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ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES

Challenging the medicalisation of birth

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Cover Picture: Sian Alexander and baby Jack
© Sian Alexander
Story on page 16

Invitations have recently gone out to AIMS members inviting them to join the AIMS Members Yahoo Group. If you are not already on the group and have not received an invitation, this probably means that we do not have an up-to-date email address for you. If you would like to update your email address on our database please could you email membership@aims.org.uk including your postcode.

Being a member of the group will not only allow you to have contact with other AIMS members and to hear what the current issues are for them, but also will allow the committee to keep you up to date with what we are doing, when and where the next meetings are planned to take place and what you may be able to do to support AIMS.

health.groups.yahoo.com/group/aimsukmembers

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In accordance with the DPA, any member is entitled to ask: 1) for a printout of his/her personal details as kept on the AIMS computer; and 2) that his/her personal details should not be stored.

The Model Matters

Vicki Williams introduces a journal which challenges the medical model

During my time as editor I have been involved in the production of some difficult Journals. There have been stories, and whole issues, which have made me openly weep – tears of joy, tears of sadness, tears of sheer exasperation, but not one issue which has left me so galvanised to campaign as this one.

For me this issue of the AIMS Journal is tinged with heavy sadness, as on pages 13, 16 and 18 it looks at the campaigns in Fife, Yorkshire and Derbyshire to retain women's rights to choose the place in which they give birth. One of the threatened services is local to me. What a huge blow closure will be to women I work with.

The closure of midwife-led, woman-centred, stand-alone birthing units and the withdrawal of a home birth service are simply spin-offs of a large, under-staffed, under-resourced medical model which does not understand or acknowledge some of the physical and emotional harms it does to women, babies and families. Often it is safer for women both physically and emotionally to birth away from that medical model or conveyor belt of one-size-fits-all care.

Suicide is still a major killer of women during the year after childbirth. It is no surprise to me to read that in the elderly, one of the biggest causes of depression in both men and women is birth trauma. It is no flippant statement that says the effects of birth last a life time![1] I am hoping those findings will be published. It is about time that it was recognised that emotional and physical health are inextricably linked and that both need to be addressed in order to support good health.

The lead article in this issue, written by AIMS Chair Beverley Beech, continues a theme on which she speaks all over the world. Once again AIMS challenges the medical profession to start taking a long, hard look at the evidence and start applying it to the care on offer. The unproven safety of ultrasound is something AIMS has been drawing attention to for over 30 years! Added to that is the complete lack of attention being paid to the voices of women, with their views brushed aside under the pretence that it is more cost-effective or safer to provide impersonal care in a large centralised obstetric unit. Of course there will always be women and babies who need a high level of medical care, for both existing long-term conditions and in emergency situations, but that is just not the case for the majority of, healthy pregnant women. As Holly Lyne so eloquently explains on page 14, human mothers have just not had enough time to evolve an inability to birth their babies.

One explanation for the apparent difficulty 20th Century women have in childbirth is discussed on page 11 by midwife and normal birth activist Rachel Reed. Rachel sums up the practice and evidence supporting the common assessment of labour progress and finds them to be fundamentally flawed, and yet women are subjected to unrealistic expectations and unscientific time-frames and are encouraged to consider it a failure should they not meet targets which bear little resemblance to the progress of a truly physiological labour.

Emmy Lomas's frank account, on page 22, of how her scar makes her feel is not an uncommon story. The emotional pain of her surgical births far out-shadows the positive experience of her VBAC, and even after a positive birth the pain is still very much in evidence. Surely care which leaves women feeling like that is not safe or good care; not good by any standard.

There is no evidence to suggest that all women and babies are safer in a large unit. Many of the practices used routinely do not ensure safety for the majority and are best reserved for those who need them. Do women not deserve the choice to birth away from a model of care which increases the risk of interventions? I struggle to find evidence that care is better in a hospital which is delivering 7000 babies a year (almost 20 a day) than in a midwifery unit or at home where a mother gets 1:1 care from a midwife she has built a trusting relationship with.

Policy-driven care in a large unit might be 'safer' for those offering insurance should there be a successful lawsuit, but it probably increases the chance that people will want to take legal action. The other thing it offers is higher profit margins. That is not the same as more cost-effective care, although that term is often used in reports.

Government payment for an uncomplicated normal birth (see AIMS Journal Vol:22 No:2[2]) is little more than the actual cost of delivering that care in a one-to-one way, whereas the payment for a complicated birth is higher, and if savings are made in the level of actual care given it becomes the more attractive option to the management, or at least it offers no incentive whatsoever for the rates of those complications to be reduced.

Vicki Williams

References

1. unpublished PhD thesis
2. Chippington Derrick, D (2010) Payment by Results. AIMS Journal Vol:22 No:2, 16

Plea for Treasurer

We have just had an extremely successful AGM including presenting a full set of audited accounts. Jackie Boden is AIMS bookkeeper and she has done a marvellous job on the accounts. HOWEVER, we desperately need a Treasurer for AIMS. We need someone to take the formal post on the committee, someone to help us make the transition to Charity Status and help us make decisions to keep AIMS in the black. This post will not require the post-holder to do the day-to-day bookkeeping as Jackie is going to carry on with that task. We will require the post-holder to provide then Annual Financial Report and timely updates throughout the year.

Please contact a member of the committee if you feel that you could do this for AIMS. We would be very grateful!

Challenging the Medicalisation of Birth

Beverley Beech talks about the difficulties in getting consumers' voices heard

The concept of 'consumers' in maternity care began to develop in the 1960s when, in the UK, three national groups involved with childbirth were established. The Natural Childbirth Association (founded in 1956) became the National Childbirth Trust (NCT), and Mother Care for Children in Hospital (founded in 1961) became the National Association for the Welfare of Children in Hospital (NAWCH), and then, in 1991, became Action for Sick Children. AIMS too was founded in 1960, and originally called the Society for the Prevention of Cruelty to Pregnant Women. All of these organisations were established as a result of an initiative from individuals who felt that something had to be done about the services at that time.

AIMS provides information and support to anyone who asks for it. Our telephone helpline, website and email facility, and the help and advice we give to women who intend to complain about their care, keep us in touch with ordinary women and alert us to trends and emerging problems.

The process of writing up the history of AIMS for my address at the 50th Anniversary Luncheon was a depressing exercise. The letters the women wrote in the 1960s are little different from the letters written today.

Maternity care in the UK, as in much of the Western Hemisphere, is dominated by obstetricians, who have moved from a position where they were called in to assist with a problem labour to the current situation where they control the majority of pregnancies and births. They have done so by persuading the population that childbirth is inherently dangerous, that women's bodies do not function well, by undermining their confidence, by claiming that only obstetric care will guarantee a healthy baby and, worst of all, by carrying out what is now an international witch hunt to remove those midwives who practise real midwifery. As a result of this control, women's voices are often ignored.

In the United Kingdom women were moved into hospital on the spurious grounds that: *'The greater safety of hospital confinement for mother and child justifies this objective.'*[1] No-one asked the women if they wished to birth in hospital, and no evidence at all was produced to demonstrate the greater safety of hospital deliveries. This report claimed that *'sufficient facilities should be provided to allow for 100% hospital delivery.'* This gave the green light to the obstetricians to embark on a campaign to get every woman into hospital. Within twenty years the home birth rate had dropped from 33% to 1.2%.

In the 1960s AIMS members campaigned for more hospital beds on the grounds that there were not enough beds for the minority of women who really needed hospital delivery [in this article 'delivery' is used to describe birth where the woman is not at the centre of the decision making process]. It was not until the 1970s that the organisation realised that, rather than providing quality care for truly high-risk women, the obstetricians had seized the opportunity to gain control of all births. Instead of women being cared for in the community by a skilled midwife, and referred to an obstetrician when the midwife detected a problem, all women were now required to book with a GP who invariably simply referred her to an obstetrician. The community midwives were brought into a centralised hospital service and converted into obstetric nurses. Unfortunately, in the UK the system does not differentiate between an obstetric nurse and a midwife; they are all called midwives.

Early user attempts to influence the quality of care were met with resentment and antagonism. Fortunately, AIMS changed its title very early on in its existence; one can only imagine what reaction the women had when they announced they were members of the Society for the Prevention of Cruelty to Pregnant Women.

In 1961 the Ministry of Health published 'Human Relations in Obstetrics'. The Report highlighted what AIMS had been saying – including poor conditions, lack of support, lack of information and lack of midwives. The Minister asked hospital authorities to take action on antenatal clinics, companionship and information during labour, comfort and convenience of mothers and an injunction that these things should be put right. How ironic that this paper could be published today and most of its comments are still relevant. It was not until 1982, after persistent lobbying by AIMS, that the Department of Health set up a Maternity Services Advisory Committee to compile a good practice plan of action. It was to consist of representatives of each profession involved in maternity care and a sole 'consumer'. AIMS again lobbied for more than one representative for parents and a second person was appointed. This committee then published three guides to good practice and a plan of action[2] which included the recommendation to set up Maternity Services Liaison Committees (MSLCs) in every area.

These committees are supposed to have a balanced membership of professionals and users, but often they are not funded; users are expected to give their time for free and, not uncommonly, pay their own travelling expenses. The meetings are at a time to suit the professionals and there is a reluctance to pay child care. However, there are MSLCs that function well and have been instrumental in effecting change.

Early in its history AIMS members would draw the hospitals' attention to women's views and the problems women had with maternity care, but these were usually dismissed as a minority of disgruntled women and the claim that the procedures were necessary.

For example, Herbert Barrie, a consultant paediatrician, said:

'A steady but growing trickle of strange ladies is infiltrating the system and arriving in labour wards up and down the country with a familiar shopping list of demands telling doctors and midwives what to do.... These patients tend to arrive, without warning, in the Labour Ward with their lethal shopping lists.... They are not entitled to tell doctors how to do their work. They are not entitled to ask us to lower professional standards and to jeopardise babies' lives.'[3]

Over the years, such attitudes have changed although in a recent radio interview an obstetrician was reported as claiming that the current problem with maternity care is *'childbirth groups of vociferous upper class women'.*

The 'shopping lists' to which Barrie referred were Birth Plans. They were an attempt by women to have some control over their labours. AIMS members have some ambivalence about these plans as research has shown that when they are presented in hospitals to staff that the women have not met before, they are often ignored and those women have been shown to have more interventions than those who did not present a plan. In commenting on this the researchers asked, *'Could patients with birth plans be receiving less support and encouragement throughout their labour than patients without birth plans?'*[4] They did not explore why the staff had such attitudes and what could be done to improve them.

The discrepancy between what obstetricians were telling us and what the women said led our members to go into the medical libraries and start reading the research, and they were shocked to find that very little obstetric practice was based on good research.

Episiotomy

Episiotomy is a classic example. It was developed in the USA where it was vigorously promoted on the spurious grounds of 'protecting the fetus'. A great deal of emotive claims were made, for example:

'…every minute the baby's head is on the perineum two points can be deducted from its IQ.'

'The fetal brain suffers prolonged pounding and congestion in a hard spontaneous delivery with possible brain damage and anoxemis [sic] or asphyxia.'

'The descent of the fetal head was also compared to the mother falling on a pitch fork which pierces the perineum, and the baby having its head crushed in a door.'

Needless to say, none of these statements was true, but they justified the expansion and widespread use of this western form of genital mutilation.

Routine episiotomy was widely used in the USA but it was not adopted in the UK until the 1960s when use began to rise dramatically. By 1967 it had reached 25% and by 1978 it had reached 53.4%. Some London teaching hospitals had a 98% episiotomy rate and we even have examples in our files of women who were given an episiotomy after the baby was delivered because the midwives were afraid of criticism for failing to do one. Needless to say, there was no good research showing the benefits of episiotomy; it had been introduced following a persistent medical campaign without any evidence demonstrating benefit when used routinely.

some London teaching hospitals had a 98% episiotomy rate

Sheila Kitzinger published a booklet about the physical and emotional impact of episiotomy. The persistent consumer criticism of episiotomy, now echoed by some professionals, resulted in Jenny Sleep, a midwife, being enabled to conduct a study, one of the first research studies conducted by a midwife. It found that routine episiotomy did not prevent tears, did not protect the baby, and did not prevent infections, and furthermore it gave us a research paper that we handed over to women who did not want episiotomies.[5] Women then started quoting the research to professionals. We also advised them to ask one specific question when being told that they had to agree to a specific procedure: *'Can you give me a copy of the research paper that supports what you are saying? I will then read it and let you know my decision.'* So often there is no research to support the advice.

Ultrasound

In 1994 AIMS published a critique of ultrasound (Ultrasound? Unsound). It is the only critical review of ultrasound research in existence. Ultrasound has been promoted as a safe technology and governments spend inordinate amounts of money exposing pregnant women to it. AIMS had been alerted to potential problems by a research paper from the USA by Dr Dorothy Liebeskind, Assistant Professor of Radiology at the Albert Einstein College of Medicine, USA, and published in RADIOLOGY in 1979, about the effects of diagnostic levels of pulsed ultrasound on the growth pattern of animal cells which persisted for many generations.[6] This was followed by other papers which showed changes in the surfaces of cells and in 1982 she noted *'the persistence of abnormal behaviour … in cells exposed to a single dose diagnostic ultrasound ten generations after insonation'* and concluded *'If germ cells were involved, the effects might not become apparent until the next generation.'*

It had become fashionable – and convenient – to dismiss Liebeskind's work because a number of other centres were not able to replicate it. But four researchers elsewhere have done so. It was not replicated by two who did not use pulsed ultrasound.[7] And one might ask, is there a connection with dyslexia or attention deficit disorder? Of course there could be a multitude of other causes, but, where ultrasound is concerned, that question cannot be answered because good-quality ultrasound research has not been done.

In October 1982 AIMS wrote to the then Minister of Health – Dr Gerard Vaughan – telling him of our concern about the widespread use of ultrasound before it had been evaluated. To our astonishment he replied that the Medical Research Council had considered the possibility of a trial to assess potential benefits and hazards of using ultrasound in pregnancy in 1976 and had rejected it:

'In the four years [sic] since then, the use of ultrasonic techniques have become so widespread that a controlled trial along the lines originally proposed would no longer be ethically possible.'

It was, apparently, 'ethically possible' to expose almost every unborn child in the United Kingdom to a procedure whose safety had not been evaluated – and is still not properly evaluated more than thirty years later.

Had a proper trial been undertaken, we would now have had children up to 18 years old followed up for possible long-term effects.

A randomised study of 2,475 women reported a four-fold increase in perinatal deaths in babies exposed to routine Doppler ultrasound examination of umbilical and uterine arteries at 19-22 weeks and 32 weeks (16 v 4 perinatal deaths of normally formed infants).[8]

The results of a large trial from Helsinki were published in The Lancet.[9] Over 9,000 women were randomly divided into groups which did or did not have routine early ultrasound scans. There were 20 miscarriages after 16 to 20 weeks in the screened group and none in the controls. Our letter to The Lancet pointing this out was not published and the authors of both these studies have not responded to our questions on this surprising difference.[10]

Intrauterine growth-retarded (IUGR) babies

In 1998 a study from Germany compared babies whose growth retardation was diagnosed by ultrasound in the womb, with those whose smaller growth was not detected until after birth.[11] Out of 2,378 pregnancies, only 58 of 183 growth-retarded babies were diagnosed before birth. 45 fetuses were wrongly diagnosed as being growth-retarded when they were not. Only 28 of the 72 severely growth-retarded babies were detected before birth.

The babies diagnosed as small were much more likely to be delivered by caesarean – 44.3% compared with 17.4% for babies who were not small for dates. If a baby actually had IUGR, the section rate varied hugely according to whether it was diagnosed before birth (74.1% sectioned) or not (30.4%). Pre-term delivery was five times more frequent in those whose IUGR was diagnosed before birth than in those who were not. The average diagnosed pregnancy was 2.3 weeks shorter than the undiagnosed one. The admission rate to intensive care was three times higher for the diagnosed babies.

This important study shows a huge difference between the percentage of IUGR babies detected in everyday care and real life, and the much higher percentage shown in published studies elsewhere. We think this is true for many aspects of medical care, where research studies show promising results which are not replicated outside centres of excellence (and maybe not even inside them). It also provides further evidence that routine scans are not benefiting babies.

routine scans are not benefiting babies

AIMS continues to campaign for a reduction in the routine use of ultrasound but while the public continues to be misled by statements such as these, we have a hard battle on our hands:

'Some 100 million people throughout the world are walking around having had scans before they were born, and there never has been a shred of evidence that it does any harm.'

Professor Stuart Campbell, Sunday Times, 10 June 1984

'There are 50 million people walking around today who were scanned in the womb, and there is not even laboratory evidence to indicate that it is a hazard.'

Professor Stuart Campbell, Mother and Baby magazine, May 1990

The observant amongst you will have noticed that between1984 and 1990 Professor Campbell has managed to lose 50 million people.

Caesarean sections

The caesarean section rate in the UK is a national disgrace: in some hospitals it has exceeded 30%; the national average is over 23%. The World Health Organisation has pointed out that there is no health improvement when caesarean sections exceed 10%. When AIMS expressed concern about the rising caesarean section rates in the 1980s we were told not to worry – they would never reach 10%. Rather than focusing on changing the provision of maternity care (women having home births or birth centre births have very low rates of caesarean sections) the obstetricians justified caesareans by claiming that women were 'choosing' them or that they were 'Too Posh to Push'. It is our experience that many of those women who have 'chosen' a caesarean have done so because they have been so traumatised by an earlier birth that they think a caesarean will be better. We have found that after discussing why the birth was as it was, the majority of women then choose to have a vaginal birth. Posh Spice made the mistake of booking into a private obstetric unit (these have the highest caesarean rates of all) with her first baby presenting by the breech – so much for choice. Claiming that women are 'choosing' caesareans deflects any discussion of changing the provision of maternity care to a system that has been shown to improve outcomes.

Maternal death

Every three years the Confidential Enquiry into Maternal and Child Health publishes its review of maternal deaths. Initially deaths were categorised by cause of death but AIMS lobbied the Enquiry to look at deaths up to three years following birth. The Enquiry extended its remit to look at deaths up to one year after

birth and found that *'suicide was in fact the leading cause of Indirect or Late Indirect maternal death over the whole year following delivery.'*[12] Suicide was the largest cause of maternal death – greater than thrombosis, infection, haemorrhage, and other well-known causes. This discovery led to better identification and treatment – but not to prevention. We have seen in recent years a huge increase in postnatal depression and post traumatic stress, the causes of which, we believe, include traumatic interventions and insensitive treatment in childbirth.

While obstetric units provide excellent care for women and babies with problems, those women and babies who have no problems are subjected to any unnecessary interventions that a medicalised system favours. Women are often traumatised by these experiences and, as the research shows, increasing numbers of them suffer unnecessary caesarean sections and operative delivery, postnatal depression and post traumatic stress, failure to breastfeed and subsequent difficulties in bonding with their babies.

Cot deaths

Recently Jean Robinson drew my attention to her report of a fascinating study from Munster which has shown that cot deaths were far lower in East than West Germany – because the East Germans discovered that prone sleeping caused sudden infant death as early as 1971. It took the West 20 years to make the same discovery and implement change.

When East and West Germany were reunited in 1991, the East Germans had worse health, higher perinatal mortality and lower life expectancy, but they had a much better record in one area – post-neonatal mortality. The death rate in babies had been lower than in the West by 1 per thousand for 20 years but it increased sharply after reunification.

East Germany had an excellent system for monitoring child deaths, including expert autopsies after the death of every child under 16. They, like everyone else, followed medical recommendations that mothers should put babies to sleep face down. However, in 1971 seven babies died in this position in day care. This led to a number of meetings held by the Ministry of Health. They issued guidelines forbidding putting babies in this position without permanent supervision, during sleep, wearing restricting clothes, lying under a duvet, in a pram, for three hours after feeding, when tired, or during illness. They were only to be prone for muscular training while awake and supervised. The post-neonatal mortality rate in East Germany was among the ten lowest in the world, in spite of limited medical resources. Shortly after reunification, a 1991 survey showed that only 10% of babies in East Berlin were sleeping prone compared with 50% in West Berlin.

Why did the cot death rate rise after reunification? The authors suggest a number of answers. More mothers may have let their babies sleep face down due to West German medical influences, the maternal consultations system collapsed (women had previously been paid to attend these), plus the autopsy rate fell sharply.

Twenty years before the 'Back to Sleep' campaign, East Germany had identified a major cause of SIDS and efficiently put a remedy into action. As we have pointed out, the epidemic increase in cot deaths was caused by faulty medical advice resulting in the deaths of many thousands of babies. Lack of communication between East and West prevented us from learning from East Germany and saving the lives of untold numbers of babies.

A Charter for Ethical Research in Maternity Care – October 1997

All over the world the medical profession carries out research on pregnant and labouring women, much of which is unethical as many women are encouraged to take part without being given adequate information.

During 1997 AIMS invited representatives of the National Childbirth Trust and Consumers for Ethics in Research to consider a draft charter for ethical research in maternity care. This set out conditions that women would find acceptable if asked to take part in research, including informing women of the reasons for the research; giving details of what the researchers hoped to find; clarifying what the risks, if any, were, and advising them of the results and follow-up.

This Charter was accepted by all the major medical Colleges, and, indeed, the Royal College of General Practitioners handed it out to all its student GPs.

Home birth

'The choice of home birth should be offered to all women.'[13]

One of the longest and continuing campaigns has been for women to birth at home. Many obstetricians persistently claim that a hospital delivery is a safe delivery and home birth is dangerous. These claims are based on false statistics and fail to take morbidity into account. In the past, the statistics counted any woman who birthed outside a hospital as a 'home birth'. As a result, women having their babies in prisons or remand centres and women who unexpectedly gave birth at home or who had concealed their pregnancies – all of whom are very high risk – were counted as having a 'home birth'.

In 1985 Marjorie Tew, a respected statistician, exposed the myth that birth in hospital is safer than birth at home when she published her statistical analysis of home v hospital birth and revealed that, in every single risk category but one, it was safer to birth at home than be delivered in hospital. Since that time there have been no reputable studies that have been able to challenge her analysis.

As Marjorie Tew has stated: *'The threat of home birth is not a threat to mother and baby, but a threat to the healthy survival of obstetric and medical practitioners.'*[14]

Following Marjorie's study AIMS changed tactics: it no longer campaigned for home births on the grounds of a woman's right to birth where she chooses but instead campaigned on the grounds of safety. Unfortunately, the safety of home birth is not acceptable to many members of the medical profession, particularly the American

College of Obstetricians and Gynecologists, which is notorious for its opposition to home birth.

it was safer to birth at home than be delivered in hospital

Its latest piece of questionable research was published in the American Journal of Obstetrics and Gynecology which concluded that *'Less medical intervention during planned home birth is associated with a tripling of the neonatal mortality rate.'*[15] Needless to say, it was taken up and quoted by the medical journals in the UK and the national newspapers. While consumer groups, all over the world, challenged the findings and showed that the conclusions were not supported by the study's own data, very little of the counter-evidence has been highlighted by the newspapers and we await with interest any further comment in the medical journals.

Normal birth

The most successful AIMS campaign has been about normal birth. In 1997 I wrote an article in the AIMS Journal, 'Normal birth – does it exist?',[16] in which I pointed out that very few women experienced a normal birth in hospital because of the amount of intervention to which they were subjected. It was not uncommon for women to tell us that they had a horrendous delivery the last time and they 'never want to have a normal birth ever again'. It transpired that many women had been told either that labour needed starting off, or that as labour had slowed down a drip would be put up to 'get you going again'. Before long the pain of induction or acceleration was intense, and made worse by continuous electronic fetal monitoring requiring the woman to lie on the bed and remain still. The women started asking for pain relief and eventually an epidural would be set up. If the woman was lucky she might be able to push the baby out, but would probably have an episiotomy in the process and the placenta would be delivered by active management. The staff would then write 'normal delivery' on her notes when the birth was in reality a long way from the AIMS definition of Normal Birth, which is: spontaneous onset and progression, with no breaking of waters, no drugs to speed progress, no narcotic or epidural pain relief, no episiotomy, no instrumental or surgical delivery and no managed third stage. A tall order in the majority of our maternity units.

Research midwife Soo Downe undertook a survey of five consultant units in one region to test my claims on intervention. She found that only 1 in 6 women expecting their first babies and only 1 in 3 women expecting subsequent babies had normal births.[17] The study excluded from the normal group women who had caesarean operations, general anaesthesia, forceps or ventouse, epidural, artificial rupture of membranes, induction or acceleration of labour, or episiotomy. It should be noted that the 'normal birth' group in this study still included women who had had electronic fetal monitoring, other drugs in labour or a managed third stage. So the true numbers of normal births are even lower.

For those who want to explore what normal birth actually means and what the effects are, I suggest they read Soo Downe's book Normal Childbirth – Evidence and Debate[18] and Nadine Edwards's book Birthing Autonomy – Women's Experiences of Planning Home Births,[19] which *'explores the difficulties and tensions women and midwives experience trying to organise a home birth in a service that pays lip service to choice.'*

The Good Birth Guide

In 1976 Ann Taylor, who was Secretary of AIMS at the time, suggested that perhaps we should publish a Good Hospital Guide, along the lines of the Good Pub Guide. Unfortunately, AIMS did not have the staff or money to undertake such an exercise, but Sheila Kitzinger did. In 1979 Sheila published the first edition of the Good Birth Guide[20] which gave star ratings to 300 hospitals in England, Wales and Scotland. Hospitals that had been dismissive of women's requests for information suddenly took a great interest.

The Maternity Defence Fund

The second very successful campaign was the one we launched to sue the medical profession for assault.

By 1982 the childbirth groups were becoming increasingly dispirited about the way in which women were being forced to accept treatment (usually pethidine, routine episiotomies and their babies being given bottled milk despite the mother's protests). It was decided that as every other avenue had been tried, all of which had failed miserably, the time had come for drastic action.

AIMS, the Society to Support Home Confinement and the Birth Centre Organisation decided to launch a fund (the Maternity Defence Fund) to sue the medical and midwifery profession for assault. Not only did it achieve a sea change, almost immediately; it did so by threatening to take legal action. For the first time ever, the professional journals published articles on patients' rights, informed consent, and long discussions of the issues involved.[21,22]

There is no doubt that legal action, and the threat of it, has provoked more changes for the better in obstetric care than any other action. It is the only sanction available to parents that the medical profession takes seriously. But legal action is a double-edged sword. Just as some obstetricians justify their practice by claiming that 'this is what the consumers demand,' so too do many obstetricians claim that the increase in technological intervention, particularly caesarean sections, is a conservative response to the threat of litigation. No-one questions the ethics of openly claiming that the reason one does a caesarean section has little to do with the best interests of the mother, but is to protect the individual from potential litigation – overlooking also the fact that successful litigation depends upon a provable case of negligence and very few litigants in maternity care are successful.

Association of Radical Midwives and MIDIRS

In 1972 the Association of Radical Midwives (ARM) was formed, with the aim of returning midwifery to its roots. Those midwives who joined this organisation, or who espoused its beliefs, often suffered considerable harassment, not only from obstetricians, but also from many of their own colleagues, who, with the passage of time, had become obstetric nurses.

In order to support and help ARM, the NCT and AIMS invited ARM members, or any midwife who was interested, to attend a monthly support meeting at the NCT headquarters to discuss issues in maternity care. This initiative increased midwives' confidence in continuing to practise real midwifery and, over a period of time, helped them establish their own networks and form a professional organisation.

Another significant initiative was taken by a small group of student midwives and members of ARM. They decided that there was a lack of scientific evidence relating to childbirth and so set up MIDIRS – Midwives Information and Resource Service – to disseminate information to midwives and encourage improvements in maternity care. This initiative has resulted in midwives and women all over the world having access to scientific research papers. Find them at www.midirs.org

Choice

In 1993 the House of Commons Select Committee published the results of its investigation into maternity care.[23] This report acknowledged what women had been saying for years. Care was over-medicalised and women needed more midwives, fewer interventions and more community based-care. The Government's response was to set up a committee and suddenly everyone was talking about 'choice'; and choice is still the mantra repeated today.

If women are to make choices they have to be properly informed and unfortunately very few women are; they rely on officially produced leaflets, TV and radio and women's magazines. None of these sources properly inform. It is little different from the woman who tells the supermarket owner that he does not have any choice of fish; he is bemused – of course they have fish – and shows her a huge array; she takes one look and says, 'But it is all frozen and I want fresh.' Research shows that at least 10% of women would choose a home birth yet fewer than 3% actually achieve one. Every hurdle possible is put in their way under the guise of 'informed consent'. While hospital staff are only too keen to graphically describe what they perceive to be the risks of home birth I have yet to hear of any unit that tells women the risks of hospital deliveries.

I became so cross about the focus on telling women the so-called risks of home birth that I produced a leaflet, available on the AIMS website, detailing some of the risks of hospital deliveries. It has been modified and has been copied in many other countries. Every woman should read one before she decides where to birth.

Over the years, criticism of obstetric care has had little effect on maternity provision. The drive to centralise obstetric units continues and local women are still fighting battles to keep their local birth centres open.

Postnatal depression

I mentioned earlier the damage that obstetric care does to women. Most of that damage is hidden. Women who have had episiotomies frequently report that their sex lives have been ruined. I have spent years failing to persuade sociologists to carry out a survey of divorced women to see whether their ruined experience of childbirth was a significant factor in their marriage break-up. When we ask women with serious complaints and problems following childbirth about the state of their marriage very few are able to say that their marriage is not under considerable stress.

For years AIMS has helped women with postnatal depression, but it was only after the vigorous use of induction and acceleration of labour that we began to see an increase in the numbers of women with post traumatic stress disorder, a very serious consequence of bad birth experiences.

Where mothers need inpatient treatment, there are far too few specialist mother-and-baby psychiatric units, where mother and baby are cared for together during treatment, and where bonding is supported so that when discharged they have not been separated and are ready for the outside world.

Providing one-to-one midwifery care based in the community would, we believe, make significant improvements in women's mental health and the health of their babies. The incidence of both depression and PTSD will vary between hospitals, but is likely to be less with continuous midwifery care, midwifery units, and home births. Unfortunately this data is not collected.

The impact of childbirth on the health of women and babies cannot be over-estimated. Childbirth has the ability to strengthen women, to empower them, to enable them to protect their children. Try taking a baby chimpanzee or a baby gorilla from its mother and she will kill you. We have been socialised into accepting that anyone can take our baby and I am disturbed every time I see a film of birth where the baby is removed by the midwives and given back to the mother sometime later. We know from those women who have been able to compare a technological delivery and a normal birth that they have different feelings, and it is only women who have experienced these different births who are in a position to judge what effects those births created.

Lack of midwives

Currently in England there is an acute shortage of midwives; at least another 5,000 are needed.

Over recent years a small mountain of research has emerged showing better outcomes when women are cared for by midwives who support them during pregnancy, labour and postnatally. A recent book edited by Robbie Davis-Floyd et al gives an analysis of the negative effects of medicalised birth and the beneficial effects of midwifery care and concludes that *'Birth models that work improve the physiological, and the social outcomes of pregnancy and birth and save money'*[24]

Over the years, every proposal to improve maternity care the way that women want has been modified to limit its effectiveness. A rash of wallpapering and putting up pretty curtains followed women's demands for birth centres, so much so that it was labelled 'pretty wallpaper syndrome'. Instead of establishing free-standing birth centres, hospitals are now promoting 'birth centres' that are along the corridor or up the stairs. This gives the illusion of responding to women's needs while ensuring continued control of midwifery practice and a ready pool of midwives when the labour ward is short. The disadvantage is that only a very small minority gain admittance and midwives are not enabled to hone their skills properly caring for healthy women. In our current climate of financial restraints we are finding that this is used as an excuse to close these birth centres down and move women into ever larger obstetric units. The industrialisation of childbirth continues.

Unfortunately, the present structure of the NHS militates against implementing the kind of change that is now needed in response to research evidence. Whilst the current system of payment by results continues to pay a hospital more for a caesarean section than it does for a normal birth, the financiers will be unlikely to look favourably on a proposal to fund more midwives and encourage more normal births. The system of capital charges increases the cost to the hospital should it establish a free-standing midwifery unit. The addition of a unit which increases the numbers of normal births will result in the hospital suffering a double whammy. It doesn't look attractive to the policy makers, certainly.

The UK already has some of the largest maternity units in Europe and appears to be intent on centralising even more to produce 'super units' delivering over 7,000 babies a year. Midwives do not like working in these units and there is no evidence at all that they improve the quality of care or have better outcomes, but that does not appear to concern the grey suits.

The book Sustainability, Midwifery and Birth contains an interesting statement:

'From a total cost-benefit perspective where financial, environmental, emotional and other short- and long-term costs and benefits are adequately considered as indirect as well as intangible costs, it would be difficult to uphold the current medical maternity model as one that is either efficient or sustainable.'[25]

The time is now ripe for action. If midwifery is to develop into the profession that is truly with women and responsive to their needs then midwives have to join with women and sympathetic doctors and demand change. Together midwives and women can make a formidable force for change. Until that happens we will only achieve marginal change. What is needed now is radical change and childbirth returning to a nurturing, supportive and humane system in which women are well informed and their decisions fully supported.

Beverley A Lawrence Beech

For those who missed the celebration, Beverley's address to the 50th Anniversary Luncheon is in AIMS Journal 22(4) and on the website.

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AIMS is currently producing an information leaflet with ideas of action you can take should your local birth centre, midwifery unit or home birth service be faced with closure.
Contact us for details.

The Assessment of Progress

Midwife *Rachel Reed* asks whether it is time for change in the way we look at stages of labour

The idea that birth should be efficient originated in the 17th century when men used science to re-define birth.[1] The body was conceptualised as a machine and birth became a process with stages, measurements, timelines and mechanisms. This belief continues to underpin our approach to childbirth today.

In current midwifery texts labour is divided into three distinct stages, and further divided into phases within those stages. The first stage of labour involves regular and coordinated uterine contractions accompanied by cervical dilatation. This stage includes three phases: latent, active and transitional. The second stage of labour begins when the cervix is fully dilated and ends when the *'fetus is fully expelled from the birth canal'*.[2] Again, the second stage is further broken down into three phases: latent, active and perineal. *'The third stage of labour is the period from the birth of the baby through to delivery of the placenta and membranes and ends with the control of bleeding'*.[2] This categorisation allows practitioners to measure progress through the stages and create limits and boundaries around what is considered 'normal'.

The tool used to measure labour in hospital settings is the partogram, which is largely based on a study carried out in the 1950s by Friedman[3] where he plotted the cervical dilatation of 100 women having their first baby in an American hospital. He found that the average rate of cervical dilation was 1.2cm per hour, but that this rate was not linear. In other words, most women gave birth within twelve hours of the commencement of labour, but there was variation in their individual dilation patterns. In the 1970s Philpott and Castle modified Friedman's graph to provide guidance for practitioners working in a remote area of Rhodesia. Their intention was to reduce the incidence of poor outcomes associated with obstructed labour in this particular setting.[4] They added an alert line, a transfer (to hospital) line and an action (augmentation) line to Friedman's graph. The resulting partogram is now a practice tool used in hospitals worldwide to monitor the progress of normal labour. A cervical dilatation rate of less than 1cm per hour is considered 'abnormal' according to most hospital policies. However, some hospitals are more generous and will consider a rate of 0.5cm per hour normal for women having their first baby.

Since use of the partogram became widespread, researchers have found that Friedman's graph does not represent normal labour progress. In contrast, research has found that cervical dilation patterns vary widely between individual women, and the average length of labour is much longer than in Friedman's findings.[5,6,7,8,9]

A recent Cochrane Review into partogram use in labour concluded that: *'On the basis of the findings of this review, we cannot recommend routine use of the partogram as part of standard labour management and care'*.[10] This evidence-based recommendation is yet to be reflected in maternity care. Instead, women have their labours managed in order to follow a partogram with limits and boundaries. Fewer than 50% of women having their first baby will manage to meet the narrow criteria of 'normal progress' and avoid augmentation of their labour.[7] The World Health Organisation estimates that the rate of obstructed labour is between 3 and 6% worldwide[11] and so a significant number of women are experiencing unnecessary intervention during their labour.

methods used to augment labour carry risks and alter the physiology of birth

Methods used to augment labour carry risks and alter the physiology of birth. Amniotomy (artificial rupture of membranes) does not reduce the length of labour, and may increase the chance of having a caesarean section.[12] Intravenous syntocinon can increase contractions and shorten labour, but requires careful monitoring of mother and baby because of the potentially dangerous side effects.[13]

When augmentation fails to improve the progress of cervical dilatation, a caesarean section will be performed for 'failure to progress'. Time limits on the second stage of labour result in midwives implementing directed pushing to get the baby out before they must notify an obstetrician. Directed pushing (Valsalva manoeuvre, sometimes called purple pushing because a woman is encouraged to hold her breath and push hard) does not significantly reduce the length of the second stage.[14] However, it does increase the risk of damage to the pelvic floor and perineum, and is associated with fetal hypoxia, in no small part due to oxygen starvation when mum holds her breath. If directed pushing does not improve progress, or the baby shows signs of stress due to hypoxia, the birth will be assisted using forceps or a ventouse. Most hospitals have policies regarding the length of time between the birth of the baby and the birth of the placenta. These vary from hospital to hospital, but failing to meet the deadline will often result in the placenta being manually removed.

The concept of managing women's labours to follow a partogram relies on the premise that it is even possible to assess the progress of labour. I challenge the notion that it is possible to identify where stages of labour start or end, or to accurately predict the future progress of a

labour. Physical changes in the cervix and uterus occur during pregnancy, and the onset of labour is a gradual happening.[15] Therefore, identifying an exact time of labour onset is not possible. The definition of 'established labour' includes regular rhythmic contractions occurring at least three every 10 minutes, lasting for 45 seconds and accompanied by progressive dilatation of the cervix.[16,2] However, women's contraction patterns are as unique as their bodies. At home births, I have observed women have infrequent, irregular contractions throughout their entire labour and give birth spontaneously. Therefore, contraction pattern is not necessarily a good indication of how a cervix is dilating.

Assessing the progression of the 'first stage of labour' also relies on knowing what the cervix is doing. Some hospitals no longer have a policy of routine vaginal examinations in labour, perhaps reflecting concerns about the practice.[17] Even when vaginal examination remains an element of routine management, the timing of assessments is usually four-hourly. A vaginal examination only reveals what the cervix is doing at the time of the examination. It cannot provide information about what the cervix was doing before, or what it will do in the future. For example, a woman's cervix may be only 3cm dilated but she could birth her baby within an hour of this assessment. Another woman's cervix may be 9cm dilated but her baby may not be born for another 6 hours. Using a vaginal examination to determine the start of the second stage is also inaccurate. If a midwife examines a woman at 3pm and finds that her cervix is fully dilated, does that mean her second stage started at 3pm? What if her cervix had been fully dilated at 2pm but the midwife didn't know? There is only one accurate time recording that can be made during labour – the end of the second stage because the baby is born. Although a time can be recorded for the birth of the placenta, the third stage ends with 'control of bleeding', which is open to interpretation.

Despite the inability to accurately measure the stages of labour, maternity documentation requires this information to be recorded. Partograms, birth summaries and perinatal data forms require midwives to record the hours and minutes a woman spends in each stage of labour. The result is creative documentation and some interesting conversations between midwives. Such as: 'What time would you say second stage started?' 'Umm not sure – she was making grunty noises around 5.30pm...' 'OK, I'll put 6pm.' And between midwives and women: 'What time would you say your labour established?' 'I don't know. The contractions were really hurting by 7am then I came into hospital.' 'Hmmm well you had your baby at 9am, so you must have been doing something before 7am… I'll put 6am.'

Midwives also manipulate the paperwork to fit policies, protect women and avoid getting into trouble. For example, recording the cervix as being 9cm dilated rather than fully dilated to buy more time for the woman. Or ignoring an hour's worth of spontaneous pushing before recording the start of the second stage. These strategies allow midwives to complete the required paperwork whilst protecting the woman from unnecessary interventions.

However, these strategies also support and maintain the structures that impose time limits. These fabricated times are recorded in standard maternity documentation and then sent to organisations that collect and analyse the data to provide information about labour and birth. By manipulating records midwives are helping maintain the myth that labour has distinct stages which can be measured accurately.

Perhaps more importantly, though, they are re-defining women's birth experiences, often in contrast to the woman's own experience. For example, recording the length of a labour only from the onset of 'established labour' disregards the hours or days that a woman may have experienced contractions before being considered to be in established labour. Abandoning the concept of stages and the notion of accurate assessment may improve outcomes and reflect women's experiences of birth more honestly. However, individual midwives may find it difficult to practise against the cultural norm. Midwives who practise openly and autonomously within a medicalised system often experience ridicule and bullying.[18,19] Therefore it is not surprising that most midwives continue to bend the rules rather than break them.

the concept of stages of labour and assessment of progress is deeply embedded in our birth culture and practise

There appears to be no simple solution to this situation. The concept of stages of labour and assessment of progress is deeply embedded in our birth culture and practice. Perhaps change could begin with an open dialogue between women, midwives, obstetricians and policy makers regarding a move to a more evidence-based approach to childbirth.

Individual midwives can also make a difference, and should support each other to do so. The content of parent education sessions can be changed to focus on what Downe and McCourt refer to as 'unique normality'[20] rather than descriptions of the stages of labour. Midwives can share the evidence with each other and midwifery students, and highlight the failures of the current situation rather than sustaining acceptance.

If enough midwives write 'not applicable' on paperwork rather than making up a time, there will be evidence that the documentation needs to change. Experience of observing non-augmented labours will assist midwives to develop their understanding of normal birth, and their

ability to identify a truly obstructed labour. These changes may be challenging but the result could be a better approach that respects women's uniqueness and embraces the unpredictable nature of birth.

Rachel Reed

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Editor's Note: The third stage of labour is comprehensively discussed in the fully revised, updated AIMS booklet Birthing Your Placenta: the third stage, published 2011, reviewed on page 24.

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Fife Axes Home Birth Service

On Thursday July 14th the BBC reported that: *'The Royal College of Obstetricians and Gynaecologists has announced that maternity services across the UK need a radical rethink. Too many babies are born in traditional hospital units, says the College, which also warns the current system is neither acceptable nor sustainable in its report on maternity care.'*

And yet today, Monday 18th July, The Courier reported that: *'Fife's NHS bosses are planning to end the service which allows expectant mothers to give birth at home. A drop in demand and improvements to maternity care in hospital have been cited as the reasons behind the move.'*

The Courier also reported that Consultant Obstetrician Steven Monaghan from NHS Fife said: *'Luckily we have a very good midwife-led unit which is being looked at nationally and internationally and in six months women will have a facility in the new hospital wing where they will labour and recover in one room and can have their whole family there if they like.'*

But what if they would LIKE to give birth at home? What about women's right to choose where to birth?

Don't get me wrong, Forth Park Midwife-Led Unit appears to be very supportive of informed choice for the women who come through its doors. For instance, the midwives have long facilitated vaginal birth after caesarean (VBAC) when few other midwife-led units would.

But while some women, for various reasons, choose to birth in obstetric-led units or midwife-led units, there are others who would prefer to birth at home. Research shows that in the UK, for a healthy woman with a normal pregnancy (including women having their first baby) a planned home birth is as safe as a hospital birth, yet we are so socially conditioned to think that birth is inherently dangerous that many women will not consider it, and of those who do, most find that it is not presented as an option.

Certainly, birthing at home was never an option offered to me during either of my pregnancies.

So, for those who are supportive of the choice to birth at home, it is extremely frustrating to hear of Trusts attempting to withdraw provision of a home birth service at a time when we are working so hard to encourage awareness of all birthing options.

What can we do? As a society we need to stop telling our horror stories to expectant mothers about birth, we need to take responsibility for our own health and well-being, making informed decisions about our care, we need to demand that our care givers continue to update their skills, and we need to stand up and fight for provision of a Home Birth Service within each Trust of the UK.

Karen Law

Article

Basic Biology

Holly Lyne looks critically at the perception that women are losing the ability to birth

I'm not a science person. I was never that interested in it at school. I don't think like a scientist, or at least I don't think I do. I was always much more interested in the arts and I still am. But I like science, I think science is important and I've picked up a few scientific facts throughout my life that have enhanced my understanding of the world.

Birth both is and isn't a topic for science. It is a normal biological function and can in some ways be studied, categorised and understood in basic scientific terms. But it is also unpredictable and a deeply emotional time for women and their families and so we cannot view it in a cold, sterile, scientific vacuum.

Here are a couple of very basic scientific facts that I think are important in understanding a little bit about human procreation.

First of all: genetics. I'm no expert, but I understand, basically, how genetics work. Everyone has genes and when a baby is conceived it has a mix of 50% maternal genes and 50% paternal. Each new baby gets half its genes from its mum and half from its dad.

Certain medical conditions are hereditary, passed down through the genetic code into each new generation. They can come from either the mother or the father.

Linked to this is evolution, an incredibly slow process that fundamentally weeds out the weak, and only the strongest traits survive. The more advanced our medical science becomes, the more we can circumvent this aspect of evolution, because those with traits of weakness are more and more often saved by science, and are therefore able to pass along their weak traits to the next generation.

Surely hereditary traits which make procreating impossible, for instance, a pelvis too small to successfully birth a baby, can't be passed on. Until the very recent rise of obstetric intervention in birth, if a woman grew a baby too big for her to give birth to then one or both of them would die in the process of birth, thereby rendering it almost impossible for the trait to make its way into the next generation. (Remember how I mentioned that evolution was a slow process? Well, I'll be coming back to that again in a minute.)

Secondly: hormones. Hormones are absolutely central to almost every aspect of human behaviour. They govern our sex drive, our temper, the female menstrual cycle, and pregnancy and birth. Never underestimate just how important these hormones are. Without the right levels of oestrogen and progesterone, it would be impossible for us to ever conceive. Without oxytocin we wouldn't be able to give birth to or feed our babies the food they have evolved to need (breast milk). Without adrenaline we wouldn't be able to fight (or flee) to defend our children against predators.

These hormones govern our entire existence.

Oxytocin burns through a woman's system quite quickly, it enters the system only under the right conditions and can dissipate within seconds if adrenaline is introduced. Adrenaline gets us ready to defend ourselves either through fight or flight. It sends blood pumping to the lungs and limbs in preparation for physical activity and it takes a very long time to leave the system. During labour, if adrenaline is released, labour will often stall, because our hormones are telling our muscles that it is not safe to give birth. Blood is pumped away from the uterus, halting contractions and allowing the baby to sit tight until the mother is once again safe.

So, these are the two basic elements of biology that are important in understanding how women give birth.

I once encountered a woman on a forum, who was absolutely adamant that she, her sister and her mother were all incapable of experiencing strong enough contractions to facilitate birth. They all needed help from an obstetrician in order to birth their babies: their bodies simply weren't up to the task. She seemed to be implying that this was a hereditary condition. I never really got into a proper, adult discussion with her about it, because she was so defensive that it was hard to have a meaningful dialogue. But what I really wish I'd been able to ask her is how did her grandmother give birth?

how did her grandmother give birth?

Synthetic oxytocin (syntocinon) is a drug given to women to increase the frequency and intensity of their contractions. It is used both to induce labour and accelerate it if deemed too slow and has only existed for a few decades. Prior to this, oxytocin did a perfectly good job of facilitating birth in the vast majority of cases. How do I know this? Because even 50 years ago the human population of the planet was more than our natural resources could comfortably sustain. We have been an incredibly successful species, in evolutionary terms.

I'm not denying that there have been deaths in childbirth, of course there have, and there are a great deal fewer deaths today in this part of the world thanks to basic hygiene and sanitation improving and the availability of world-class midwives and obstetric help when necessary.

But from an evolutionary perspective it is pretty obvious that reproduction has been very successful.

If this woman was right and her maternal genetics were compromised, making it virtually impossible to give birth without synthetic oxytocin, where did the trait come from? How was it passed down? What did her grandmother, and every woman in her family before her, do to enable the healthy birth of any babies?

My point is, of course, that this woman did not have a hereditary defect.

I dare say her mother was just like the vast majority of her generation, directed into hospital to give birth, away from the comfort and safety of her nest (home) and forced to labour on her back, routine enema on arrival etc. etc. ad nauseam. It's an old story, the theft of birth from women and given into the hands of medical men and their marvellous machines. Adrenaline takes over because the woman is afraid and has no strong female support, oxytocin production halts and, yes, the synto is plugged into her vein in order to get labour going again.

It has been happening for at least two generations to huge numbers of women, it happened to me (not the routine enema, I hasten to add) and it is my very strong suspicion that this is exactly what happened to this woman and her family members.

On 16 April 2011, Amelia Hill's article in the Guardian about home birth left me unable to sleep due to the extreme rage running through me (thank you, adrenaline). Philip Steer, a professor in obstetrics and gynaecology at Imperial College London, made some remarks that fly in the face of every sensible lesson in biology and the journalist did nothing to counter his absurd assertions.

He implied that up to 75% of women were unable to give birth normally. He claimed that 50% of women develop a problem during pregnancy that renders them high risk. Now, I happen to know that approximately 50% of women are booked under a consultant during pregnancy, but this can be for reasons including a history of depression, slightly elevated BMI or a previous c-section. None of which automatically means she is in need of obstetric care during pregnancy or birth.

Steer went on to claim that of the remaining 50%, 50% would develop a problem during birth requiring the attention of an obstetrician. That brings the total to 75%.

I'd like to point out at this juncture that the national normal birth rate is over 40%, normal birth as defined by the NCT. So of his 75% 'requiring' obstetric aid, some at least are still actually having a normal birth, a fact he seems to be claiming is impossible. I happen to believe that far more than 40% could be having a normal birth if they were supported properly. Currently in the UK, around 10% of births are by avoidable caesarean section (the WHO suggests that a c-section rate in excess of 10–15% does not improve outcomes; our country performs this surgery in more than 25% of all births; therefore at least 10% of births are by unnecessary caesarean), so that's potentially up to a further 10% having a normal birth, never mind the rest, but more on that later.

Professor Steer claims that we have actually evolved to be unable to give birth to our own babies, stating that the pelvis has shrunk and the skull has enlarged over the last 500,000 years. This is an extreme over-simplification of the facts designed purely to defend his profession. He ignores the fact that the pelvis expands during pregnancy and birth and that the skull plates of a baby in utero and after birth are not fused and can overlap one another. These facts facilitate a smooth birth for the vast majority of birthing dyads.

If a woman remains upright and mobile during birth and especially during the second stage (pushing) then her pelvis can expand by up to 30%!

creating problems where they need not exist

Remember my point about evolution being slow? Well, it is. It is practically impossible to see large-scale results over just a few generations. Modern obstetrics is just that, modern. Synthetic oxytocin was invented in 1953. Caesarean sections have been around for more than a thousand years, but as recently as 1865, the mortality rate was 85%. It is really only in recent decades that birth surgery has become a common procedure that most mothers and babies survive.

So one cannot even begin to claim that modern obstetric interventions are already saving enough lives to have fundamentally impacted on hereditary traits (i.e. made it possible to override hereditary weaknesses sufficiently to render 75% of women incapable of giving birth without intervention).

Steer also fails to acknowledge the harm done by many interventions when they are routine, rather than for true necessity. By 'playing it safe', we are so severely interfering with a pretty effective natural process that we are actually creating problems where they need not exist. Adrenaline is ruining perfectly normal births. Making women lie down, hooked up to monitors that are known to increase the chances of a caesarean without improving outcomes, routine induction of labour with synthetic oxytocin and the widespread use of epidural anaesthesia are all making it harder for women to give birth.

I'm not saying that there isn't a place for hospital birth or that obstetricians don't save lives. If a woman feels safest in hospital then that is where she should be. If a woman or her baby has a serious problem that requires the help of an obstetrician then one should be on hand to help if needed.

But for Steer to claim that most women need people like him flies in the face of very basic biology and his comments will echo in the minds of countless readers of the Guardian, probably for years to come. I hope that this article will, to some small extent, undo some of that damage.

Holly Lyne

Encouraging Normal to Become the Norm

Protecting the future of a birth centre by *Sian Alexander*, mother and birth centre campaigner

Birth is a natural thing. Why shouldn't we be encouraged to do it naturally?

This was the question raised by supporters of the Jubilee Birth Centre (JBC) in East Yorkshire, which faces an uncertain future due to budget cuts. In January 2011 mothers gathered at a meeting to share their experiences and discuss strategy in a bid to stop a series of temporary closures from becoming permanent and to protect the choice of natural birth in the region.

This is not the first time mothers have mobilised to save the JBC. In 2006 Hull and East Yorkshire Hospitals Trust announced it was reviewing the centre's future. Mothers who had used the JBC, backed by MPs and others, campaigned for the centre to be saved. The Trust did indeed keep the centre open, albeit with new targets to increase the number of births there – ostensibly to make it more cost efficient.

I was among the journalists who covered the campaign and when last year I became pregnant I had already decided I would like to have my baby at the JBC. As I was in good health and keen to have a 'normal' birth, the decision to go to the JBC was easy. I had been impressed by the ethos of natural birth, passionate staff and calming atmosphere when I covered the centre's story years before and, unless medical complications arose, I wanted to have my baby there.

However, as this was my first pregnancy, my GP (the stereotypical older male doctor) told me I should instead go to the larger, more medicalised Hull and East Yorkshire Women & Children's Hospital (W&CH) 'because it's safer'. There was no medical reason for this. I felt his opinions on the centre's safety were just opinions; the JBC doesn't take high-risk women, and if complications do arise the woman is transferred, so I simply ignored him. But this advice is all too common, and since then I have heard women from across our region tell the same story about their own GPs and even midwives.

As my pregnancy continued, my husband remarked on how strangely I was being treated by health professionals, as if there were something wrong with me. I was pregnant, not ill, yet felt that my care was geared up as if to 'cure' me. It felt as though the health service worked well when someone was sick, or hurt, but was not as effective at being supportive and proactive.

Much of the advice available, whether from healthcare professionals, internet forums or well-meaning family members, is conflicting and makes it hard for first-time parents to decide upon a path to take. If you have never given birth before, why would you think it was going to be any different from what you see in the movies? That is the prevailing message in the mainstream media and wider community. A truly physiological birth is less common. I lost count of the number of people who told me I would be 'screaming for an epidural' as though that were an appropriate thing to tell a heavily pregnant woman. Whilst people were quick to tell the horror stories, they didn't often share their positive experiences.

It was not until I began writing this article that I realised that the experiences and concerns of the JBC supporters were far from unusual. Sheila Kitzinger asks in her book Birth Crisis (2006): *'How is birth turned into an ordeal?'* and her research found women feel like they are on a factory production line when giving birth in a large-scale maternity hospital. The same words have been used by some of the women involved in the JBC campaign. Some are still clearly traumatised by the interventionist treatment they received elsewhere and they are desperate to have a more natural experience one day. Rather than the campaign just being about women like me who birthed at the JBC, many are involved because they didn't birth there, but want to in the future.

I find it shocking that their experiences were so bad, and even worse that those experiences are sadly so common. Although birth is vaginal, a 'normal birth' isn't necessarily the norm in our large-scale maternity units.

The JBC has a 100% normal birth rate (324 births in 2009). Women can use one of the two birthing pools, are encouraged to move around in labour, and to use aromatherapy oils and music to relax, and the labour rooms are not fitted with traditional 'beds' at all. Gas and air and Pethidine are available, but in my case were not offered as I didn't ask – and so I didn't miss them. If complications arise, the woman and accompanying midwife transfer to the W&CH around 15 minutes away by ambulance. The current transfer rate is around 20% but women are encouraged to return to the JBC for postnatal care and breastfeeding support if needed.

The W&CH has a 25.9% normal birth rate (Healthcare Commission figures), with around 5,000 births a year. Anecdotal feedback from women has found that although there are some similar facilities such as a birthing pool and access to aromatherapy oils, they are not as commonly used as at the JBC, and instead the atmosphere is more medicalised and less personal.

The high rate of normal births at the JBC raises the Trust's normal birth rate overall to 32.3% against the English average of 41.7%. The JBC can be seen to be 'propping up' the normal birth rate at the Trust, and the

threatened closure of the JBC seems irresponsible in the face of this – surely taking pressure off the over-subscribed W&CH would increase normal birth rates.

The Trust is currently reviewing how the Jubilee might continue, perhaps by asking women to pay for some aspects of their care – what Chief Executive Phil Morley has publicly called 'Birth Plus' experiences. These might be aromatherapy, water births and other facilities seen as expensive luxuries. The JBC supporters argue that these provisions are actually far less expensive than anaesthetist-administered pain relief such as epidurals or the oft-discussed 'cascade of intervention'.

Certainly from the women I have spoken to as part of this campaign there is a feeling that by even setting foot in a more medicalised maternity environment they are increasing their chance of intervention. Indeed many of the women I have spoken to say they would choose a home birth if the JBC was not available. Whilst this arguably is a victory for the natural birth lobby, and potentially cheaper for the Trust, it does call into question why these women have such a negative view of the main maternity unit in the area.

Fear and its impact on labour via the release of adrenaline was something discussed in our antenatal classes and stuck in my mind as I prepared for birth. I feel that although at times it was tough, being well supported by an experienced midwife and able to feel what was happening really helped me give birth naturally and reasonably quickly. While I would not judge someone for deciding to use medicinal pain relief in labour, I maintain that the process itself is not to be feared.

Confidence in care is vital, but the JBC closed at short notice more than 60 times in 2010 due to staff shortages across the Trust's maternity services and a policy of not using Bank staff. Staff from the JBC were drafted in to cover at the larger unit, and the JBC would close for those shifts. This happened the evening after I gave birth and although I was offered the chance to go to W&CH for the night, I opted to go home. I returned to the JBC for breastfeeding support and postnatal recovery. Whilst neither me nor my baby needed medical care, I did feel that the closures left us very unsettled and breastfeeding took longer to get established. That was why I contacted my old newspaper and began campaigning.

A Freedom of Information request found that 78 women due to give birth at the JBC had to be redirected to W&CH due to temporary closures between January and November 2010. No-one knows how many made the decision themselves. There was not much advance warning – the women would have found out the centre was closed when they telephoned in labour. I can only imagine how frustrated and potentially worried they must have been to find out their preferred birth place was not available.

One mother who was unable to use the JBC told me how she was so unhappy with the midwife at the W&CH that she tried to lock herself in the bathroom and focus on labouring alone, but was confronted by what she described as a 'bloodbath'. The room had not been cleaned since the previous labouring woman had used it. When she returned four hours later, it still hadn't been cleaned. This, coupled with her lack of confidence in a young and inexperienced midwife who didn't support her decision to move around or use a birthing pool, led to a tense and frightening labour, and she needed surgery afterwards. She believes none of this would have happened if she could have birthed at the JBC.

At the JBC the buck stops with the midwife, and the staff appear to relish the responsibility. Take away that autonomy and you lose years of experience, not just in birthing mechanics, but in the postnatal and emotional care which is so important.

More than 80% of women leave the JBC breastfeeding, and I do not doubt this is another area where the Trust's overall figures are propped up by the JBC. For breastfeeding rates to be healthy, you cannot beat getting it right at the beginning.

Whilst there is pressure for the JBC and other similar units to improve efficiency and birth rates to prove their worth in this time of cuts, the value of such a centre in the encouragement of normal birth must be addressed. The JBC's very presence in our community encourages women to explore the option of a normal birth.

Since January, Hull and East Yorkshire Hospitals Trust Chief Executive Phil Morley has met with mums twice, and discussed the issues surrounding the JBC and the Trust's maternity services as a whole. Whilst temporary closures are still ongoing at the JBC, the Trust has committed to continuing to provide midwife-led care and has expressed a wish to increase the number of 'normal' births. The Trust is currently considering the future focus of maternity services as the Trust will need to invest in extending capacity as the service is stretched to capacity even when both units are fully operational.

Mr Morley has also expressed a wish to increase the home birth rate, which is currently much lower than average in the Trust area, and to cross-train midwifery staff (including community midwives) to be able to cover both JBC and W&CH equally. This training has not yet started but a Midwifery-Led Care Forum has been founded to try and improve communication and practice.

When we next meet with Phil Morley as a supporters group we will be asking how we can secure the future of the JBC and seeking assurances that the temporary closures will be stopped. If women cannot be reassured that the JBC will be open when they need it, how can they choose to give birth there? We have dubbed the practice 'closure by stealth' as we believe that by allowing the JBC's reputation to slip away, eventually too few women will want to go there and it will be easy to close. Instead we are fighting to keep the JBC in the limelight and hopefully get more women through the door.

It may be an uphill struggle, and we may never change some people's minds about normal birth, but we believe it is crucial for the women of East Yorkshire that we try.

Sian Alexander

Find us on Facebook – Keep the jubilee birth centre open

Expectant Mothers Denied Choice

Claire Rajah campaigns for the Corbar Birth Centre in Derbyshire

In May 2011 Derbyshire Primary Care Trust (PCT) publicly announced that as part of its annual spending review, it is proposing to abolish North Derbyshire's midwife-led birthing unit Corbar Birth Centre in Buxton and Darley Dale Birth Centre in Matlock, South Derbyshire.

The PCT's case for proposing the closure of the region's birth centres is purely financial, based just on the actual cost per birth and not antenatal or postnatal care, or the complete maternity service required for mothers and babies in the region. Following the Board's announcement, the National Childbirth Trust (NCT) in the High Peak area of Derbyshire is leading the campaign to ensure Corbar Birth Centre stays open.

Corbar Birth Centre provides antenatal and postnatal care as well as birthing facilities for women across the rural villages and towns within the High Peak as well as the Derbyshire Dales and Staffordshire Moorlands. In addition to dedicated home-from-home birthing rooms, the centre also has a dedicated pool room. All low-risk women in labour from this catchment can give birth at Corbar. If Corbar was to close, the options left for low-risk women in labour who do not wish to birth at home are the already over-crowded facility at Stepping Hill Hospital (SHH) in Stockport or Macclesfield General Hospital (MGH). One of the chief concerns for those opposing the closure of Corbar are the transport links. To reach either hospital from the High Peak takes at least 25 minutes in the car, and during the winter the road can be impassable. The road from the High Peak to MGH, the A537, has been categorised as one of the most dangerous in England.

On 25 May 2011 Save Corbar Birth Centre campaign group held its first public and peaceful display at Scarsdale Hospital in Chesterfield to coincide with Derbyshire PCT's board meeting to discuss Corbar's consultation processes. The display came to the attention of the local media, and interviews took place with BBC Radio Derbyshire, Buxton Advertiser and High Peak FM. At the meeting the board decided to enter into a period of pre-engagement for Corbar with a full formal engagement period starting on 1 August 2011 and finishing on 21 October 2011.

On Saturday 18 June 2011 over 1700 people in the region signed a petition to maintain the service that allows expectant mothers the choice of having their baby at a midwife-led unit in Derbyshire.

Campaigners from Save Corbar Birth Centre (SCBC), which has the backing of the NCT, High Peak MP Andrew Bingham and more than six local councillors from the area, were in the towns and villages in the area to make people aware of the proposed cuts to maternity services in their county.

Fiona Lichfield, from SCBC, said the response from people asked to sign the petition was very positive: *'It's apparent from our petition signing on Saturday that people living in the High Peak want to save Corbar not just for its strategic location, more importantly, to keep the centre's midwives here. We heard countless stories of Corbar's midwives going above the call of duty to care for women and babies from the area. It was a very heart-warming experience.'*

She added: *'On behalf of SCBC, I'd like to thank everyone who signed up to our campaign to keep Corbar Birth Centre alive. Saturday's support shows that we have the backing of the High Peak community.'*

It's a long battle ahead of us and there is still lots to be done to ensure that Corbar stays open. We hope that members of AIMS will help us to raise awareness of our campaign and provide us with guidance and advice to make sure our birthing unit does not close.

Claire Rajah

A Facebook page, 'Save Corbar Birth Centre', has been established and is the main platform for communications, with a Twitter account @SaveCorbar for the group, to help followers keep abreast of the campaign and to increase its reach.

For more information, email savecorbarbirthcentre@yahoo.co.uk

Copies of the petition are available at shops and offices across the High Peak.

The Buxton Advertiser weekly paper is also running a campaign to keep Corbar open 'Hands off Corbar', see www.buxtonadvertiser.co.uk/news/how_to_support_our_hands_off_corbar_campaign_1_3444074

Campaigning against the closure of Corbar Birth Centre

Third Stage Reviewed

Nadine Edwards summarises the Cochrane Review of active v expectant management

In 2010, Cecily Begley, Gill Gyte, Deirdre Murphy, Declan Devane, Susan McDonald and William McGuire updated the Cochrane Review on *'Active versus expectant management for women in the third stage of labour'*. The full Review can be viewed at www.thecochranelibrary.com.

In the UK, most women routinely receive active management of the third stage of labour. This usually means that as the baby is being born, the midwife gives the woman an injection of the drug syntometrine (a combination of ergometrine and syntocinon), or syntocinon on its own. These drugs are called oxytocics and cause the woman's womb to contract. The midwife then immediately clamps and cuts the umbilical cord, and pulls the woman's end of the cord with one hand and applies counter-pressure against her womb (controlled cord traction) to get her placenta out quickly. Most researchers, doctors and midwives have recommended this for many years because overall, it was, and still is, believed to speed up the birth of the placenta and reduce heavy bleeding after birth.

The potential for heavy blood loss is a concern, even in a relatively healthy population. Thankfully, very few women in the UK die during childbearing, but very heavy bleeding after birth is still a cause of death.[1] Heavy blood loss can also affect a woman's health after birth when she has a new baby to care for, just when she needs to feel healthy and well. In low-income countries heavy bleeding after birth continues to be a major cause of death and ill-health among childbearing women for complex reasons that centre on poverty and the unequal distribution of wealth and resources.

Over the last years there has been a growing body of research which has given us a more detailed understanding about the birth of the placenta and how a baby makes the transition from life inside its mother's womb, to the outside world.

Research has looked at managing the birth of the placenta with drugs, cord clamping and cutting, and controlled cord traction, compared with not giving oxytocic drugs, leaving the cord unclamped and uncut, and not pulling on it (expectant management of the third stage of labour).

The lastest Cochrane Review on third stage management by Cecily Begley and her colleagues[2] sets out to examine the research on active compared with expectant management of the third stage of labour, and how this impacts on the woman and on the baby's transition to life in the outside world. The Review authors have also considered the uncertainties around this issue and what we do not know about the third stage of labour.

The Review is based on five randomised controlled trials carried out in the UK, Ireland and Abu Dhabi between 1988 and 1998. While randomised controlled trials are often thought to be the best way of finding out about the impacts of treatments, they can only tell us how most people in a population will respond to the treatment, they cannot tell us about individuals. There are those who are critical about using the results of randomised controlled trials on their own because they cannot take into account complexities that could change the meaning of the results, and can miss important factors. The research carried out by Helen Stapleton and her colleagues[3,4] about the impact of the MIDIRS Informed Choices leaflets on women's decision making is a good example. The randomised controlled trial showed that giving the leaflets to women made little difference to the choices they made about maternity care. If this trial had not had a qualitative arm to it (where researchers talked to midwives and women, and watched how the leaflets were given out and used), it might have been assumed that it is a waste of resources to give women information! However, from the qualitative research, it became clear that the leaflets were often not always being given out, or that they were being given in a way that made it difficult for women to use the information in them, or that the women were discouraged from acting on the information they received in the leaflets if the information contradicted obstetricians' usual practices.

There were criticisms of the five randomised controlled trials on active and expectant management of the third stage of labour used in the Cochrane Review. Cecily Begley and her colleagues acknowledged and examined the potential flaws in these trials and the uncertainty of their findings in their Review. They also drew on other interesting research and suggested that even with all the research we have, we cannot be sure about many aspects of active or expectant third stage management.

The authors of the Review defined active management of labour as:

- routinely giving a drug to make the woman's womb contract (a uterotonic)
- clamping the cord quickly (i.e. before it stops pulsating)
- pulling on the cord (controlled cord traction) to deliver the woman's placenta.

They defined expectant management of the third stage of labour as:

- waiting for signs that the placenta has separated from the wall of the woman's womb
- letting the placenta be born without drugs or pulling on the cord – ie, 'spontaneously'.

The main findings of their Review are as follows:

When active management of the third stage of labour is used routinely for all women – whether or not they are likely to bleed heavily after birth:

- it reduced the average risk of heavy bleeding (over 1000mls) immediately after birth
- fewer women had a blood count of less than 9g/dl
- there were not more babies with lowered APGAR scores (below 7) five minutes after birth
- babies were lighter because they received less of their blood that is in the placenta during pregnancy and birth, due to the early cord clamping
- more women had increased blood pressure
- more women had after-pains
- more women used painkilling drugs (analgesia)
- after going home from hospital, more women returned with heavy bleeding (secondary bleeding).

For women who were at low risk of bleeding, the Review suggests that the results are the same, except that there is no difference in severe bleeding. This was of particular concern to the authors because it means that women at low risk of bleeding suffer the side effects of active management of the third stage of labour with no reduction in bleeding over 1000ml.

The Review concludes that while routinely applying active management for the birth of the placenta *'reduced the risk of haemorrhage greater than 1000ml in an unselected population'*, there are harmful effects. The authors state that women should be told about the benefits and harms so that they can make their own decisions. They also suggest that we need to know more about each component of active management of the third stage of labour because:

- early cord clamping reduces the amount of blood a baby receives at birth, which can lead to anaemia, and growth and developmental problems
- pulling on the cord might cause secondary bleeding
- some uterotonic drugs might have more harmful side effects than others.

The Review is very detailed, covers a great deal of ground and is definitely worth reading. The following issues are just a few of those that might be of particular interest. For example, the authors of the Review and other researchers have pointed out that all the randomised controlled studies considered in this Review and others took place in obstetric units, where midwives and doctors were much more used to using active rather than expectant management of the third stage of labour. This is important because, as the Review notes, in one of the trials[5] the rate of heavy bleeding in the women who had expectant management of the third stage of labour fell during the trial. In the pilot study it was 21%, during the first four months of the trial it was 12% and in the last six months it was 7% as the midwives became more skilled. This and other commentaries suggest that the skill of the practitioner is extremely important and that therefore all midwives need to be knowledgeable and skilled in helping women birth their placentas safely, physiologically. However, in a recent survey Diane Farrar and her colleagues[6] found that only 2% of UK obstetricians and 9% of UK midwives always or usually facilitated physiological placental birth.

The World Health Organisation and others have suggested that for a healthy woman, a blood loss of 1000mls might not be excessive

Another interesting point is that heavy bleeding, or too much bleeding, is defined in nearly all third stage research as being a blood loss of 500ml or more. The World Health Organisation and others have suggested that for a healthy woman, a blood loss of 1000ml might not be excessive. If 1000ml and over was considered to be a heavy blood loss (postpartum haemorrhage) rather than over 500ml, this would change the findings of the trials. As we suggest in our new AIMS Third Stage booklet (see page 24).

'the standard definition of a postpartum haemorrhage was 500ml, which is the same volume of blood that is taken during blood donation, after which people are offered a cup of tea and a biscuit rather than being considered to have had a haemorrhage!'[7]

One could argue (as we do in the new AIMS Third Stage booklet) that having an arbitrary figure for blood loss is unhelpful on its own, and that research needs to examine how well or unwell a woman is and feels. Blood loss might be unique to each woman and some women might lose a small amount of blood and feel unwell, while others might lose much more and feel well. The other associated and well-known problem, of course, is that blood loss after birth is very difficult to measure accurately.

The Review includes some interesting research from New Zealand and the Netherlands, where midwives are used to women giving birth to their placentas physiologically and where women do not bleed more than women who have actively managed third stages. In fact, in New Zealand, the records of nearly 34,000 women who had normal births were studied: nearly half had physiological third stages and had slightly less bleeding than the other women, who had actively managed third stages.

Some researchers[8,9] have pointed out that expectant management of the third stage of labour described in the Review and other third stage research is not the same as a holistic midwifery approach which works with the physiology of the birth process including the birth of the

placenta. They suggest that women need a calm, private, quiet, warm, supportive environment where they know and can fully trust all those around them to support their decisions. This helps them feel safe, and they can then focus on the process of labour and birth. Their bodies will produce all the hormones they need to help the birth unfold straightforwardly, and when the baby is born, if the woman feels safe, secure and focused, her body will produce a surge of the hormone oxytocin, which helps her to birth her placenta without the use of drugs or interventions. For example, Kathleen Fahy and her colleagues[10] compared active management of the third stage of labour in an obstetric unit with holistic care from skilled midwives in a birth centre. They found that the women in the birth centre who had holistic care had less blood loss than women who gave birth in the obstetric unit and had active management of the third stage of labour (see Edwards and Wickham[7] and MIDIRS[11] for more detailed information on this research).

The Review states that when the baby's cord is clamped and cut immediately after birth, the baby is lighter because it does not receive all the blood that is circulating in the placenta. It also acknowledges that this might be the cause of anaemia and affect growth and development in childhood and later life. Some of the researchers who have looked into this most closely are Peter Dunn in the UK, and Judith Mercer and her colleagues in North America.[12] We now understand from this work that the blood in the placenta is the baby's blood, that it takes at least a few minutes for it to flow from the placenta into the baby after birth and that the baby needs this blood to help it make the transition to life outside its mother's womb. While the cord is pulsating, as it does for several minutes after birth, the baby is also getting oxygen. Judith Mercer and her colleagues suggest that this is extremely important for compromised babies. A helpful chapter to read is by Judith Mercer and Debra Erikson-Owens[12] about the baby's transition in its first hour of life.

Finally the authors of the Review suggest various avenues for further essential research and suggest that all further research should consider 'maternal, fetal and infant outcomes.'

Nadine Edwards

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STOP PRESS

Closure in Hull

Hull and East Yorkshire Hospitals NHS Trust has announced the Jubilee Birth Centre is to close as of 29 July. An inspection by the Care Quality Commission found the Trust had breached regulations by not being able to guarantee the birth centre would be open when needed, and also highlighted a shortage of staff to cover both the birth centre and the main maternity unit. The Trust said it was unable to meet the CQC's recommendations to increase staffing and stop the disruption of temporary closures, and as a result the board voted for closure.

Those campaigning to protect the centre were devastated by the news and whilst the Trust had pledged to maintain the option of midwifery-led care at its main maternity unit, as well as home births, campaigners feel this may be the final nail in the coffin for natural birth services in East Yorkshire.

Campaigner Sian Alexander said: 'In other areas where birth centres have closed, the home birth service is the next casualty. Maternity services are being squeezed to unsafe levels, and the lives of future generations are being put at risk, yet this issue is still not taken seriously.

'The decision to close the JBC is a body blow for the safety and well-being of mothers and babies in this area. Our only hope is that this staffing crisis can be resolved and the birth centre reopened as quickly as possible.'

Quotation Corner

'I don't want to book a home birth because I don't want to be disappointed when I have to transfer in like so many other people I know.'

First-time mum

What My Scar Means to Me ...

Emmy Lomas recounts how her two traumatic caesareans still haunt her

When I was expecting my first child in May 2000, my mother assured me that despite the horror stories, I would be 'just like her'. She found birthing her five children 'just like shelling peas'.

Imagine my horror when I finally went into labour, two weeks 'overdue', and was hurried into hospital by my doctor father, immediately strapped to a monitor and, at barely 3cm dilated, had my waters broken by a well-meaning midwife who thought it would speed things along.

The contractions were horrific, I wasn't allowed to move off the bed, group after group of medical personnel suddenly appeared in my room while I suffered with the contractions, screaming my head off in pain.

Intervention after intervention later, including vaginal exams I wasn't even asked to consent to, drips stuck in me (when did that happen?) pethidine, dehydration (why won't anyone give me something to drink? Please I'm so thirsty ...) and six attempts to get an epidural in, a doctor at the end of my bed is talking about ripping my child from my body with forceps or a ventouse.

I couldn't speak for pain. My mother, who was supposed to be my support, spent most of my labour watching me, with her bag on her knee, from across the other side of the room. The only time she offered comfort was if there was someone else in the room with us.

My mother told them to give me a section.

The doctor, in her defence, did try to discuss it with me, but my mother interjected and the main discussion was between them.

Suddenly, they are telling me my child is in distress, I need an emergency section.

They all leave, including my mother.

Blessed silence.

I'm on my own, the pain dies down as I'm finally allowed off of the bed to use a bed-pan.

Everything is quiet for a while and then all these people pile in, dragging me back onto the bed. The pain becomes bad again and I can feel the panic rising as they wheel me down the corridors into this freezing cold room. There's someone at the end of the bed by my head, pulling it back to start shoving something down my throat. I'm screaming in pain as the contractions are on top of each other, over and over and over again. They don't care.

As the tube goes down my throat and my panic attack reaches its peak, I'm put under.

I wake up and I don't even know where I am. I'm so thirsty.

The nurse, or midwife, I don't know who she is, comes round the side of the bed and asks how I am. I can't talk, I'm so thirsty and try to indicate I need water. She understands (hooray!) and tells me she will get me some straight-away. Suddenly the water is there and it is great!

She tells me my baby is there in the cot next to me, and it's a girl ... What, she's born? I'm so confused ... what happened?

The nurse/midwife asks me how I want her to be fed. My dad told me I had to breastfeed, it was for the best ... so breast it was. She hands me this child ... is she mine? How do they know she is mine? This beautiful little girl attaches herself to my breast, but I feel nothing but confusion and detachment.

Suddenly my mother is there and she is 'proud of me'. It doesn't matter that I FAILED, and that she had been so scared for me, for my life and how she told them that if it came down to between me and 'the child' then they should save me first. Don't you worry that you FAILED to do things the normal way, at least you are safe.

It's not your fault you FAILED to progress, or FAILED to birth your child. Be grateful, you are alive, and that your child is too.

Failure.

That word hurts so much more than the wound I am sporting, the scar that it only takes two weeks to turn into.

Failure.

It hangs around my neck, heavy in its implication.

It sits above my head like a huge neon sign that my parents regularly bring back to life by discussing my FAILURE.

I'm diagnosed with PND and put on meds, just as my parents want. It dulls down the pain, but the FAILURE is always there and the weight of it drags down everything I try to do. FAILURE suddenly becomes expected of me ...

Five years later and I meet my husband. We get pregnant very quickly and I tell him I want to have our child myself, no section. I want to know that I can birth my child. My parents tell me straight that I won't be able to do it, and I tell them I will discuss it with the midwife and consultant and see what they think before committing to anything. My parents go out of their way tell me I will fail, the midwife tells me she can't agree to anything, but that the consultant 'might' give me a trial by scar, especially as it has been so long since my last labour.

I try to inform myself using the internet and whatever is in the library, but that is cut short by the computer dying and developing SPD [symphysis pubis dysfunction, also known as pelvic girdle pain.] I try for so long to ignore the pain, to hold onto the dream of a VBAC, but the registrars and consultant midwives laugh at me, throw pieces of information and statistics at me that I simply don't and couldn't understand. Suddenly they are talking about my baby being too big (at least 10–11lb), how will I deliver with SPD, the restrictions on movement and why I will have to be put on continuous fetal monitoring and be there the second I go into labour, they don't now how embedded the placenta will be, or how much I will bleed. Is there nothing positive about having a VBAC?

My poor husband tries to support me but in the end, I give in. If nobody at the hospital thinks I can do it, and my midwife is having a panic attack every time I mention it, and neither of my

parents want to support me, then what chance do I have?

The night before my section, I've packed my bags and got everything in order. I've already had a show, so I know my plug is coming away little by little and in my desperation, I cry and beg my body to go into labour so that I don't have to go through this operation. My body doesn't understand and remains silent.

The next morning I'm wheeled down to theatre.

It isn't until that moment of signing the consent forms that I see all of the problems, all of the risks I'm taking on by having another section. Why didn't anyone discuss this with me?

But I'm here now and I'm resigned to my fate.

From the get-go it is going badly. The socks to stop me getting a DVT don't fit properly. They can't get the spinal in, they have to try four times. I tell them that they can try one more time and then it's tough luck, they aren't trying again. The midwife tells me not to be silly, and of course I will try again and again, because I will want my husband in the theatre with me won't I? There is loud discussion of longer, bigger needles that frighten me, but it is done and I am laid down. I want my husband there, I need his reassurance, for him to hold my hand or stroke my face. I don't want to be alone in this cold room where I don't know anyone and the lights are so bright and no-one is talking to me. He's finally here, looking so funny in his scrubs. As he sits down, it starts to become difficult to breathe. I'm gasping, and husband becomes concerned and looks for someone to ask. They are all so busy getting ready to open me, that no-one has noticed. It feels like someone is kneeling on my chest.

Finally, someone is there and asks if I'm struggling. I nod and gasp that I can't breathe, it's making me feel sick. He shoves an oxygen mask on my face and I'm given a few minutes for things to calm down.

There are voices coming over the screens they have put up, talk of spraying me ... 'Can you feel that, Mrs Lomas?' No. 'OK.' The anaesthetist makes small talk with us until I am told I will feel some tugging. Tugging? Feels like they are ripping my entire insides out of my body!

Suddenly, the midwife shows me this tiny child, screwed up and starting to cry. They take her away to be cleaned and weighed and she is a whopping (!) 7lb 5oz. I'm suddenly feeling a bit confused ... where is this huge child they said I was going to have? Why did they tell me she was going to be big and that I had to have this operation if really she was that small? They give her to my husband. I watch with longing ... I want to hold my child, but I can't even reach her to touch her face. Eventually I resign myself to the fact that I won't get to hold her for some time.

We get into recovery and the nurse talks to me about these things they put on my legs in place of the stockings and about the drain they installed into my abdomen. Assistants come along to feed my child when I want to do it, and I have to scream hysterically to get them to stop laughing at me and to give me my baby. I complain bitterly to the head midwife on the ward and she assures me it will be taken care of. They remove my drain the next day; even with gas and air it makes me scream with pain. The midwife looks sympathetic as she continues to tug at the damned thing that won't come out despite her best efforts. It takes 20 minutes, and no amount of gas and air stops the pain. Afterwards she sends me for a shower, and I stand there in the hot water weeping from the pain in my abdomen and the heaviness that comes from having had surgery, the swirl of too much blood going down the drain.

I go home and very quickly, it is clear my wound is infected. The midwife can't get the stitches out and it's making me sick from pain. I'm sent back up to the hospital for gas and air and to have a surgeon remove them.

I hate the place so much ... my anger at my section, my inability to bond with my tiny daughter who only ever wants her father, the infection that is making me sicker and sicker, nightmares from the drain being pulled out of me and SPD that doesn't seem to want to resolve itself. Eventually, they get the infection under control, after much complaining from my GP that he can smell me as I enter the room because the infection was that bad. My wound breaks down and I have gaping holes where stitches poke through. If I pull on them, I can feel the tugging on the inside. It is strange and unfamiliar, and not one of the 'holes' I have got in my body seems to want to heal.

To make matters worse, I am pregnant again. It's only four months since my section and I'm struggling. My husband has developed mild agoraphobia and severe social anxiety disorder, there is no support. My parents demand a termination, my nightmares increase and all I know is that I CANNOT have another section. My scar suddenly means more than failure. It means pain, and waking in the nights sweating from the bad dreams, feeling abnormal and unable to be a mother. I hate myself for being so weak and taking the 'easy' option, for the long after-effects my decision has left me with.

I can barely look at my baby without feeling that anger, for feeling distanced from her, that we don't have a connection. I cannot look at my child or my wound, or even sometimes myself, without feeling utter revulsion. The breakdowns in my scar finally heal when I am seven months pregnant. I give birth to my baby. The scar is pitted and red, tender to touch with parts of my stomach still numb. It is only with time, and my successful VBA2C [vaginal birth after two sections] that I am able to touch it, to look at it, in all its glory.

I hate my scar. I hate what it represents. How it signifies FAILURE and a profession so willing to cut with no thought of the emotional and mental effects. I hate how 'normal' having a section has become and I panic with each subsequent pregnancy that my body will 'fail', even though it never actually let me down in the first place. Given time, a bit of persuasion and some patience or even encouragement on my care givers' part, I honestly believe I would not have had any cut in my body at all.

I hate how I feel guilt for both my section children, that I did them some serious wrongdoing and how my bond with my VBAC children is different, stronger than the bond I have with my section children.

As a rule, I no longer look at my scar. It regularly becomes sore and I stroke it in sympathy for the hurt it feels and causes, as though it is a separate entity entirely. Perhaps because, to me it is separate. It shouldn't be there.

It doesn't belong.

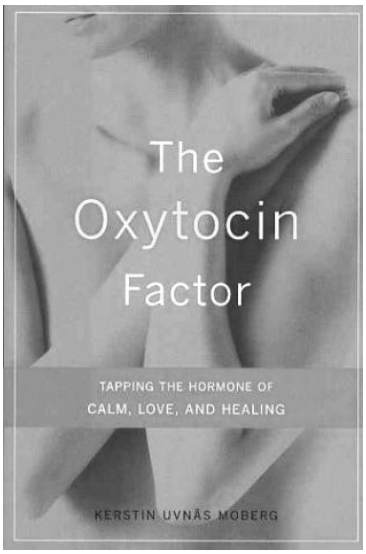
Emmy Lomas

For support with difficult birth experiences please contact the AIMS helpline (helpline@aims.org.uk or 0300 365 0663) or see www.aims.org.uk/support.htm for other resources and organisations.

Reviews

The Oxytocin Factor – Tapping the Hormone of Calm, Love and Healing

By Kerstin Uvnäs Moberg (translated from Swedish by Roberta W. Francis)
Da Capo Press, 2003
ISBN - 0-7382-0748-9



As a somewhat relaxation-obsessed antenatal teacher and hypnotherapist, I was keen to read and review this book. Dr Moberg is a professor of physiology, who is dedicated to raising the profile of oxytocin, not only with regards to childbirth, but also relating to health and well-being generally.

Moberg points out that there is now ample research about the effects of stress on the body, our 'fight or flight' responses, but very little looking at relaxation and calm. She hypothesises that the focus on physiological and psychological stress may be due to our 'goal-directed culture' and the dramatic effects that stress produces. As a contrast, Moberg describes the effects of the alternative 'calm and connection system' as occurring slowly, gradually and subtly.

The word 'oxytocin' comes from the Greek words meaning 'quick' and 'childbirth labour' and was first identified as being produced by the pituitary gland in 1906. Moberg expands on this, explaining that oxytocin is not only a hormone, but also a neurotransmitter, influencing operations throughout male and female bodies. She gives the examples of lowering blood pressure, heart rate and stress hormones, increasing skin circulation, and creating a more effective digestive system.

Oxytocin and the calm and connection system are promoted by touch, warmth, sexual activity, relaxation and meditation, by security and support, and by breastfeeding our babies. Moberg believes that we all need this system to grow, heal, bond with others and experience happiness. The implications for childbirth and breastfeeding are immense but not unfamiliar to us: women will produce more oxytocin throughout labour and the postnatal period if they feel safe, nurtured and relaxed.

There are sections in the book that deal with how the brain, the nervous system and hormone interactions work, and these are well explained, giving illustrations and everyday examples that are easy to relate to if the reader is not medically qualified.

As the 2nd edition is due to be published on 1 July 2011 (www.pinterandmartin.com £9.99), with a foreword by Michel Odent, I shall be keen to see if there has been any more empirical evidence concerning the calm and connection system since the 2003 edition. Even without further evidence, there is a great deal to learn by reading this book, not only for birthing and breastfeeding women, but also for society as a whole.

Jules King

Birthing Your Placenta: The Third Stage

by Nadine Edwards and Sara Wickham
AIMS, 2011

Written by Nadine Pilley Edwards, Vice Chair of AIMS, and Sara Wickham, an experienced midwife and author, this is a very timely and necessary book. The book begins with a powerful quote from Justus Hofmeyr et al (2008):

'Care for pregnant women differs fundamentally from most other medical endeavours. "Routine" care during pregnancy and birth interferes in the lives of healthy people, and in a process which has the potential to be an important life experience. It is difficult to measure the extent to which our efforts may, for example, disturb the development of a confident, nurturing relationship between mother and baby. The harmful effects we measure in randomised trials are limited to those we have predicted may occur. Sometimes after many years unexpected harmful effects surface only because they are relatively common, or striking in their presentation. Many unanticipated harmful effects probably never come to light. For these reasons, interventions in pregnancy and childbirth need to be subjected to special scrutiny. Our guiding principle is to advise no interference in the process of pregnancy and childbirth unless there is compelling evidence that the intervention has worthwhile benefits for the mother and/or her baby – only then is there a good chance that benefits will outweigh both known adverse effects and those which may not have been thought of.'

In the last couple of years research has increasingly questioned the supposed benefits of many routine interventions commonly carried out by midwives and doctors during birth. Written in clear and jargon-free language, this book provides a comprehensive overview of relevant evidence relating to the birth of the placenta (or the 'third stage of labour' as it is often termed), with the aim of assisting women to make informed decisions about this central part of their birth experience. As the

authors note: *'[this] can be a particularly delicate and awesome time, as the mother sees her baby for the first time and, if all is well, is able slowly to come to terms with becoming a mother and get to know her baby'.*

The book explains many different issues women may have questions about, for example, what it means when a 20-week ultrasound scan report states that the placenta is low, what are the side effects of oxytocic drugs used to help contract the uterus, lotus birth, birth of the placenta in water, and timing of clamping the cord – to name only a few of the aspects covered. The chapters of the book cover the historical background, the development and birth of the baby and placenta, active management of the third stage, research evidence, and wider issues, with a list of useful resources and references.

Reading this book I was impressed by the care the authors take throughout to use language which conveys respect for the power of women's bodies and the amazing complexity of the birth process. There is an interesting discussion of the term 'management of the third stage'. The authors prefer to use the term 'placental birth' pointing out that 'management' is something done to women, and that indeed a physiological process does not need to be 'managed'. They also note that *'the artificial division of labour into stages that has emerged as part of the medical view of childbirth is not necessarily representative of how women themselves experience this journey'* (p17). Language is crucially important and indeed the terms 'physiological' or 'expectant' management sound quite offputting, while 'active management' could be confused with 'active birth'. When I discussed this recently, my midwifery students suggested that midwives should start to offer women the choice between a 'natural birth' of the placenta or a 'medically managed' one, as these are clearer descriptions of the two approaches.

The chapter on active management summarises the evidence and explains the procedures and drugs used, including the disadvantages and side effects of the drugs on the mother (hypertension and nausea being the most common). There is a discussion of the latest evidence regarding the detrimental effects on the baby of early cord clamping, including lower iron stores and anaemia, increased intraventricular haemorrhage (bleeding into the brain), fewer stem cells going to the baby and less 'protected' time for adaptation to extrauterine life. In the chapter on the research evidence, the authors carefully examine the research studies which led to the widespread implementation of routine 'active management' and analyse the more recent evidence which shows that a physiological third stage has many benefits for mother and baby. There is discussion of the most recent Cochrane systematic review which suggests that women should be informed about the benefits and harms of active management and that their decisions should be supported (Begley et al 2010). There is an interesting section on 'Women, birth and time' which will strike a chord for many; it quotes from an ethnography of midwifery practice: *'Syntometrine was said to be used in the third stage of labour 'to shorten the third stage' as if there was some urgency to end this undesirable condition.'* (Hunt and Symonds 1995). One of the strengths of this book is the insight the authors bring to the context in which care is given.

There is also a section on how a woman feels during the birth of her placenta, a subject sadly ignored in most of the research studies, with some great quotes which you will need to read for yourself when you buy the book (very reasonably priced at £8!) I liked the drawings of separation of the placenta which depict the mother in an upright position holding her baby, beautifully showing the symbiotic nature of the mother-baby relationship (p16).

Overall this is a powerful, readable short book (116 pages), packed with relevant research evidence. It describes the contradictions of a system where midwives are committed by their statutory rules to providing woman-centred, individualised care, yet at the same time many are working in hospitals where guidelines (based on NICE 2007) advocate routine active management of the third stage for all women (including those who have had a normal labour), unless a woman specifically requests otherwise. This book makes it clear to me that it is time such guidelines were changed and provides copious evidence (including 22 pages of references!) to inform anyone setting about this task. It will be of use to midwives, doctors and students, giving detailed evidence and reminding them of the importance of respecting this special time, interfering only if medically necessary. It will be invaluable for women wanting information to help them take control of their own birth experiences.

Sarah Davies

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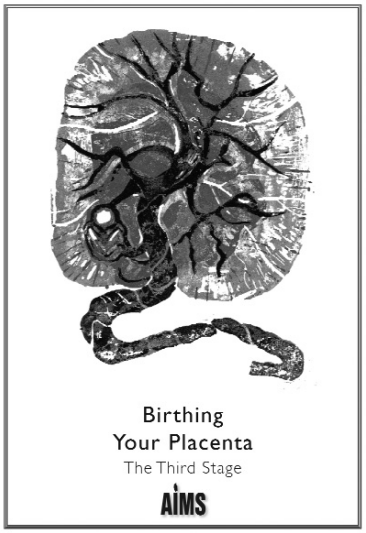

Letters

Resisting Pressure

My final showdown with the midwife started on 21 December. Having not spoken to or seen her since 17 November I got an answer phone message from her stating that she hasn't seen me for a while and she wants to catch up ... she leaves no number and, even though she had four other contact numbers, she called none of them.

The next day I get a panicky answer phone message at 5pm saying she is very worried as she has not heard from me and can't get hold of me (remember this is only the second time she has called, I have no number for her and she has four other numbers that she has not phoned), she actually leaves me a mobile number. The next day I go to call her BUT I get an answer phone message from the Community Midwife Manager saying the midwife is really concerned that she can't get hold of me. At this point I am furious, so I call the manager and leave a message explaining the lack of effort on behalf of the midwife. She can't be that worried or she would have called the other numbers or at least left me a contact number. If she is that concerned, why doesn't she come to my house?

Then I call the midwife ... I tell her that she has made the last six months of my pregnancy dreadful with her panicking, that she needs to rethink her vocation in life, and that if it had been any other woman they would be a nervous wreck by now and convinced that they were going to die along with their baby. She couldn't say a word. BUT weirdly she announces that she has JUST found out the ambulance service has a 4x4 vehicle for rural areas and the air ambulance has been notified of my impending birth ... funny she didn't know about this before! I kind of get the impression she forgot about me and panicked as she hadn't really been doing her job. I feel she tried to manipulate the whole thing to get her own way!

Anyhow, I ended up speaking to the Community Midwife Manager and because it had been over a month since the midwife had seen me and my due date was a week away they just wanted to do a check-up. I arranged to go into the hospital on Christmas Eve as I was working most days and couldn't get there sooner.

The midwife finally left an answer phone message on my partner's phone threatening to call the police!

At the hospital all the tests were good and Oliver was happy, then I tell them that I have been leaking fluid for four days or so (it had actually been two weeks but as his movements hadn't changed and everything felt right I didn't bother to get it checked). They decide they want to do an internal and a longer monitor of the baby ... fair enough.

I was 1cm dilated and Oliver still happy. That's when the hospital started talking of booking me in for an induction ... I stood my ground and said NO. Then the nurse wanted me to see the paediatrician and could I wait? I said no. She said that they are worried about infection now my fluids have been leaking. I say that I hadn't got an infection in four days (actually two weeks), what's going to happen in the next 48 hours? I ended up putting on my coat and standing over her to hurry up my notes as she made a meal of filling them in and getting distracted. I asked how much of this 'precaution' is actually to cover the hospital's back rather than for mine or the baby's health; she declined to answer. She made me sign a discharge form (I wasn't aware that I had been admitted).

Back at home in the bath I started getting contractions. They were coming really strong every few minutes, which doesn't feel like first stage labour to me. Then at 9.20pm my waters broke properly.

I told my partner and he timed the contractions (lasting 50 secs and two mins apart) – looks like we are in stage two labour already (we are still not sure what happened to stage one) – so he called the hospital to get the midwife out when I started to bleed. He checked with the hospital and THEY panicked and said we needed an ambulance. Luke told them it would be quicker for us to get to the hospital, as we are only 13 mins away.

So off we went to the hospital ... when we got there the on-duty midwife (who was really amazing, calm and made it clear that what I want will happen) said everything was normal! 5cm dilated, she said if I want to go home that's absolutely fine but birth is close. While I was contemplating what to do, the contractions got overwhelming and closer and I kept getting the urge to push, BUT at only 5 cm dilated I knew that can be dangerous. I told the midwife, who checked me again and says she needs to get me into a delivery suite NOW!

So 3 hours and 48 minutes from my waters breaking Oliver Khan was born!

We managed to get a lovely midwife (based at another surgery) to do the follow-up visits ... she has been great and weirdly she was down to attend my home birth.

I am gutted I didn't have a home birth but I realise that I was up against it from the beginning. I don't think that my midwife is cut out to do her job and using fear as a control method is, quite frankly, sick ... especially when dealing with first-time mums who need trust and guidance from their midwives. I know midwives are up against it as far as funding and staffing are concerned BUT this is where pressure on the government must take precedence.

Childbirth is definitely not something that should be governed by the NHS. Modern science and medicine is there to complement nature, not dictate to it. And unfortunately all the NHS cares about is targets and middle management.

Lucie Eadon

And Again

I can honestly say that if it wasn't for your website and the advice and information you gave me on the telephone I know I wouldn't have had the strength to stop the hospital scaring and pressuring me into getting induced even though it was not what I wanted.

With your help I was able to hang on in there a bit longer and achieved the natural birth I wanted.

Debbie

JOURNALS & BOOKS

AIMS Journal: A quarterly publication spearheading discussions on change and development in the maternity services, this is 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, including 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 them. Invaluable for expectant mothers and professionals alike. See AIMS website www.aims.org.uk

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

Choosing a Waterbirth by Beverley Beech: How to arrange a water birth, pool rental, hospitals with pools; help to overcome any obstacles encountered £5.00

The Father's Home Birth Handbook by Leah Hazard: A fantastic source of evidence-based information, risks and responsibilities, and the challenges and complications 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: AIMS has replaced Choosing a Home Birth with this 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

Safety in Childbirth by Marjorie Tew: An updated and extended edition of Marjorie's 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

MISCELLANEOUS

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

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- What's Right for Me?
- Birthing Your Baby: Second Stage
- Breech Birth: What Are My Options?
- Birth after Caesarean
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Speakers including Sheila Kitzinger and Cathy Warwick.

www.armconference.co.uk

Sheffield Home Birth Conference 5th Annual Conference

Enhancing Endorphins

10 March 2012

Speakers to include Mavis Kirkham, Denise Tiran and Maggie Howells.

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www.sheffieldhombirth.org.uk

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