 2014 in various locations around the UK.
Please email talks@aims.org.uk to receive updates or to volunteer to help organise a talk in your area.

***To include events on the AIMS website and to arrange for an AIMS stand or publicity material for your event please email eventsdiary@aims.org.uk***

## *Buying something from Amazon?*

If you are going to make a purchase from Amazon, please consider doing so via the following link. AIMS will get about 5% commission on purchases that you make without any cost to you.
**www.aims.org.uk/amazon.htm**

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



Hon President
Jean Robinson

**AIMS Research Group**
A group has been established to review research for the Journal. If you are interested in joining the team, please email research@aims.org.uk

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Journal Editor
**Vicki Williams**
email: editor@aims.org.uk

Guest Editor
**Emma Ashworth**

Editorial Assistant
**Vacant**

Journal Production Team
**Beverley Beech**
**Gill Boden**
**Debbie Chippington Derrick**
**Nadine Edwards**
**Judith Payne**

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Val Davies breastfeeding her daughter Georgia.

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# Contents

# Making the Most of Change

*Debbie Chippington Derrick* looks at care and campaigns springing from NHS reform

**Two pieces of research have been published recently that provide yet more evidence that midwifery based care from a known midwife results in excellent outcomes for all mothers and babies.**

A Cochrane Review of midwife-led continuity models versus other models of care for childbearing women was published in August and shows continuity of care improves outcomes for both mothers and babies.[1] This was followed in September by a study by the University of Sydney which shows that for women of any risk caseload midwifery is safe and cost effective.[2]

Midwives and women alike are pressing for continuity of care and caseloading midwifery to be the cornerstone of maternity services (for example, www.m4m.org.uk/petition.html). This common cause to secure midwifery care from a known and trusted midwife for all women, whatever their financial or health status, has led to initiatives such as Neighbourhood Midwives,[3] One-to-One[4] and IMUK.[5]

These initiatives are being developed in the context of changes to commissioning and fragmentation of the NHS, amid compelling calls to stop privatisation and fears about where this will lead[6] – as seen from the reports below. We urgently need to understand what this will mean for maternity care in the future. Because the healthcare landscape is changing fast, we need to think carefully about how we can now best campaign to secure good midwifery care for ALL women.

### Insurance for Independent Midwives

News has recently come out that IMUK has identified a suitable insurance provider which, if successful, will provide Professional Indemnity Insurance cover allowing Independent Midwives to practise after 25 October this year, when all health practitioners will be required by law to have PII. However, they now need to raise £72,000 for this insurance. Currently the IMUK website is saying that it has raised £15,000 and is making a range of suggestions for raising the rest of the money.

### Neighbourhood Midwives (NM)

This employee-owned, midwifery social enterprise, launched in July, is now offering a community-based caseload midwifery service across London and the surrounding areas, with a plan to establish practices across England in the coming months and years. NM is fully insured and registered with the CQC. Care packages currently cost £4500 for a fully insured home birth, £600 for 10 days of postnatal care and £1,100 for 6 weeks of postnatal care.

NM states that providing a private service will enable it to build a track record and prove that the model is viable and sustainable, providing eligibility to bid for NHS contracts via CCGs (Clinical Commissioning Groups).

### RCM Pressure Points Survey and Campaign for Better Postnatal Care

RCM is inviting midwives, maternity support workers, student midwives and mothers to let it know their experiences of postnatal care in a series of questionnaires.

RCM says that services are stretched, mothers are sent home too early and aren't getting enough help with caring for themselves and feeding and caring for their babies. It states that midwives and maternity teams feel frustrated and helpless under the increasing pressure. RCM also reminds us that these early weeks are crucial and that the support of midwives has a huge impact on women's long-term physical and emotional wellbeing.

RCM says that there are not enough midwives and it is pushing for better funding and more resources to relieve the pressures. However, it does not currently seem to acknowledge the difference that a known and trusted midwife can make for women struggling postnatally.

Please do complete the surveys that are relevant to you and let RCM know what you think.
Midwives: www.surveymonkey.com/s/9HQ7V85
Maternity support workers: www.surveymonkey.com/s/88DG3GS
Student midwives: www.surveymonkey.com/s/G9VVMSK
Mothers: www.surveymonkey.com/s/RCMpostnatalcare

### Maternity Services put out to Tender

Wiltshire Maternity Services are being put out to tender (to a value of £63 million). This tendering is compulsory under the new Health and Social Care Act. Jon Skewes, director for policy, employment relations and communications at the RCM, said:

*'I am deeply disappointed with the government because they seem to have promised one thing and delivered the opposite.*

*'We were repeatedly assured by ministers that compulsory competitive tendering would not be imposed on organisations commissioning maternity services. The regulations as they stand will mean that this is exactly what will happen.*

*'I call upon Peers and MPs to look at these regulations very carefully. Continuity of care is vital in maternity services if we are to have safe and high quality care.*

*'I fear that the fragmented service that these regulations could lead to will mean poorer care for women, babies and their families.'*[7]

We need to hear from our members about all of these issues and carefully consider future action.

*Debbie Chippington Derrick*

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7. RCM (2013) Royal College of Midwives attacks new NHS tendering rules. www.nursingtimes.net/nursing-practice/clinical-zones/midwifery-and-neonatal-nursing-/royal-college-of-midwives-attacks-new-nhs-tendering-rules/ 5055428.article

# Supporting Breastmilk

*Vicki Williams* talks about some of the barriers to supporting breastfeeding

**Supporting breasts is about so much more than finding a good bra, but, let's face it, that in itself is hard enough! The simple lack of well fitting, well fitted bras, in a wide range of sizes (just like breasts themselves), on the high street is a sad reflection on how little care our society gives to breasts unless they are on show and dressed up for bill-board viewing.**

So, breasts are great for showing off, approved of for attracting a mate, but it still seems like they aren't getting enough support for their other biological function, nourishing human babies until they are ready to wean.

On page 6 Katherine Dettwyler looks at our biological feeding patterns. The core aim of this issue is to support the rights to breastmilk for as long as mum and baby wish to continue their feeding relationship or give human milk to their babies.

Whilst it may be sad that it should need a law to protect the right to breastfeed, it is great news that we have got one. Thanks to some hard campaigning from many corners, the Equality Act 2010 includes breastfeeding. The legislation says that it is sex discrimination to treat a woman unfavourably because she is breastfeeding. It applies to anyone providing services, facilities or premises to the public in any way. Service providers include most organisations that deal directly with the public and they must not discriminate against, harass or victimise a woman because she is breastfeeding.[1] Discrimination includes refusing to provide a service, providing a lower standard of service or providing a service on different terms. This means a restaurant manager cannot ask you to stop breastfeeding, refuse to serve you or request you relocate. UK law protects you for as long as you wish to breastfeed your child, which is a clear message, the Government supports extended breastfeeding.

This is a great starting point for publicity campaigns and breastfeeding welcome schemes, and NCT and other local action groups are achieving great things. NCT has recently launched a breastfeeding package to help healthcare teams to increase and improve the support offered to women alongside their Breastfeeding Welcome Scheme (see page 15) and in Wakefield, Association of Breastfeeding Mothers (ABM) counsellor Emma Ashworth has helped to re-establish the local scheme in conjunction with the local council and NHS. Multi-agency working, and a consistent approach, is great for mothers, along with high-quality information such as that given by the Breastfeeding Network (BfN) Helpline as discussed on page 9.

It is now time that local and national government and our healthcare services went the next step in breastfeeding support by ensuring that babies receive equitable access to donor breastmilk if for any reason they can't have their own mother's milk. The World Health Organisation and the UNICEF Baby Friendly Initiative are very clear – breastmilk direct from mother's breast is the first choice nutrition for an infant. If that is not an option, then their mother's own expressed breastmilk is second choice. Third choice is banked milk from another human donor, with infant formula the fourth choice of nutrition.[2]

A commitment to access throughout the UK to donor breastmilk from central milk bank services, as in Scotland and Northern Ireland (see page 14), rather like the Blood and Transplant Service, would make a massive difference. Imagine if access to blood or organs depended on whether there was a 'blood' bank in the hospital you happened to be in!

This issue is packed, but in a future issue we will look at supporting women to initiate successful breastfeeding and consider the thorny issue of the use of drugs and interventions in labour. Often women are not told that these can seriously affect getting breastfeeding off to a good start and exhausted mothers are left believing that problems are their fault. Baby Friendly Status and access to NHS-funded lactation specialists for all units providing maternity, neonatal or paediatric care would also be a big step forward. If that were to happen then women would get good-quality information to help them decide how they wanted to feed their babies, they would get better support to make their choices a reality if they wish to breastfeed and they would get accurate information about starting solids and continuing breastfeeding for as long as they and their child wish. If Norway can manage a breastfeeding rate of over 90% at three months, there is no reason why it could not happen in the UK.[3]

The other great commitment that could be made at a national policy level is to firmly get behind the WHO International Code of Marketing of Breast-milk Substitutes.[4] Currently UK law has adopted a watered-down version, and adverts that circumvent the code abound. Whilst on the surface these adverts might appear to be safe advertising, aimed at babies over the age of six months, toddlers and preschool children, actually they subtly undermine confidence in breastfeeding at every stage and not only do they not give accurate information for parents to make informed decisions, they seek to deliberately misinform. This is damaging to breastfed babies and it denies formula-fed babies the chance for their parents to have high-quality and unbiased information. The inflated benefits and pseudo-scientific claims encourage parents to think positively about brands that have no evidence to back up the health claims of active ingredients advertised. Every time an advertising complaint is upheld the advert is simply removed and replaced with a new one. Without a retraction or public statement, parents can be forgiven for thinking that the advert has just done its time. For more information on this thorny issue, one which space in this issue has not given us a chance to cover in any depth, please visit Baby Milk Action at www.babymilkaction.org.

*Vicki Williams*

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# Full-term Breastfeeding

*Katherine Dettwyler* discusses how biological norms are overwritten by culture

**I have spent my career as a biocultural anthropologist researching, pondering, observing, and writing about breastfeeding and weaning.**

My experiences have included:

- conducting research for almost three years in Mali, West Africa – a country where everyone breastfeeds, whenever and wherever they wish, and no one thinks of breasts as being sexual;
- conducting research on what would be a 'natural age of weaning' for humans as a species, using the term 'weaning' to mean the very end of any breastfeeding;
- conducting research on women in the US who breastfeed for three years or longer;
- providing scientific backup for mothers to use in court cases where they are either being accused of sexual abuse for breastfeeding their older children, or are struggling to maintain their milk supply and breastfeeding relationship in the face of shared custody or extended visitation orders;
- breastfeeding my own three children, the longest for five and a half years, in the US and watching my daughter Miranda breastfeed my grandchildren.

Over this stretch of time – more than 30 years already – I have seen a number of changes in how breastfeeding is perceived, how it is supported (or not) by society, and how it is practised. Breastfeeding research has taught us so much over the past three decades. We know that breastfeeding is essential to the normal development of a child's gut, immune system, eyes, and brain. We know that breastmilk is full of factors that help protect a child from illness and help her recover if she does get sick. We know that formula-fed children have higher rates of death in childhood, higher rates of many diseases throughout life, and lower IQs than their comparable breastfed counterparts. We know that mothers who breastfeed gain from the experience, in terms of their own health (including lower rates of reproductive cancers and better bone density) but perhaps, most importantly, in the strong bond they develop with their child through the presence of high levels of the mothering hormones prolactin and, especially, oxytocin in their bloodstream.

My own work on what I call 'a natural age of weaning' is based on comparing life-history variables in the nonhuman primates (our closest relatives in the animal kingdom) and exploring the relationship between such variables and the typical age of weaning for the species. The life-history variables include length of pregnancy, rates of growth in childhood, dental eruption patterns, age at sexual maturity, weight of adult females, and others. Taken together, these data suggest that for human children – who have relatively huge brains, grow very slowly, and end up as large-bodied adults – the natural length of breastfeeding is between two and a half and seven years (adding solids at around six months of age).

But what are we, as healthcare providers and/or as parents, to make of these research findings? Must everyone breastfeed for two and a half years? For seven years? What does it mean to say that two and a half to seven years is normal or typical for our species? If I only breastfed my child for one year, or only for six months, does that make me a bad mother? If I want to let my child self-wean and they're still going strong at four years, what do I tell my disapproving family members, friends, neighbours, and even random strangers who question my motives? How do I balance my child's need to continue feeding with my ex-partner's desire to have long visitations, including overnights?

I'd like to make several points. First, I think any breastfeeding is better than no breastfeeding. If, for whatever reason(s), a mother breastfeeds for six months, or six weeks, or six days, that's still wonderful. It's not a competition to see who can feed the longest, or who can persist through the most difficult obstacles and setbacks. I nursed one of my children for only four months due to serious complications on both my part and his. I breastfed the other two much, much longer. We need to educate healthcare professionals and mothers about the importance of breastfeeding, but we also need to work to provide all mothers with the information and support they need to be able to breastfeed as long as they wish. That means better prenatal care, more humane childbirth experiences, skin-to-skin immediately after birth with no separation, well-trained lactation consultants to help in the first days if needed, and sufficient maternity leave. It also means making sure that mothers know that they need to breastfeed early and often (several times an hour in the first weeks and months), around the clock, and let their babies just 'hang out at the breast' even when they are not actively breastfeeding. Breastfeeding is about way more than just getting food into the baby.

Second, we need to remember that breastfeeding is a relationship between two people, both of whose needs and preferences should be considered. Not all mothers will want to, or be available to, breastfeed for several years. A mother may have postponed childbearing and want to fit in another child before she gets too close to menopause, and whilst it is not necessary to cease breastfeeding for another pregnancy, some women find that their fertility does not return until their baby is weaned. A mother may want to return to a job that involves extensive travel or a significant time commitment. In addition, not all children will want to breastfeed for several years. Some children will be happy to feed for 4-5-6-7 years, while others seem to lose interest on their own before the age of three. We must find a way to balance the offer of information and support to continue breastfeeding with the needs of a particular mother-child pair to stop for any number of reasons, and not put mothers on the spot to justify their decisions.

Third, we need to understand that when a mother is breastfeeding an older child, she is behaving in a manner that is perfectly normal for a member of our species. Breastfeeding a 4-5-6-7 year old is quite different from breastfeeding a newborn or young infant. The child may breastfeed first thing in the morning and last thing before naps and bedtime. The child may breastfeed more when they are cutting teeth, or when they are stressed, sick, injured, or frightened. They may breastfeed only once every few days for the last months of their breastfeeding experience. No matter how old the child, mother's milk provides her child's diet with an excellent source of protein, carbohydrates, and fats. The milk doesn't suddenly lose its nutritional value when the child reaches a specific age! No matter how old the child, mother's milk provides immune factors that help build and augment the child's own developing immune system. No matter how old the child, the act of being held in her mother's warm loving arms, hearing her heartbeat and her voice, smelling her familiar smell, and the very act of suckling itself help to relieve stress and pain, lower the child's blood pressure and heart rate, and provide immense emotional comfort. Additionally, the act of breastfeeding provides a boost of oxytocin to the mother, helping her remain calm and loving in the face of whatever challenges life is throwing at her that day.

Fourth, we need to understand that 'full-term breastfeeding' (or 'extended breastfeeding', or 'biological breastfeeding', or whatever you want to call it) does not involve sexual feelings on the part of either mother or child – it is not sexual in any way, shape, or form. It is only in a few cultures around the world – regrettably mostly Western ones – that breasts are viewed as sexual objects and manipulated during sexual activity. The standard Western obsession with breasts as sex objects is actually quite strange – it is not found in any other mammals, and not found in the majority of the world's cultures. A child will not 'suddenly realise' that he is having sex with his mother, as some critics have suggested. A mother does not breastfeed a five year old for sexual pleasure – far from it. There is no evidence to suggest that breastfeeding a child, even for seven years or longer, is in any way harmful to the child – not emotionally, not nutritionally, not physically.

Expert recommendations on how long children should breastfeed include the following:

- Exclusive breastfeeding (nothing other than breastmilk) for the first six months, then slowly adding appropriate solid foods.[1]
- Continued breastfeeding for a minimum of one year[2] or a minimum of two years.[3]
- Continued breastfeeding beyond one to two years for as long as mother and child wish.[4]

Fifth, we need to understand that there is no need for a child to give up breastfeeding before she is ready in order to facilitate a deep bond with a parent who is no longer living full-time with the mother and child. These two options are often juxtaposed as though it must be either/or, when in reality, it is quite possible for the breastfeeding relationship to be protected while still allowing the other parent to have plenty of time with the child. Both relationships are important. It may require flexibility and compromise, and working together for the benefit of the child, but it can be done.

Ideally, the non-breastfeeding parent would have several opportunities to spend time with the child each and every day. When the child is younger, these should not be for too long a time at a stretch, so that the child is not upset and so that the mother doesn't have to pump, or the other parent provide formula. As the child gets older and is eating solids, these visits might extend to several hours' duration. Still, when the child expresses a desire to be with his mother to breastfeed to sleep for a nap, or because he has fallen and scraped his knee, or whatever, he should be returned to his mother. Most children will continue to breastfeed to sleep and breastfeed several times during the night until they have finished cutting their baby teeth around two years. Overnight visits should be based on the child's needs, their temperament, and their patterns of breastfeeding. Most of the night, the child will be asleep, so it isn't as though anyone is really missing out if overnight visits are postponed until the child is three or four years of age or older. As long as the child continues to breastfeed, both parents should avoid planning excursions that would separate mother and child for more than a couple of days, even if the child is four or five or six years of age. A strong bond with the non-breastfeeding parent is very important for a child throughout their life, but there is no reason why it need require that the mother and child stop breastfeeding.

*Katherine A. Dettwyler, PhD*
*www.kathydettwyler.org*

## Toddler milk is a con...

Healthy, full-term infants aged 6–12 months were fed iron-fortified or low-iron formula milk. At 10 years old the children were assessed for cognitive development. The low-iron group scored higher on every outcome. This suggests that high-iron formulas do not offer any additional benefit, and that the pressure put on breastfeeding mothers over their babies' iron intake is misplaced.

www.unicef.org.uk/BabyFriendly/News-and-Research/Research/Mental-development/Iron-Fortified-vs-Low-Iron-Infant-Formula-Developmental-Outcome-at-10-Years/

For more information on the iron content of UK follow-on formula milk see the Caroline Walker Trust report Infant Milks in the UK (2011) www.cwt.org.uk

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Article

# Night Feeding

*Vicki Williams* sheds some light on the benefits of night feeds

**It is no real surprise that the lure of using controlled crying and other 'sleep training' methods to gain more sleep is so powerful. Exhausted parents, at the end of their reserves, are easily persuaded, especially when their health professionals advocate it. Tragically many of these health professionals and self-professed 'sleep experts' only know that it does work, not why. If they knew why it worked or the potential consequences, they might be a little more reluctant to suggest it and keener to encourage tired mums to feed their babies at night.**

In essence, sleep training aims to teach a child not to ask for his needs to be met during hours specified by his parent(s). It does not teach a child not to have those needs, for comfort, food, drink during the night, but it does teach that child that whatever his needs, they are not likely to be met. Children learn fast, and it only takes a few sessions to teach the 'rules', but many parents have started to question what lessons they really want their children to learn, and to ask if teaching a child that their needs are dictated by the adults is a helpful long-term strategy to getting more sleep. If you want to know more about the potential effects or about other methods, there are some great scholarly articles,[1] some lovely empowering books with evidence-based information[2] and baby-centred courses[3] out there.

Parenting groups and forums are full of parents who are sleep-deprived, stressed and anxious. Some because of their children's night-time needs, others because of the pressure being exerted from outside to solve the issues of night waking, yet few are asking if the night waking is a problem that actually needs to be solved. Breastfeeding often shoulders the blame, and mothers who are breastfeeding are frequently in the position where it is their input that is needed, and some mothers are even persuaded to stop night feeding, or even breastfeeding altogether, to solve the problem. There is no doubt that tiredness is not good for anyone's health and wellbeing, least of all for the parent who spends their day meeting the needs of a dependent young person, but is there more going on than first meets the eye?

There are also some really important things happening during night feeds which you may or may not know, and it just goes to show how truly amazing our bodies are.

Firstly, breastmilk is easy to digest and passes rapidly through a baby's immature digestive system. This means that they need to feed frequently. Frequent feeding is a good thing, it means your baby is sure to have a stable blood sugar level, without the meal-related peaks and troughs known only too well to adults and to the parents of hungry or 'sugar-fuelled' children. The rapid passage of food through the gut is also protective against gastric upsets as pathogens are rapidly flushed through.

The next, and arguably the most important, thing to know is that night waking is normal behaviour for babies and adults. Older children and adults meet their needs (hunger, thirst, loo, comfort, rearrange the blankets and so on) and then go back to sleep, or not. Babies not only have the same needs as older humans, they are also programmed to check regularly they are safe by waking and signalling to their parent that they are alone. It is a good thing from an evolutionary perspective, and it might also be a factor in helping to prevent cot-death.

Babies aren't born knowing day from night, it takes time for their natural body cycle to establish, and whilst it does that, our breastmilk is high in our sleep hormone melatonin and in the protein tryptophan which our bodies use to produce serotonin, a hormone involved in the regulation of mood, appetite, sleep, memory and learning. It isn't just the suckling that is comforting, breastmilk really does make babies sleepy.

Breastmilk production and the hormones associated with breastfeeding follow our natural sleep cycle, and prolactin is highest in the early hours of the morning, making our milk production highest then, which means that night feeding boosts supply.

Now for something less well publicised. Breastfeeding mothers actually get more sleep than their bottle-feeding peers. According to one study, breastfeeding parents got an average of 40-45 minutes more sleep per night during the first three months than parents who were formula feeding or supplementing in the evenings.[4] Over a three month period, that is a lot more sleep, and as being short of just 30 minutes' sleep a day can result in a loss of function, it might just be crucial. Research also tells us that sleep deprivation is a factor in postnatal depression, so any extra sleep may make a big difference.[5]

Our bodies don't get it wrong often, and this is just one more situation where evolution got it right; we just got so tired we missed the message.

*Vicki Williams*
*NCT Breastfeeding Counsellor and IBCLC*

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# Drugs in Breastmilk

*Wendy Jones* looks at the reality and the evidence

**We know that over 90% of women take some form of medication whilst breastfeeding – it could be anything from paracetamol for a headache to strong medication to treat infections or long-term conditions. We also know that every pack of tablets or tube of cream we pick up has a leaflet inside which says something along the lines of 'do not use if you are breastfeeding.' So what are we supposed to do?**

Searching the internet is a minefield of personal experiences and horror stories. The Drugs in Breastmilk Helpline was set up by the Breastfeeding Network, up until that point I had been taking calls on my own home telephone!

### What do the information leaflets mean?

Drug companies don't have to submit any research on use during breastfeeding when they market a drug: it would be unethical to expose any baby in such circumstances. So the data sheet says 'do not use if you are breastfeeding,' then if a doctor prescribes the drug or a pharmacist sells it to a breastfeeding woman they take the full responsibility for the safety of mother and child. To do so without a clear understanding of the qualitative and quantitative information is not safe. However, we do have this information either on a theoretical level (from an understanding of the way a drug is handled by the body) or studies of where it has been used. This information is available in specialised texts, but often not the standard ones on a GP's desk.

### What drugs are not suitable for a breastfeeding mother?

The simple answer is very few! There are obvious examples such as chemotherapy, which our instincts say would not be safe. Others are ergot derivatives (such as in migraine products such as Migril), drugs which lower volume of fluid in the body (diuretics), lithium a strong drug used to treat bi-polar symptoms, some contraceptives, drugs that contain iodine or gold, or those drugs that are used to reduce or stop breastmilk supply.

### What about beauty treatments?

Many mothers ask if they can have their hair coloured or straightened, have false nails fitted and spray tans applied. All these are compatible with breastfeeding.

### What about contraception?

Breastfeeding mothers can take the progesterone pill (mini pill). Anecdotally, some seem very sensitive to the progesterone and notice a reduction in milk supply. Swapping the pill for barrier contraceptives can restore supply again with frequent feeding. Anyone wanting to use a depo product could try a month of tablets to test their own reactions. The combined oral contraceptive should be avoided because the oestrogen content frequently dries milk up and there is a potential effect of oestrogen on the baby.

### Long term medication

If a mother is taking long-term medication any problems with use during breastfeeding should be discussed antenatally. Sadly this doesn't always happen and it is not unusual for a midwifery unit to call the helpline to say that a mum is in labour and an answer as to safety is needed before the baby is born. Babies receive less drug through breastmilk than they do via the placenta; however, before birth, the drug is returned to the mother to metabolise (detoxify), but after birth the baby's own liver and kidneys need to carry out this function. These organs do not work fully for the first six weeks, so prescribing for mothers with young and premature babies should be undertaken with care.

### Dental treatment

Many mothers are apparently being advised by dentists to stop breastfeeding in order to have fillings or extractions of teeth. From a common sense point of view, if you have a dental injection how far does the numbness spread? Does the other side of your mouth go numb, what about your arm, the rest of your body? If the drug were being absorbed into the system then these other areas would be affected, but, in fact, the reaction stays very local. So can the anaesthetic get into breastmilk? It doesn't in any significant quantity, so a breastfeeding mother can have a local anaesthetic injection and continue to breastfeed as normal.

### Antibiotics

In a society with concerns about over-use of antibiotics there remains a lot of confusion as to whether it is a good idea to continue breastfeeding whilst taking them. Everything that we take, eat or drink passes to some degree into our milk – some in greater amounts than others. The magic thing about breastmilk for me is the speed with which women produce antibodies to infections that they encounter. So, a stranger coughing over a mum in the supermarket will elicit a response within about 20 minutes to protect the baby. If a mother develops a severe bacterial infection it may need treating with antibacterial drugs – antibiotics. We all know that some of us, after taking antibiotics, will develop vaginal thrush due to an imbalance between the natural fungal and bacterial load of our bodies, but our babies are unlikely to develop thrush because the gut balance is continually maintained by natural components of breastmilk. So we can continue to feed as normal whilst on antibiotics.

### Conclusion

Far from what is believed by some healthcare professionals, we know quite a lot about the safety of the majority of drugs taken by breastfeeding mothers. I'm always happy to answer questions via my website www.breastfeeding-and-medication.co.uk or on my Facebook page Breastfeeding-and-Medication.

Never take the patient information leaflet as meaning that you, or mothers you are caring for, need to stop breastfeeding to take a medication as this is rarely necessary. We need to balance the need of the baby to receive optimal nutrition, the need for the mother to take a particular medication and the risks to both mother and child of stopping breastfeeding.

*Wendy Jones*
*PhD MRPharmS*

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# Apple Dumplings

*Virginia Howes* shares her breastfeeding video

**Making breastfeeding trendy, fun and glamorous, this video aims to promote and normalise breastfeeding. It is a catchy song; the lyrics are all slang words for breasts.**

The video includes young mums dressed in sassy burlesque costumes dancing a glamorous and innocently funny routine. Breastfeeding mothers and babies from all over the country turned up on the day to give support and are featured in the video. I hope to dispel the myths and make breastfeeding an exciting and womanly thing.

As we live in a celebrity-dominated society the idea was to tap into celebrity culture and I thought of none other than Big Brother winner Brian Belo. I thought that Brian would bring comedy, youth and words for breasts (for didn't he have a task to name as many as he could in the diary room?) to the video.

Most women want to breastfeed, a fact that is evidenced by the numbers of women who initiate it, yet drop-off rates are high in the early days and weeks following birth. It may be that for some women social conditioning dominates biological instinct or they may encounter problems, get little support and eventually resort to using bottles and formula, which has long-term health consequences and links to obesity.

There is a feeling among professionals that many young women regard breastfeeding as a middle-class activity, done by older, somewhat elitist or hippie-like women and while there are many ways to reverse opinion, breastfeeding could benefit from attempts to make it attractive to women. What better way to appeal to young women and get their attention than to make breastfeeding attractive, trendy and fun and to tap in to the celebrity glamorous culture?

Perhaps we will make Apple Dumplings a number one hit ... or at least a YouTube viral. Watch it at www.youtube.com/watch?v=Yn8tsHyJaCI.

*Virginia Howes*

# Latch Key


*© Alison Blenkinsop from Fit to Bust*

*'When we trust the makers of baby formula more than we do our own ability to nourish our babies, we lose a chance to claim an aspect of our power as women. Thinking that baby formula is as good as breastmilk is believing that thirty years of technology is superior to three million years of nature's evolution. Countless women have regained trust in their bodies through nursing their children, even if they weren't sure at first that they could do it. It is an act of female power, and I think of it as feminism in its purest form.'*

*Christine Northrup*

# Myth Busting Milk Banking

*Gillian Weaver* throws some facts at the misconceptions that abound

**There are so many myths surrounding milk banking, donation and use of donor breastmilk that it seems time to address some of them.**

**First the big one – milk banks all closed in the 1980s**

I keep thinking that this one has been scotched for good and then along comes someone who tells me that milk banks closed several decades ago. So, for anyone who is under this misapprehension – milk banks are alive and thriving and growing in both activity and number throughout the world. There are 17 milk banks in the UK, almost 200 in Europe, well over 200 in South America and new milk banks have recently been established in New Zealand and China as well as new banks to add to the numbers in Italy, Poland and India. There are milk banks in several African countries and, although this is a relatively new development, the numbers are growing there too. For details of national associations see the UK Association of Milk Banks website www.ukamb.org.

**Myth 1 – Pasteurising breastmilk destroys all the good things in the milk**

The temperature and time combination used for the special heat treatment applied to breastmilk in milk banks (62.5 degrees C for 30 minutes) certainly makes the milk less valuable than freshly expressed raw milk that has not been heat treated, but there are plenty of beneficial components left. Pasteurisation makes donated milk safer for feeding to a baby other than the donor's own, as it generally inactivates viruses and bacteria. This is especially important when feeding it to immune-compromised, preterm or sick infants. Live cells in breastmilk are destroyed when milk is frozen but pasteurising will also inactivate them. It will slightly reduce the main immunoglobulin (secretory IgA) and lysozyme but significantly reduce the lactoferrin. However, if you're looking for these in breastmilk substitutes (infant formulas), they're not present, making pasteurised breastmilk a much better source of them all.[1]

Lysozyme should be less affected by the heat treatment, leaving much of this very valuable anti-infective component of breastmilk intact and functional. Finally the lipase in breastmilk that aids fat digestion is completely inactivated and this means that heat-treated milk is less able to deliver all the calories that are contained in the fats because some may not be fully digested. But again, there's no lipase in formula either. The oligosaccharides that act as important prebiotics remain intact, as does most of the readily bio-available nutrition. The extent of the reduction in valuable immune-boosting properties in breastmilk will, in part, depend on how much is there to begin with and this varies but it is also influenced by the pasteurisation method. The main factors will be how accurately the temperature is maintained and how quickly the milk can be heated to the correct temperature and cooled down again after the 30 minutes has elapsed. New methods of pathogen reduction in breastmilk that will better protect the immunological components are being developed around the world but for now the equipment used provides a product that, according to WHO, is the next best thing to raw breastmilk.

**Myth 2 – Babies won't grow on pasteurised milk**

Term babies grow perfectly well on pasteurised breastmilk and the experience of milk banks in North America, where they have provided donor milk to term babies for several decades now, has consistently shown this. Preterm babies may not initially gain weight as fast as they would if fed with a specialised infant formula but many neonatologists now question the desirability of premature babies growing too fast, especially if the weight gain is due to fat and not lean body mass.[2] Because it is easily and well digested and absorbed, total volumes of pasteurised breastmilk can be increased to greater amounts than with formula and so, if necessary, it is possible to deliver extra calories and protein from pasteurised donor milk by giving a bigger feed volume.

Additional nutrients such as iron and vitamins can be added and the breastmilk can still be supplemented with protein and calcium-based fortifiers. Additionally, and very importantly, preterm babies are more likely to develop necrotising enterocolitis if fed with infant formula and babies with this potentially fatal disease become too ill to grow well. If as a result of this condition they need to have a section of their gut surgically removed, this is likely to affect their later growth too.

**Myth 3 – You can't donate milk if there isn't a milk bank close by**

This was true for a while in the UK, but since the widespread involvement of volunteer couriers provided by Blood Bike groups (see Nationwide Association of Blood Bikes website www.bloodbikes.org.uk), this is no longer the case for much of the UK. Having said that, the islands of Great Britain still present a problem and it is unlikely that milk banks will currently be able to recruit mums from Scottish Islands, the Scilly Isles or the Channel Islands without an offer to deliver the milk to the mainland by the donor or family. Islands aside, much of the UK is now covered by the Blood Bikes, who not only give their time but also pay for their own petrol and other bike costs. The areas in which they operate are growing and so, although there are still some exceptions, mothers can donate over much longer distances than they once could as long as the milk banks have a need for the milk.

**Myth 4 – If your baby is close to six months old, milk banks won't want your milk**

The guidelines for milk banks that were published by the National Institute for Health and Clinical Excellence (NICE) in 2010 recommend that milk banks determine

the criteria for accepting donations of milk according to their local requirements. Many milk banks will recruit mothers as long as their babies are less than six months old but will then support them to continue donating until their baby is between nine months and one year. There are good reasons for limiting the time for donation if milk banks are mainly supplying donor milk to premature babies as the changes that take place in breastmilk over time can make it less able to support healthy growth in preterms, especially if they need donor milk for a prolonged period. However, the main reasons why banks prefer to recruit mothers with younger babies is because of the economics of milk banking. Donor recruitment is expensive and mothers with younger babies tend to donate more milk over a longer period, which helps to stretch the limited budgets that most banks rely on to keep operating.

**Myth 5 – Milk banks give breastmilk to formula companies for research**

I am not aware of any milk bank in the UK supporting research by the formula industry by providing them with breastmilk. What may happen is that if a hospital-based clinical trial is being undertaken that is evaluating different methods of feeding babies – for example, using different supplements or fortifiers – milk banks may be supplying any donor milk that is being used by the hospital.

# Every Drop Counts

**Myth 6 – You have to donate large volumes of breastmilk to be considered as a suitable donor**

The motto of UKAMB is 'Every Drop Counts' and the charity even has a specially recorded song by West London singer-songwriter Sedleigh that ensures this message is heard whenever and wherever it can be.

Once mothers are recruited, their breastmilk will be valued, treated with great care and everything done to ensure it is used wherever possible. Unfortunately it isn't economically viable for milk banks to do all the expensive recruitment screening and blood tests if a mum is only going to be donating small amounts of milk. Some milk banks ask donors to commit to providing a minimum volume, but it is usually an amount that can easily be achieved by expressing regularly and donating for at least a month.

**Myth 7 – There's always a shortage of donors in the UK**

Milk banks always need to recruit new donors because mothers who have been donating stop. Sometimes they stop because they are stopping breastfeeding altogether, sometimes because they are returning to work or are just getting too busy as their baby gets older and sometimes because they have reached the end point at which the milk bank will accept their breastmilk. However, currently few milk banks are experiencing a shortage of new donors wanting to be recruited and so take the place of those who are stopping. This is in part because of increased media interest in and publicity about milk banking, in part because of the great work of UKAMB in promoting the fact that mothers can donate some of their milk, but also because mothers who have donated tell their family and friends and so the message spreads.

I would encourage any breastfeeding mother to check the UKAMB website to see if she is eligible to donate and then contact UKAMB or her nearest milk bank to find out the next step. However, whilst new donors are always needed, there is a preference amongst milk banks for mothers with younger babies (preferably starting before the baby is three months old) and if the milk bank is well stocked with milk, you may be turned away if your baby is six months old or if you are only going to be able to donate for a short period of time.

Milk banks all vary so it is best to check but advisors at UKAMB can help. So, whilst there isn't currently a national shortage of donors, milk banks always need new ones. Also as demand from neonatal units rises, which it is doing, more donors will be needed to meet the increased need so always check to be sure.

**Myth 8 – You can collect milk for milk banks that drips from one breast whilst your baby feeds at the other**

So called 'drip milk' used to be banked by milk banks and, whilst it contains many of the useful immunological and protective components of breastmilk, it is very low in energy (calories) because it has a very low fat content. Most of the babies who receive donor milk have been born prematurely and it is important that they grow optimally so that their lungs are better able to work and their other organs develop and mature. Fats are essential for brain development and breastmilk contains the essential fatty acids needed by babies. In addition, the fat in breastmilk helps to ensure that the protein content isn't used up to provide energy but is available instead for the growth of muscles and lean tissue and to make enzymes and support other essential systems in the body. For this reason milk banks ask mothers to express their milk and to empty the breast that is being expressed completely and so collect the fat-rich hind milk.

**Myth 9 – You can't donate breastmilk in England, Scotland or Wales if you've had a blood transfusion**

Everyone who believes this can be forgiven, as this is something that is currently in the process of being changed. In Northern Ireland the exclusion will continue. What is true is that you may not be able to donate milk if you have recently had a blood transfusion (in the past three to six months). This is because the milk bank will have to wait sufficient time to ensure that you haven't acquired any infection from the blood you received. This would be a very rare occurrence but, because it can in theory happen, milk banks have to delay doing the blood tests. In some milk banks, donors who have been partially recruited via the general health screening can express and store milk for the milk bank which is then quarantined until after the blood tests can be done. If a mother has previously been turned away as a milk donor on these grounds and is still eligible or has had a

subsequent baby and would like to donate, it is worth trying again. If in doubt, contact UKAMB for further advice. The reason for the change is due to new and better understandings of the spread of vCJD (variant Creutzfeldt-Jakob disease) and updated information and knowledge about the possible risks of transmission of the disease.

**Having scotched a few myths, here are some milk banking facts that may seem unbelievable but are actually true!**

Breastmilk was flown from London to Cambridgeshire in the 1930s by the daughter of a local doctor. She had her own plane and flew down to Hendon twice a day to collect the milk that was delivered there by motorcycle from the wards at Queen Charlotte's Hospital in West London. The milk was fed to the first set of quads in the UK to survive and as a result of these endeavours the first milk bank in the UK was established at Queen Charlotte's. It is now the world's longest continually operating milk bank.

**Breastmilk is able to kill cancer cells**

Dr Catharina Svanborg, working in Lund in Sweden, showed that alphalactalbumin, a component of breastmilk, causes apoptosis (cell death) under certain defined conditions.[3] The clinical application of this is under investigation. The component has been given the acronym HAMLET, which stands for human alphalactalbumin made lethal to tumours. HAMLET has also recently been shown to decrease the resistance of some bacteria to antibiotics and so its use may aid treatments against infection in the future.[4]

**In Brazil, fire fighters collect breastmilk for milk banks**

Using specially provided vehicles the firemen and women visit mothers' homes and deliver their donated milk to the milk bank. If they are called to fight a fire or attend another emergency whilst out on a collection they suspend their journey. In the meantime the milk is kept cold in specially designed cool boxes.

**Breastmilk ice cream was on sale**

The Icecreamists, a Covent Garden based ice cream emporium, caused one almighty commotion with, on the one hand, people queuing to buy it and, on the other, health and safety officials seizing samples. The seizure was temporary because the mothers providing the milk had undergone blood tests and the milk was heat treated. If you have breastmilk to spare and wish to turn it into ice cream to feed to your toddler or young child you can easily find recipes on the internet. However be warned, selling it may land you in hot water!

**Breastmilk has on rare occasions been used to help patients with Crohn's Disease and Ulcerative Colitis.**

The anti-inflammatory properties of breastmilk together with its other immunological benefits have led to its use in severe cases. Breastmilk has also had a number of other clinical applications in older children and adults, including as a means of treating post operative cancer patients whilst undergoing chemotherapy. The volumes required would currently make it impossible to universally treat even older children who could benefit from breastmilk and without clinical trials doctors are very reluctant to consider recommending its use.

**Breastmilk changes**

Changes happen within each feed, between feeds, throughout the day, from one week to the next, and this continues as a baby gets older. There is no such product as standard breastmilk and whilst artificial infant milks are made to a 'formula', and so will taste the same from one feed to the next, breastfed babies will start to get used to the infinite possibilities of dietary changes through food from their very first feed of colostrum. The variations that take place in breastmilk are an everyday sight in milk banks where it is reflected in the milk's appearance.

**There is a Guinness World Record for breastmilk donation**

It is currently held by Alicia Richman of Texas who donated more than 86 gallons over a 10-month period. Alicia hopes to break her record when she has her next baby!

All astonishing but true!

*Gillian Weaver*
*President; European Milk Bank Association (www.europeanmilkbanking.com)*
*Chair – UKAMB National Milk Bank Forum (www.ukamb.org)*
*Manager – Milk Bank, Queen Charlotte's and Chelsea Hospital, Imperial College Healthcare NHS TrusGillian.weaver@yahoo.com*

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AIMS editor, Vicki, is a milk donor. Baby Ted models his breastfeeding promotion hat

# Campaigning for Equal Access

*Donna Scott* gives a petitioner's perspective of requesting donor breastmilk through the Scottish Parliament

**Donor breastmilk banking is an idea whose time has come. As many countries see an upsurge in the number of milk banks and as organisations such as the World Health Organisation and the American Academy of Paediatrics endorse the medical benefits of donor breastmilk, it was inevitable that calls would be made for equal access for preterm and vulnerable babies in clinical need across the UK.**

The speed at which we have moved from a situation in Scotland where there was no way of accessing donor breastmilk out of the Glasgow area at the beginning of 2011, to establishing the first nationwide donor milk bank service in the UK by 2013 is notable. This new development is due to a combination of expertise, drive and commitment from healthcare professionals within NHS Scotland and the existence of a pro-active voluntary sector who provide ongoing support for this flagship initiative. My role within this process was as a petitioner to the Scottish Parliament, which also helped to give the issue exposure in the local and national media.

In Scotland, healthcare is a devolved matter. Initially, I raised the lack of access to donor breastmilk with constituency and regional MSPs after contacting the Glasgow milk bank at Yorkhill hospital to arrange to become a donor. I discovered donations could not be accepted from out of the Glasgow area because there was no way of safely transporting frozen breastmilk. This also meant that donor milk could not be used by neonatal units outside the Glasgow area for the same reason. MSP Brian Adam raised this in the Scottish Parliament with the Public Health Minister in January 2011 and, although there were no plans to increase provision, MSP Mark McDonald followed up the matter with my local health authority and wrote to the Cabinet Secretary for Health on my behalf. He also arranged a meeting with my local health authority which we both attended, but the responses still fell short of a commitment to an equal provision of donor milk. It was at this point it was suggested that I think about petitioning the Scottish Parliament as a way of calling for evidence from various bodies, which would bolster the case for improving donor milk provision nationally.

I lodged the petition in March 2012. As the e-petition section of the Scottish Parliament website was being reworked, I chose to bypass the option to collect signatures in order that it could be looked at sooner so there was only ever one name on the petition – mine! I presented the petition to the Public Petitions Committee at Holyrood early in May 2012 and the decision was taken to explore the matter further. It was revisited on a further three occasions before finally being closed in April 2013 as parallel developments within NHS Scotland meant that the local health authorities had reached agreement to proportionally fund the running costs of an expanded donor milk bank at the Southern General in Glasgow which would now serve the whole country.

The Scottish Parliament was a very effective avenue to take as a way of driving forward the issue of donor milk banking. The evidence base is growing, which made a very strong case for expanding access to donor milk on both medical and cost-saving grounds. Donor milk banking in Scotland was also operating with a 'postcode lottery', which local elected representatives were keen to address. It was also relatively easy to pursue this process by email at a time that suited me – my input was frequently provided in the evenings once my children were in bed, from the comfort of my own sofa! The resulting media coverage from the parliamentary questions and the petition also raised the profile of donor milk banking as stories were run in the national press and on television and radio. I also set up a Facebook page (One-Milkbank-For-Scotland) early on in the process, which helped to raise awareness through sharing links as well as making contact with other organisations with similar interests.

My political campaigning as an individual would have been of limited effectiveness had there not been important 'behind-the-scenes' developments that were making the establishment of a nationwide service more and more feasible. Considerable financial investment was provided by the Yorkhill Children's Charity to fund equipment for the expanded milk bank at the Southern General and it was the establishment of ScotsERVS, the volunteer medical courier service, that finally meant that frozen donor milk could be collected from anywhere in Scotland, taken to Glasgow for processing and then sent out to neonatal units round the country at no cost to the NHS. In addition, the Glasgow milk bank was going above and beyond its remit in the years before a nationwide service was secured by making surplus donor milk available to other local health authorities wherever possible, which also meant that demand from parents and clinicians had already begun to grow.

It's been hugely rewarding to have been part of the process that has seen Scotland become the first part of the UK to achieve equal access to donor breastmilk based on clinical need, regardless of geographical location. It would be fantastic to see the same achieved in the rest of the UK, and hopefully the success of the nationwide service north of the border will put appropriate pressure on politicians and local health authorities in other areas to find a workable solution to this soon.

*Donna Scott*

www.scottish.parliament.uk/GettingInvolved/Petitions/PE01426

# NCT Breastfeeding Package

## Commissioning communications crisis will hit breastfeeding targets, says NCT

NCT, the UK's largest parent charity, has launched a new breastfeeding package to help healthcare commissioners take advantage of breastfeeding support.

Local support for mothers to breastfeed varies significantly across regions yet it is estimated that a moderate increase in breastfeeding could save the NHS £17 million every year.[1]

In response to these concerns NCT has re-launched the Breastfeeding Welcome Scheme. This scheme aims to normalise breastfeeding in public by inviting businesses and organisations to make their support public, at no cost to them, with welcome signs and logos.

The move marks an expansion of the breastfeeding support NCT offers to local commissioners, enabling them to reach their breastfeeding targets. NCT's breastfeeding package will now include:

- Breastfeeding Peer Support, providing training to women to enable them to support breastfeeding women, with a similar socio-economic background, in their local community, alongside NHS services and NCT's network of Breastfeeding Counsellors;
- Baby Café, which provides a relaxed, café-style environment where mums can drop in to meet, chat and learn about breastfeeding from qualified health professionals.

For more information, and to get involved, visit www.nct.org.uk or email CommissionedServices@nct.org.uk

### Breastfeeding Welcome Scheme to champion breastfeeding

NCT is working to help all parents breastfeed but the package of support offered to local commissioners has been created to target hard to reach groups including teenage mums and families living in poverty.

Candy Perry, Healthcare Business Development Director, NCT said,

*'The re-launch of the Breastfeeding Welcome Scheme marks the latest initiative by NCT to improve the breastfeeding support available to clinical commissioning groups, foundation trusts and local authorities. Combined with our Breastfeeding Peer Support scheme and Baby Cafés it creates a comprehensive package of support for local commissioners looking to meet their breastfeeding targets and save on long term costs.*

*'The health benefits of breastfeeding for mother and baby are well-documented, as are the long-term economic rewards generated through reductions in medical intervention. A few thousand pounds to get a scheme up and running will be paid back again and again by future savings.'*

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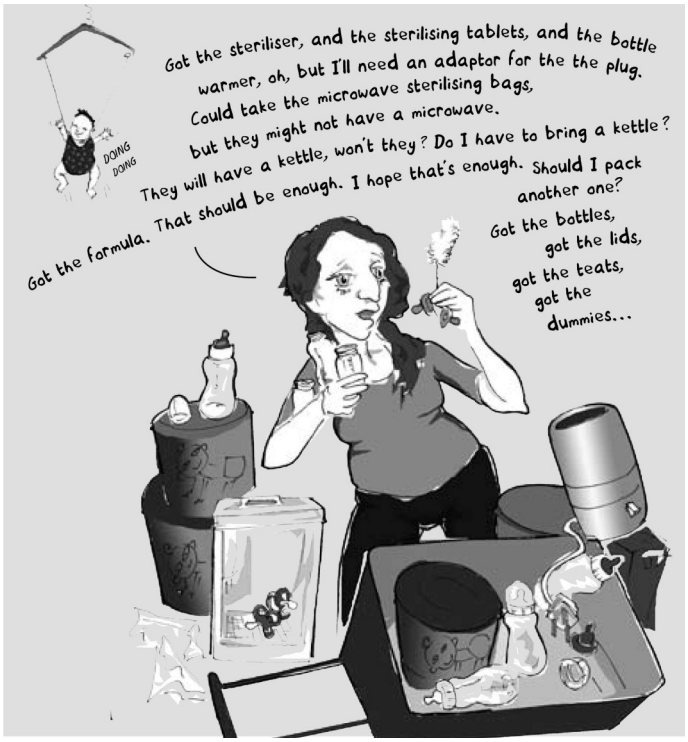


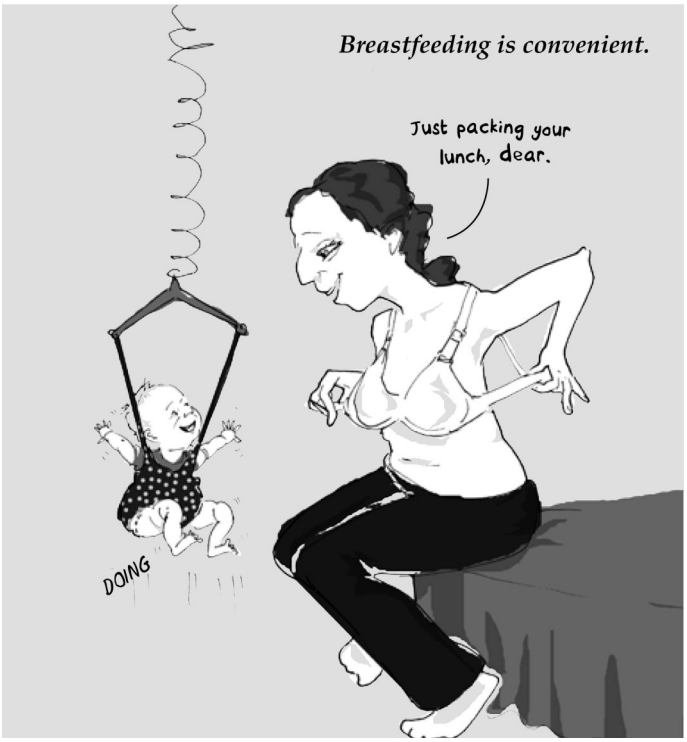

# Welcome in Wakefield

*Emma Ashworth* introduces Wakefield's Breastfeeding Welcome Scheme

**When my first child was born, almost 9 years ago, I was given a list of places in the town that I was living in which had signed up to its 'Breastfeeding Welcome' Scheme. I found it to be extremely helpful, knowing that I would be fully supported when feeding my little one.**

A few years later I moved to Wakefield, and had another baby. At that stage I was completely confident about public breastfeeding (not to mention the Equality Act which had by that point clarified the law protecting mums while breastfeeding in public), and I would breastfeed anywhere and everywhere without thinking about it. But I did remember where I started out, and when I heard that there had been a scheme running which needed a new volunteer to get it going again, I decided to jump in.

I firstly put together an information pack for businesses. This included information about the scheme and its benefits to the business, a sheet for staff to read so that they were aware of how to support mothers and how to deal with the unlikely situation of a complaint, and a sign-up form where the business agreed to place our sticker in their window and for us to promote their business on our website. We were very lucky to have a beautiful logo donated to us by local designer Ian Harrison.

The stickers were funded by the local NHS Trust, and we had some printed for windows (with a sticky front) and some for walls (sticky back). Places such as soft play centres put the sticky-back ones on the walls around the room.

**AIMS guest editor, Emma, is a tandem feeding mother, former milk donor and UKAMB Trustee**

The Council's 'Eatwell' Scheme (Scores on the Doors) had included 'being breastfeeding friendly' in their pack, and I worked with them to upgrade the breastfeeding section of their pack to include all of our material. That helped to get more businesses included, which was really helpful in a city like Wakefield which covers a very large area.

## Building a team of volunteers was crucial

Building a team of volunteers was crucial, and Facebook was a wonderful tool for that. We now have a volunteer who collates new sign-ups, records them and sends them to be updated to the website's database. We have a team of people who go round doing sign-ups as and when they can, and another who wrote a tool to audit companies who had been signed up.

We had great coverage by the local media, and I've done a number of radio and newspaper interviews. I was able to point out how rare it is for a breastfeeding mum to actually come across any negative reactions, yet because they are reported in the media it seems like they happen far more often than they actually do.

Our local NHS Trust has been very supportive, including us on its website pitterpatterchatter.org. This is a work in progress, but once it's running properly will have a full database of signed-up companies, and lots of information about the scheme and how companies can join it.

I have been approached by a town in Kent wanting to use our pack for their own scheme, and I'm looking to expand into the next town along from Wakefield as well. It's not hard to do, it just takes a bit of time and enthusiasm!

I really hope that the scheme helps other women to feel comfortable breastfeeding in public. As 9 out of 10 women who stopped breastfeeding in the first six weeks stopped before they wanted to,[1] and an estimated 40% of women stop breastfeeding before they want to because they are worried about breastfeeding in public, anything that helps them to be more confident could really help to improve breastfeeding rates.

*Emma Ashworth*

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# Breastfeeding in Public

I thought it was ok
I could understand their reasons
They said 'There might be young children or a nervous man seeing'
this small piece of flesh that they weren't quite expecting
so I whispered and tiptoed with nervous discretion.
But after six months of her life sat sitting on lids
Sipping on her milk nostrils sniffing up piss
Trying not to bang her head on toilet roll dispensers
I wonder whether these public loo feeds offend her?
Cos I'm getting tired of discretion and being 'polite' as my baby's first sips are drowned drenched in shite,
I spent the first feeding months of her beautiful life
Feeling nervous and awkward and wanting everything right.
Surrounded by family until I stepped out the house
It took me eight weeks to get the confidence to go into town
Now the comments around me cut like a knife
As I rush into toilet cubicles feeling nothing like nice.
Because I'm giving her milk that's not in a bottle
Wishing the cocaine generation white powder would topple
I see pyramid sales pitches across our green globe
and female breasts banned. Unless they're out just for show.
And the more I go out, the more I can't stand it,
I walk into town feel I'm surrounded by bandits
Cos in this country of billboards covered in 'tits'
and family newsagents' magazines full of it
W H Smith top shelves out for men - Why don't you complain about them then?
In this country of billboards covered in 'tits'
and family newsagents magazines full of it
W H Smith top shelves out for men, I'm getting embarrassed
In case a small flash of flesh might offend.
And I'm not trying to 'parade' this, I don't want to make a show
But when I'm told I'd be better just staying at home
And when another friend I know is thrown off a bus
And another woman told to get out the pub
Even my grandma said maybe I was 'sexing it up'.

Alison Pridmore and baby Thomas, hat courtesy of Sharon Spink from Boobie and the Beads


And I'm sure the milk makers love all this fuss
All the cussing and worry and looks of disgust
As another mother turns from nipples to powder
Ashamed or embarrassed by comments around her and
As I hold her head up and pull my cardy across and she sips on the liquor made by everyone's God, I think
For God sake, Jesus drank it
So did Sidhartha, Muhammed and Moses and both of their fathers
Ganesh and Shiva and Brighid and Buddha and I'm sure they weren't doing it sniffing up piss as their mothers sat embarrassed on cold toilet lids
In a country of billboards covered in 'tits'
In a country of low cut tops, cleavage and skin
In a country of cloth bags and recycling bins and as I desperately try to take all of it in,
I hold her head up
I can't get my head round
The anger towards us and not to the sounds
of lorries offloading formula milk
into countries where water runs dripping in filth
In towns where breasts are oasis of life
now dried up in two for one offers, enticed by labels and logos and gold standard rights
claiming 'breastmilk is healthier powdered and white'
packaged and branded and sold at a price so that nothing is free in this money fuelled life.
Which is fine
If you need it or prefer and can afford to use bottles,
where water is clean and bacteria boiled,
but in towns where they drown in pollution and sewage
bottled kids die and they knew that they'd do it
In families where pennies are savoured like sweets
We're now paying for one thing that's always been free
In villages empty of hospital beds
babies die, diarrhoea fuelled that breastmilk would end
So no more will I sit on these cold toilet lids
No matter how embarrassed I feel as she sips
Cos in this country of billboards covered in 'tits'
I think I should try to get used to this.

*Hollie McNish*

*video available at www.holliemcnish.com*
*and at www.youtube.com/watch?v=KiS8q_fifa0*

# Birth Story

Sheffield Screening of *Birth Story: Ina May Gaskin and the Farm Midwives*

**An assortment of midwives, students, lecturers, doulas, health commissioners, pregnant women and people just curious about birth flocked to their cinema seats and the evening got underway. I am an avid reader of Ina May Gaskin's books and love her common sense approach to childbirth. I felt strongly about getting *Birth Story* screened in my hometown of Sheffield in the independent cinema, The Showroom.**

Ina May has inspired generations of people, including myself, to their calling as midwives, doulas and childbirth educators. With over 200 people in attendance, it fills me with confidence that she still continues, at the age of 72, to draw in the crowds.

The film takes us back to The Farm's very beginnings in the early 1970s when young people were speaking out and exploring alternative ways of thinking. Ina May's husband Stephen Gaskin started 'The Monday Night Class' in San Francisco, where he lectured others on his revolutionary views of life. His previous college lecturing contract had ended and he became 'too weird' to be rehired. His class was a success so they took to the road with 50 buses and bread vans filled with young hopefuls, which affectionately became known as 'The Caravan'. They settled on a patch of land in Tennessee where they founded America's biggest and longest running intentional community (commune), 'The Farm'. They were 'spiritually seeking', said one of the midwives, and they did. When there was so much violence in the world, including behind hospital gates, it became necessary for them to create a new culture where 'fear wasn't going to play a big part'.

Ina May recounts her first pregnancy when her obstetrician told her: as it was her first birth she would definitely require a forceps delivery, otherwise her baby was 'at risk of brain damage'. Ina May remembers this seemed illogical that nature would design all first borns like this but didn't want to argue with the doctor! This was a time in America when obstetricians were using forceps and episiotomies like kids with new toys and human atrocities were going on behind closed doors.

In stark contrast when she witnessed her first birth in the back of one of the converted buses, she was awestruck by the power and beauty emanating from the woman. Ina May had a knowing, a kind of deep, feminine, intuitive knowledge that the sacrament of birth needed to be respected and kept within the family. So the women learnt midwifery themselves in order to sustain their community and ideals. The Farm's midwifery centre grew from the determination of the group to create a better birth experience for the women. It is significant to note that although they were steering away from the masses, they had safety as a priority. Trucks were meticulously maintained to ensure safe transport of women in an emergency and, as well as two Farm residents training as doctors, they had close ties with a compassionate local GP. Yet what remains so incredible about their practice is their low rates of intervention. Between 1970 and 2000, 4.9% of women required transfer, 0.55% had instrumental deliveries and only 1.4% of women needed caesarean sections.[1] Her book 'Spiritual Midwifery', which arose from the birth stories women were sharing with each other, has since been translated into many languages and is still used in the Dutch midwifery curriculum today.

We could view this film as a historical look at how wrong we were to over medicalise birth and how we've moved on, but have we? Ina May's job is not over. When even the surrounding states outlaw midwifery, women come to use the birth centre to this day. She's shown in the film continuing to speak at conferences worldwide about the importance of the midwifery profession and her concerns about the rising rates of caesareans worldwide and maternal deaths in the United States. A culture of fear is rising again in the west. Negative views of birth continue to be perpetuated by the media. It begs the question, are we becoming too clinical and straying away from the spiritual, wise, 'with woman' role?

The film ended and I introduced our speaker, Jane Evans, a UK expert on twins and breech birth and author of the AIMS book *Breech Birth: What are my options?* A midwife since 1976, practising independently since 1991, she was perfect to speak after the screening as she has spent time on The Farm. In the movie we saw a clip of a breech birth; Jane noted that in this birth, the lady was on her back. It was archival footage and she made us aware that The Farm midwives were sourcing knowledge from obstetric textbooks in the very early days.

Jane gave us an excellent demonstration of a breech birth using her handy pelvis and doll. She expressed the importance of using gravity; ensuring women are in an all-fours or similar upright position which additionally allows the coccyx bone to make more room for the baby. Breech presentation occurs in 3-4% of pregnancies. In 1% of births, undiagnosed breech still occurs and Jane spoke about the importance of reskilling birth attendants in the vanishing art of vaginal breech birth. Without skilled providers in breech birth, we are doing women a serious disservice and limiting their choice.

I left with a memory of the film's final scene: a beautiful water birth in one of The Farm cabins. The woman was surrounded by her family and caught her own baby as it came into the world; a reminder that we women are pretty awe-inspiring. The audience disbanded, and a quote from the film came to mind: *'it's not just a few hippies interested in better birth, it's all kinds of people!'*

*Amy Barker*

**References**

1. Gaskin I.M. (2002) Spiritual Midwifery. 4th ed. Book Publishing Company: Summertown, Tennessee.

# ABM Conference

Association of Breastfeeding Mothers, June 2013

**My baby, Jacob, and I had a great time at the ABM conference in June 2013! I went armed with a great selection of 'Bosom Buns' and a great UKAMB cake, kindly donated by Sue Balmer and my friend and United Kingdom Association for Milk Banking (UKAMB) supporter Victoria.**

There was lots of interest in the UKAMB stand, and not just in the delicious cakes (which incidentally raised £108 towards improving awareness of donor breastmilk). With most attendees being breastfeeding supporters with the ABM or other organisations, there were plenty of people wanting to ask questions and find out more about donor breastmilk banking. We were able to talk directly with those likely to be in the position of supporting donor mums, as well as parents of babies in need of donor milk. As well as being a UKAMB volunteer and Trustee, I'm also an ABM Breastfeeding Counsellor so it was doubly interesting for me.

The last conference I attended with UKAMB saw Baby Jacob just starting to crawl. That was the huge Baby Friendly conference with hundreds of attendees, and he gave me plenty to do just to keep him near our stand. This time he had just started to get up onto his feet and he decided that the room with the stands in was really designed for walking practice, so I apologise to all those women whose conversations were abruptly severed when I had suddenly to run to re-capture my small boy!

The conference itself had an amazing line up of speakers. Gill Rapley discussed baby-led feeding of milk and solids. She explained how respecting a baby's ability to judge how much he or she wants to eat and not encouraging a baby to eat past satiation ('just one more spoon for mummy!') was likely to lead to them growing up retaining their ability to not over-eat. She talked about how babies are people too, who, if given the opportunity, will thoroughly enjoy the texture, shape, feel, colour and smell of different foods rather than having them all mushed up into one single flavour, colour and texture.

Kim Jones spoke about relactation and induced lactation, reminding us breastfeeding counsellors, mother supporters and lactation consultants that while we can explain to mums that she might 'need' to express 8-10 times in 24 hours, including overnight, we really need to work with that mum to find what actually would work for her and her family life.

Next was a fascinating update on the ISIS infant sleep project, and we were all immensely impressed that, despite the speaker being unwell and therefore unable to attend, ABM set up a Skype link to her colleague who presented the talk on projection screens via the Internet! The ISIS project (www.isisonline.org.uk) has been hugely important in supporting parents in making informed choices about the option of safe bed-sharing, and how it can support breastfeeding, which itself reduces the risk of SIDS.

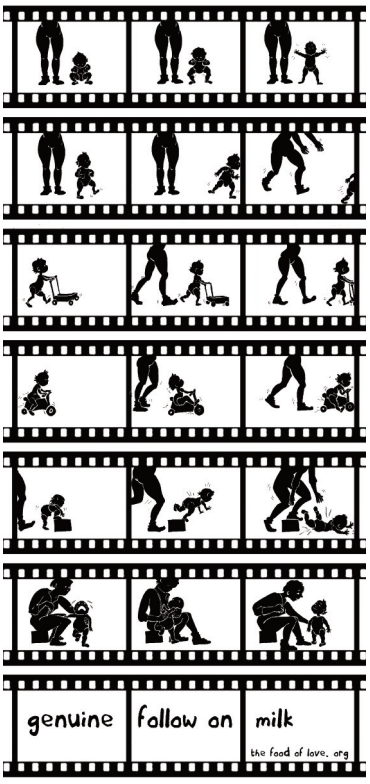
Mike Brady of Baby Milk Action (www.babymilkaction.org), as always, spoke passionately about the ways that artificial baby milk advertising undermines breastfeeding, breaks the WHO Code and sometimes breaks UK law. He shared our frustration that companies whose adverts were found to be illegal, such as the recent *What's the best milk after Lisa's?* campaign, do not have to advertise a retraction; they just have to stop the adverts which will be several months into their release, and from the public's point of view the advert simply seems to have run its course.

The final speaker was the wonderful Kate Evans, cartoonist and author of the utterly fabulous book, *The Food of Love*. This book is a wonderful introduction to breastfeeding and normal baby behaviour, illustrated by Kate's funny, inspiring and informative cartoons. Kate's talk was on feminism and breastfeeding, and how the two are actually eminently compatible. Being a feminist does not mean that we can't cherish our femininity and our unique ability to nourish a child at the breast.

In all, it was a superb conference, with great speakers, very professionally managed and an exceptional lunch to boot! A very valuable conference for UKAMB, and a very enjoyable and informative day for me.

Thank you ABM!

*Emma Ashworth*



# Who's Afraid of the Big Bad Birth

An AIMS talk by Kathryn Gutteridge, July 2013

**Heading up to Birmingham with a couple of birth enthusiasts was a great start to an evening of birth talk. We arrived at the beautiful venue early and were able to mingle as others arrived and find out who was coming. There were many local midwives, as well as doulas, yoga teachers, antenatal teachers and mums who came to hear Kathryn speak.**

Kathryn has been working as a midwife since the 1980s, through community midwifery, and now as a consultant midwife. She is heavily involved in research, hoping to complete her PhD from this, and this meant that her information is not only current, but includes a wonderful amount of case study, often from her own experience or experiences from within her trust. Kathryn was also (and still is) responsible for setting up the two very successful birth centres in Birmingham, Halcyon, a stand-alone midwifery centre, and Serenity, a midwifery centre alongside a consultant unit.

Kathryn began the evening giving us a wonderful image of her start to midwifery, of the community she worked and trained in and how this normalised birth for her in a wonderful way. She began her midwifery career in a community in which home birth was the norm and her experience reflected this. Midwifery training in which she had the privilege to learn about birth by watching and by being present with women, seeing, hearing and sensing progress in labour.

Women take their memories of birth and those who supported them to the grave, good and bad. Kathryn asks midwives, would you want to be the midwife who is remembered as 'the bad one'?

We were shown a blog post of what women's views of birth were, mainly that it was 'scary'. Not only that it was scary but that the 'fear' makes the birth longer and worse so we should try to avoid being scared. This in turn makes women even more scared! So Kathryn pulled out research that looks at what women are afraid of, the facts of maternity health and how women's life today and approach to birth today differs from in previous decades.


Kathryn looked at the change in the mid 20th century from home birth to hospital, how doctors were advised to get more involved with birth so that their patient numbers would grow.

She covered the move to hospital births, which was meant for those in poverty whose homes or situations were considered more dangerous for home birth, but which actually became the place where middle-class women were encouraged to go, where analgesia was more readily available.

Kathryn looked at the power that political, legal and medical professionals have had over birth and women's choice since the 1920s, evident even from conservative calls to women voters.

Kathryn touched on other roots of fear for women, circumstances that can create huge problems for pregnancy and birth. Women who have eating disorders, who have suffered sexual abuse, those whose mothers had a traumatic birth and constantly told the story or those with traumatic experiences of birth themselves.

The main three sources of information about birth are family and friends, TV/media and medical information, with the first two being a constant source of information through women's lives. These representations are very powerful whether positive or negative and are hugely influential in how women form ideas of birth.

Kathryn visited the morbidity and mortality report, to see whether the fear of injury and death was justified. This shows that most injuries and deaths are caused not by birth, but by surgical complications, hospital-acquired infections, haemorrhage (which can be caused by mismanaged or over-managed births) or suicide, which stands as the second highest cause of maternal death. This information, although not new, is still horrifying to be reminded of. There is a lot wrong with current maternity services, she emphasised, if the lack of support before, during and after birth can create so much trauma.

Kathryn recommends an increase in antenatal visits, and that these need to be in the early weeks of pregnancy when women are forming their ideas and fears about birth. The lack of informed support during this time is currently damaging. Without the positive and normal images of birth from family and community that used to be present, women are often now left alone and uninformed until almost 24 weeks of pregnancy.

As a mum who had a previous caesarean I was particularly interested in the comments Kathryn made about caesarean section. There needs to be a huge

improvement in looking at the true impact of an emergency caesarean. Alongside this there needs to be more accurate representations from obstetricians of the risks of caesarean surgery, the benefits of vaginal birth and the comparisons of the two.

An image that stood out from the presentation was the image from one hospital of a smiling couple and surgical team during a caesarean – this was used as the hospital's main maternity services image! How interesting (and frightening to me) that a hospital should see that as such a normal part of birth that it should be how they advertise their services.

Kathryn pointed out that women are already uncertain about their body's ability, what birth entails and how long it can last. When they are told that, 'If they go for a vaginal birth they *can* have anaesthetic including an epidural *but* they will need to wait for a doctor to prescribe this,' or 'There is a lot of indignity and blood involved in birth which can be "avoided" with a caesarean,' or that 'Big babies won't fit anyway' and 'Babies may become distressed with birth' it leads to the increased belief that the body will not work correctly, heightening anxiety and often leading a woman into 'choosing' a caesarean section. This is a frightening consequence of the lack of some professionals knowledge, understanding and trust in the process of normal birth.

Kathryn looked at some recent research that showed anxiety levels over birth were increasing every year and that those being diagnosed with tokophobia are also increasing. Tokophobia is a phobia of birth which can be either primary – when the fear comes before a woman has experienced birth, often from some other trauma in earlier life – or secondary – where the phobia has been caused by a previous birth experience. There are women who are looking for ways of avoiding birth, through abortion or caesarean section, as well as those avoiding repeating previous birth trauma through caesarean section or by birthing alone at home.

Finally, Kathryn looked at how we can reduce fear through the midwifery model of women-centred care. She suggests there are three main points:

- The birth environment. Attitude, behaviour, trust, safety, strength and belief of birth as normal.

- The relationship between the woman and midwife being one of belief and trust.
- Grounded knowledge of birth.

Then Kathryn asked us, 'What can we do?'

This led to a great discussion about current practice, access, availability, choice, language, unnecessary interventions and unhelpful recommendations, respect and lack of it, lack of education in schools, and professional fear influencing lay fear. However, many of the changes that need to happen are within institutions, within policy, and within the culture of birth as it stands. There are certainly no quick answers.

The birth centres that Kathryn has set up are great places in terms of finding good practice. Women's choice is respected, they have midwives that they know and trust. Kathryn insists that trainee midwives and doctors within her Trust spend time within her birth centres. This is to ensure that they are seeing normal birth as part of their training and has been very well received. This is a shining example of changes that need to be made across the country.

Some suggestions from the floor were: campaigning for more and better antenatal provision and support and for more postnatal support; more midwives and one-to-one care; better use of language so that women are more aware of their choices; reducing unnecessary interventions such as induction for post dates; better education for children and teenagers, focusing on a respect, acceptance and celebration of women's bodies, menstruation and subsequently birth; allowing midwives the time, space and support to truly be able to support women and protect their birth space and believe in them.

The change, Kathryn concluded, has to come from women. Women need to acknowledge that things are not how they should be and push for change.

A wonderful evening that left me with lots more questions. This is definitely an area that needs revisiting frequently.

Also a special thanks to Chloe Bayfield, without whom these talks would simply not happen!

*Susan Merrick*

# Family Constellations

A workshop with Julia Duthie, January 2013

**For me, January 2013 turned out to be quite a busy start in the birth world. The two days following the AIMS lecture in Bristol, saw a workshop from Julia Duthie on Family Constellations and then a day from Relaxed Birth and Parenting on Birth Trauma. I was lucky enough to go to both, so here's a quick round-up of Julia's talk for those of you interested in discovering more about her work.**

Family Constellations is a 'therapeutic' process blended from cognitive, behavioural and psychodynamic psychotherapy. I say therapeutic in the broadest sense of the word: it's definitely resolution-based therapy. It guides participants to more closely examine any contributing factors within the genealogy first to get an understanding of the root causes of (dysfunctional) events that show up, particularly in a birthing situation.

**insight could be gained into any effects my ancestral line has had**

For the last twelve months I've been peering into my own birth 'story' with a bit of a magnifying glass. As I learnt more about the psychological impact of your experience (as the baby) at birth and even before, it occurred to me that there could be things to learn from my ancestral line. I have no knowledge of the details of the birth experiences for my mother and hers but I have noticed a pattern between the generations regarding the way family relationships have gone.

So, even though my interest was initially academically motivated, I hoped that some insight could be gained into any effects my ancestral line has had on my 'modus operandi' and the significant emotional events that I'd experienced around giving birth.

Julia Duthie is a true master, as midwives so often are, at holding space in which healing and resolution can take place. She explained that her midwifery experience had often revealed, when she really knew a mother giving birth, that some of the root causes of a stall or some challenge in labour could be attributed to a pattern or unresolved event or events in the maternal (and sometimes paternal) ancestral line.

*'The woman [giving birth] or a midwife could subconsciously inherit suppressed or unresolved challenges of her ancestors. Sensitive people at a birth can notice that she's carrying something even though its not been spoken.'*

The Family Constellations process, in particular for birth workers sensitive to the broader picture of a person, could notice that if things aren't flowing easily and if they really know the woman they can identify a pattern or an event with similar attributes to a pattern or event that may have occurred in the ancestral line.

You really have to experience or witness the technique for yourself to get a true handle on how you could apply it to enhance someone's birth. The simplest description I can give is that it is almost like role playing, using symbols that feel right, as representative of people related to the person working on their healing. Then, the conflicts or resistances are assessed in a resourceful state which facilitates perspective, understanding and learning and ultimately allows a healing to take place.

During the one day workshop Julia Duthie also gave practical advice about how to use aspects of the technique even if your relationship with and knowledge of the birthing mother are limited, for example in cases where there has been a termination or relations with family members is strained, as these can all have an impact on the flow of birth.

*'If the woman has had a termination it's really good for the midwife to acknowledge those babies because often the guilt about that can affect this birth.'*

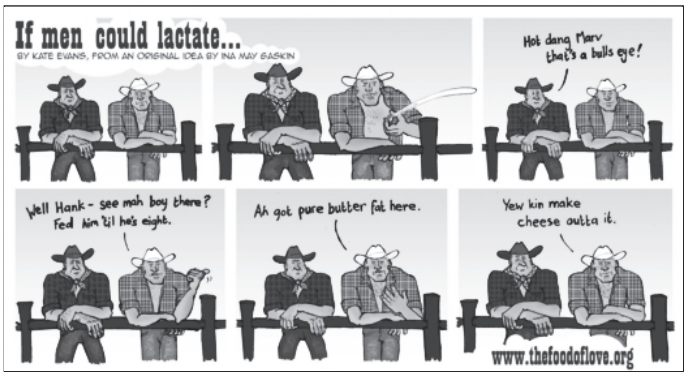
Whilst the workshop did not address my 'constellation' it did present an opportunity to re-examine aspects, particularly of my maternal ancestry, that seemed to be a repeat of patterns in place many generations before. Therefore it does exactly what it says on the tin:

*'In a single session, a Family Constellation attempts to reveal a previously unrecognized systemic dynamic that spans multiple generations in a given family and to resolve the deleterious effects of that dynamic by encouraging the subject to accept the factual reality of the past.'*

Julia Duthie is an independent midwife in Devon, specialising in home birth. She runs regular Family Constellations workshops.

*Marie J Taylor*

**Further details can be found at:**
**www.familyconstellationssouthwest.co.uk**



# Tickery Quackery Mock

Alison is a retired midwife and International Board Certified Lactation Consultant, and author of *Fit To Bust*, a celebration of breastfeeding and motherhood. She wrote her thoughts in answer to advice on strict feeding regimes. Charlie responded with a second verse.

These 'experts' should go in the dock,
Defending the role of the clock,
Successful lactation
predates its creation;
Our verdict is 'pure poppycock!'

A guru, an expert, a doc,
all saying you must watch the clock,
to sleep or to feed,
there's really no need,
'cos mother's own instinct just rocks.

*by Alison Blenkinsop and Charlie Young*

Alison also penned this wonderful poem, in celebration of the Breastfeeding etc. (Scotland) Act 2005. This Act of the Scottish Parliament was passed by the Parliament on 18th November 2004 and received Royal Assent on 18th January 2005. Full text is available at www.legislation.gov.uk/asp/2005/11/contents.

Morag has two little bairns
with clothes of pink and blue;
And everywhere that Morag goes
the breastfed twins go too.
Now people never harass them,
because of Scottish Law;
Her nurslings don't embarrass them
'cos that's what breasts are for!

This act says:

*An Act of the Scottish Parliament to make it an offence to prevent or stop a person in charge of a child who is otherwise permitted to be in a public place or licensed premises from feeding milk to that child in that place or on those premises; to make provision in relation to the promotion of breastfeeding; and for connected purposes.*

*"child" means a person who has not yet attained the age of two years;*

*"feeding" includes—*

*(a)breastfeeding; and*

*(b)feeding from a bottle or other container;*

*"milk" means breastmilk, cow's milk or infant formula;*

*"public place" means any place to which, at the material time, the public or any section of the public has access, on payment or otherwise, as of right or by virtue of express or implied permission.*

Alison's book, *Fit to Bust*, is sold in aid of Baby Milk Action www.babymilkaction.org. Her website is www.linkable.biz.

# Breast Feed is the Best Feed

## A programme to improve breastfeeding support for women in India

**The Goal**

The goal of this programme is to encourage exclusive breastfeeding for the first six months, and continued breastfeeding for two years in accordance with the WHO guidelines.

**Why a Breastfeeding Initiative?**

According to both the World Health Organization and UNICEF, breastfeeding is critical in ensuring infant survival. This is particularly true in impoverished communities. Unfortunately, the current breastfeeding 'education' that these mothers receive consists of billboards from formula companies claiming 'breast is best' and programmes that may help women initiate breastfeeding but do not provide ongoing postpartum support as described in UNICEF's Baby-Friendly Hospital Initiative.

**The Current Initiative**

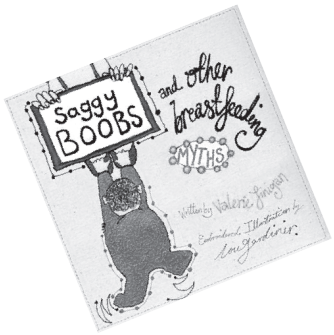
Shabnam Resources plans to train peer counsellors from low-income neighbourhoods in Chennai to provide education about breastfeeding to prospective mothers and provide support once these mothers have had their babies. The peer counsellors will have regular interactions with the mothers because they live in the same communities. Chennai is the capital of the Indian state of Tamil Nadu, the 11th largest state, with a population of approximately 75 million.

**About Shabnam Resources Trust**

Shabnam Resources Trust is a registered non-profit charity focusing on children's and young mothers' welfare in rural and semi-urban areas in India. Its activities also extend more broadly to the needs of children, the destitute and senior citizens. Shabnam means the first refreshing rain after a dry spell.

For more information about the project, contact
**M R. Hubert, Founder Director**
Shabnam Resources (registered charitable non-profit organization)
www.shabnamresources.com
shabnam.resources@gmail.com

# Reviews




*Saggy Boobs and Other Breastfeeding Myths*
*by Valerie Finigan*
*Embroidered illustration by Lou Gardiner*
*Pinter and Martin 2009*
*Publisher's recommended price £5.99*

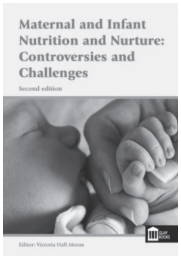
Myths about breastfeeding exploding all over the place in a rainbow coloured embroidered set of cartoons make this attractive book a brilliant and unstuffy way to give important evidence about the benefits of breastfeeding to mothers and babies: this would be a perfect book to have on the coffee table at a peer-support breastfeeding session.

The book began as an idea by Val Finigan, infant-feeding coordinator for the Pennine Acute Hospitals NHS Trust. Val wanted to work with mums and breastfeeding groups to dispel myths and Lou Gardiner was commissioned to work with breastfeeding support groups to make embroidered illustrations of the myths and rumours they had heard.

Commonly expressed doubts about breastfeeding that we've all heard, such as your baby will wake up all the time, be clingier, not grow as well and so on, are dispensed with simply and authoritatively; the positive aspects are cheerfully brought out and the effect is refreshing. Research is mentioned in a calm, authoritative way but not referenced. This little and amusing book is a pleasure to read and a lovely present for a new Mum.

***Gill Boden***

*Maternal and Infant Nutrition and Nurture: Controversies and challenges*
*Edited by Victoria Hall Moran and Fiona Dykes*
*Quay Books 2013*
*Publisher's recommended price £29.99*




This book comprises an interesting collection of topical subjects relating to the subject matter, presented in an evidence-based manner. Not a light read, the writers present their chapters in an intellectually stimulating manner; they invite the reader to consider innovative ideas, to update their knowledge base and to challenge existing beliefs and practices.

A holistic 'socio-biological perspective' to maternal and infant nutrition permeates, and the complex interactions between physiological, socio-economic, political and cultural factors are considered in relation to each topic.

In the first chapter Fiona Dykes and Victoria Hall Moran look at transmitted nutritional deprivation from mother to child. Complex issues are considered and the need for more research in this area is highlighted. What is made clear is the life long influence of good or bad nutrition on not only mothers but their offspring too. The authors refer to research that shows that a mother's nutritional status throughout her life, including her own in-utero experience, is more significant to the wellbeing of her baby than her nutritional status during pregnancy. The impact of poverty on health is explicit and the need to address the issues surrounding nutritional deprivation highlighted.

In the second chapter Victoria Hall Moran discusses nutrition during adolescent pregnancy. She describes the nutritional needs of adolescent mothers and the broader socio-economic, cultural and behavioural factors that are important too. The need for a multidisciplinary, lifestyle approach is described, as is the need for more research.

Darren Hart looks at the evidence surrounding eating and drinking in labour, questioning current practice and the lack of a united policy.

Sally Inch writes about feeding the newborn baby. She considers the physiological, socio-economic, political and cultural factors surrounding breast and bottle feeding. She also charts the historical development of breastmilk substitutes and the problems associated with formula milks.

In the following chapter Magda Sachs reflects on the feeding policy for HIV positive mothers and their babies in the UK. Another fascinating read, it opens eyes to the short-sightedness of policy makers and also to the lack of conviction surrounding the advantages of breastfeeding.

Sue Battersby explores attitudes towards infant feeding in mothers, health professionals and society at large. The importance of self-awareness and the need for reflection on our attitudes to infant feeding are made clear and a model for use in education is suggested.

Alison Spiro describes her research with Gujarati women. She examines their attitudes to breastfeeding and to decision making. She looks at how cultural and religious beliefs, alongside their kinship structures, influence infant feeding. This information offers an interesting insight into how another culture's views differ from those of the indigenous UK population.

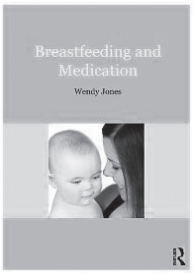
Mavis Kirkham and colleagues describe 'Breastfriends' Doncaster – the story of their peer support project. This interesting chapter clearly demonstrates the benefits that peer support programmes have to offer.

Gill Rapley suggests that baby-led weaning is the natural progression for breastfed babies and suggests further research into its suitability for bottle-fed babies.

Fiona Dykes and Victoria Hall Moran summarise with a focus on the importance of considering nutrition and infant feeding within the broader context of a socio-biological framework. Their comments made me wonder, when nutrition holds the key to so many health and social benefits, how we can allow commercial interests to dictate the future health of our nation.

This book will be of interest to all who want to learn more about the importance of maternal and infant nutrition and the complex factors influencing them. The comprehensive references will make this an extremely useful resource for many. I would suggest that it is a 'must read' for all those concerned with policy-making.

***Clare Bartos***




*Breastfeeding and Medication*
*by Wendy Jones*
*Routledge 2013*
*Publisher's recommended price £28.99*

Wendy Jones is well known amongst breastfeeding supporters for her work running the Breastfeeding Network's Drugs in Breastmilk helpline. Wendy is both a pharmacist and a breastfeeding counsellor.

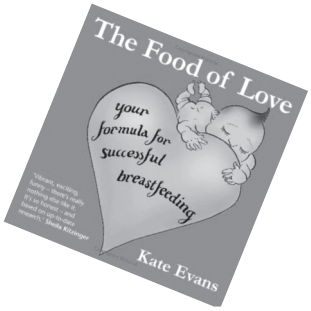
As a breastfeeding counsellor myself, I regularly refer women to the BfN website (www.breastfeedingnetwork.org.uk) for information on drug safety, and was fully expecting the book to be extremely useful. In fact, I used it the day after it arrived in the post for myself, and took it along to the pharmacy with me to discuss a specific drug with the pharmacist. She then decided to buy a copy too! It is now my main reference book while on the ABM breastfeeding helpline and barely a session passes that I don't refer to it at least once to give mums information to take back to their GP or other healthcare professional.

Wendy Jones has worked out the safety of hundreds of common drugs using a variety of methods and evidence sources, clearly referenced in this book, allowing mothers to make an informed choice about treatment, and giving prescribers the ability to really understand the safety of each drug for breastfeeding mothers. The reference section, which fills about half of the book, is clear and easy to navigate. It includes detailed information on Wendy's conclusions about each drug as well as references and explanations of specific instances of, for example, reported adverse reactions. There is a very clear and detailed explanation of the way that she has calculated drug safety, giving prescribers information quickly, but in-depth, so they can make decisions about prescribing an item off-licence.

If this wasn't enough to make every doctor, health visitor, midwife, pharmacist and breastfeeding counsellor rush out to buy this book (and they should), Wendy has also written the clearest explanation of the importance of breastmilk that I have ever read. She discusses breastfeeding from a historical, cultural and scientific perspective and explains why it is that breastfeeding is so incredibly important to the health of both babies and mothers. She writes for the medically trained with full biological explanations, but her writing is still clear and fully accessible to the lay reader. There is an excellent section about common breastfeeding/infant feeding concerns, both real and common myths, including mastitis, thrush, worries about low milk supply, milk intake, Raynaud's syndrome, colic and so on.

The importance of good positioning and attachment is referred to time and again, together with their relevance to good milk transfer, and how poor position and attachment can lead to a multitude of misdiagnoses which are then unnecessarily medicated. This underlines the real value of this superb book – the combination of a highly experienced breastfeeding counsellor and pharmacist to produce a depth of knowledge and understanding of the subject that I truly have not found anywhere else.

***Emma Ashworth***




*The Food of Love*
*by Kate Evans*
*Myriad Editions 2008*
*Publisher's recommended price £12.99*

The Food of Love is an illustrated breastfeeding handbook, first published in 2008. I first heard of it through the author's blog when I came across the post 'Lashing back against the backlash' (www.thefoodoflove.org/lashing-back-against-the-backlash/) which addresses the tangled argument of 'breastfeeding as anti-feminist'. This quote particularly resonated with me: *'Look, this is amazing! Food comes out of our chests! And it grows incredibly healthy children! And it's free! And it feels nice! And it's full of stem cells! And it cures cancer! And it kills HIV!'* At the time I was breastfeeding my two-week-old baby and thought, 'Must get around to reading the book!'. Now 15 months later and still breastfeeding, I've finally managed to read it and would highly recommend it to anyone who wants to breastfeed or who wants to share their passion for breastfeeding with others. What makes this book stand out among breastfeeding manuals are the hilariously realistic cartoon illustrations. The topic of breastfeeding can be a minefield of cultural taboos and judgement – and these cartoons portray this reality, as well as the blissful joy of breastfeeding for mum and baby, in a non-patronising, entertaining way. The illustrations not only offer detailed practical information on breastfeeding positions and techniques, but will make you laugh out loud. You'll have to read it for yourself to find out what Kate's sister's second most embarrassing moment was, which has now become an 'urban legend' among breastfeeding mothers.

The book also explores and illustrates topics related to attachment parenting such as co-sleeping, sling wearing and full-term breastfeeding. However, the book does not go in-depth about scenarios where mothers may need additional support such as breastfeeding after a caesarean birth or accessing and using donor milk.

The entire book is grounded in evidence-based research and also includes a well-referenced section on additional resources. From my experience I believe there is no replacement for good human face-to-face support, but this book is just about the next best thing.

If you purchase online from www.thefoodoflove.org.uk (£15, free postage within the UK) Kate will write a dedication if you request one. It's an ideal gift not only for an expectant or new mum, but also a trainee doula, antenatal teacher or breastfeeding supporter.

***Virginia Hatton***

# Letters

## Breastfeeding

I write today about my breastfeeding journey – 5 years and 5 months virtually to the day …

My journey spans three babies one of whom is now 5 years and 5 months – we weaned together, Christmas just gone, my just over 3 year old and my 8 month old.

I never imagined breastfeeding beyond a few months 'it was nice' I was sure but I had not breastfed my eldest, no woman in my family had breastfed beyond the first day, for a LONG time.

The tins back then said 'closer than ever to breastmilk' so I did what was my best at that time, I bought the tinned milk that was the closest, I fed her with love and care, I made all her baby food.

I genuinely thought the tinned milk was better, I believed the hype. I believed my mother, my sister, the midwife, the health visitor.

My son was born at home under the moon, in the dark he crawled up and latched on.

The days and weeks slipped by and suddenly I had a grinning chubby 8 month old falling asleep with my nipple in his mouth, then a 1 year old signing milk! Then a toddler tapping my leg and wham … I had a speaking small person who could say, 'nummies pwease!'

It's had its down days, days where I want to scream because my toddler thinks I am a tap, or when the baby is having a growth spurt ... then up days, the days where I feel SO proud, so glad and so awesome to be breastfeeding.

These days it's nothing short of normal – my boys sit and play act breastfeeding their dolls, they carry them in makeshift slings and I sit and smile ... two boys who will go on to smile at women breastfeeding, hopefully two men who will hold their partner and say you're awesome, thank you.

I wish this for all women, we are slowly taking back our bodies, our breasts, reclaiming our journey and attaining our own goals – be that to breastfeed for a day, a week, a year ..

*Sarah Holdway*

## Hidden Values

I thoroughly enjoyed reading the article *Improving our Thinking* by Elselijn Kingma. Looking at hidden value-claims in maternity, it seems an absolutely vital aspect to consider in decision making with reference to birth.

It was eye-opening to be shown that not only media reporting (which I am more than aware looks for the drama) but also our own maternity policies are based on hidden value-claims.

The article not only confronts the value-claims but also discusses the massive impact these can and do have on policy and perception of birth and women. It angered me to realise that so many assumptions in policy or attitudes of professionals suggest that pregnant women come low down the list of priorities in much decision making.

This surely should be a must-read topic for all professionals entering into the world of maternity.

Thank you as always for your journal, of the moment and challenging.

*Susan Merrick*
*Mother and Doula*

## They said what?

**'You can buy test strips to check for alcohol levels in your milk.'**
These magic strips of course do not tell you what, if any, harm it might do, or that formula is also full of potentially harmful additives, or that if you are parenting whilst severely impaired due to alcohol, the levels in your milk might be less of a concern than being responsive to your baby.
This is a gadget that preys on women's concerns about doing the best for their baby, feeds into the misconception that breastmilk may not be best and into the myth that breastfeeding stops you from going out and having fun.
Alcohol concentration in milk is roughly the same as the alcohol concentration of the blood plasma generating the milk. 0.5% blood plasma alcohol is a deadly level, yet drinking a liquid with a 0.5% alcohol content will have little or no effect. A person with a 0.1% blood concentration of alcohol is likely to be intoxicated, 0.08% blood alcohol content is the UK's drink driving limit. However, 0.1% alcohol is the level of alcohol that occurs naturally in fresh orange juice. These strips detect alcohol at 13.1mg/dL; 100mg/dL would be equal to a 0.1% concentration of alcohol, so it would seem that they are encouraging women to worry over an alcohol level that may be undetectable in their baby.

**'You can buy a gadget to check your milk production.'**
Another gem from a similar mindset. It is a pump, and evidence shows clearly that the amount a woman can express bears little relation to the quantity of milk available to her baby. Should marketing of gadgets designed to knock women's confidence come under the WHO Code?

# NMC – Still Unfit for Purpose

*Beverley Beech* explains some of the issues with the NMC fitness to practise system

**Following an inquiry by the Council for Healthcare Regulatory Excellence into the activities of the Nursing and Midwifery Council (which concluded that it was not fit for purpose) the government has awarded the NMC £20 million to address 'the problems it faces in terms of administration and management'. But it is not just the performance that needs addressing. As far as midwives and users of the service are concerned there is a far greater problem – the dichotomy between nursing and midwifery practice. The Midwifery Committee has been emasculated and barely a peep has been heard from the profession.**

In 1983 the government proposed a single 'nursing' professional council. Despite opposition from midwives, AIMS and other groups, it amalgamated the Central Midwives Board into the UK Central Council for Nursing, Midwifery and Health Visiting, which, in 2002 became the Nursing and Midwifery Council. Midwives fought for a separate Midwifery Committee within the NMC but it has recently had its support staff withdrawn and Council members reduced until only one midwife remains on the main Nursing and Midwifery Council.

Over recent years, too many excellent practising midwives (most of them independent) have been reported to the NMC, where midwives are no longer judged by their peers. AIMS recently attended a hearing where a community midwife was judged by a labour ward manager who was not up to date with the research, and, from his questions, had no concept of the principles of informed consent. Some more recent examples:

***Beatrice Carla*** – this case encapsulates the struggle between midwifery evidence, knowledge and skills, and accepted medical evidence, protocols and policies. This struggle was very apparent among the panel members. Perhaps the most worrying aspect of this case was that while the Chair of the panel, Professor Paul Lewis, was an exemplary Chair, showing fairness, care, courtesy and regard towards all concerned, he had repeatedly to draw the attention of the other panel members to the fact that routine practice, which they thought all midwives should adhere to, is not necessarily supported by research evidence. It is a serious issue that the NMC has failed, and is continuing to fail, to address.

***Debs Purdue*** – struck off by the NMC for a variety of reasons, none of which justified striking off the register and one of which was *'failing to bring a breech baby into hospital soon enough'* despite the evidence that she brought the woman into the hospital as soon as she diagnosed that the baby was presenting by the breech. The baby was fit and healthy when she handed over to the staff who then conducted an obstetric breech delivery and the baby died. Someone had to carry the can and only Debs's practice was investigated.

***Clare Fisher*** – still fighting the NMC system, despite an Ombudsman investigation which resulted in criticism of how Health Professions Wales and the LSA investigations were carried out. A further investigation has revealed the lack of equity and impartiality in the NMC. During one of her NMC hearings a panel member, Eunice Foster, fell asleep, repeatedly, and no steps were taken to remove her. See www.aims.org.uk/Journal/Vol21No3/welshWitchHunt.htm

***Becky Reed*** – an internationally respected midwife offering woman-centred care. In January 2010 Becky was referred, without her knowledge, to the NMC by the Head of Midwifery at King's, Katie Yiannouzis. The referral cited seven cases, spanning a period of over three years, dating back to July 2006. Becky was primary midwife in only two of the cases. Katie Yiannouzis had been Becky's midwifery supervisor until February 2009 and had raised no concerns with her about her practice. In 2010 Becky was ordered by an interim orders (IO) hearing to undertake 450 hours of supervised practice. At the IO review in April 2011, her conditions of practice were entirely revoked and she was free to practise again, but the NMC decided to continue investigation. An NMC hearing to be held in March 2013 was postponed until July for a one day hearing to dispose of the case. The prosecuting lawyer offered no evidence but both he and the panel referred frequently to the 63 charges and the expert witness report for the NMC. Becky was not allowed to challenge this or present her evidence. The panel report lists the unproven charges in full, portrays Becky as a midwife who had had serious (but entirely unproven) failings, before noting that *'there was no case to answer'*.
www.facebook.com/JusticeForBeckyReed?ref=ts&fref=ts

***Julia Duthie*** – one of the few midwives who was able to appeal to the High Court against an NMC decision to strike her off for a number of alleged and disputed failings, for example that she had *'persuaded her client not to go into hospital to have her baby.'* Mr Justice Irwin quashed the NMC Panel's finding on the grounds that *'the panel failed to assess the evidence properly',* but did direct that a fresh Fitness to Practise Panel should consider whether four other findings, which did not relate to the treatment she provided, constituted misconduct. The hearing, which is open to the public, is scheduled for 12-14th November.

Supervision of midwives was introduced and promoted as a method of ensuring high-quality midwifery care which would give midwives support and the opportunity of dealing with errors in practice quickly and fairly. Unfortunately, too often it is used as a method of penalising midwives who step out of line; it is unfair and often punitive. Midwives are frequently told they cannot challenge the contents of a supervisor's report and, as was seen in Becky Reed's case, they have no opportunity to challenge evidence the NMC gathers together to charge them with.

Until midwives have their own Midwifery Council and allegations of failure in practice are judged by expert midwives who understand midwifery philosophy, knowledge and practice these injustices will continue; and women will be deprived of skilled midwives who really understand the meaning of normal, undisturbed, physiological birth, informed consent and women-centred care.

***Beverley A Lawrence Beech***

# Publications

**AIMS Journal:** A quarterly publication spearheading discussions on change and development in the maternity services, and a source of information and support for parents and workers in maternity care. Back issues are available on a variety of topics, including miscarriage, labour pain, antenatal testing, caesarean safety and the normal birthing process. £3.00

**Am I Allowed?** by Beverley Beech: Your rights and options through pregnancy and birth. £8.00

**Birth after Caesarean** by Jenny Lesley: Information regarding choices, suggestions for ways to make VBAC more likely, and where to go to find support; includes real experiences of women. £8.00

**Birthing Autonomy: Women's Experiences of Planning Home Births** by Nadine Pilley Edwards, AIMS Vice Chair: Is home birth dangerous for women and babies? Shouldn't women decide where to have their babies? This book brings some balance to difficult arguments about home birth by focusing on women's views and their experiences of planning to birth at home. Invaluable for expectant mothers and professionals alike. £22.99

**Birthing Your Baby: The Second Stage** by Nadine Edwards and Beverley Beech: Physiology of second stage of labour; advantages of a more relaxed approach to birth. £5.00

**Birthing Your Placenta: The Third Stage** by Nadine Edwards and Sara Wickham: Fully updated (2011) evidence-based guide to birthing your placenta. £8.00

**Breech Birth – What Are My Options?** by Jane Evans: One of the most experienced midwives in breech birth offers advice and information for women deciding upon their options. £8.00

**The Father's Home Birth Handbook** by Leah Hazard: A fantastic source of evidence-based information, risks and responsibilities, and the challenges of home birth. It gives many reassuring stories from other fathers. A must for fathers-to-be or birth partners. £8.99

**Home Birth – A Practical Guide** (4th Edition) by Nicky Wesson: The fully revised and updated edition. It is relevant to everyone who is pregnant, even if they are not planning a home birth. £8.99

**Induction: Do I Really Need It?** by Sara Wickham: An in-depth look into the options for women whose babies are 'overdue', as well as those who may or may not have gestational diabetes, or whose waters have broken but have not gone into labour. £5.00

**Making a Complaint about Maternity Care** by Beverley Lawrence Beech: The complaints system can appear to many as an impenetrable maze. For anyone thinking of making a complaint about their maternity care this guide gives information about the procedures, the pitfalls and the regulations. £3.00
pdf available for free download

**Safety in Childbirth** by Marjorie Tew: Updated and extended edition of the research into the safety of home and hospital birth. £5.00

**Ultrasound? Unsound!** by Beverley Beech and Jean Robinson: A review of ultrasound research, including AIMS' concerns over its expanding routine use in pregnancy. £5.00

**Vitamin K and the Newborn** by Sara Wickham: A thoughtful and fully referenced exploration of the issues surrounding the practice of giving vitamin K as a just-in-case treatment. £5.00

**What's Right for Me?** by Sara Wickham: Making the right choice of maternity care. £5.00

**Your Birth Rights** by Pat Thomas: A practical guide to women's rights and choices in pregnancy and childbirth. £11.50

**A Charter for Ethical Research in Maternity Care:** Written by AIMS and the NCT. Professional guidelines to help women make informed choices about participating in medical research. £1.00

**AIMS Envelope Labels**: Sticky labels for reusing envelopes
100 for £2.00

**My Baby's Ultrasound Record:** A form to be attached to your case notes as a record of your baby's exposure to ultrasound £1.00

**AIMS Leaflet**: available FREE
from publications@aims.org.uk

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- Am I Allowed?
- Birth after Caesarean
- Birthing Your Baby: The Second Stage
- Birthing Your Placenta: The Third Stage
- Breech Birth: What Are My Options?
- Induction: Do I Really Need It?
- Safety in Childbirth
- Ultrasound? Unsound!
- Vitamin K and the Newborn
- What's Right for Me?

**First–Time Mothers' 7 Book Bundle** £30.00
This book bundle contains 7 AIMS publications at a discounted price, an excellent gift for a newly pregnant friend or relative.

- Am I Allowed?
- Birthing Your Baby: The Second Stage
- Induction: Do I Really Need It?
- Safety in Childbirth
- Ultrasound? Unsound!
- Vitamin K and the Newborn
- What's Right for Me?

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